The Integrated Risk and Assurance Report

Author: Head of Risk & Assurance Sponsor: Interim Director of Corporate & Legal Affairs

Trust Board paper J

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	Monthly	Review and update operational risks on Datix risk register
Executive Board	EFPB Jan 2022	To receive 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 for the UHL Trust Board to receive assurance on the current position with progress of the risk control and assurance environment, including risks recorded within the Board Assurance Framework (BAF) and the organisational risk register.

Questions:

1. What are the highest rated principal risks on the BAF?
2. What are the key changes on the BAF during the current reporting period?
3. What are the key themes on the organisational risk register during the current reporting period?
4. What's going well with the risk register, what are the challenges and how are they being addressed?

Conclusion:

1. The highest rated principal risks on the current BAF, all with a current score of 20 include:

PR Ref.	Principal Risk Titles	Executive Lead Owner	Current Rating: (L x I)	Target Rating (L x I)
1	Adverse impact on quality of care	MD/CN	4 x 5 = 20	2 x 5 = 10
2	Failure to meet constitutional performance targets	ACOO	5 x 4 = 20	3 x 4 = 12
3	Inability to ensure adequate staffing capacity, capability and diversity	CPO	5 x 4 = 20	3 x 4 = 12
4	Failure to achieve and maintain financial sustainability	CFO	4 x 5 = 20	4 x 5 = 20
6	Failure maintain / improve existing critical infrastructure	DEF	4 x 5 = 20	4 x 5 = 20
8	Inability to achieve recovery and restoration (COVID-19)	ACOO	5 x 4 = 20	3 x 4 = 12

2. There have been no significant changes to current risk ratings on the BAF during the reporting period, ending 31st December 2021. Gaps that feature across a number of the principal risks on the BAF concern system wide planning and resources. Whilst there have been no recommendations made for change in any of the principal risk scores, the risk score related to the finance principal risk will be reviewed further by the CFO and Executive team in view of the many actions now implemented.
   The new highlight report (enclosed as part of a trial for PRs 2 and 3) was discussed at the AC meeting in Jan 2022 and will be further developed and rolled-out for all principal risks on the BAF, along with a wider review of the BAF governance to ensure pertinent information is reported and escalated as required.
3. There are 332 risks open on the organisational risk register. The common risk causation themes captured on the register are workforce capacity and capability; protocol compliance; and demand for services exceeding capacity. The significant impact theme is around quality (safety, experience and outcomes).
4. All owners of principal risks on the BAF and operational risks on the Datix register have been reminded about their responsibility to review and, where necessary, update their risks during the reporting period. Performance is reported in section 3.5 and is showing good compliance with risk reviews. Performance is monitored at CMG Boards, CMG Performance Review Meetings, at the Audit Committee, and at Executive Team.

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.

Note: Risk Register & BAF Rating System: Based on risk event occurring (L x I):

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

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 cycle

6. Executive Summaries should not exceed **5 sides** My paper does comply

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST

REPORT TO: **UHL TRUST BOARD**

DATE: **3RD FEBRUARY 2022**

REPORT BY: **GILBERT GEORGE – INTERIM 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 a governance tool to enable the Board to assure itself that the principal risks to the achievement of its organisational objectives are being appropriately managed. The BAF is informed by strategic themes from the organisational risk register, in addition to external threats to the delivery of the Trust's priorities.

2.2 The BAF has been developed as part of a Trust Board Development Session and is based on the UHL Quality Strategy, including revised annual priorities, and an updated version is attached at appendix one. Executive leads have updated the risks and they have been reported to Executive Board as part of the established BAF governance procedure. There have been no recommendations made for change in any of the principal risk scores, however the risk score related to the finance risk will be reviewed further by the CFO and Executive team in view of the many actions now implemented.

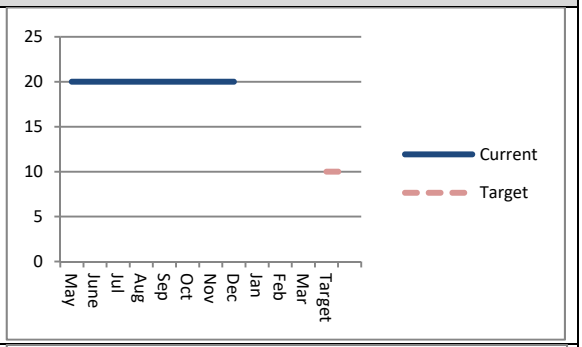
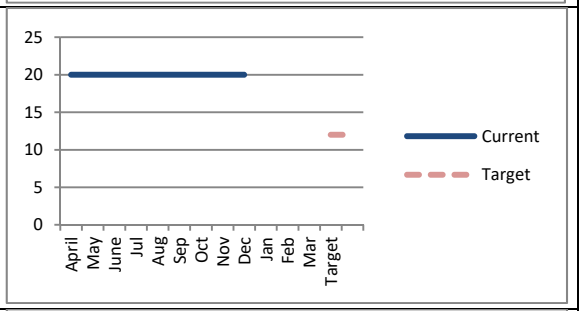
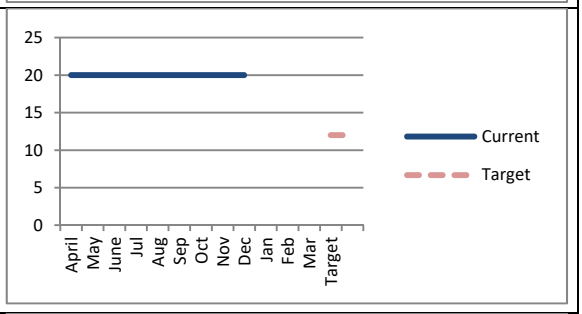
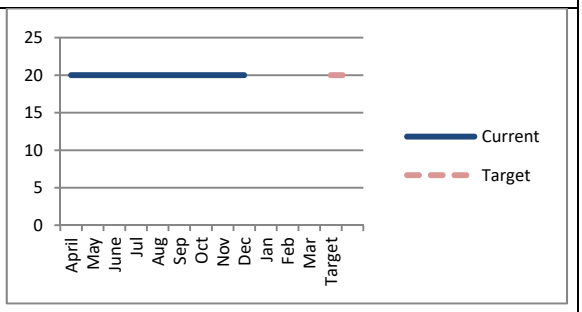
2.3 The framework summarises the controls in place to mitigate each risk, and highlights where there are gaps in these controls. It also provides a summary of positive assurances received by the Board and its sub-committees in relation to these controls, highlighting where there are gaps in assurance.

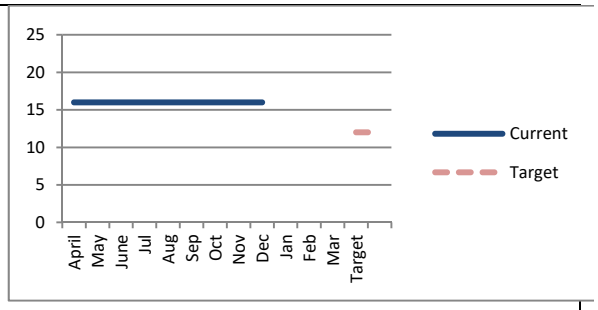
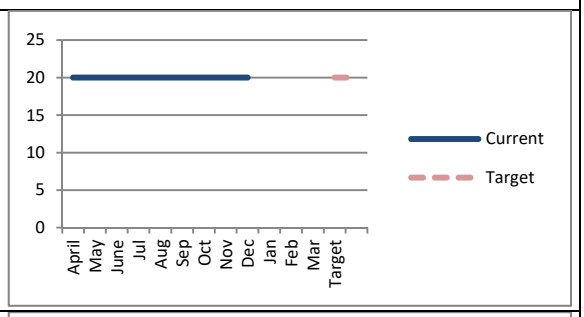
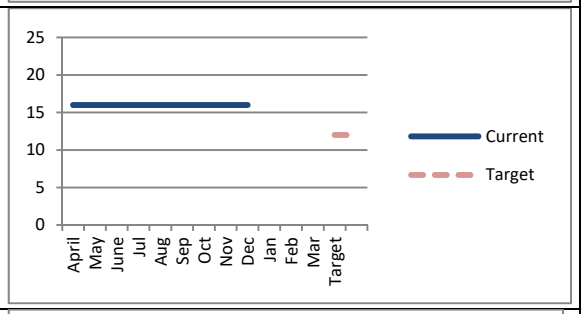
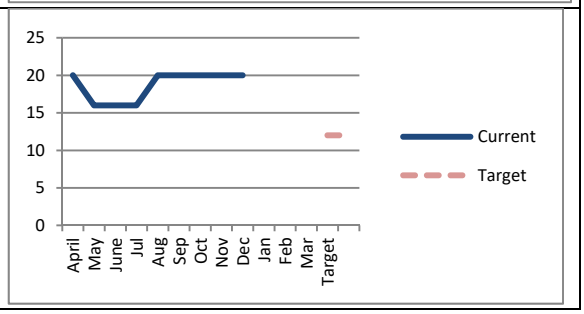
2.4 A revised BAF was discussed at the Trust Board Workshop in September and, although there was agreement in principle to the proposal to update the BAF to more closely link in to Programmes of Work for the supporting priorities in the current Quality Strategy, following further discussion between Executive Directors at the Executive Planning Meeting in October it was agreed that the development of the new BAF will be paused pending the development of a new Trust Business Strategy in 2022. In the meantime, the Executive Directors, in conjunction with the Chief Executive and Chairman, agreed to maintain the existing BAF and use the established governance process to identify any matters of strategic importance that require escalation to the Trust Board.

2.5 There was a discussion at the AC meeting in December to trial a new BAF highlight report to ensure pertinent information about a principal risk on the BAF can be escalated to the Board or sub-committee for discussion and assurance.

The trial included principal risk 1, adverse impact on quality of care, and principal risk 3, inability to ensure adequate staffing capacity, capability and diversity and a copy of the highlight reports are attached at appendix 2 (a and b). Following discussion at the Audit Committee meeting in January 2022, the highlight report will be further developed and rolled-out for all principal risks, along with a wider review of the BAF governance to ensure key information is escalated in a timely manner.

2.6 The table below provides an overview of the principal risks on the BAF:

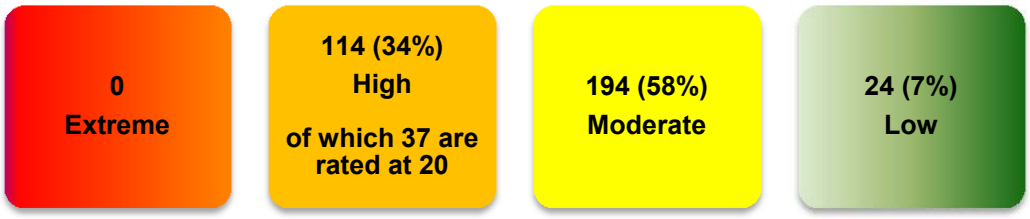
Principal Risk Event and notable changes	Executive Lead Owner	Executive Board	Current Rating (L x I)	Target rating (L x I)	Rating timeline
1. Adverse impact on quality of care No significant change to rating this period	MD/CN	EQB	4 x 5 = 20	2 x 5 = 10	
2. Failure to meet constitutional performance targets No significant change to rating this period	ACOO	EFPB	5 x 4 = 20	3 x 4 = 12	
3. Inability to ensure adequate staffing capacity, capability and diversity No significant change to rating this period	CPO	EPCB	5 x 4 = 20	3 x 4 = 12	
4. Failure to achieve and maintain financial sustainability No significant change to rating this period. Risk score under review by CFO and Execs	ICFO	EFPB	4 x 5 = 20	4 x 5 = 20	

5. Failure to realise the benefits of the e-Hospital programme and maintain / improve critical IT infrastructure No significant change to rating this period	CIO	EIM&TB	4 x 4 = 16	3 x 4 = 12	
6. Failure maintain / improve existing critical infrastructure No significant change to rating this period	DEF	ESB	4 x 5 = 20	4 x 5 = 20	
7. Failure to create and sustain an estate fit for the future No significant change to rating this period	DEF	ESB	4 x 4 = 16	3 x 4 = 12	
8. Inability to achieve recovery and restoration (COVID-19) No significant change to rating this period	ACOO	ESB	4 x 4 = 20	3 x 4 = 12	

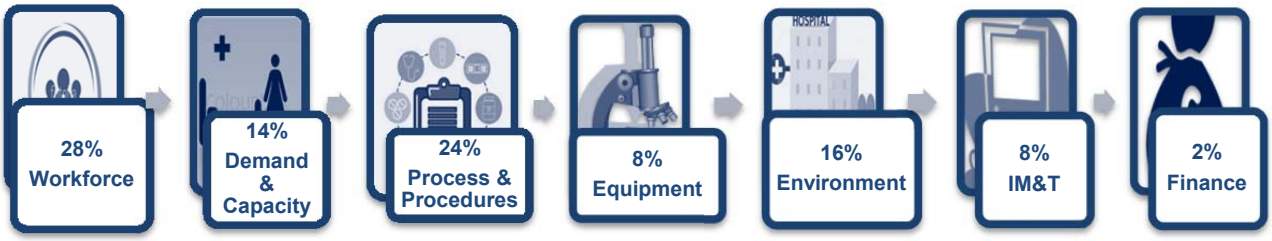
3 UHL ORGANISATIONAL RISK REGISTER SUMMARY:

3.1 At the end of the reporting period (December 2021), there are 332 risks recorded on the organisational risk register. A dashboard of risks rated 20 is attached at appendix three. The graphic below illustrates the Trust's risk profile by current risk rating:

Fig 1 - UHL Organisational Risk Register Profile



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



3.3 Analysis of the organisational risk register shows the risk impact themes illustrated in the graphic below:

3.4 New risks continue to be identified by CMGs and corporate directorates and presented to the Executive Board meetings on a weekly basis for review and endorsement ahead of being reported on the organisational risk register. CMGs who have risks with elapsed 'due dates' are required to review their risks in a timely manner and performance is monitored at the following monthly meetings:

- Executive Team – via the monthly integrated risk and assurance report;
- CMG Boards – via the monthly risk analysis paper; and
- CMG Performance Review Meetings – via the monthly risk analysis slides.

3.5 Organisational risk register performance against the indicators agreed by the Executive Team is detailed in the table below:

Performance Measure Indicator – as at 27/01/2022	Target Level	Risk Register Total (1 – 25)	Risk Register Extreme (25)	Risk Register High (15 – 20)	Risk Register Moderate (8 – 12)	Risk Register Low (1 – 6)
No. of active risks (open)	N/A	332	0	114	194	24
% of risk reviews completed on time / within set review date	No.	314	0	107	184	23
	(>90%)	95%	0%	94%	95%	96%
% of risks with mitigating actions lapsed/overdue (i.e. beyond target date)	No.	27	0	9	14	4
	(<10%)	8%	0%	8%	7%	17%
New risks added to the risk register	N/A	6	0	2	4	0

4 RECOMMENDATIONS

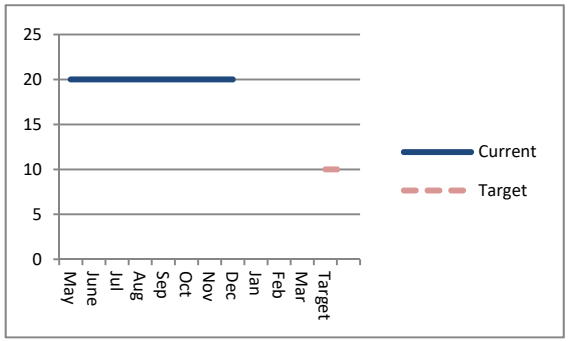
4.1 The Board is invited to receive assurance on the process of risk management through the content of this report, noting the work to the principal risks on the Board Assurance Framework and the position to entries on the organisational risk register, and to advise as to any further action required.

Appendix 1 - UHL Board Assurance Framework – (FINAL VERSION – Dec 2021 – Trust Board in Feb 2022)

UHL 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	Executive Lead Owner	Decision Boards /Monitoring Forums		BAF Current Rating: (L x I)	*Target* - (L x I)
	1	Adverse impact on quality of care	MD/CN	EQB	QC	4 x 5 = 20	2 x 5 = 10
	2	Failure to meet constitutional performance targets	ACOO	EFPB	PC	5 x 4 = 20	3 x 4 = 12
	3	Inability to ensure adequate staffing capacity, capability and diversity	CPO	EPCB	PPPC	5 x 4 = 20	3 x 4 = 12
	4	Failure to achieve and maintain financial sustainability	ACFO	EFPB	FIC	4 x 5 = 20	4 x 5 = 20
	5	Failure to realise the benefits of the e-Hospital programme and maintain / improve critical IT infrastructure	CIO	EIM&T	QC / PPPC	4 x 4 = 16	3 x 4 = 12
	6	Failure maintain / improve existing critical infrastructure	DEF	ESB	TB	4 x 5 = 20	4 x 5 = 20
	7	Failure to create and sustain an estate fit for the future	DEF	ESB	TB	4 x 4 = 16	3 x 4 = 12
	8	Inability to achieve recovery and restoration (COVID-19)	ACOO	ESB	TB	5 x 4 = 20	3 x 4 = 12

Appendix 1 - UHL Board Assurance Framework – (FINAL VERSION – Dec 2021 – Trust Board in Feb 2022)

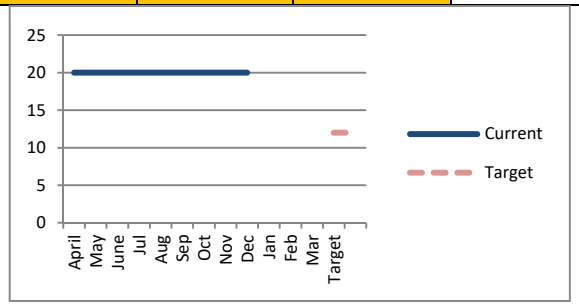
PR Ref:	PR 1	**PR Title:**	Adverse impact on quality of care								**Last Updated:**	06/01/2022
Executive lead(s):	Medical Director & Chief Nurse		**Lead Executive Board:**	EQB		**Lead TB sub-committee:**	QC		**Strategic Objective**	Quality Priorities		
BAF tracker - month	**APR 2021**	**MAY 2021**	**JUN 2021**	**JULY 21**	**AUGUST 21**	**SEPT 21**	**OCT 21**	**NOV 21**	**DEC 21**	**JAN 2022**	**FEB 2022**	**MAR 2022**
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			
Rationale for score:	Trust Board workshop presentation (9/12/2021) and Quality Committee paper (23/12/2021) set out the potential risks to quality of patient care and the mitigating actions being taken to address these. • Levels of harm detected by Datix reporting and the Learning from Deaths process are low. • UHL currently undertaking work to more accurately define the level of risk it is carrying due to the effects of the pandemic; and in particular to define harm that is as a result of unintended consequences of prioritising certain patients groups over others. • Harm that has been detected has been appropriately investigated so that learning can be embedded. • As the ICS develops there is also a need to design a system for capturing harm across patient pathways and feeding into relevant Design Groups and System Teams to ensure collaborative improvement.					**Risk rating tracker:**					**Target rating (L x I)**	2 x 5 = 10

Causes	**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** 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 mortality, and significant reduction in patient satisfaction	• 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, 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	**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 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	• 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. • Backlogs in outpatients and clinics due to restricted attendance to comply with COVID-19 requirements. • Quality Governance and Assured Services process isn't fully established.	• 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 stream. • Review and implement GIRFT actions. • Commencement of Pressure Ulcer QI collaborative. • Linking nursing and midwifery assessments completed on NerveCentre

	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. • Quality Impact Assessment process for investments and CIPs. • Mutual aid support processes. • Surgical prioritisation process. • Waiting list risk stratification. • Command and Control arrangements to manage COVID-19 (including Strategic and Operational functions).	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 to EQB. • Patient on ambulance harm review process showed very few cases of harm following over 1000+ patient reviews. This process has now discontinued. • Covid-19 Delay in treatment/follow up harm review process. • Cancer waiting times harm review process. • HCAI Covid-19 probable and definite infections reporting and investigation process in line with NHSE/I guidance. • TCS reporting with feedback reporting into system TCS Board. • Learning from Death process and focus on HSMR and SHMI. **External** • CQC inspection reports. • PwC safety audits. • CCG quality visits. • GIRFT reviews. • HSIB reviews for Maternity Services. • CQC engagement meetings. • Peer reviews and accreditation.	• Outcomes and findings from external assurance reviews which have been on hold during Covid-19. • Established risk appetite framework under review. • Internal and peer review of Maternity Governance and safety processes.	directly through to the indicators dashboard. • Harms review process for Covid-related delays / harms. • Development of a Quality Governance Assured Services process. • Corporate risk team working with internal auditors (2021/22 programme) to identify Key Risk Indicators as part of the risk appetite work programme. • Maternity Governance review commissioned by Chief Nurse will review corporate, CMG and Team governance processes. Peer review TOR to be finalised. • Focus on restoration and recovery plans to reduce 52 week waits. • New Never Event action plan developed and presented to the Executive Board.
An outbreak of infectious disease (such as pandemic) that results in significant and ongoing disruption to one or more areas of the hospital and adversely impacts quality of care	• Chief Nurse identified as DIPaC. • IP service provided Trust wide by the IPC Team incl Lead IP Nurse and IP Doctor. • Infection Prevention policy. • Infection Prevention procedures, including: o Management of infected linen. o Provision of food to quarantined patients • Staff training including mandatory e-learning and fit testing.	**Internal**: • Infection Prevention Team providing expert and professional advice to the DIPaC (CN) and Executive Team. • Extraordinary TIPAC meetings (Covid-19: to review/ outline guidance/SOP to CMGs). • In receipt of national guidance re Covid-19 swabbing of patients, which the Microbiology team and ICD advise 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. • Inconsistent supply of preferred FFP3 masks to UHL (and to other	• A mask fit 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 develop short and long term plans to carry out fit-mask testing to staff in UHL. • Review programme for mask fit testing, following approval for non-recurrent

	• 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 hubs established at LGH, LRI and GH to vaccinate staff, patients and others (public, contractors etc.). • Asymptomatic staff testing programme. • Additional capacity to manage number of cases (including planned Nightingale unit).	and the Demand and Capacity Group. • Vaccination hubs risk assessments completed and endorsed by EFPB. • National IP Board Assurance Framework completed and reviewed by EQB and QOC, as well as submitted to CQC as part of Emergency Framework Review. • Qliksense dashboard for lateral flow testing. • Nursing midwifery and AHP workforce strategic coordination centre established to oversee real-time staffing. **External** • CQC Infection control Board Assurance Framework. • LLR SLT providing a co-ordinated response to threats.	Healthcare organisations in UK). • Difficult to maintain safe staffing levels due to high level of staff sickness due to Covid -19.	funding of PPE team.

Appendix 1 - UHL Board Assurance Framework – (FINAL VERSION – Dec 2021 – Trust Board in Feb 2022)

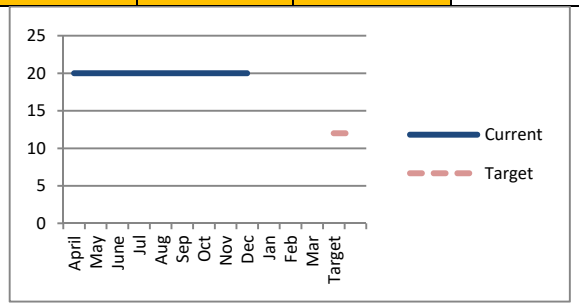
PR Ref:	PR 2	PR Title:	Failure to meet constitutional performance targets							Last Updated:	19/01/2022
Executive lead(s):	Acting Chief Operating Officer	Lead Executive Board:	EFPB		Lead TB sub-committee:	PPPC / QOC		Strategic Objective	Quality Priorities		
BAF tracker - month	APR 2021	MAY 2021	JUN 2021	JULY 21	AUGUST 21	SEPT 21	OCT 21	NOV 21	DEC 21	JAN 2022	FEB 2022	MAR 2022
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			
Rationale for score:	Continued risk of cancellations on the day aligned to emergency pressures particularly for inpatients and DCs converting to IPs. Feeling the impact of Omicron – day to day bed and flow challenges resulting in ad hoc cancellations but no blocks of theatres taken down. Increase in staff sickness due to COVID. High volumes of medical fit for discharge patients.					Risk rating tracker:				Target rating (L x I)	3 x 4 = 12	

Causes	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 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 care funding; increased acuity leading to more admissions & longer length of stay; operational system failure (including GP ability to cope with demand) Also the requirement to cohort patients by COVID create a risk on emergency care flow.	• Implementation of a Discharge Hub with a philosophy of discharge within 24 hours of medically fit for discharge. • Maximise the use of SDEC. • Timely booking of transport to avoid delay to patient discharge. • Identification of next day discharges to support early flow. • Operational command meeting with OPEL triggers appropriate to each level. • Admission prevention & avoidance projects owned by LLR. • Alert to system partners to ensure action is triggered prior to the 10.30am call. • 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	Internal: • ED patients waiting time report. • Bed occupancy report. • UHL Capacity Reports. • Daily medically fit for discharge numbers. • Daily medically fit for discharge complex patient list. • Stranded and super-stranded patient data. • Discharge hub outcomes data. • Daily intelligence report for all ED areas.	• Capacity gap for patients to be discharged within 24 hours of becoming medically fit especially for county patients. • Ability to discharge patients to community beds and care homes due to waiting for COVID-19 swabs. • Bed capacity modelling identifies a shortfall in medicine beds. • Patients cannot wait on the back of ambulances. • Medical workforce to cover 2 emergency departments and assessment areas.	• Utilisation of available community beds – support earlier identification and handover of patients on the day prior to discharge to support better discharge planning. Maximise the use of the discharge hub. • Timely completion of Home First Forms and referral to the discharge hub. • Implementation of Think 111 across LLR. • Implementation of UTC in partnership with Elite. • Initial discussions on the implementation of the NSHE/I streaming tool (self-service tool providing algorithms for walk-in ambulatory patients). • 8-10 week improvement plan with ECIST will commenced mid-October focusing on Red2Green and SAFER best practice; the plans for this support will be developed this month across UHL. • CMG focus on increasing pre-noon and 5pm discharge numbers.

	admission where possible. • Maximise Use of GPAU/SDEC pathways. Simplified pathway changes maximise use of GPAU/SDEC pathways.			
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.	• Trust Access Policy. • NHS Constitution. • Demand and capacity modelling. • Weekly calls with NHSE/I. • Weekly RTT submission.	Internal: • Weekly Access Meeting. • Performance Review Meeting. • Long Waiters Report. • Weekly 40+ week report.	• 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 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. • Reduction in theatre capacity to support ITU.	• Demand management plans including RSS supporting to bridge capacity gap. Waiting list is currently 108373. This is now being managed through the weekly access meeting with each speciality. • COVID-19 has impacted with cancellation of non-essential face to face activity and conversation to virtual/telephone appointments. Outpatient activity has been reinstated with the focus of locking in the benefits of COVID-19 such as virtual outpatient appointments. • 15877 x 52 week breaches at the end of December. • Planning commenced for 2021/22 to include resources required for elective recovery. • To ensure we follow planning guidance it is essential we are focusing on these cancer and urgent recovery. This means that we will not see significant recovery within the first quarter of 21/22 for long waiters. • ERF plan developed to support recovery. - Insourcing of Theatre staff – Vanguard theatres to come on site in January and February - exploring Mutual Aid • IS activity contracted extended into 22/23 - External Validation team started to support waiting list management until March 22. • Pre-surgery with independent activity to increase IS activity.
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	• 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).	• 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. • All surgical pts are being priority scored. • Use of the IS for as much activity as possible.

to PPE and social distancing and patients choosing not to attend.		• 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.		

Appendix 1 - UHL Board Assurance Framework – (FINAL VERSION – Dec 2021 – Trust Board in Feb 2022)

PR Ref:	PR 3	**PR Title:**	Inability to ensure adequate staffing capacity, capability and diversity								**Last Updated:**	17/01/22
Executive lead(s):	Chief People Officer		**Lead Executive Board:**	EPCB		**Lead TB sub-committee:**	PPPC	**Strategic Objective**	People Strategy			
BAF tracker - month	**APR 2021**	**MAY 2021**	**JUN 2021**	**JULY 21**	**AUGUST 21**	**SEPT 21**	**OCT 21**	**NOV 21**	**DEC 21**	**JAN 2022**	**FEB 2022**	**MAR 2022**
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			
Rationale for score:	Given the sustained operational pressure and fragility of the workforce, further work is required to determine the right balance between actions to address immediate operational needs whilst still maintaining a clear strategic focus for both the medium and longer term. This includes understanding what can be paused and how our support should be refocused during the 'here and now'.					**Risk rating tracker:**					**Target rating (L x I)**	3 x 4 = 12

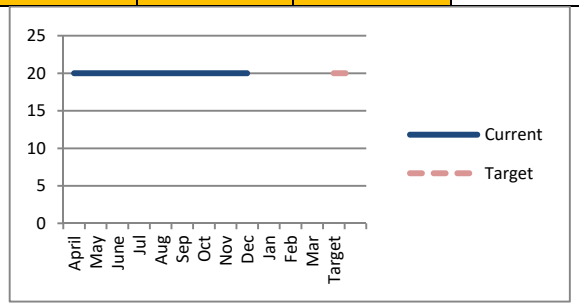
Causes	**Primary controls:** What controls/ systems & processes do we **already** have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat)	**Sources of assurance** Evidence that the controls/ systems which we are placing reliance on are effective. Internal & 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** Are there further controls possible in order to reduce risk exposure within tolerable range?
Failure to plan, redesign and transform the workforce	• 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 appropriate. • Vacancy management and recruitment / retention process (TRAC system) – Time to Hire KPI in place, Apprenticeships, Graduate scheme monitoring reported	Internal: • Validation of CMG WF risks monitored monthly via PRMs. • Monthly Workforce Data Set. External: • PWC audit in Q4 19/20.	• 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. • Within UHL - Fully joined up and integrated reporting/ IT	• Refresh of people strategy 12 month deliverables in progress. Update to EPCB in November 2021 and TB Development day in Nov – Focus on the immediate / over winter – HWB support / WF availability / improving staff experience & getting the basics right – pause UHL people strategy publication. • WF submission 22/23 in progress – narrative and numbers plans – triangulation undertaken to Finance / Activity plans. • Scoping impact of restoration and recovery plans which may lead to further gap in workforce supply. Surge plans in development /challenge which continues. • WF supply / redeployment cell in place and co-ordination through professional leads for planning and deployment activity. • Rebranding recruitment campaigns following successful £450m monies – initial review complete – forms part of people promise deliverables. Development of refreshed / new BRAND in progress • WF Reporting – supporting data for key areas (Vacancy, absence, Vaccinations). • Vaccinations as a condition of deployment project in place to maximise the number of staff taking up the invite for vaccination, to identity exemptions as appropriate, and support consistent handling of individual circumstances. EIA in progress. • Confirming system & organisational capacity for delivery of the core offer/ people promise. Plans for additional capacity in place • Strong focus on healthcare worker support as part of priority planning/ next steps/ international nurses on-boarding /priority recruitment activity to key posts.

	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.		systems across Finance, Workforce (ESR) and E rostering in regard to WF numbers.	• Re-initiated regional talent management activity with key focus on inclusivity and widening participation. Regional BAME Nurse Leadership programme underway. System BAME Nurse Development Programme drafted. • Agree on EDI high impact recruitment actions at organisation and system level by the end of June complete Action plans will form part of our overall WRES plan. Reported against Workforce Race Equality and Inclusion Strategy Outcomes to regional team in November- complete. • Review and Publish WRES and WDES latest performance data before the end August - complete with presentation at UHL EDI Board and EPCB & TB (in October) in setting out performance and next steps. • Commenced scoping for NHSI Retention pilot. Refocus – to recommence in FEB aligned to people promise. • HEE AHP WF strategy programme commenced Oct 21 – March 22. • Refreshed strategic WF strategy plans to EPCB in April 22
Failure to develop staff capability	• 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). • Agreement of LLR EDI System Programme of work - new priority BAME Voice Gripe Tool	• 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. • 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. Implementation plan on taking forward Compassionate Leadership approach agreed and incorporated as part of our UHL People Plan. People and Culture support framework currently being worked up / focus on building on what is already measured and in place to provide targeted support. • Review of people policies and practice to support People plan delivery in progress as part of refresh. • LLR Leading on developing an Active Bystander Development Programme in partnership with NHSI/E Civility and Respect Team. Draft framework and implementation plan to be presented to EPCB in February – complete and work underway in planning system engagement workshops. Town Hall Events and focus group sessions have taken place with strong representation from across health and social care. Next steps agreed with LLR Senior Responsible Officers and implementation plan being drafted complete. Your Voice Tool engagement sessions held in November. Active Bystander Programme workshop (including leadership module) content agreed. • Commence scoping of ICS Systems Leadership Development incorporating cultural intelligence. Cultural Intelligence Programme agreed and external partner sourced. Cultural Intelligence Implementation plan agreed. • System Clinical Executive Development commenced and reflective of expectations set out within ICS Design Framework. Development also underway with Transforming Care Safely Team. • Exploration meeting re: ICS Culture and Leadership Programme with NHSE/I • Set out draft Inclusive Talent Management Approach with People SRO in November. Complete Programme aligned to LLR Innovation programme

Appendix 1 - UHL Board Assurance Framework – (FINAL VERSION – Dec 2021 – Trust Board in Feb 2022)

Failure to build a compassionate and inclusive culture	• 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. • New LGBTQ+ Network	• 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. • LGBTQ+ Rainbow badge campaign early adoption in Peads and ED with 170 staff pledges made.	• 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, recruitment plans oversight though PRM's. • HWB Strategy and work programme agreed for 20/21 – comms in place strategy to support. On-going with a bridging the WF challenge over the winter focussed actions / getting the basics right. UHL Looking after our People Group refreshed group commenced Sept 21, REACT and TRIM training launched. • System HWB priorities agreed and reflect system strategic objectives. Planning underway for system wide health and wellbeing festival to take place in November (commencing on World Kindness Day – 13 November) LLR Lead Connect and Care Festival Week commenced on the 13 November on World Kindness Day with over 500 registrations from across the system. • Scoping of system wide mental HWB HUB to provide additional support complete – complete and launched on 3 February. LLR Hub Board established and agreement on implementation projects and resource requirement. Leadership and management engagement event on 5 March. Further event on the 15 April complete and further events planned for June complete. New arrangements agreed to enhance existing website to ensure single 'front door'. Together all HWB Application being explored. • 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 (IDMF) programme of work. Reconfiguration Programme Case study drafted and communicated across senior teams. Implementation commenced with system design teams. IDMF system wide workshops to be delivered until August- complete with IDMF showcase event taking place at the end of September • Strengthening approaches to flexible working and enabling an agile workforce. Agile work stream established – meeting as part of enabling services project board/ Reconfiguration. Stake holder group commenced for wider Trust roll–out. • Commenced Flexible working NHSi/E 6 month programme to share good practice and provide continued development of approaches. • Staff testing for symptomatic staff scaling up due to increasing demands – in place. Staff asymptomatic testing – lateral flow testing roll-out for all staff who request it is in place – T&F group established for further considerations in response to national guidance. • Roll out of COVID vaccine for COVID BOOSTER now in place, 55% take up for substantive staff. Plans in place to target non-take up of vaccine, pending national changes for front line staff mandatory COVID vaccine. System wide Equality Impact Analysis completed • Work to scope health inequalities collaboration and system governance being established. System wide Health Inequalities Champion Development Programme drafted. • Participation in Equality Delivery System Consultation review.

Appendix 1 - UHL Board Assurance Framework – (FINAL VERSION – Dec 2021 – Trust Board in Feb 2022)

PR Ref:	PR 4	**PR Title:**	Failure to achieve and maintain financial sustainability								**Last Updated:**	21/01/2022
Executive lead(s):	Chief Financial Officer		**Lead Executive Board:**	EFPB		**Lead TB sub-committee:**	FIC		**Strategic Objective**	Well governed finances		
BAF tracker - month	**APR 2021**	**MAY 2021**	**JUN 2021**	**JULY 21**	**AUGUST 21**	**SEPT 21**	**OCT 21**	**NOV 21**	**DEC 21**	**JAN 2022**	**FEB 2022**	**MAR 2022**
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			
Rationale for score:	Any reduction in the risk score is dependent on the delivery of improved financial controls and governance and delivery of operational and long term financial plan trajectories. The continued high-risk rating reflects the need for the Trust to confirm strategic plans with System Partners. Current challenge is delivery of 2021/22 Capital Programme: Assurance sought on capital scheme delivery from Sub Group leads. Detailed review of capital scheme forecasts being undertaken. Discussions regarding capital programme risks and potential flexibility being undertaken at a System and Regional level.					**Risk rating tracker:**					**Target rating (L x I)**	4 x 5 = 20

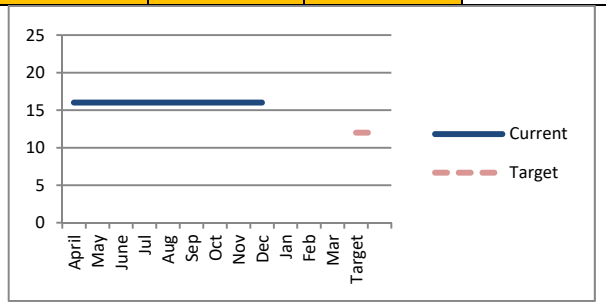
Causes	**Primary controls:** What controls/ systems & processes do we **already** have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat)	**Sources of assurance** Evidence that the controls/ systems which we are placing reliance on are effective. Internal & 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** 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. • April to September 2021 Control Totals for CMGs and Corporate Directorates, reflecting national baseline planning guidance. • October 2021 to March 2022 Control Totals for CMGs and Corporate Directorates, reflecting national baseline planning guidance (subject to approval on 21st December 2021). • H1 workforce and operational plans. • Trust H2 workforce and operational plans. • CMG and Directorate 2021/22 savings plans. • 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/	• EPPB chaired by 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 and Corporate PRMs, Directorate and CMG service line reviews. • Monthly reporting of savings to EFPB and FIC, incorporating progress on key actions and savings delivered. • Cost pressures and service developments minimised and managed through the EFPB. • 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.	• 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. • Reporting of service Line financial performance and patient level costs to EFPB and FIC (initially on a quarterly basis, and then monthly), from September 2021.	• Development and support of the Finance and Procurement function: It is proposed that the initial development programme 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 via accreditation against the NHS Future Focused Finance Programme, the application for which is planned to be submitted by May 2022. 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. Permanent appointments have been made; Deputy Director (Financial Services) commenced in January 2021, and Deputy Director (Financial Management) appointed and commenced in April 2021. Additional interim resources secured, as agreed with NHSE&I within the Financial Improvement Plan, and reported to FRB and FIC.

	demand/capacity challenges. This process is overseen by the COO, Medical Director, Chief Nurse & Chief Financial Officer. • Strengthened financial controls and governance as approved through the FRB, in line with national and Trust guidance. • Enhanced PMO structure to support identification and delivery of 2021/22 CIPs.	• Delivery of the Internal Audit Plan reported to Audit Committee.		• Restructuring of the Finance Department, to go live from January 2022. • Strengthening financial performance management via the CMG and Directorate 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. • Introduction of Corporate Directorate and Estates and Facilities PRM meetings from April 2021. • Enhanced Financial Performance Report to EFPB, FIC and TB. • Training and development programme on financial management for budget holders and other staff, commencing March 2021. • Approval of the 2021/22 H1 Trust I&E Plan at the Trust Board on 3rd June 2021, following endorsement by FRB and FIC • Delivery of the H2 planned cash releasing savings of £8m by CMG and Directorates, with oversight and support from the PMO. • Submission of Trust H2 Financial Plan to NHSE&I by 25th November 2021, following approval by FIC on 25th November 2021. • Finalisation of CMG and Directorate H2 budgets for approval by EFPB on 21st December 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), now incorporated into EFPB. • Trust Standing Financial Instructions (SFI's), Standing Orders (SO's) and Scheme of Delegation (SoD). • Board and budget holder training and development programme on NHS financial management and governance.	• 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, EFPB, FIC and TB.	• NHSE&I oversight via Financial Oversight meetings.	• An update on Grip and Controls was reported to FRB on 21st July 2021 and 29th September 2021, EFPB on 21st December 2021, and Audit Committee on 21st January 2022. • Linked to the above, an initial review and amendment to the Trusts SFI's, SO's and SoD, capturing key changes for the procurement of goods and services, was approved by the Audit Committee on 20th August 2021.

Appendix 1 - UHL Board Assurance Framework – (FINAL VERSION – Dec 2021 – Trust Board in Feb 2022)

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), EFPB and FIC.	• Monthly reporting of capital expenditure to CMIC, EFPB, FIC and TB.	• Development of a long term Trust and LLR system capital plan, incorporating the Trust's Reconfiguration plan and Estates Strategy.	• 2021/22 capital scheme expenditure forecasts reviewed and signed off by CMIC, and reported to EFPB, FIC and Trust Board. • Review of capital governance and processes (Terms of Reference) reported and approved by CMIC on 17th June 2021. • Development and approval of 2021/22 capital plan by the Trust Board on 6th May 2021, following confirmation of the LLR System and Trust 2021/22 Capital Resource Limit. • Approval of the CMIC Terms of Reference at FRB on 23rd June 2021. • Review of 2021/22 capital expenditure forecast, to manage land purchase within CDEL, including review of accounting treatment of land purchase. Signed off at FRB on 21st July 2021. • Management of the Trust's capital programme reflecting slippage and new scheme commitments reported to FIC on 28th October 2021, to ensure delivery of CDEL. Update provided at month 8 to EFPB and FIC. • Detailed forecast by scheme of 2021/22 Capital Programme being undertaken by 28th January 2022.
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.	• EFPB chaired by CEO (internal). • LLR NHS Board and System Operational Group to oversee delivery of 2021/22 System Financial Plan (external)	• Development of Trust and LLR system long term plan (operational, workforce, estate, and financial plan).	• Development of a Trust and LLR System long term plan (operational, workforce, estate and financial plan/strategy) to deliver financial recovery by 31st August 2021. • Regular reporting of development of Medium Term Financial Plan (MTFP) at EFPB and FIC. • Board workshop on 12th August 2021 to review MTFP.

Appendix 1 - UHL Board Assurance Framework – (FINAL VERSION – Dec 2021 – Trust Board in Feb 2022)

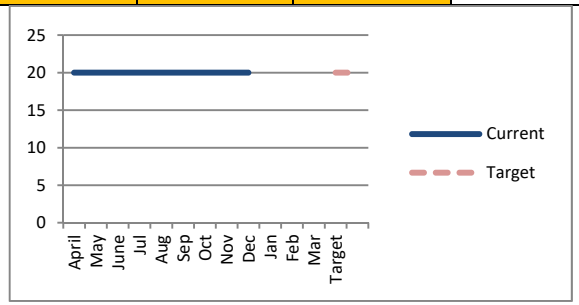
PR Ref:	PR 5	**PR Title:**	Failure to realise the benefits of the e-Hospital programme and maintain / improve critical IT infrastructure								**Last Updated:**	17/01/2022
Executive lead(s):	Chief Information Officer		**Lead Executive Board:**	EIM&TB		**Lead TB sub-committee:**	PPPC		**Strategic Objective**	e-Hospital		
BAF tracker - month	**APR 2021**	**MAY 2021**	**JUN 2021**	**JULY 21**	**AUGUST 21**	**SEPT 21**	**OCT 21**	**NOV 21**	**DEC 21**	**JAN 2022**	**FEB 2022**	**MAR 2022**
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			
Rationale for score:	IM&T capital infrastructure and e-Hospital (EPR) programmes are in progress with additional focus on cyber security and digital workplace. The scale and complexity of technology modernisation required and the ongoing challenge of enacting digitally enabled transformation under significant operational pressures, remain key drivers of the risk score which remains at 16.					**Risk rating tracker:**				**Target rating (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											

Causes	**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** Are there further controls possible in order to reduce risk exposure within tolerable range?
Lack of capital funding / historic investment in IT infrastructure (failure of software / hardware, cyber-attack, information security breach – loss of patient data, Big Bang or Rising Tide event - fire, flood, terrorist attack)	• Emergency Preparedness, Resilience and Response (EPRR) Board - chaired by AEO, meets quarterly to review (3 year) work plan, which includes include IM&T resilience work, with representative from all CMGs and corporate services. • EPRR Policy & Incident response plans on Insite, in date. • Cyber security measures in place including monitoring of threats via NHS Digital CareCert, vulnerability scanning & anti-virus/anti malware tools, Monthly Cyber Security Board, IG toolkit, IG Steering Group and GDPR plan, regular penetration testing and close working	• 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). • 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 audit completed June 2021. • PwC internal audit of cyber security controls in place to mitigate risks arising	• 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 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	• Standardisation work undertaken in Dec 21 to ensure consistency of ward business continuity materials and standard operating procedures. Routine checks are now built into ward assessment & accreditation activities. • Undertake Corporate Records Audit and completion of the Info Asset Register (IAR). Annual update complete. Information asset owner training and awareness scheduled for Q1 21/22 to further improve coverage and quality. • Progress data centre strategy including improved redundancy via cloud hosting options. Input into reconfiguration programme and data centre plans progressing as joint project with estates capital team. • Update and validate Information Asset Register (IAR). Annual update complete. Information asset owner training and awareness - completed Q1 21/22 to further improve coverage and quality. Aiming for 60% coverage by March 22. • Achieve Cyber Essentials Plus equivalence. Data Security & Protection Toolkit submission completed

	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.	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.	items (Windows XP/7) tied to medical equipment and legacy applications are connected to protected network infrastructure. • 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.	and core cyber security standards met in June 21. Further mitigation work and investment scheduled in 21/22 to achieve CE+ equivalence certification. (Mar 22) • Cyber Essentials Plus remediation plan agreed and support activities scheduled with NHSD funded support from Templar. Complete, Further mitigation work and investment scheduled in 21/22 aimed at working towards achievement of CE+ equivalence certification. • Cyber security service to be re-specified as a priority following strategic IT partner restructure in July 2021. Responsibility transitioned by 30th April. Re-specification of services. In progress with external support, for completion by March 22. • IM&T team security expertise to be reviewed and strengthened. UHL IT Security Lead post to be in post by end March 22. • Business case for SIEM solution to be developed and submitted. Proof of concept project completed Dec 21 to assess scale of investment required to cover mandatory elements of the data security & protection toolkit requirements. Further investment decision to be taken as part of 2022/23 planning (March 2022).
Failure to change and adapt to the developing EPR	• 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. • Intranet and social media presence including 'what does this mean to me' content to raise staff awareness of the eHospital and digital agenda at UHL • Benefits realisation plan in place monitored via the programme board, including for delivery of change to working practice • Digital aspirant funding stream to be utilised during 21/22 to enable fixed term clinical backfill to support a broader involvement from staff and more in depth engagement from teams as part of project	• 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 • Lack of long term secure funding - Inability to plan beyond the current financial year and unable to meet digital aspirant timelines. • Pace of change a particular challenge when implementing simultaneously alongside other programmes (e.g. efficiency, reconfiguration) • Operational pressure may	• 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. PPI included in Engagement approach for eHospital for 21/22, work ongoing to determine options as projects progress. • Close working with senior operational management team to ensure that clinical services are prepared, aware and resourced for critical system go lives (ongoing, review Sept 21) - Complete

		development and go live. • Alignment with becoming the best PMO in place to ensure transformation support and resources are aligned in support of the eHospital programme. • eMeds go live successfully managed with support from ops team. Learning will feed into future deployments to avoid unnecessary delays and deferments	result in delays or deferment of critical project implementation.	

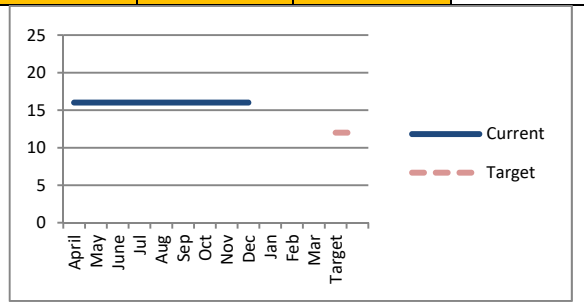
Appendix 1 - UHL Board Assurance Framework – (FINAL VERSION – Dec 2021 – Trust Board in Feb 2022)

PR Ref:	PR 6	**PR Title:**	Failure maintain / improve existing critical infrastructure								**Last Updated:**	24/12/2021
Executive lead(s):	Director of Estates & Facilities		**Lead Executive Board:**	ESB		**Lead TB sub-committee:**	TB		**Strategic Objective**	Sustainable estate		
BAF tracker - month	**APR 2021**	**MAY 2021**	**JUN 2021**	**JULY 21**	**AUGUST 21**	**SEPT 21**	**OCT 21**	**NOV 21**	**DEC 21**	**JAN 2022**	**FEB 2022**	**MAR 2022**
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			
Rationale for score:	Significant maintenance backlog Potential delay to reconfiguration programme Impact of COVID-19 on ability to access areas and staffing availability					**Risk rating tracker:**				**Target rating (L x I)**	4 x 5 = 20	

Causes	**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** 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 2021/22 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. • 24/7 response from Estates & Facilities and specialist contractors, including 'out of hours' arrangements.	• Backlog maintenance reported in the ERIC return to the Department of Health and benchmarked against other NHS Trusts annually (internal). Backlog Maintenance liability reported to DoH in the 4th September 2020 ERIC submission. • Annual assurance reports from independent specialists for services including: Electrical, Piped Medical Gas, Water and Specialist Ventilation (internal). • Annual Premises Assurance Model (PAM) evidence gathering is coming to a close in early April 2021 and this data will be uploaded into the new DoH online PAM assessment tool before the end of July. A Trust Board	• 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 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 & Legionella). • There is still a risk to the capital works programme because of Covid	• Following the successful emergency backlog maintenance bid, the £10.3 work was scheduled for completion in the 2020/21 programme; however, this has now been carried over into the 2021/22 capital work programme. • E&F management restructure completed and plans are in place to implement operational changes including recruitment into key roles. Management of change process (shift pattern changes) is progressing across Estates workforce. Recruitment into key operational roles by 31/10/2021. The Deputy Director of E&F (Operational Services) is a key driver for 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. Due to a lack of progress to deliver a permanent engineering solution to areas where we are experiencing repeat positive water sample results, a multi-disciplinary task and finish group will be set up in September 2021 to develop and agree a programme of works with clinical colleagues that minimises impacts on patient service delivery. IDU at

	• Some critical plant and equipment have back-up systems (contingency plans) in the event of 'loss of' power/engineering services.	PAM report will follow. • Annual Patient-led Assessments of the Care Environment (PLACE) with scorecard reported nationally and benchmarked (internal). These are yet to be scheduled for 2021 due to Covid-19. 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.	infections/isolations affecting contractors and staff. We are now experiencing supply chain disruption across building and engineering new and spare parts with procurement dates extending due to manufacturer/supplier pressures from staff disruption. We are still seeing incidents of contractor staff disruption and project managers having to self-isolate. An increase in the Covid-19 'R' rate, or a third wave can still significantly impact on capital work programmes.	the LRI has had microbiological water filters fitted to patient facing water outlets following receipt of elevated Legionella results in July 2021. A steering group, including Public Health England representatives was set up to oversee investigations and actions and to establish if there is any link to a patient transferred to another Trust from IDU who was found to have contracted legionellosis, either pre, during or after a short stay at UHL. The patient also attended AMU and this area was also tested and investigated to confirm quality. The steering group has concluded their work and UHL Infection Prevention will produce the investigation report in early September 2021. • 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. E&F are putting together a paper to highlight the ventilation issues and to propose options to upgrade critical ventilation systems to support clinical strategy and achieve compliance to current standards. The plan was presented to the Executive Board/Trust Board in September 2021. Priority ventilation and water works have been evaluated for cost and access requirements by the Capital Development Team and included in the 2021/22 capital plan. The E&F Capital Development team were successful in a bid for endoscopy compliance funding and the programme has been completed to upgrade UHL endoscopy suites to enable full compliance to current endoscopy unit standards.

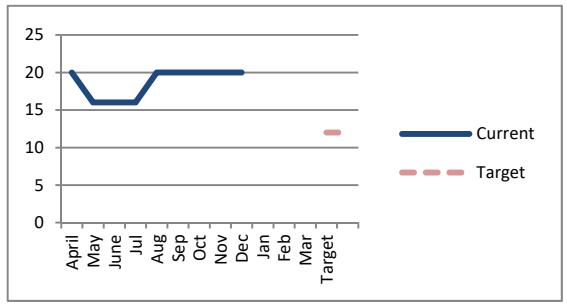
Appendix 1 - UHL Board Assurance Framework – (FINAL VERSION – Dec 2021 – Trust Board in Feb 2022)

PR Ref:	PR 7	PR Title:	Failure to create and sustain an estate fit for the future							Last Updated:	20/12/2021
Executive lead(s):	Director of Estates & Facilities	Lead Executive Board:	ESB		Lead TB sub-committee:	TB		Strategic Objective	Sustainable reconfiguration		
BAF tracker - month	APR 2021	MAY 2021	JUN 2021	JULY 21	AUGUST 21	SEPT 21	OCT 21	NOV 21	DEC 21	JAN 2022	FEB 2022	MAR 2022
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			
Rationale for score:	Uncertainty around National Hospital Programme (NHP) funding for current financial year, resulting in programme delay and cost pressure. NHP are submitting a programme business case to Treasury in March '22, so we do not expect to hear the agreed funding until May 2022.					Risk rating tracker:					Target rating (L x I)	3 x 4 = 12

Causes	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 Are there further controls possible in order to reduce risk exposure within tolerable range?
Funding and timeline for reconfiguration uncertain	• The Decision Making Business Case was approved by the CCG Governing Body on the 8th June 2021. • Commitment from NHSE & NHSI to streamline business case approval process, which is further supported by the establishment of the New Hospital Programme. • Development of robust programme with adequate time allowed for external approval process. • One Outline Business Case for the whole scheme, with 3 separate Full Business Cases aligned to the overall 6 year delivery programme. • Budget aligned to delivery programme with allowance in budget for inflation, optimism bias and contingency. • Cash flow developed to request early draw down of resource for business case development before FBC is approved. • Regular dialogue with NHP and NHSE/I regional team.	• Robust programme management through Reconfiguration Programme Committee with monthly progress reporting to, executive committee and the Trust Board (internal). • Governance process agreed, establishment of a formal Trust Board Sub-Committee 'Reconfiguration and Transformation Committee' will also report on transformation on which the reconfiguration programme is dependant. First meeting will take place 13th September. • Appointment of Trust Side professional advisors to provide assurance: PwC on finance and governance; Ryder Levett Bucknell (RLB) on project and cost management; Capsticks on legal issues.	• Agreement of capital drawdown through business case development. • New Hospital Programme identified the strategy of zero carbon and a fully digital hospital: precise details unknown so requirements for UHL and impact on capital unknown. • We need to agree the detailed scope of the scheme to take account of the assessment of the impact of COVID (future pandemic proofing) and the standardised design features from the centre. • Creation and adoption of a Social Values strategy to take account of the opportunities generated by the Reconfiguration capital investment.	• Continue to progress discussions on drawdown of capital for 2021/22 in order to continue resourcing the programme. Verbal support has been given; further validation on activities is required to release funds and discussion ongoing. Pre OBC drawdown submitted for review pending receipt of formal template from NHP. • PwC have undertaken a Project assurance stock take for the Programme SRO on processes and systems. An action plan has been developed to take forward their recommendations; both the action plan and the report was shared at ESB, delivery of the pan is ongoing. • 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 and policy guidance to be published. Feedback from UHL on Draft NZC guidance submitted to NHP. • RLB have been commissioned to produce a Social Values strategy for UHL. Draft report was presented to the Reconfiguration Programme Committee for information; an updated version will be produced once the capital envelope is confirmed. • Focus on scope of the Outline Business Case to validate the clinical capacity provided.

		• Capsticks have confirmed legitimacy of consultation during COVID pandemic using virtual media. • Collaboration Agreement signed between UHL and the New Hospital Programme.		• Having completed review process with New Hospital Programme, formal feedback report received and meeting with Mott Mac team in mid-June took place to address clarification points. Key actions being worked on including agreement of cost model. Further work with Mott Mac paused by New Hospital Programme until outcome of HM Treasury is announced.

Appendix 1 - UHL Board Assurance Framework – (FINAL VERSION – Dec 2021 – Trust Board in Feb 2022)

PR Ref:	PR 8	PR Title:	Inability to achieve recovery and restoration								Last Updated:	29/12/2021
Executive lead(s):	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 2021	MAY 2021	JUN 2021	JULY 21	AUGUST 21	SEPT 21	OCT 21	NOV 21	DEC 21	JAN 2022	FEB 2022	MAR 2022
Current rating (L x I)	4 X 5 = 20	4 X 4 = 16	4 X 4 = 16	4 X 4 = 16	5 x 4 = 20	5 x 4 = 20	5 x 4 = 20	5 x 4 = 20	5 x 4 = 20			
Rationale for score:	Level 4 National Incident declared on the 13th December 2021 in response to the discovery of the Omicron variant. All parts of the NHS are being asked to: • Maintain diagnostic, first outpatient, elective inpatient and day case capacity as far as possible • release staff to support the vaccination programme and respond to the potential increase in COVID-19 cases • separate elective and non-elective capacity where possible and the use of mutual aid between trusts and across systems and regions where necessary to maintain access to urgent elective care • Maintain a focus on eliminating waits longer than two years					Risk rating tracker:					Target rating (L x I)	3 x 4 = 12

Causes	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 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	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. • Strong collaborative working with system partners. • Weekly ERF, key programme mobilisation meetings and clinical	• 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 which require significant revision in the current climate of ITU surge and strategic reduction in theatre sessions for elective services. • 100% restoration of baseline theatre activity. • Substantive mutual aid arrangements in place	• 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. • Update capacity and demand for 6 high volume specialties (commencing July 2021). • Additional recovery plans linked to ERF investment are mobilised and ramping up towards Dec 21 onwards

	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, TCIs and on the day cancellations	theatre scheduling meetings (TPPM) in place		• Insourcing for ITU is partially in place with 6 out of 8 planned beds live. This programme will continue to be monitored in terms of impact on elective restoration and recovery – currently support service restoration to over 85%. • Robust implementation of insourcing. • Mobilisation of the Vanguard programme Robust implementation of insourcing. • Mobilisation of the Vanguard programme has begun as the capital works have commenced.
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 community.	• UHL COVID-19 Escalation Framework provides a clear response framework for managing demand in response to COVID-19 • UHL COVID-19 Response Plan. • UHL COVID-19 Strategic Recovery Group chaired by member of the Executive Team. • UHL COVID-19 Tactical Group chaired by Deputy COO to monitor operational matters and escalate to UHL Strategic Group as appropriate. • The Trust has an Emergency Planning Team. • The Trust has identified Priority Work Streams (including IP; Demand, Capacity & Escalation; Procurement & Supplies, Estates & Facilities; HR & Occupational Health; Communications; Data; Finance; IM&T) and CMGs, each with a Nominated Lead & Deputy. • The Trust is an active member of the LLR Strategic and Tactical Coordinating Groups (HSCG). • The Trust is an active member of various LLR 'work stream' cells. • Accountable Emergency Officer (COO) in place. • NED in place with oversight of EPRR. • Daily SITREP reporting internally and externally to NHSEI. • The Trust has financial approval and monitoring arrangements with specific Covid-19 cost code to record and monitor expenditure - Must be of a standard to meet public and parliamentary scrutiny and external audit. • Participation in national & regional executive specific COVID-19 webinars. • Tactical Group maintain a log of deviations from national directives, local policies / best practice / guidance during COVID-19 for learning purposes.	• UHL COVID-19 Daily SitRep. • Collaborative decision making through UHL COVID-19 Tactical and Strategic Groups and Board meetings (Internal). • Compliance with Midland region command and control arrangements (External). • Transparency and oversight of rapid decision making provided through regular weekly updates to Governors and non-executive directors (Internal). • BAF Principal Risk 8 reviewed at UHL COVID-19 Strategic Group and escalated to Chairman and NEDs (via TB papers) (Internal).	• Ensuring 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 to manage the COVID-19 related demand in addition to the capacity required for elective restoration and recovery. • Process for system-led risk stratification of waiting lists is not yet in place although a solution has been identified and is being procured via the ERF programme. • Substantive plan for 22/23 additional capacity to continue elective wait times recovery	• 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. Local workforce is being supplemented in specific areas by insourcing arrangements. • Work with specialist providers and local information experts to understand feasibility of a more holistic approach to capturing multi-morbidity of patients waiting for procedures, surgery and OPs. • Building early strategy for 22/23, to ensure balance is met between clinical risk, delivery of capacity and the associated risk of insourcing into high acuity, clinical areas

Appendix 1 - UHL Board Assurance Framework – (FINAL VERSION – Dec 2021 – Trust Board in Feb 2022)

BAF Scoring process:

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

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

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

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

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

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

BAF Scoring Matrix: (L x I)

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

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

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

Audit Committee – Deep Dive outcomes:

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

Appendix 2 (a) - BAF Strategic Hot Risk Commentary

Date: 13/01/2022	
Enabling Strategy: Becoming the Best Strategy	
Strategic Objective: Quality Priorities	
BAF Risk Ref: PR1	Adverse impact on quality of care: 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 results in significant and ongoing disruption to one or more areas of the hospital and adversely impacts quality of care
Current Risk Score:	**20**
Target Risk Score:	**10**
Exec Lead:	**MD & ACN**
RAG Rating on achieving Outcome by Target Date:	**Off Track**

What's going well:	**What are the current challenges:**
• Mask Fit testing • Strategic oversight of nurse staffing through nursing midwifery and AHP workforce strategic coordination centre • Levels of harm detected by Datix reporting and the Learning from Deaths process are low • Harm that has been detected has been appropriately investigated so that learning can be embedded	• High staff sickness levels (13.8% to include COVID and other absence – 16/01/2022 – Covid-daily SitRep) • Emergency pressures through ED and CDU, with admissions remaining fairly consistent (Performance briefing for urgent and emergency care – EFPB Jan 22). • Increasing community Covid-19 cases • Increasing Covid-19 Admissions (Covid-19 daily SitRep) • UHL currently undertaking work to more accurately define the level of risk it is carrying due to the effects of the pandemic; and in particular to define harm that is as a result of unintended consequences of prioritising certain patients groups over others

How are we meeting the challenges:

- Mobile Urgent Treatment Centre in place
- Surge Capacity Planning
- Preparation of the Nightingale (slightly behind schedule)
- As the ICS develops there is also a need to design a system for capturing harm across patient pathways and feeding into relevant Design Groups and System Teams to ensure collaborative improvement

Appendix 2 (b) - BAF Strategic Hot Risk Commentary

Date: 14/01/2022	
Enabling Strategy: Becoming the Best Strategy	
Strategic Objective: Supporting Priority	
BAF Risk Ref: PR1	Inability to ensure adequate staffing capacity, capability and diversity: • Failure to plan, redesign and transform the workforce • Failure to develop staff capability • Failure to build a compassionate and inclusive culture
Current Risk Score:	**20**
Target Risk Score:	**12**
Exec Lead:	**CPO**
RAG Rating on achieving Outcome by Target Date:	**Off Track**

What's going well:	**What are the current challenges:**
• Expansion of wide ranging Health and Wellbeing offer being communicated to staff • Increased AMICA counselling – 24//7 advice line and access to resources through new portal / website. • Positive staff survey response rate (45%) which will support us to develop services to support staff • Improving Work force supply initiatives - Intakes of international nurses being supported into UHL • EDI Board workshop to reset the EDI agenda at UHL and prioritise key actions held in November 2021 • Re-establishment of Redeployment and recruitment cells to co-ordinate priority activities	• Significantly increased absence levels (13.8% to include COVID and other absence – 16/01/2022) • Management of Workforce / staffing gaps • Burnout of the workforce due to ongoing significant operational pressure and increasing waiting lists • Emerging risk of Mandatory Vaccinations (Vaccinations as Conditions of Deployment - VCOD) impacting on workforce availability • Local labour market challenges due to unprecedented demand for workforce in partner organisations.

How are we meeting the challenges:

Extensive engagement exercise with CMG management teams held in November 21 to establish the following priorities and provide clarity and make it manageable / realistic in the now & immediate term - Key priorities for now - staff support, wellbeing and getting the basics right, streamlining recruitment & bank processes, meaningful recognition, strengthening leadership and building inclusion into all that we do. Maintaining & developing medium and longer term objectives alongside delivery of the NHS People Promise and NHS People Plan in collaboration with wider system colleagues.

Health and wellbeing

- Publicising the wellbeing programme that the Trust offers / reframing the offer to keep it simple & accessible –4 Levels/categories - Looking after yourself / Looking after others / Let's talk / I need help

- REACT training to support leaders to have conversations with colleagues that may not know that they are struggling and Trauma Risk Management (TRiM) trauma-focused peer support system designed to help people who have experienced a traumatic, or potentially traumatic, event (70 UHL staff have undertaken training)
- In reach of H&WB advice, including the development of People Services pop up clinics to signpost and help support the resolution of issues at the earliest opportunity

Workforce Supply

- Continuing to support bulk recruitment for Healthcare Assistants and international Nurses. Continue to build LLR system resourcing strategy for key groups.
- Prioritise additional capacity posts through the recruitment process
- Developing recruitment trajectories for existing vacancies and emerging workforce plans.
- Operational Workforce Plans being developed with CMGs. Reviewing feasibility of proposed plans and reviewing options for workforce transformation /alternative roles / ways of working.
- Developing capacity in our temporary staffing function to maximise the number of temporary workers we can bring into the Trust
- Implementation of the ERF rate card and other premium rates for additional work / pay incentives.
- Continue to embed Kick start and Apprenticeships in order to build future supply
- Continue to embed Agile and Flexible working through the Flex for the future programme
- Progress the LLR system retention project and implement new exit questionnaires process.

Equality, Diversity and Inclusion

- Work with Corporate Nursing on a programme to enable the retention of ethnic minority oversees nurses
- Launch of Active Bystander Programme and opening of the booking process for Cohorts 1 &2
- Launch of the UHL Womens Network
- Project SEARCH – intern programme for students with SEND.
- Rainbow Lanyard scheme for those with Hidden Disabilities
- Meetings to be facilitated with CEO, Network Chairs, and EDI Coordinator to understand specific needs scope and vision of each network.
- Introduction to draft EDI Data Dashboard to support more accessible data to support decision making

Mandatory Vaccinations (VCOD)

- Project group in place to support the management of this process
- Vaccine hesitancy listening events held
- Risk assessment and Equality impact of this change currently being assessed

Leadership development

- Continuing to offer coaching and mentoring support. Promote LLR Leadership Academy offer of development
- Delivery of Compassionate Leadership series workshops focusing on building resilience,
- Embedding the Leadership and Management getting the basics right tool which provides simple habits that support and engagement with teams

Recognition of our people

- Above and beyond (1200 per month) and continuing the sessional Caring at its best awards

Appendix 3 - Risk Register summary for risks rated 15 and above

Risk ID	CMG	Risk Description
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 bre delivery of national targets
3139	CMG 1 - CHUGGS	If the ageing and failing decontamination equipment in Endoscopy is not improved / replaced, then it may result in delays and inaccuracies with patient diagnosis or treatment, leading to potential for patie to meet national guidelines with diagnostic targets and decontamination and Infection Control requirements, increasing waiting list size and failure to secure JAG approval.
2264	CMG 1 - CHUGGS	If an effective solution for the nurse staffing shortages in CHUGGS at LGH and LRI is not found, then it may result in detrimental impact on safety & effectiveness of patient care delivered, leading to poten harm.
3727	CMG 1 - CHUGGS	If additional capacity and space cannot be identified to meet the increasing demand on Osborne Day Case services, caused due to Covid-19 space requirements, and need to support SACT and specialist Osborne, then this may result in delayed treatment for patients with curative or highly treatable cancers, leading to potential patient harm, adverse reputation and financial impact
1149	CMG 1 - CHUGGS	If demand for cancer patients' service exceeds capacity, then it may result in widespread delays with patient diagnosis or treatment, leading to potential for patient harm and waiting time target breach
3333	CMG 1 - CHUGGS	If staffing levels in Oncology service remains below clinic capacity, then it may result in significant delay with patients receiving their first appointments, leading to potential adverse impact on their outcome
3258	CMG 1 - CHUGGS	If the radiotherapy service unable to deliver treatments and activity has to be diverted to other radiotherapy service providers, caused due to ageing equipment, then it may result in delays with patient diag potential for a poor patient experience with potential of adversely affecting their outcomes, non-compliance with 62 day standard and a loss of income for the service.
3789	CMG 2 - RRCV	If the acute respiratory response team is not operational during peak COVID waves as an extension of the ventilation team to deliver enhanced respiratory care and monitoring, then it may result in delays treatment, leading to potential for patient harm, including impacting on ITU capacity and and elective care admissions
3820	CMG 2 - RRCV	If there is a continued reduction in available theatre sessions for cardiac surgery elective and clinically urgent patients, caused due to theatre and recovery staff being released to staff the ICUs, then it may extended waiting times for clinically urgent patients, leading to potential for significant patient harm or death, adverse reputation, service disruption and financial loss
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 between patients, leading to potential for patient harm and adverse reputation
3825	CMG 2 - RRCV	If the Assisted Automated Peritoneal Dialysis Service provided by Baxter under the Pan Renal Framework is unable to cover all dialysis sessions cause due to a shortfall in Renal Technicians then this ma patients having missed or inaccurate dialysis leading to significant patient harm (fluid overload or electrolyte imbalance), adverse reputation and service disruption
3734	CMG 2 - RRCV	If Cardiology do not have the required number of scrub nurses in the Angiocatheter suite to meet the patient demand (due to lack of funding) then it may result in an incident that threatens the safety of pa potential harm, adverse reputation, service disruption and financial loss.
3359	CMG 3 - ESM	If ESM CMG do not recruit and retain into the current nursing vacancies within Specialist Medicine, including the extra capacity wards opened, then it may result in widespread delays with patient diagnosi leading to potential harm.
3769	CMG 3 - ESM	If demand for skin cancer patients' service continues to exceed capacity, caused due to consultant vacancy and SPR gaps, as well as reduced clinical space, then it may result in widespread delays with p or treatment, leading to potential for patient harm and cancer waiting time target breach increasing the potential delays in both diagnosis and treatment.
3699	CMG 3 - ESM	If medical and nursing workforce capacity in Majors is not increased commensurate to meet demand (caused due to reorganised services in ED as a result of the COVID-19 pandemic), then it may result i delays with patient assessment, diagnosis and treatment, leading to potential harm, adverse reputaion and service disruption.
3202	CMG 3 - ESM	If there are shortfalls or gaps in medical staffing of the Emergency Department, including EDU, then it may result in widespread delays in patients being seen and treated leading to potential harm.
3077	CMG 3 - ESM	If there are delays in the availability of in-patient beds leading to overcrowding in the Emergency Department and an inability to accept new patients from ambulances, then it may result in detrimental impa delivered care and patient safety within the ED leading to potential harm.
3475	CMG 4 - ITAPS	If there is no effective maintenance programme in place to improve the operating theatres at the LGH, LRI & GGH sites, including ventilation, and fire safety, then it may result in failure to achieve compliar required regulations & standards, leading to reputational impact and service disruption.
3791	CMG 5 - MSK & SS	If there is a decrease in staff uptake of additional work to meet demand for Breast Surgery, caused due to the Trust's plans to reduce WLI Local Allowance Schemes and ask admin and nursing teams to w rather than WLI, then it may result in delay in patint treatment and diagnosis of conditions, leading to potential harm for those patients on a 2WW suspected cancer pathway and breach of 2WW performan
3773	CMG 5 - MSK & SS	If ENT services are unable to meet current demand and address the backlog of 18 week and 52 week RTT patients (caused due to the COVID 19 pandemic) then this may result in delays in patient diagnc treatment leading to potential harm to patients on the 2WW pathway, significant service disruption, adverse reputation and financial loss
3714	CMG 5 - 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 (failing to achieve 2WW 14 Day appointments for patients and 62 Day Cancer Breaches), adverse reputation, service disruption and financial loss.
2615	CMG 6 - CSI	If a critical infrastructure failure was to occur in containment level 3 laboratory facility in Clinical Microbiology, then it may result in a prolonged disruption to the continuity of core services across the Trust, service disruption
3023	CMG 7 - W&C	If the split site Maternity configuration strategy is not enacted, then it may result in a detrimental impact on safety & effectiveness of Maternity services at the LGH site leading to potential harm
3093	CMG 7 - W&C	If there is insufficient Midwifery establishment to achieve the recommended Midwife to Birth ratio, in view of increased clinical acuity, then it may result in patient care being delayed leading to potential har increase in maternal and fetal morbidity and mortality rates
3483	CMG 7 - W&C	If the Viewpoint Maternity Scan system is not upgraded to the supported 6.0 version and the archiving solution is not addressed, then it may result in a detrimental impact on quality of delivered care and p with missed fetal anomalies, leading to harm
3083	CMG 7 - W&C	If gaps on the Junior Doctor rota in the Neonatal Units at both the LRI and LGH reach a critical level, then it may result in widespread delays with patient diagnosis or treatment, leading to potential for harr
3084	CMG 7 - W&C	If split site Consultant cover of the Neonatal Units at the LRI and LGH is not addressed, then it may result in widespread delays with patient treatment leading to potential harm and withdrawal of the neona the LGH site impacting significantly the Maternity Service.
3332	CMG 7 - W&C	If the paediatric asthma service remains below clinic capacity, then it may result in significant delay with reducing the waiting list and patient review or treatment leading to potential patient harm
3823	CMG 7 - W&C	If additional capacity and space cannot be identified to meet the increasing demand on the Children's Hospital services, caused due to Covid-19 and compliance with PHE guidance on maintaining social d space requirements, then it may result in a reduction in infection control, leading to potential patient harm, adverse reputation and financial impact
3824	CMG 7 - W&C	If during periods of high activity children cannot be isolated or cohorted based on their clinical needs in line with PHE guidance, then it may result in a reduction in infection control, leading to potential patie adverse reputation and financial impact
3661	CMG 7 - W&C	If clinical staffing levels in the general respiratory paediatric service are not increased to meet the high levels of demand, then it may result in delays in diagnosis and treatment for new referrals and follow- appointments, leading to potential harm, adverse reputation and service impacts
2404	Corporate Medical	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 leadin harm and increased morbidity and mortality.
3143	Estates & Facilities	If sufficient capital funding is not committed to reduce backlog maintenance across the estate and infrastructure, then it may result in a prolonged disturbance to the continuity of core services across the T potential service disruption and patient harm
3144	Estates & Facilities	If Estates & Facilities are unable to recruit and retain staff, or fund posts to deliver services to meet the Trust's expectations, then it may result in a prolonged disturbance to the continuity of core services a leading to potential service disruption, patient harm, failure to achieve required standards
3655	Finance & Procurement	If the Trust is unable to maintain an adequate supply of critical clinical supplies and equipment, caused by critical supply chain failure affecting supply of medicines, medical devices such as ventilators, NIV 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.
3722	Corporate Nursing	If during the Covid-19 Pandemic there is dilution of registered nursing skill mix in adult wards and critical care, caused due to expansion of the bed base, reduction of staff availability and national directive critical care capacity, then it may result in a detrimental impact on safety & effectiveness of patient care delivered, leading to potential harm and poor patient experience
3148	Corporate Nursing	If the Trust does not recruit the appropriate nursing staff with the right skills in the right numbers, then it may result in detrimental impact on safety & effectiveness of patient care delivered leading to poten poor patient experience
3846	CMG 1 - CHUGGS	If the establishment of trained SACT nurses in the Chemotherapy Suite continues to fall below the levels required to meet the increased demand for its service's (due to significant staffing vacancies and lo sickness) then this may result in delays in treatment and extended waiting times for chemotherapy patients leading to potential for patient harm, service disruption and adverse reputation
3260	CMG 1 - CHUGGS	If medical patients are routinely outlied into the Surgical Assessment Unit at LRI along with surgical admissions and triage, then it may result in widespread delays with surgical patients not being seen in a therefore not getting pain relief or appropriate treatment in the right place, leading to potential for patient harm and impact on surgical flow.
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 patients, leading to potential harm.
3350	CMG 1 - CHUGGS	If staffing levels are not increased within the radiographic workforce of the radiotherapy department during times of peak activity, then it may result in widespread delays with patient diagnosis or treatment potential patient harm
3519	CMG 1 - CHUGGS	If availability of essential replacement uroscopes in Urology is not adequaltely resourced, then it may result in delays with patient treatment due to insufficient effective/working scopes available to undertak leading to potential for harm (increased patient waits both cancer and RTT), disruption to the service and adverse effect on reputation.
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 pro Respiratory Home Ventilation Service (Adults) leading to service disruption and potential harm to patients
3724	CMG 2 - RRCV	If the green pathway and risk stratification for undertaking transplantation is compromised during COVID-19, due to the significant movement of patients and staff between the renal nephrology wards and ward, then it may result in an incident occurring that threatens the exposure of COVID19 to patients and staff, leading to potential harm and disruption to the transplant programme.
3748	CMG 2 - RRCV	If diagnostic capacity is not increased in Cardiology and Respiratory Services to deliver both referral demand and current diagnostic waiting lists (backlog), then it may may result in delays with patient diag treatment, leading to potential for patient harm and breach against delivery of national targets
3751	CMG 2 - RRCV	If capacity is not increased in RRCV specialties to deliver referral demand for 31 day, RTT and Elective patients then it may result in delays with patient diagnosis or treatment leading to potential for patier breach against delivery of national targets
3847	CMG 2 - RRCV	If we continue to use a manual paper based system and are unable to install a clinical system in the Cath Labs as recommended by the GIRFT review in Cardiology, then it may result in a delay in patient discharge, leading to harm, service disruption and adverse reputation
3844	CMG 2 - RRCV	If there's insufficient provision of nursing and medical staff to meet demand in the Ambulatory Pleural Service, then it may result in delays with diagnostic and therapeutic treatment for patients including the lung cancer and other primary/metastatic malignancy, leading to potential harm and adverse reputation
3533	CMG 2 - RRCV	If there is insufficient Medical staff at consultant and registrar level within cardiology services to meet inpatient and outpatient demand, then it may result in widespread delays with patient diagnosis, progn treatment, leading to potential patient harm.
3309	CMG 2 - RRCV	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 poter
3835	CMG 2 - RRCV	If the dialysis unit private provider is unable to adhere to the UHL contract to provide the required standards of care, then it may result in an event that threatens the safety of patients, leading to the potenti patient harm, significant adverse reputation, service disruption and financial loss
3413	CMG 2 - RRCV	If nurse staffing levels are below establishment and availability of appropriate monitoring equipment is not increased to care for patients requiring acute NIV, then it may result in delays with patient diagnos and failure to achieve compliance national recommended guidance, leading to potential harm and increased length of stay for patients requiring NIV
3848	CMG 2 - RRCV	If the nurse staffing workforce is below the required level to meet demand for post operative thoracic patients, particularly those requiring High Dependency Care, caused due to sickness, maternity leave a then it may result in theatre cancellations and delays with patient treatment, leading to potential for patient harm, including impact on elective, emergency and interhospital transfers, adverse reputation ar
3855	CMG 3 - ESM	If Children attending the Emergency Department (ED) are not visually assessed by a doctor or nurse immediately upon arrival with clinical assessment undertaken within 15 minutes to determine priority ca due to significant staffing vacancies and lack of assessment rooms, then it may result in delays in diagnosis and treatment within standard timeframe's leading to potential for major harm as children are at than adults for early deterioration due to their non-specific features of illness and ability to verbalise concerns
3697	CMG 3 - ESM	If there is no suitably trained and competent transfer team to transfer an unstable patient for Emergency Care who is not requiring mechanical ventilation, then it may result in delays to time-critical definitiv management, leading to potential for harm, adverse reputation and financial impact
3796	CMG 3 - ESM	If there are high levels of registered nurse vacancies within the Adult Emergency Department at the Leicester Royal Infirmary, caused due to difficulty recruiting and poor retention of nursing staff within the this may result in an incident that threatens the safety of patients and staff, leading to potential harm (widespread delays in assessment and in initial treatment/care and staff burnout), adverse reputation, s disruption and financial loss.

Risk ID	CMG	Risk Description
3797	CMG 3 - ESM	If there are high levels of registered nurse vacancies within the Children's Emergency Department at the Leicester Royal Infirmary, caused due to difficulty recruiting and poor retention of nursing staff with then this may result in an incident that threatens the safety of patients and staff, leading to potential harm (widespread delays in assessment and in initial treatment/care and staff burnout), adverse reputat disruption and financial loss.
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 impact on safety & effectiveness of patient care delivered leading to potential harm from microbiological contamination in the theatre environment.
2333	CMG 4 - ITAPS	If we do not recruit into the Paediatric Cardiac Anaesthetic vacancies to maintain a WTD compliant rota, then it may result in suboptimal patient treatment leading to potential for patient harm.
3799	CMG 5 - MSK & SS	If Fracture clinic demand exceeds capacity, caused due to ED occupying parts of the pre-covid Fracture clinic department, then it may result in an event that threatens the health and/or safety of patients, and/or the public, leading to potential harm, adverse reputation, service disruption and financial impact.
3738	CMG 5 - MSK & SS	If there is a gap in the senior clinical MSK workforce specialising in sarcoma in outpatient and surgical diagnostic settings, caused due to single handed practitioner at consultant level not being readily ava may result in delays in patient diagnosis and investigative surgery, leading to harm, adverse reputation and financial impact.
3759	CMG 5 - MSK & SS	If the Maxillofacial / Orthodontics and Restorative Dentistry services are unable to meet current demand and address the backlog of 18 week and 52 week patients (caused due to the reconfiguration of ac COVID 19 pandemic) then this may result in delays in patient diagnosis and treatment leading to potential patient harm, significant service disruption, adverse reputation and financial
3852	CMG 5 - MSK & SS	If the maxillofacial department are unable to fill to the critical SHO vacancies, then it may result in delays to patient diagnosis and treatment, leading to potential harm, adverse reputation, service disruption impact
3765	CMG 5 - MSK & SS	If there is a lack of optical coherence tomography scanners to meet increased patient demand in the Ophthalmology service, then it may result in a delay in review and treatment and poor flow of patients timely manner, leading to harm with potential patient sight loss or worsening of condition.
3683	CMG 5 - MSK & SS	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 care they require)
3341	CMG 5 - MSK & SS	If there is a lack of theatre time and lack of acknowledgement of urgency for getting NoF patients operated on, then it may result in widespread delays with patient treatment, leading to harm (mortality and patient outcome compromised the longer they await theatre.
3801	CMG 6 - CSI	If diagnostic capacity is not increased in diagnostic services to deliver both referral demand and current diagnostic waiting lists, caused due to an increased gap in demand and capacity throughout the Co pandemic then it may result in delays with patient diagnosis or treatment leading to potential for patient harm and breach against delivery of national targets
3817	CMG 6 - CSI	If the pharmacy service (inclusive of clinical trials) is under-established and / or unable to recruit & retain adequate staff (in either individual teams or across multiple parts of the service) then this may resu being unable to maintain current and future workload requirements and meet emerging service development opportunities leading to potential for significant service disruption, patient harm and adverse re
3206	CMG 6 - CSI	If staff are not appropriately trained on the usage of POC medical device equipment, then it may result in detrimental impact on safety & effectiveness of patient care delivered with inaccurate diagnostic te leading to potential harm to the patient.
3788	CMG 7 - W&C	If UHL does not effectively embed genomics testing into its clinical pathways (to enable genomic data to inform treatment choices), then it may result in delays with patient diagnosis and clinical care being leading to the potential for major patient harm, service disruption, adverse reputation and financial loss
3663	CMG 7 - W&C	If we fail to address the staffing shortfall in Medical and Nursing cover for the Paediatric Nephrology Service, then it may result in delayed diagnosis and treatment to Nephrology patients in the region, lead patient harm, reputational damage, service disruption and financial loss
3647	CMG 7 - W&C	If the medical staffing issues within the Paediatric Rheumatology Service can't be resolved then it may result in delayed patient diagnosis and treatment (due to increased waiting times) leading to potentia and service disruption
3628	CMG 7 - W&C	If we fail to address the shortfall in consultant cover for paediatric and TYA haematology and oncology, then it may result in delays with diagnosis and treatment to non-malignant and malignant haematolo patients in the region, leading to Patient harm and reputational damage.
3558	CMG 7 - W&C	If paediatric neurology is unable to secure cover for current consultant vacancy and cover long term sickness of specialist nurse, then it may result in widespread delays with patient diagnosis and treatmer patient harm and substantial service disruption.
3560	CMG 7 - W&C	If Children's services are unable to comply with the recommendations in NICE Guideline Recommendations in NG61 (End of life care for infants, children & young people), then it may result in Children ha inappropriate treatments and interventions, leading to potential for harm.
3561	CMG 7 - W&C	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, lea for harm.
3585	CMG 7 - W&C	If HDU provision within Leicester Children's Hospital continues to be inadequate for children requiring higher levels of care, then it may result in poor quality of care, flow, and patient harm.
2153	CMG 7 - W&C	If the high number of vacancies of qualified nurses working in the Children's Hospital is below establishment, then it may result in widespread delays with patient diagnosis or treatment leading to potential
3842	CMG 7 - W&C	If the UHL Paediatric Metabolic Service fails to reinforce its service provision in line with the increased demand for its services then it may result in delays with patient diagnosis and treatment leading to po patient harm; adverse reputation and significant service disruption
3217	CMG 8 - The Alliance	If a solution is not found for flexible endoscope decontamination across all UHL and Alliance units then the organisation will not be compatible with HTM 01-06 or JAG regulations and will not be able to pro quality, reliable process for the decontamination of flexible endoscopes, to support the endoscopy service, which could result in lost activity and income, reduced patient satisfaction with the service and pa delayed or cancelled procedures.
3201	Communications	If the Mac desktop computers fail/break down or the shared server fails, then it may result in a prolonged disruption to the continuity of photography and/or graphics services across the Trust leading to ser
3344	Corporate Medical	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 tuberculos result in a detrimental impact on health & safety of staff, patients and visitors, leading to harm.
3489	Estates & Facilities	If water stagnation occurs in the hospital water system and Pseudomonas aeruginosa bacteria form, then it may result in a detrimental impact on patient safety, leading to potential harm, reputational impa disruption
3141	Estates & Facilities	If the integrity of fire compartmentation is compromised, then it may result in a detrimental impact on the health and safety of staff, patients and visitors due to fire and/or smoke spread through the building ability to utilise horizontal and/or vertical evacuation methods leading to potential life safety concerns and loss of areas / beds / services.
3145	Estates & Facilities	If there is not a significant investment to upgrade electrical infrastructure across the UHL, then it may result in prolonged disturbance to the continuity of core services across the Trust leading to potential s disruption and patient harm
3138	Estates & Facilities	If there are insufficient management controls in place to meet Regulation 4 of the Control of Asbestos Regulations (CAR), then it may result in failure to achieve compliance with regulations & standards lea potential reputational impact, enforcement action by the HSE, and significant financial penalties.
3688	Estates & Facilities	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 dis clinical services
3340	Human Resources	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 specificat requirements, leading to potential service disruption, financial and reputational impact
3862	IM&T	If there was a breach of UHL IT systems (caused by a cyber attack on the Log4j open-source Java logging library which is widely used in many IT applications) then this may result in a breach of informatio leading to major service disruption with services becoming unavailable, unreliable or unstable and adverse reputation
3755	Corporate Nursing	If workforce capacity in the patient safety team is unable to cover the workload, caused by staff vacancies, then it may result in untimely information provided internally / externally (including in the following Complaints, PHSO cases, Serious incident identification and timely investigations, Duty of Candour compliance and IRMER investigations), leading to non-compliance with regulatory standards, service di adverse reputation
3617	CMG 1 - CHUGGS	If LLR system-wide governance (including policy, paperwork, process, audit and education) is not agreed for use of subcutaneous medications to manage symptoms in adult patients at the end of life, then delays for symptom control or medications could be administered without an appropriate assessment of reversible causes of deterioration, leading to potential harm to patients.
3576	CMG 2 - RRCV	If there is not 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, re life for patients, increased costs of oxygen provision and potential for withdrawal of CCG funding.
3762	CMG 2 - RRCV	If there is inadequate physical environment for the Cystic Fibrosis Service to operate both inpatient and outpatient services, caused due to building works for Critical Care and poor ventilation in treatement may result in a reduction in infection control, leading to potential patient harm with recurrent respiratory infection, adverse reputation with non compliance to service specification laid out by NHS England fo service disruption with delay in commencement of treatment and financial impact
3043	CMG 2 - RRCV	If cardiac physiologists staffing levels are below establishment, then it may result in diagnostics not being performed in a timely manner, leading to patient harm
3047	CMG 2 - RRCV	If the service provisions for vascular access at GH are not adequately resourced to meet demands, then it may result in patients experiencing significant delays for a PICC, leading to potential harm.
3832	CMG 2 - RRCV	If the Dialysis Units are unable to meet the increased demand on its services (due to an increase in haemodialysis activity as a result of patient's delaying the start of their dialysis and a reduction of transp year during the COVID 19 pandemic), then this may result in extended waiting times for patients requiring dialysis, leading to patient harm, deterioration in patient conditions, service disruption and adverse
3014	CMG 2 - RRCV	If there is no fit for purpose Renal Proton Clinical System to collect all information required for reimbursement of dialysis, then it may result in poor impact on the patient experience poor leading to reputatio
2804	CMG 3 - ESM	If the ongoing pressures in medical admissions continue and Specialist Medicine CMG bed base is insufficient with the need to outlie into other specialty/ CMG beds, then it may result in detrimental impa delivered care and patient safety leading to potential for patient harm
3222	CMG 3 - ESM	If a member of the public is violent or aggressive outside or inside ED receptions/waiting rooms, then it may result in a detrimental impact on health, safety & security of staff, patients and visitors leading to
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 leading to poor experience and reputational impacts
3830	CMG 5 - MSK & SS	If the retiring Head of Service for the Leicester Bone Bank is not replaced in a timely manner, then this may result in delays withtreatment and suspension of the service (due to the authorisation of bone tra allowed by the Head of Service as per Human Tissue Authority regulations), leading to significant adverse reputation, service disruption and patient harm
3704	CMG 6 - CSI	If the oncology/ haematology & aseptic pharmacy team do not have sufficient resource to complete preparatory works associated with the upgrade to version 6 of CIS's ChemoCare software, then it may r patient treatment and incorrect dosing of systemic anti-cancer therapy (SACT), leading to potential harm, adverse reputation, service disruption and financial loss
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/haemato result in increased medication errors, leading to potential harm, adverse reputation, service disruption and financial loss
3860	CMG 6 - CSI	If the Radiopharmacy service is unable to replace the degrading Air Handling Unit and Laminar Air Flow cabinets then this may result in major service disruption leading to potential harm with delays in pat diagnosis and loss of reputation from Nuclear Medicine service users and regurlatory bodies (MHRA)
3839	CMG 7 - W&C	If the Women's & Children's specialties with patients on RTT pathways are unable to address the backlog of 52, 78 and 104 plus week waits (caused due to the reconfiguration of activity during the COVID then this may result in delays in patient diagnosis and treatment leading to potential patient harm, service disruption, adverse reputation and financial loss
3657	CMG 7 - W&C	If Newborn bloodspot samples do not arrive in the screening laboratory within 3 working days, caused due to samples being delayed or lost in the post, then it may result in delay in the diagnosis and treat 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 implica repeat samples.
3492	CMG 7 - W&C	If demand for the maternity ultrasound scan provision exceeds capacity, causing a delay, then it may result in a preventable stillbirth or an increase in the risk of the fetus developing cerebral palsy due to 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
3694	CMG 7 - W&C	If there is a reduction in Paediatric Surgery, Paediatric Urology and Paediatric Orthopaedic services, caused due to Paediatric resources needing to be assigned to support other services within the Trust i the Covid-19 pandemic, then it may result in delays in patient treatment and surgery, leading to potential for harm, service disruption and adverse reputation
3090	CMG 8 - The Alliance	If the poor condition of the estate at the Hinkley and District Hospital is not rectified, this will hinder the delivery of activity and stop developments and transformation of care in line with the STP
2394	Communications	If there is no service agreement to support the image storage software used for Clinical Photography, then it may result in widespread delays with patient diagnosis or treatment because Clinicians would n view the photographs of their patients leading to potential harm
3695	Estates & Facilities	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 re infection control, leading to potential patient harm, adverse reputation, service disruption and financial loss
1615	IM&T	If flooding occurs in our Data Centre at the LRI site, then it may result in limited or no access to Trust systems, leading to potential service disruption and provision of patient care

Risk ID	CMG	Risk Description
3654	Operations (Corporate)	If the number of patients with suspected or confirmed COVID-19 increases across Leicester's Hospitals, caused by either a new variant or reduced vaccine efficacy, then it may result in operational instabi 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.
3677	Operations (Corporate)	If we are unable to secure funding (withdrawn due to the impact of COVID-19) to deliver Personalised Stratified Follow Up (PSFU) in Breast, Colorectal and Prostate, then it may result in delays in identifyi concerns and timely addressing of patient physical, psychological, emotional and practical needs, leading to potential patient harm, poor experience and adverse reputation.