INTEGRATED RISK AND ASSURANCE REPORT: SEPTEMBER 2018 FINAL

Author: Risk and Assurance Manager Sponsor: Medical Director **Trust Board paper F**

Executive Summary

Context

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

Note - The BAF should also be reviewed in the context of the assurances being provided in other reports also being considered at this Board meeting.

Questions

1. What are the highest rated principal risks on the 2018/19 BAF?
2. What are the significant changes on the organisational risk register since the previous version?
3. What are the key risk management themes evidenced on the organisational risk register?

Conclusion

1. The principal risks on the BAF have been identified by the Board and are linked to Trust objectives. They relate to: PR1 – Quality standards; PR2 – Staffing levels; PR3 – Financial sustainability; PR4 – Emergency care pathway; PR5 – IM&T service; PR6 – Estates and Facilities service; PR7 – Partnership working. The highest rated principal risks (currently rated at 20) concern staffing levels, emergency care pathway and financial sustainability.
2. There are 224 risks recorded on the organisational risk register (including 72 with a current rating of 15 and above). The Trust's risk profile continues to demonstrate active review across all CMGs and corporate services. There have been six new risks scoring 15 and above entered on the risk register during this reporting period.
3. Thematic Analysis of the CMG risks shows the two key risk causation themes as gaps in staffing levels and demand pressures. Financial challenges, including funding and internal control arrangements are recognised as key enablers to support the delivery of the Trust's objectives.

Input Sought

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

For Reference

Edit as appropriate:

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

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

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

a. Organisational Risk Register [Yes]

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

b. Board Assurance Framework [Yes]

BAF entry	BAF Title	Current Rating
	See appendix one	

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

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

5. Scheduled date for the **next paper** on this topic: [Monthly to TB meeting]

6. Executive Summaries should not exceed **1 page**. [My paper does comply]

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

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST

REPORT TO: **UHL TRUST BOARD**

DATE: **1ST NOVEMBER 2018**

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

SUBJECT: **INTEGRATED RISK AND ASSURANCE REPORT (INCORPORATING UHL BOARD ASSURANCE FRAMEWORK & ORGANISATIONAL RISK REGISTER – SEPT 2018 - FINALS)**

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1 INTRODUCTION

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

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

2. 2018/19 BOARD ASSURANCE FRAMEWORK SUMMARY

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

2.2 The BAF remains a dynamic document and all principal risks have been reviewed by their lead Directors (to report performance for September) and have been scrutinised and endorsed by their relevant Executive Boards during October 2018. There have been no concerns raised by the Executive Boards for escalation to the Board meeting today. An updated version of the BAF is attached at appendix one.

2.3 The three highest rated principal risks relate to financial sustainability, emergency care pathway and workforce capacity, and are described below:

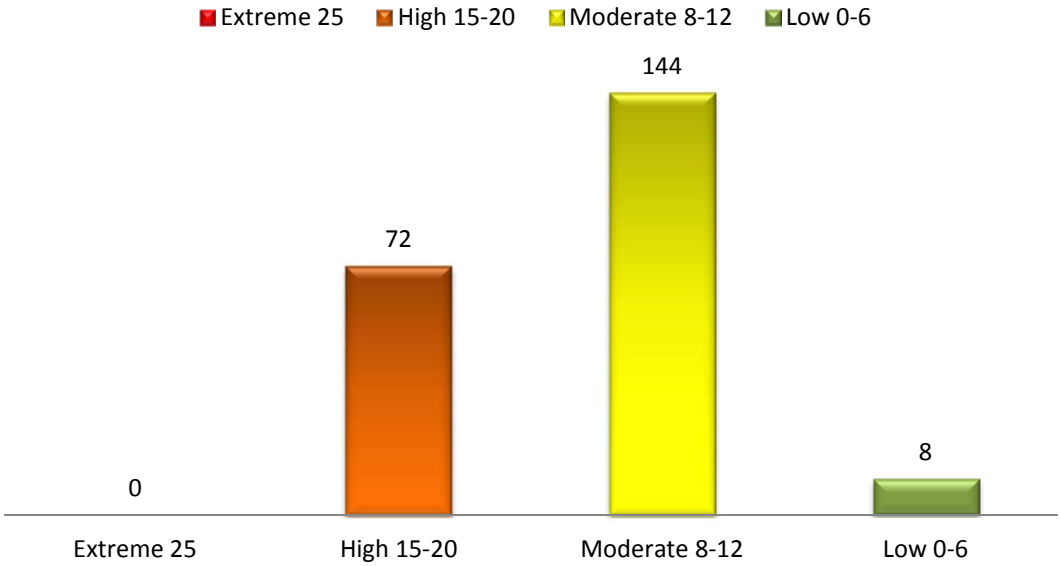
Principal Risk Description	Risk Rating	Objective & Lead Director
PR2: If the Trust is unable to achieve and maintain the required ***workforce capacity and capability*** standards, then it may result in widespread instances of poor clinical outcomes for patients and increased staff workloads, impacting business (quality / finance) and reputation (regulatory duty / adverse publicity).	20	Our People DPOP
PR3: If the Trust is unable to achieve and maintain ***financial sustainability***, then it will result in a failure to deliver the financial plan, impacting business (finance & quality) and reputation (regulatory duty / adverse publicity).	20	Financial Stability CFO
PR4: If the Trust is unable to effectively manage the ***emergency care pathway***, then it may result in widespread instances of poor clinical outcomes for patients and sustained failure to achieve constitutional standards, impacting business (quality & finance) and reputation (regulatory duty /	20	Organisation of Care COO

adverse publicity).		

3. ORGANISATIONAL RISK REGISTER SUMMARY

3.1 The Trust's risk register has been kept under review by the Executive Performance Board and CMG Boards during September and displays 224 organisational risks. The Trust's risk profile by current risk rating is illustrated in Figure 1, below and a dashboard of high risks is attached at appendix two.

Figure 1: UHL Risk Register profile - residual risk rating



3.2 There have been six new risks, rated 15 and above, entered on the risk register during the reporting period and these are described below:

CMG /ID	Risk Description	Current Rating	Target Rating
Corp Nursing / 3298	If the outbreak of Carbapenem-resistant Organisms continues, we are at risk of under achievement of key clinical standards and a decrease in bed capacity for emergency admissions so reducing our ability to continue to provide an acceptable level of health service, resulting in potential harm to patients, adverse reputation and service delivery impact.	20	5
ESM / 3275	If the aging Neurophysiology investigative/diagnostic systems are not replaced, then the EMG, EP, EEG services, including Telemetry, Ambulatory, OP & IP and Portable across UHL and community may become unsustainable, resulting in an inability to diagnose patients' disorders of the function of nervous system.	16	6
CSI / 3286	If continual failure in meeting key performance indicators for urgent blood cancer diagnostic testing, caused by limited Consultant Immunologist availability then this will result in delayed diagnosis and treatment of acute leukaemia patients and withdrawal of weekend standby service	16	6
CSI / 3317	If breast care services are unable to consistently deliver the 2WW demand, due to high volumes of vacancies, lack of equipment and adequate space to house the service, then patients may experience delayed appointment time and treatment, resulting in harm	15	9

CSI / 3262	If the pressure on the Cellular Pathology Urology service caused by the continuing increase in cases from external sources is not effectively matched with appropriate resources, then the service will become unsustainable leading to reporting errors, resulting in patient harm.	15	3
Ops / 3289	If the Trust fails to improve its emergency preparedness, resilience and response arrangements, caused by a lack of appropriate time and resources to develop them, then there is a risk that the Trust is not adequately prepared to respond to a business continuity, critical or major incident.	15	6

3.3 One risk has been increased from a moderate to a high rating during the reporting period and is described below:

CMG /ID	Risk Description	Current Rating	Target Rating
RRCV / 3109	If additional capacity, resource and support are not provided for the Respiratory Consultant Pharmacist then it may result in widespread instances of Detrimental impact on quality, resulting in patient harm.	16	8

3.4 One risk has reduced from 20 to 15 during the reporting period and is described below:

Dept / ID	Risk Description	Current Rating	Target Rating
CSI / 2615	Integrity and capacity of containment level 3 laboratory facility in Clinical Microbiology.	15	2

3.5 No risks, rated 15 above, have been closed during the reporting period.

3.6 The organisational risk register performance against the agreed indicators is detailed in the table, below:

Performance Measure Indicator	Target Level	Risk Register Total (1 – 25)	Risk Register High & Extreme (15 – 25)	Risk Register Moderate & Low (1 – 12)
No. of active risks (open)	N/A	224	72	152
% of risk reviews completed on time / within set review date	>90%	95% (212)	100% (72)	92% (140)
% of risks with mitigating actions in place	>90%	90% (202)	100% (72)	86% (130)
% of risks with mitigating actions elapsed (i.e. beyond target date)	<10%	7% (15)	1% (1)	9% (14)
New risks added to the risk register	N/A	28	6	22

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

- Staffing shortages;
- Imbalance between demand and capacity.

3.8 A number of operational risks make reference also to financial pressures, as a result of limited funding and challenging internal control arrangements, which are recognised as enablers to support the delivery of the Trust's

operational and strategic objectives. These thematic findings from the risk register are reflective of the highest rated principal risks on the BAF.

4 RECOMMENDATIONS

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

UHL Board Assurance Framework 2018/19:

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

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

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

The BAF is linked to performance metrics with detective risk indicators as a further source of evidence to inform the regular review and re-assessment. The assurance sections focus on where internal and external scrutiny of the operation of primary controls takes place, along with a summary of what the evidence received tells us in relation to the effectiveness of the controls which are being relied on.

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

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

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

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

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

2018/19 BAF Dashboard

Principal Risk Description	Strategic Objective	Exec Direc	Exec Team	Trust Board Cmttee	Current Rating I x L	Change
1) A) If the Trust is unable to achieve and maintain the required quality and clinical effectiveness standards, ***caused by inadequate clinical practice and/or ineffective clinical governance,*** then it may result in widespread instances of avoidable harm to a large number of patients, affecting reputation (breach in regulatory duty / adverse publicity).	Quality Commitment: to deliver safe, high quality, patient centred, healthcare	MD / CN	EQB	AC / QOC	4 x 3 = 12	↔
B) If the Trust is unable to achieve and maintain the required quality and patient safety standards, ***caused by inadequate clinical practice and/or ineffective clinical governance,*** then it may result in widespread instances of avoidable harm to a large number of patients, affecting reputation (breach in regulatory duty / adverse publicity).	Quality Commitment: to deliver safe, high quality, patient centred, healthcare	MD / CN	EQB	AC / QOC	4 x 4 = 16	↔
C) If the Trust is unable to achieve and maintain the required quality and patient experience standards, ***caused by inadequate clinical practice and/or ineffective clinical governance,*** then it may result in widespread instances of avoidable harm to a large number of patients, affecting reputation (breach in regulatory duty / adverse publicity).	Quality Commitment: to deliver safe, high quality, patient centred, healthcare	MD / CN	EQB	AC / QOC	4 x 3 = 12	↔
2) If the Trust is unable to achieve and maintain the required workforce capacity and capability standards, ***caused by employment market factors (such as availability and competition to recruit, retain and utilise a workforce with the necessary skills and experience), lack of extensive education, training and leadership, and demographic changes***, then it may result in widespread instances of poor clinical outcomes for patients and increased staff workloads, affecting business (finance) and reputation (breach in regulatory duty / adverse publicity).	We will have the right people with the right skills in the right numbers in order to deliver the most effective care	DPOD	EWB / EPB	AC/ PPPC	5 x 4 = 20	↔
3) If the Trust is unable to achieve and maintain financial sustainability, ***caused through delivery of income, the control of costs or the delivery of cost improvement plans***, then it will result in a failure to deliver the financial plan, affecting business (finance) and reputation (breach in regulatory duty / adverse publicity).	We will continue on our journey towards financial stability - deliver target 18/19	CFO	EPB	AC / FIC	5 x 4 = 20	↔
4) If the Trust is unable to effectively manage the emergency care pathway, ***caused by persistent unprecedented level of demand for services, primary care unable to provide the service required, ineffective resources to address patient flow, and fundamental process issues***, then it may result in widespread instances of poor clinical outcomes for patients and sustained failure to achieve constitutional standards, affecting business (finance) and reputation (breach in regulatory duty / adverse publicity).	We will improve our Emergency Care Performance	COO	EPB	AC / PPPC	5 x 4 = 20	↔
5) If the Trust is unable to deliver a fit for the future IM&T service, ***caused by inability to secure appropriate resources (including external capital and workforce), a critical infrastructure failure, ineffective system resilience and preparedness of an external IT supplier or an external shut-down attack***, then it may result in a significant disruption to the continuity of core critical services, affecting reputation (breach in regulatory duty / adverse publicity).	To progress our strategic enabler – IM&T	CIO	EIMT / EPB	AC / PPPC	4 x 4 = 16	↔
6) If the Trust does not adequately develop and maintain its estate to meet statutory compliance obligations and minimise the potential for critical infrastructure failure, ***caused by a lack of resources to address the backlog maintenance programme, insufficient clinical decant capacity and the sheer volume of technical work to address ageing buildings***, then it may result in an increased risk of failure of critical plant, equipment and core critical services leading to compliance issues, risk of regulatory intervention, impact upon business and patient critical infrastructure and adverse publicity.	To progress our strategic enabler - Estates	DEF	ESB	AC / QOC	5 x 3 = 15	↔
7) If the Trust is unable to work collaboratively with partners to secure the support of community and STP stakeholders, ***caused by breakdown of relationships amongst partners and ineffective clinical service strategies of the local population***, then it may result in disruption to transforming sustainable clinical services, affecting business (finance) and reputation (breach in regulatory duty / adverse publicity).	To develop more integrated care in partnership with others	DSC	ESB	AC / PPPC	4 x 4 = 16	↔

2018/19 BAF Bubble Chart – Current Rating (I x L)

			← Impact →				
			1	2	3	4	5
			Rare	Minor	Moderate	Major	Extreme
Likelihood ↓ ↑	1	Rare					
	2	Unlikely					
	3	Possible				PR1A PR1C	PR6
	4	Likely				PR1B PR5 PR7	PR2 PR3 PR4
	5	Almost certain					

DATE: @ Sept 2018	Director:	MD / CN (SH / JJ / RB)	Executive Board:	EQB	TB Sub Committee:	AC / QOC
Linked Objective	Our Quality Commitment… to deliver safe, high quality, patient centred, healthcare: To improve patient outcomes by greater use of key clinical systems and care pathways					
BAF Principal Risk: 1A– Quality & clinical effectiveness	If the Trust is unable to achieve and maintain the required quality and clinical effectiveness standards, ***caused by inadequate clinical practice and/or ineffective clinical governance,*** then it may result in widespread instances of avoidable harm to a large number of patients, affecting reputation (breach in regulatory duty / adverse publicity).				**Current Risk & Assurance Rating (I x L):**	**4 x 3 = 12**

BAF Ratings	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	JAN	FEB	MAR
Exec Team:	New risk entered in June		**4 x 3 = 12**	**4 x 3 = 12**	**4 x 3 = 12**	**4 x 3 = 12**						

Primary Controls

Quality and Clinical Effectiveness Reporting

- 2018/19 UHL Quality Commitment measured through PIDs reported to EQB monthly in relation to:
  - Improve patient outcomes by greater use of key clinical systems and care pathways.
- Quality Framework (Strategy) outlining how quality is managed within the Trust reported in AOP.
- Schedule of external visits maintained and reviewed at CMG service and Exec Team levels
- Clinical service structures, resources and governance arrangements in place at Trust Exec and CMG / Specialty levels ensuring appropriate escalation of quality matters.
- UHL Q&P Report reported to EPB and QOC monthly.
- Monthly reporting of Mortality Rates and Learning from Deaths (LFD) to the UHL MRC.
- CMG monthly Performance Review Meetings chaired by CN, MD, COO, CFO and DPOD.
- Reporting to Commissioner led Clinical Quality Review Group (CQRG) on compliance with quality schedule and CQUINS – including Commissioner Quality visits schedule for 2018/19.
- CQC improvement plan monitored at CMG Boards, Exec Team and Trust Board.
- NHSI Board to Board performance review meetings.

Quality and Clinical Effectiveness Work Programmes

- Clinical Policies, guidelines, SOPs including NatSSIPs/ LocSSIPs on INsite.
- Trust wide risk management and governance structure in place including: risk register, CAS, incident reporting, Complaints, Claims & Inquest management. Datix risk management software.
- Clinical audit programme, including participation in national audits.
- Consultant outcomes, participation in national clinical registries
- GIRFT and External Peer Reviews.
- Management and assessment against NICE guidance.
- Professional standards and Code of Practice / Clinical supervision.
- Appraisal and Revalidation process.
- Learning from Deaths work stream to include Medical Examiner and Specialty M&M Processes and the Bereavement Support Service.
- Clinical Harm review process - Case note reviews, morbidity reviews and thematic findings.
- Analysis and benchmarking of UHL's mortality rates using Dr Foster's Intelligence and HED data.
- Stroke and Fractured Neck of Femur improvement programmes.
- Quality Commitment 'Improving patient outcomes' work programmes to include: Implementing the Clinical Frailty Score; Embedding use of Nerve Centre for all medical handover board rounds and escalation of care; Fully implement plans to standardise Red2Green.

Detective Risk Indicators

	Ref	Indicators	18/19 Target	Sept - 18	18/19 YTD
EFFECTIVE	E1	Readmissions <30 days – Discharge work stream – one month in arrears	Red >8.6%		9.1%
	E2	Mortality (SHMI) – JJ	<=99	Apr 17 to Mar 18 = 95	95
	E5	Crude Mortality Emergency Spells – JJ	<=2.4%	1.9%	2%
	E6	#NOF <36 hours – CMG / Max Chauhan	Red <72%	77.2%	67.4%
	E7	Stroke – 90% stay on stroke unit – one month in arrears – CMGs/ S SNAP – RACHEL MARSH	Red <80%		83.9%
	E8	Stroke – TIA – RACHEL MARSH	Red <60%	28.7%	54.8%

Internal Assurances	External Assurances	Gaps Identified & Pending Actions
• UHL Quality Commitment components monitored at Exec Team and QOC, quarterly. • Both Operational management and Executive/Board reporting is in place. Reports provide assurance and highlight threats to delivery of the programme along with any mitigating actions. Latest reports received include: ➢ NEWS2 NPSA alert (NHS/PSA/RE/2018/003) compliance monitored via ADPB and confirmed to EQB. ➢ Stroke - Actions currently taken have meant the TIA clinic has met the target for high risk referrals of 60% within 24 hours for the last two months. 90% Stay on a Stroke Unit has been achieved for 80% of patients for the past 12 months. • Mortality - the latest published SHMI (period April 2017 to March 2018) has reduced to 95 and is within the threshold, but now very close to "below expected", for the first time. • Latest Mortality report to QOC and Trust Board highlighted capacity constraints in the Learning from Deaths programme. • LLR Frailty Task Force (led by UHL) is in place with a focus on identifying and responding to the needs of frail multi morbid patients. This group is responsible for the overall embedding of the CFS in ED and the wider hospital, and responding to these patients holistically in the community to ensure better outcomes and prevent readmission into acute care. • A readmission working group has been set up within UHL to understand the data and identify a mechanism to refer these patients to STP provided community neighbourhood teams. Community partners are now involved with this group to ensure a system wide response. • Task and Finish group met to discuss problems and develop a new action plan. This involved senior consultants from Trauma, Anaesthetics, Orthogeriatrics, ED as well as Nursing, Theatres and Management. • Development of a new/reinvigorated Action Plan jointly owned by ITAPS and MSS is in its early phase at present.	• CQC comprehensive review in 2017/18 - inspectors have rated our Trust overall as Requires Improvement; rating us Good for being effective and caring, and Requires Improvement for being safe, responsive and well-led. • CQC unannounced inspection 29.5.18 with written feedback provided. • Human Fertilisation & Embryology Authority Inspection – UHL's IVF and ICSI success rates in line with national average. • GIRFT review of Orthopaedic Services found UHL has very low revision rates but potential area for reduction in Length of Stay • **Internal Audit Programme 2018/19:** ➢ Data Quality review – scheduled Q3; ➢ Learning from deaths – scheduled Q3; • **Internal Audit 2016/17:** ➢ Clinical Audit - medium risk (associated with CMG engagement).	**Mortality** • Funding approved for additional administrative and analyst support for the LFD programme – recruitment in progress to be reviewed **30th Sept 2018 (AMD).** • Funding of Bereavement Support Nurses remains through CQUIN budget – **Review Sept 18 (AMD).** **#NOF** • Plans to undertake a 'Rapid Cycle Fortnight' from 1st to 12th October are underway. This will be a trial fortnight when additional resources are provided by all relevant CMG's to test the systems abilities to get these patients operated on and moved through our system as rapidly and safely as possible whilst maintaining a safe and quality service to our patients. • Agreement that Fractured Hip Operating lists are to be protected for NOF patients with immediate effect. There has been a drift over time which needs to be stopped. These lists can only be used for other trauma cases if there are no patients with fractured NOF waiting or if the alternative trauma case is life/limb threatening and there is no other trauma theatre available. • Introduction of the senior 'Hot' consultant of the week for Trauma. This commenced beginning of August. This new process should help support the NOF service. **Review Dec 18 (MSS CMG CD)** **Readmissions** • Although the process for reviewing patients has been agreed in principle, a formal proposal has yet to be designed and tested pre-winter 2018. This includes allowing a field on discharge letters specifying what the readmission risk for patients is and requesting the GP to refer patient for MDT review. **Review Dec 18 – (HoSD)** **Frailty** • The CFS score has been built into NerveCentre and tested through August. It is ready to be formally launched across the Trust. A training and education plan has been devised specifically for ED and will be rolled out through Sept-Oct 2018. **Review Nov 18 – (HoSD)**

DATE: @ Sept 2018	Director:	MD / CN (MD / CM)	Executive Board:	EQB	TB Sub Committee:	AC / QOC
Linked Objective	Our Quality Commitment… to deliver safe, high quality, patient centred, healthcare: To reduce harm by embedding a 'Safety Culture'					
BAF Principal Risk: 1B – Quality & patient safety	If the Trust is unable to achieve and maintain the required quality and patient safety standards, ***caused by inadequate clinical practice and/or ineffective clinical governance,*** then it may result in widespread instances of avoidable harm to a large number of patients, affecting reputation (breach in regulatory duty / adverse publicity).				**Current Risk & Assurance Rating (I x L):**	**4 x 4 = 16**

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

Primary Controls

- 2018/19 UHL Quality Commitment measured through PIDs reported to EQB monthly in relation to:
  - To reduce harm by embedding a 'safety culture'.
- Clinical service structures, resources and governance arrangements in place at Trust Exec and CMG / Specialty levels ensuring appropriate escalation of quality matters.
- Clinical Policies, guidelines, SOPs including NatSSIPs/ LocSSIPs.
- Professional standards and Code of Practice / Clinical supervision.
- Trust wide risk management and governance structure in place including: risk register, CAS, incident reporting, Complaints, Claims & Inquest management. Datix risk management software.
- Clinical audit programme & monitoring arrangements including assessment against NICE guidance.
- Patient safety improvement programme including sign up to safety and patient safety portal.
- Never Events action plan and walkabout sessions.
- Infection Prevention and Control programme including policies / procedures; staff training; environmental cleaning audits and inspections.
- Freedom to Speak up Guardian and escalation processes.
- Senior leadership safety walkabout programme.
- Quality Framework (Strategy) outlining how quality is managed within the Trust reported in AOP.
- Schedule of external visits maintained and reviewed at CMG service and Exec Team levels.
- CQC improvement plan monitored at CMG Boards, Exec Team and Trust Board.
- NHSI Board to Board performance review meetings.
- Maintenance of defined safe staffing levels on wards & departments – nursing and medical.
- Clinical staff recruitment campaigns, induction processes, registration and re-validation practices.
- Regular liaison meetings with Leic Coroner re hospital deaths and inquests.
- UHL Q&P Report including 'safe' indicators reported to EPB monthly.
- CMG monthly Performance Review Meetings chaired by CN, MD, COO, CFO and DPOD.
- Reporting to Commissioner led Clinical Quality Review Group on compliance with quality schedule and CQUINS – including Commissioner Quality visits schedule for 2018/19.
- Learning from claims and inquests – key themes identified and reported to EQB / QOC.
- Medical Examiner and Learning from Deaths reviews and triangulated with patient safety incidents.
- GIRFT reports and NHSR scorecard.
- Recent analysis on harm with targeted action for improvement.
- Increased incident reporting.
- UHL Patient Safety Alert Panel.

Detective Risk Indicators

	Ref	Indicators	18/19 Target	Sept - 18	18/19 YTD
SAFE	S1	Reduction for moderate harm and above PSIs - reported 1 month in arrears	9% REDUCTION FROM FY 16/17 (<12 per month)		114
	S2	Serious Incidents - actual number escalated each month	<=37 by end of FY 18/19	1	21
	S8	Overdue CAS alerts	0	0	0
	S10	Never Events	0	0	4
	S11	Clostridium Difficile	61	2	34
	S12	MRSA Bacteraemias - Unavoidable	0	0	0
	S13	MRSA Bacteraemias (Avoidable)	0	0	1
	S14	MRSA Total	0	0	1
	S23	Falls per 1,000 bed days for patients > 65 years (1 month in arrears)	<6.6		6.5
	S24	Avoidable Pressure Ulcers Grade 4	0	0	0
	S25	Avoidable Pressure Ulcers Grade 3	<27	0	3
	S26	Avoidable Pressure Ulcers Grade 2	<84	10	36

Internal Assurances	External Assurances	Gaps Identified & Pending Actions
• Annual Governance statement providing assurance on the strength of internal control regarding risk management processes endorsed by Audit Committee (May 2018). • Patient Safety Report (September 2018) to EQB/QOC: One Serious Incidents escalated in September. There are currently 12 finally approved incidents showing evidence gaps for full Duty of Candour compliance, with CHUGGS & ESM showing the highest numbers. Note the NRLS update showing UHL compared to peers in Central Midlands region in terms of incident reporting numbers and levels of harm. CAS performance is 100%. • No Never events reported in Sept as at 27/09/18. The action plan has been further revised to provide further interventions at corporate and ward level to improve management of Never Events in the Trust and a gap analysis has now been undertaken. The 15 poster produced and circulated to all clinical areas. • Patient safety data in Q2 revealed drop in SIs to 8 from 14 in Q1. • Pressure Ulcers - Grade 2 Pressure Ulcers – 10 reported in September.	• CQC comprehensive review in 2017/18 - inspectors rated Trust overall as Requires Improvement; rating us Good for being effective and caring, and Requires Improvement for being safe, responsive and well-led. The Trust must embed learning from never events in order to prioritise safety and reduce risk; ➢ The Trust did not always control infection risk well - Staff did not always adhere to trust policy in relation to cleaning of equipment, completing infection control risk assessments and hand hygiene. ➢ CQC Warning notice issued following unannounced inspection in Nov 2017 – re the care given to diabetic patients in relation to the management of their insulin requires significant improvement. Evidence supports actions have delivered improvements. However, the CCGs visited some of the same wards during April, which the CQC had visited, and found some areas still had some improvements to make. • CQC unannounced inspection 29.5.18 with written feedback provided. • **Internal Audit Programme 2018/19:** ➢ Quality Commitment review – scheduled Q1 (insulin) ➢ Patient Safety Alert review – scheduled October 2018; ➢ Data Quality review – scheduled Q3; • **Internal Audit 2016/17:** ➢ Risk management – medium risk (associated with CMG processes). ➢ Clinical Audit - medium risk (associated with CMG engagement). • **External Audit 2016/17:** ➢ Incident reporting and evidence of validation of grading of harm – outcome assured (safety nets in place and being monitored). • National Freedom to Speak up Guardian visit in Q3 2017 – positive verbal feedback received about systems and processes in place in UHL. • Parliamentary ombudsman enquires – only 1 partially upheld case in 17/18, reduced from 7 the previous year. • Healthwatch – independent complaints review panel – Feedback received from the Independent Complaints Review Panel that met in June 2018 and actions to be taken as a result • Commissioning review of the Emergency Department – report awaited. • Human Fertilisation & Embryology Authority (HFEA) Inspection June 2018 – Two major areas of non-compliance, 1) Safety and suitability of premises (including inadequate storage facilities including for storage of liquid nitrogen dewars) and 2) Medicines management (carry over stock not recorded in the controlled drugs register and only a single patient identifier used in the controlled drugs register).	• Communication of key safety messages to front line staff: develop strategy to embed learning from never events in order to prioritise safety and reduce never events / patient safety culture programme to be developed / increase awareness via website and intranet broadcasting – during Q2 2018/19 (CN / MD). • IP team to undertake sample audit of completion of paper RA with feedback to the Nurse in Charge in real time and a report to the Matron / Review all Infection Prevention policies with a one page 'at a glance' care bundle produced for each organism / Convert current paper patient Risk Assessment (RA) booklet to electronic format – during Q2/3 2018/19 (CN). • Internal Audit of Patient Safety Alerts (reference NHS Improvement letter 1st June 2018) – Starting in Oct 2018. • Overdue RCA actions require urgent attention from relevant CMGs (CMG CDs). Items also monitored at CMG PRMs. • Improve culture and empower staff to 'Stop the Line' in all clinical areas – QC priority 2018/19 – Stop the line audit currently in progress – results expected in Oct 2018 (AMD). • More work required to embed systems to ensure abnormal results are recognised and acted upon – QC priority 2018/19 – Reviewed at EQB quarterly (AMD). • Improve the management of diabetic patients treated with Insulin – QC priority 2018/19 – Reviewed at EQB quarterly (AMD). • Some critical nurse staffing gaps reported in Sept. • Action plan to address the two major non-compliances in HFEA Inspection report - Consultant Embryologist, Leicester Fertility Centre & Medical Director – to be reviewed at future EQB meeting. • Full review of CRO outbreak to be undertaken in Q3. • Non-integrated / weak IT systems remain a patient safety risk – UHL IM&T e-hospital programme established.

DATE: @ Sept 2018	Director:	MD / CN (HL)	Executive Board:	EQB	TB Sub Committee:	AC / QOC
Linked Objective	Our Quality Commitment… to deliver safe, high quality, patient centred, healthcare: To use patient feedback to drive improvements to services and care					
BAF Principal Risk: 1C – Quality & patient experience	If the Trust is unable to achieve and maintain the required quality and patient experience standards, ***caused by inadequate clinical practice and/or ineffective clinical governance,*** then it may result in widespread instances of avoidable harm to a large number of patients, affecting reputation (breach in regulatory duty / adverse publicity).				**Current Risk & Assurance Rating (I x L):**	**4 x 3 = 12**

BAF Ratings	**APR**	**MAY**	**JUN**	**JUL**	**AUG**	**SEP**	**OCT**	**NOV**	**DEC**	**JAN**	**FEB**	**MAR**
Exec Team:	New risk entered in June		**4 x 3 = 12**	**4 x 3 = 12**	**4 x 3 = 12**	**4 x 3 = 12**						

Primary Controls

- 2018/19 UHL Quality Commitment measured through PIDs reported to EQB monthly in relation to:
  - Use patient feedback to drive improvements to services and care.
- Clinical service structures, resources and governance arrangements in place at Trust Exec and CMG / Specialty levels ensuring appropriate escalation of quality matters.
- Clinical Policies, guidelines, SOPs including NatSSIPs/ LocSSIPs on INsite.
- Professional standards and Code of Practice / Clinical supervision.
- Trust wide risk management and governance structure in place including: risk register, CAS, incident reporting, Complaints, Claims & Inquest management. Datix risk management software.
- Clinical audit programme & monitoring arrangements including assessment against NICE guidance.
- CMG monthly Performance Review Meetings chaired by CN, MD, COO, CFO and DPOD.
- Complaints process including Trust Policy.
- Staff surveys and FFTs monitored at local and Exec Team levels.
- Patient and public involvement forums and patient experience focus groups.
- Engagement / Patient Experience issues monitored through the Patient Involvement, Patient Experience and Equality Assurance Committee (PIPEEAC).
- UHL Q&P Report includes 'caring' indicators reported to EPB and Trust Board Monthly.
- Reporting to Commissioners led Clinical Quality review Group on successful collection of feedback from patients across clinical areas.

Detective Risk Indicators

	Ref	Indicators	18/19 Target	Sept - 18	18/19 YTD
CARING	C1	Formal complaints rate per 1000 IP,OP and ED attendances	No Target	1.8	1.6
	C2	% of upheld PHSO cases	No Target	0	0
	C3	Published Inpatients and Daycase Friends and Family Test - % positive	97%	97%	97%
	C6	A&E Friends and Family Test - % positive	97%	95%	95%
	C7	Outpatients Friends and family Test - % positive	97%	95%	95%
	C10	Single sex accommodation breaches (patients affected)	0	0	32

Internal Assurances	External Assurances	Gaps Identified & Pending Actions
UHL Quality Commitment components monitored at Exec Team and QOC quarterly. Outpatient Programme Board leading and monitoring the improvements in outpatients identified in response to patient feedback. Monthly reports shared at clinic level with CMGs. End of Life Care and Palliative Care Committee monitors improvements to increase positive patients experience in relation to feeling involvement in care. The Trust seeks to ensure services develop in response to patient's feedback and therefore all "suggestions for improvement/complaints/areas that were lacking from the patients perception", referred to as SfI's, are triangulated allowing overall themes at Trust and CMG level to be derived. The CMGs are then able to demonstrate their response to this feedback. The Clinical Audit Team have streamlined this process facilitating the production of high level themes with minimum workload as it is acknowledged that understanding the themes from feedback from patients and monitoring CMG response to these themes is necessary to ensure patient led services and care. The areas for improvement identified by patients in the triangulation of feedback are the areas of focus identified in the Trust's Quality Commitment and overseen at PIPEEAC. Complaints Data report (Sept 2018): Decrease in performance for 10 day, 25 and 45 day complaints remain at the same performance as previous month. The Emergency Department is the speciality with the most complaints and concerns this month. Decrease in the number of formal complaints this month. Increase in the number of re-opened complaints this month. We have received three new PHSO cases this month. No PHSO cases were closed this month.	• CQC comprehensive review in 2017/18 - inspectors have rated our Trust overall as Requires Improvement; rating us Good for being effective and caring, and Requires Improvement for being safe, responsive and well-led. • CQC unannounced inspection 29.5.18 with written feedback provided. • **Internal Audit Programme 2018/19:** ➢ Quality Commitment review – scheduled Q1 & Q3; • **Internal Audit 2016/17:** ➢ Risk management – medium risk (associated with CMG processes). ➢ Clinical Audit - medium risk (associated with CMG engagement).	• Improving experience of care for patients in the outpatient facilities. As part of the Trust's Quality Commitment there is a Trust wide improvement plan and an Outpatient Group with representatives from all CMGs to drive this forward – QC priority 2018/19 – Reviewed at EQB quarterly (ACN). • Improving patient involvement in care in ED. This is being taken forward through the End of Life Care Hospital Improvement Programme (ELCHIP) programme and monitored via the End of Life and Palliative Care Committee – QC priority 2018/19 – Reviewed at EQB quarterly (ACN). • Independent Complaints Review Panel actions are to review ToR and to revise complaint letter templates to include mentioning PHSO in first response letter – due Q2 2018/19 (DSR).

DATE: @ Sept 2018	Director:	DPOD	Executive Board:	EWB	TB Sub Committee:	AC / PPPC
Linked Objective	We will have the right people with the right skills in the right numbers in order to deliver the most effective care					
BAF Principal Risk: 2 - workforce	If the Trust is unable to achieve and maintain the required workforce capacity and capability standards, ***caused by employment market factors (such as availability and competition to recruit, retain and utilise a workforce with the necessary skills and experience), lack of extensive education, training and leadership, and demographic changes***, then it may result in widespread instances of poor clinical outcomes for patients and increased staff workloads, affecting business (finance) and reputation (breach in regulatory duty / adverse publicity).				**Current Risk & Assurance Rating (I x L):**	**5 x 4 = 20**

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

Primary Controls

- Executive Workforce Board (meet Quarterly) – reports to Trust Board.
- People, Process and Performance Committee – Sub-committee of the Trust Board (meet monthly) – report to Trust Board.
- Local workforce Action Group – report to – Local Workforce Action Board – report to – LLR Senior Leadership Team.
- Leadership and people management policies, processes and professional support tools (including training & UHL Way tools).
- Temporary staffing approval and recruitment process with appropriate authorisation levels.
- Vacancy management and recruitment/ retention system and processes – i.e. TRAC system. Revised ERCB Board and CON in place from July 2018.
- Staff communication & engagement forums – *LiA events, Ask the Boss events, Freedom to Speak up forum, Insite staffroom forum.*
- Staff appraisal systems and people capability framework.
- Core Skills Learning & Development including statutory & mandatory training system – i.e. HELM.
- Employee Health & Wellbeing Plan.
- Equality & Diversity Board, delivery plan, dedicated lead in place, and Equality Impact assessments undertaken for policy and procedure function.
- Defined safe medical and nurse staffing levels for all wards and departments.
- Medical Education Workforce Group & Medical Education and Training Committee – report to EWB (Quarterly).
- Embedded Medical Education Strategy to address specialty specific shortcomings.
- GMC 'Approval and Recognition' of Clinical and Educational Supervisors.
- Working with deanery and medical schools re medical staffing (gaps).
- CMG Performance Review/Assurance Meetings (Monthly).
- Establishment of financial recovery board (FRB) and executive oversight of workforce actions.
- Cultural Ambassador Programme, delivered by the RCN, following concerns regarding the disproportionate impact of formal disciplinary and grievance processes on BAME staff.

Detective Risk Indicators

	Ref	Indicators	Red RAG/ Exception Report Threshold (ER)	Sept-18	18/19 YTD
Well Led	W7	Friends & Family staff survey: % of staff who would recommend the trust as place to work (from Pulse Check)	TBC		60.3%
	W8	Nursing Vacancies overall	Separate report submitted to QOC		14.1%
	W10	Turnover Rate	Red = 11% or above ER = Red for 3 Consecutive Mths	8.6%	8.6%
	W11	Sickness absence (reported 1 month in arrears)	Red if >4% ER if 3 consecutive mths >4.0%		3.6%
	W12	Temporary costs and overtime as a % of total paybill	TBC	10.8%	11.0%
	W13	% of Staff with Annual Appraisal (excluding facilities Services)	Red if <90% ER if 3 consecutive mths <90%	92.2%	92.2%
	W14	Statutory and Mandatory Training	95%	88%	88%
	W15	% Corporate Induction attendance	Red if <90% ER if 3 consecutive mths <90%	96%	97%
	W16	BME % - Leadership (8A – Including Medical Consultants)	4% improvement on Qtr 1 baseline		29%
	W20	DAY Safety staffing fill rate - Average fill rate - registered nurses/midwives (%)	TBC	78.1%	83.2%
	W22	NIGHT Safety staffing fill rate - Average fill rate - registered nurses/midwives (%)	TBC	86.6%	90.5%
Education		Improve the number of good/satisfactory 'overall satisfaction' score in the GMC NTS from 76% to >80%			
Education		Maintain the number of trainee and trust grade doctors reporting satisfaction with their post at 80%			

Internal Assurances	External Assurances	Gaps Identified & Pending Actions
• Workforce risks in CMGs recorded on organisational risk register – *majority relate to nursing and medical.* • Workforce and Organisational Development Plan, with a delivery plan to reduce our nursing and medical vacancy rates and reduce time to hire reports agreed at EWB in July 2018. • Staffing levels on wards (for nursing and medical groups) continue to be challenging and are monitored through daily operational command meetings, with action plans identified to mitigate operational pressures, and reported to Exec Boards. • UHL Medical Education Survey - *415 junior doctors responded to the survey in 2018. 88% recommend UHL as a place to work, which is an improvement since March 2017 (83%).* • Monitoring agency spends and tracker through Premium Spend Group with EWB, EPB, PPPC oversight. • Friends & Family staff survey 2017: *– 4808 returned a completed survey, giving a response rate of 34%, a decrease of 2.2% from 2016. Compared to the 2016 survey, in 2017 scored:* o *Significantly BETTER on 3 questions* o *Significantly WORSE on 4 questions* o *The scores show no significant difference on 81 questions* • *57% of staff would recommend the trust as place to work (from Pulse Check – March 2018).* • Our latest national staff survey results for 2017 were not as good as the improving trend we saw in previous years. • Equality and Diversity Board discussions on workforce race equality targets show current overall workforce reflects local BAME communities (32%) and that leadership representation is continually improving (14.2% up from 13.6% year-end). • We now have 9 Cultural Ambassadors. • CMG Performance Review / Assurance Meetings – *all CMGs reviewed during July and appropriate action plans developed and being monitored.*	• **Internal Audit 2018/19:** ➢ Workforce planning – scheduled Q2 – to review the Trust's progress in developing the 18/19 workforce plan and the 2018-2023 strategic workforce plan. • GMC visit report of 2016 – report received and *actions implemented.* • GMC Survey - 82% of programmes within UHL had satisfactory or good scores in the 2018 GMC survey (includes all programmes with >3 trainees). • HEEM quality management visits **-** *HEE re-visited Cardio-respiratory on May 4th 2018 to review progress against their action plan – HEE now formally confirmed happy with progress; risk will be removed from HEE risk register and have been removed from GMC enhanced monitoring.* • Leicester Medical School feedback **–** *retention rate report demonstrates a 1% increase from 2017 to 2018 of Leicester students staying in Leicester.* • Performance monitored by NIHR Central Commissioning Facility **–** *UHL are currently ranked 11th in league one and delivering 76% of trial to time and target (March 2018).* • East Midlands Clinical Research Network – *UHL remains the highest recruiting Trust within the East Midlands (March 2018).*	• We will launch our People Strategy in Q2 2018/19 to attract, recruit & retain a workforce that reflects our local communities across all levels of the Trust, with a specific focus on meeting the Workforce Race Equality Standards. Refresh of People strategy taking place and to EWB in October 2018 to ensure alignment. • Improve levels of employment from distinct populations/ communities to all levels of the Trust e.g. MOD veterans, disabled people, women, BAME, LGBT so they are representative of LLR population. Targets for each agreed at Diversity Board meeting and PPPC in July 2018. Overarching action plan in place with defined objectives and timescales - Paper outlining next steps to EWB in October 2018. • Based on the feedback in the national staff survey, key themes to make improvements during 2018/19 are: o Making appraisals more meaningful o Treating our staff equally o Looking after UHL – health and well-being o Tackling behaviours Health & wellbeing annual plan agreed at EWB in July 2018. New full staff survey to be undertaken for 18/19. - closing date 30th November 2018. • Creation of CT3/FY3 innovative posts in order to aide retention of Junior Doctors by providing greater training experience and reduced agency costs and improve out of hours cover. Development plan incorporated into CMG workforce plans with oversight obtained by EWB quarterly. Paper to EWB in October 2018 to define implications and propose next steps. • Review of Undergraduate and Postgraduate medical education roles (including Educational Supervisors) to ensure identified time included in job plans. • Understanding of the impact of Brexit and national shortages of nurses and consultants – monitor in line with our strategy and maintain communication & engagement with EU staff & their managers. • Developing workforce safeguard national guidance received in October 2018 and to be reviewed to ensure fully incorporated into planning processes. • Agreement being sought for implementation of the National change to medical training – Shape of Training – report to EWB in October 2018.

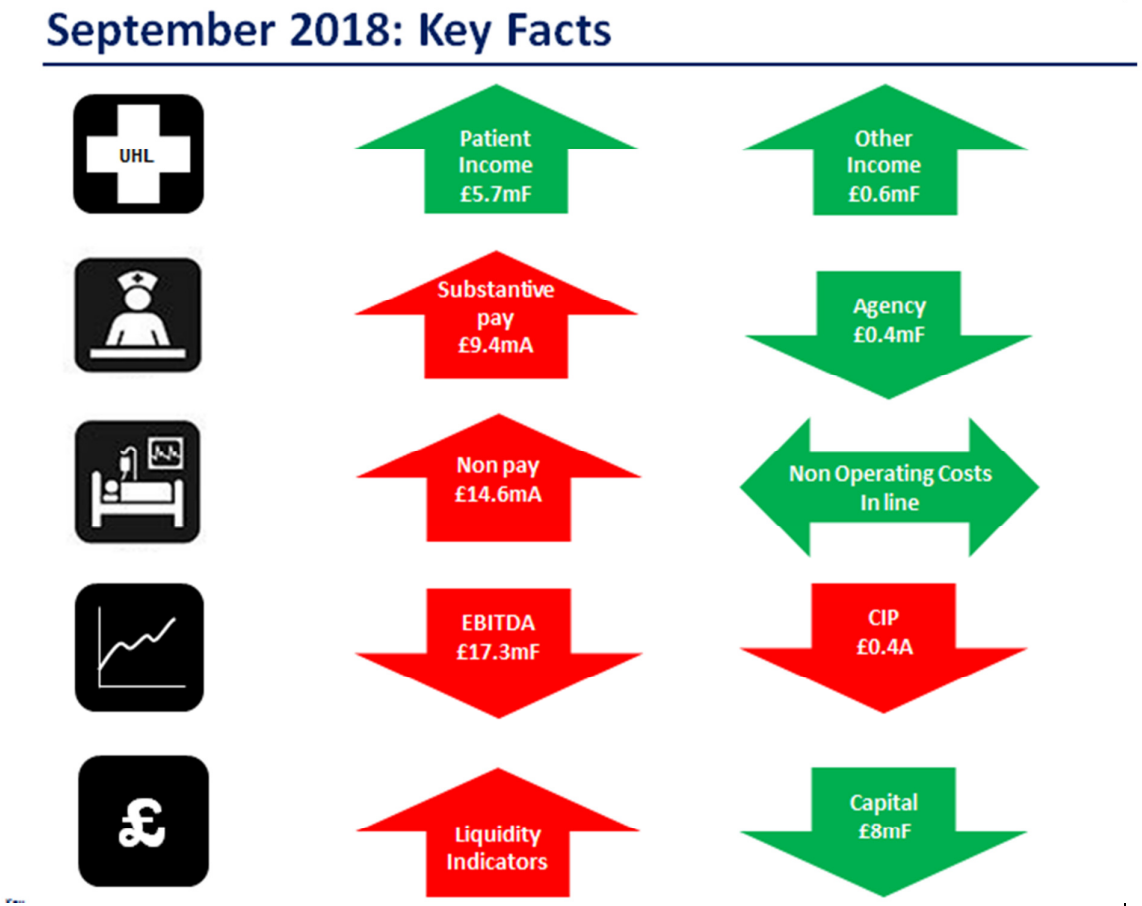
DATE: @ Sept 2018	Director:	CFO	Executive Board:	EPB	TB Sub Committee:	AC / FIC
Linked Objective	We will continue on our journey towards financial stability - deliver our target of £29.9m in 18/19					
BAF Principal Risk: 3 - Finance	If the Trust is unable to achieve and maintain financial sustainability, ***caused through delivery of income, the control of costs or the delivery of cost improvement plans***, then it will result in a failure to deliver the financial plan, affecting business (finance) and reputation (breach in regulatory duty / adverse publicity).				**Current Risk & Assurance Rating (I x L):**	**5 x 4 = 20**

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

Primary Controls

- Annual and long-term financial model describing a statement of income and expenditure, a statement of long and short term assets and liabilities (including capital expenditure) and a statement of cash flow.
- Working capital, capital loan, and internal capital funding arrangements.
- CIP Plans for CMGs and Corporate Departments with cross-cutting schemes being supported by corporate based resource in addition to local CMG transformation leads.
- Finance Improvement and Technical planning processes and project management led coordination of delivery.
- Control Totals for CMGs and Corporate Departments that are being monitored and managed within the Financial Accountability Framework.
- Appropriate level of investment supporting the resolution of the demand/capacity challenges.
- Financial governance and performance monitoring arrangements at Trust Board (FIC), Audit Committee, Executive (EPB), directorate and CMG service line levels.
- Cost pressures and service developments minimised and managed through RIC and CEO chaired 'Star Chamber'.
- NHS I performance review meetings including I&E submissions and additional monthly review meetings with NHSI Finance team to review financial position including CIP and assessment of financial risks.
- Commercial Strategy - to help exploit commercial opportunities available to the Trust and working with NHSI to ensure a consistent and jointly agreed position statement is made with regards the Trust's subsidiary company.
- Corporate Services review (in line with the requirements of the Carter report).
- Quality safeguards - to reduce expenditure are subject to Quality Impact Assessment – overseen by the COO, Medical Director, Chief Nurse & CFO.
- Financial Recovery Board chaired by CEO. Meets fortnightly to monitor progress of the Financial Recovery Action Plan.
- Financial Recovery Operational Group is in place to support the work of the Financial Recovery Board and the delivery of the benefits.

Detective Risk Indicators



Internal Assurances	External Assurances	Gaps Identified & Pending Actions
• CFO's Financial Reports to EPB (monthly) key issues considered at the meeting for month 5 relate to delivering the planned deficit of £23.8m. The financial impact caused by the recent NHSI decision to not allow the LLP to go live in October 2018 will be recognised within Q2 reporting and as agreed by NHSI. • The income position has over-preformed and a corresponding overspend within non-pay has been seen. The pay bill (substantive) is overspent by £8.1m to plan (including £4.3m relating to A4C national pay award). Cost improvement plans are in line to plan at month 5. Capital expenditure has under-spent within the year to date position and will not lead to an over spend within the programme. Cash flow and deficit funding has been received in line with the submitted plan. • FIC Summary to Trust board (Monthly). Key issues are as described above and as reported to EPB. The Committee also reviewed the additional report detailing a more granular analysis of the Trust's cash position. • Capital Monitoring and Investment Committee (monthly). A detailed review of month 4 capital expenditure was reviewed with key variances explored in the context of the overall capital programme. • Revenue Investment Committee (monthly). The committee had a limited number of business cases for review. All actions are being progressed. • Update on the Commercial Strategy. The Trust Board, at its last thinking day, has an agreed approach to ensure successful delivery of year 2 of the commercial strategy.	• **External Audit of Financial Systems 2018/19:** ➢ Work programme for 2018/19 to be reviewed and approved at the relevant meeting of the Audit Committee. • **Internal Audit 2018/19:** ➢ Financial systems Q3 - financial systems controls work to meet the requirements of External Audit and to address specific risks identified by management. Work will include data analysis on specific areas of risk in order to identify trends/ anomalies and to direct our controls-based work. ➢ Review of cost improvement programme Q2 - will review the adequacy of arrangements for delivery of the CIP and the robustness of planning for future years. • NHSI Carter Corporate Service review: **-** *Carter Target for back office cost to be no more than 6% of turnover by March 2020.* The Trust's Director of Efficiency and CIP is leading this initiative, as part of the overall review of Model Hospital, and engaging across the Corporate Teams to ensure robust plans are in place to achieve the 2020 target. • Four Eyes support is being deployed within the cross cutting theatre/elective pathway work-stream. • NHSI increased scrutiny through monthly performance review meetings and specific Finance focused monthly meetings.	**Gap:** Effectiveness of budget management and control at CMG and Corporate directorate levels**.** **Actions:** 2018/19 planning requires the delivery of a deficit of £29.9m inclusive of a £51m CIP programme. Each CMG and Corporate Directorate has an allocated budget totalling £29.9m however due to the current work in progress with respect of demand and capacity modelling CMGs are yet to sign-off a fully phased month by month budgetary control position in line with the accountability framework. This process has concluded with MSS being finalised as part of month 5 reporting. Within June the Trust received a revised Control Total offer from NHSI. This revised Control Total was subject to review and subsequent approval at a special Trust Board meeting held on 18 June 2018. As a response to this challenge a Financial Recovery Board has been created and is chaired by the CEO. The financial recovery board action plan currently had an identified gap of £11m and included the risk within the Cost Improvement Programme of £3.2m when compared to the target of £51m. The Financial Recovery Board meets fortnightly with each work-stream being sponsored by an Executive Director. As part of Q2 reporting the Trust as reported a revised forecast outturn for 2018/19. This includes the impact of not progressing with the FM LLP and recognition of a further deterioration of £8.7m. A revised deficit of £51.8m was submitted with a recovery action in place to address the remaining £3.2m financial challenge. Star chamber process (led by CEO) reviewing the new investment requirements. There is a significant shortfall in available funding compared to the complete list of investment requirements with the Star Chamber prioritising and approving spend. The allocation of funds to investment requirements has been agreed but further scrutiny is required and forms part of the Financial Recovery Board. The capital programme has been approved by CMIC and then further ratification by the Star Chamber in May. The relevant scheme holders are providing further analysis on a risk based assessment detailing the potential risks due to the limited availability of capital funds. Cash flow and enhanced cash reporting continues to be reviewed and discussed at FIC. Cash for deficit funding has been received in line with planned levels. This planned level of cash excludes any additional working capital requirements that will be required as a result of the revised deficit position. An application for this additional cash has been made in October.

DATE: @ Sept 2018	Director:	COO	Executive Board:	EPB	TB Sub Committee:	AC / QOC / PPPC
Linked Objective	We will improve our Emergency Care performance					
BAF Principal Risk: 4 – Emergency care	If the Trust is unable to effectively manage the emergency care pathway, ***caused by persistent unprecedented level of demand for services, primary care unable to provide the service required, ineffective resources to address patient flow, and fundamental process issues***, then it may result in widespread instances of poor clinical outcomes for patients and sustained failure to achieve constitutional standards, affecting business (finance) and reputation (breach in regulatory duty / adverse publicity).				**Current Risk & Assurance Rating (I x L):**	**5 x 4 = 20**

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

Primary Controls

- **Emergency management:**
  - Emergency care pathway;
  - 4 times daily operational command meeting;
  - Capacity Flow and escalation policy;
  - Robust escalation protocols including OPEL triggers, CMG triggers, Full Hospital Process, Breach process for 8, 10 & 12 hour occurrences;
  - LLR system calls daily to review the position and ensure whole system responsiveness;
  - NHSI reporting;
  - System support provided by the National Emergency Care Improvement Programme (ECIP).
  - Red to Green embedded in medicine and RRCV and Trauma.
  - In Hospital (SAFER Care Bundle, Ambulatory Care and workforce) and Out of Hospital (DTOC) as well as admission prevention & avoidance projects.

- **Forums to identify and implement changes:**
  - A&E Delivery Board and sub groups - system wide actions, chaired by CCG MD.
  - New Emergency Care Board chaired by the COO.
  - Flow and Outflow board.
  - Monthly winter planning forum.
  - Demand and capacity work streams including plans for the vital few.
  - Performance Review and Assurance arrangement between CMGs, Specialties and Executive Directors / Executive Team.
  - System wide Frailty Board chaired by UHL CEO.

- **Emergency performance monitoring:**
  - 4 hour wait;
  - ED attendances;
  - Time to assessment;
  - Time to discharge;
  - Total breaches;
  - Emergency admissions;
  - Beds status.

Detective Risk Indicators

	Q&P Ref	Indicators	18/19 Target	18/19 Red RAG/ Exception Report Threshold (ER)	Sept-18	18/19 YTD
Responsive	R1	**ED 4 Hour Waits UHL**	**95% or above**	Red if <85% Green 90%+	**79.5%**	**79.8%**
	R2	**ED 4 Hour Waits UHL + LLR UCC (Type 3)**	**95% or above**	Red if <85% Green 90%+	**84.7%**	**85.4%**
	R3	**12 hour trolley waits in A&E**	**0**	Red if >0 ER via ED TB report	**0**	**0**
	R12	**% Operations cancelled for non-clinical reasons on or after the day of admission UHL + ALLIANCE**	**0.8% or below**	Red if >0.8% ER if >0.8%	**0.7%**	**1.1%**
	R14	**Delayed transfers of care**	**3.5% or below**	Red if >3.5% ER if Red for 3 consecutive mths	**1.4%**	**1.4%**
	R15	**Ambulance Handover >60 Mins (CAD+ from June 15)**	**0**	Red if >0 ER if Red for 3 consecutive mths	**1%**	**2%**
	R16	**Ambulance Handover >30 Mins and <60 mins (CAD+ from June 15)**	**0**	Red if >0 ER if Red for 3 consecutive mths	**5%**	**6%**

Internal Assurances	External Assurances	Gaps Identified & Pending Actions, responsible officer & measure
• There remain significant nursing and medical staffing vacancies in ED and Specialist Medicine. This is a CMG board agenda item and there is a CMG recruitment plan to manage vacancies supported by corporate nursing. Additional medical staff commence in post in October. Alternative skill mix models are being considered and have been implemented e.g. medical step down ward. Additional investment in Phase II emergency floor posts currently being recruited. 51 international nurses to commence during November and December. • ED process: ➢ Time from arrival to decision to admit was 52% (average) in September. ➢ Bed request to allocation in 60 mins was 48% (average) in September. • DTOC: ➢ Remain within tolerance • Acuity: ➢ Reducing number 80+ age in ESM beds ➢ Super stranded numbers improvements in ESM, but deterioration in MSS, CHUGGS and RRCV. Deputy Medical Director to support discussions. • Internal Action plans: ➢ Recovery action plan ➢ Winter plan • CMGs have a range of operational demand and capacity risks reported on the UHL Trust risk register which (for items scoring 15+) is reported to Exec Team and Trust Board monthly.	• NHSE national ranking official figures: 94 –115 (out of 137). • NHSE September UHL 4 hour performance = 79.5%. LLR performance = 84.7%. • AEDB fortnightly to manage system wide actions. • NHSI Escalation meetings to provide system wide assurance. • **Internal Audit 2018/19:** ➢ Review of ED front door service contract - scheduled Q1. ➢ Discharge processes – Red to Green – scheduled Q2 - to review how effectively the Red to Green process is operating and how well embedded this is across the Trust. • Stranded: ➢ Rated by NHSI in the best performing group as an organisation - Decreased +21 day LOS.	• IT Booking systems for DHU and OOH (MN - 1.9.18 – system available to measure outcome); • Nerve centre embedding with teams to increase usability (CMG Heads of Ops 1.10.18 – admission discharge and transfer data to measure outcome); • Red to Green in medicine and RRCV – gap in delivery in the rest of the organisation (GS - 1.1.19 – gradual role out across UHL – Red to Green metrics to measure outcome - started in Children's 20/08/18). • Significant bed gap – activity and demand planning and bridge for the gap is under development (SL - 1.6.18 gap identified and actions to bridge – action log to measure outcome); • Variation in process in ED and on the wards (Heads of ops – minimise pre winter 1.10.18 – NAB performance to measure outcome); • TASL resource flexibility – managed via CCG (JD 1.10.18 – decrease re- beds – TASL data to measure outcome); • ESM nursing and medical staffing vacancies – managed by CMG Board (Heads of Ops – on-going recruitment strategy – vacancy numbers to measure outcome); • DHU staffing gaps – managed through weekly meetings with ESM CMG and DHU and through Executive presence (MN -1.8.18 – measured by staffing numbers increasing). Trial of new assessment/deflection process at front door started on 18/09/18 – 2 different rapid cycle tests were explored. 2 Further tests to take place following evaluation. Urgent care action log has further details about the actions, owners and completion dates.

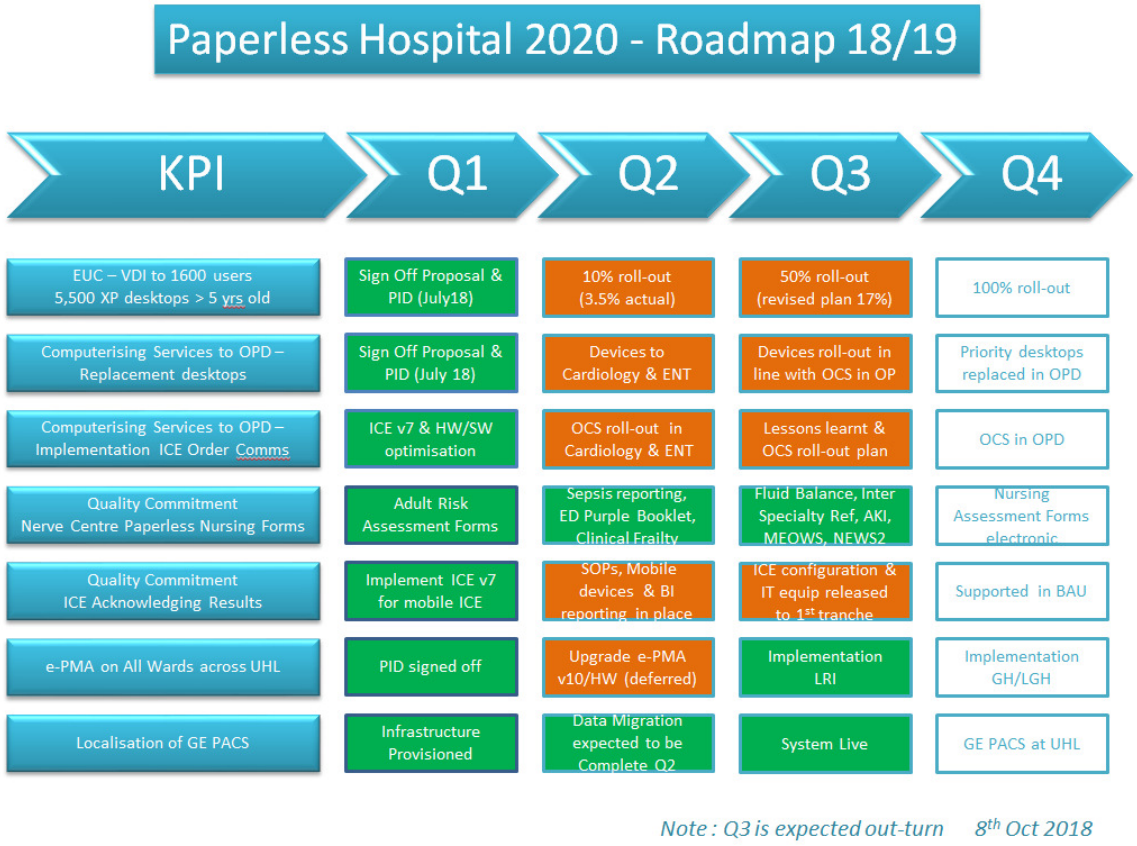
DATE: @ Sept 2018	Director:	CIO	Executive Board:	EIM&T (quarterly)/EPB	TB Sub Committee:	AC / PPPC
Linked Objective	To progress our strategic enabler – IM&T					
BAF Principal Risk: 5 – Information Technology	If the Trust is unable to deliver a fit for the future IM&T service, ***caused by inability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

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

Primary Controls

- IM&T eHospital (previously known as Paperless hospital 2020) strategy including Board structure and clinical leads in place.
- Overarching 18/19 IM&T strategic plan.
- Cyber security measures in place including regular assessments and close working relationship with managed business partner.
- Information Governance arrangements including IG toolkit, IG Steering Group and GDPR plan.
- Working arrangements aligned with clinical strategies through clinical and medical workforce information officers.
- Disaster Recover plans in place for IM&T systems.
- IM&T governance and performance monitoring through IM&T Service Board reporting to Trust Board (via FIC/PPPC), Audit Committee and Executive (EMI&T).
- IT Network providers early warning notifications monitored.
- Resources against service demand – IM&T prioritise CMGs work requests/demands against their service constraints through the IT request form and prioritisation matrix.
- Organisational change capacity – CMGs liaise with IM&T to agree IM&T support required to implement new IT programmes / systems for each (sub) project. Process defined in the PID and LORA (local organisational readiness assessment).
- CMGs Business Continuity Plans (following BIAs) included in the EPRR work plan and progress monitored through UHL EPRR Board.

Detective Risk Indicators



Internal Assurances	External Assurances	Gaps Identified & Pending Actions
• Information Governance IG Toolkit reported to AC – All components of the IGT in relation to data quality were self-assessed as the highest level 3 for 2017-18 – UHL is a trusted organisation as defined in the IG Toolkit. With the move from IGT to the Data Security and Protection Toolkit from April 2018, specific requirements for management of Data Quality are still being finalised. We have contacts with NHS Digital as well as good connections across a network of peer Data Quality leads at other regional Trusts. • GDPR progress reported to Exec Team (EIM&T) and AC – GDPR Project Lead appointed in July 2018. • Paperless hospital 2020 strategy reported to Exec Team and to Trust Board sub-committees on a regular basis - The pace of achievement of the Paperless Hospital 2020 is dependent on available resources to effect the changes and prioritisation of other demands on IT services. • The Trust's avoidance of any significant impact from the WannaCry ransomware has highlighted the good standard of our processes related to cyber security, although with no room for complacency given the speed with which this threat evolves. • IM&T Capital Plan Briefing to PPPC.	• **Internal Audit 2018/19:** ➢ Information Governance – to perform validation work on the Information governance toolkit in line with the annual audit requirement – Audit review completed March 2018 – Medium Risk. ➢ Paperless 2020 programme review - following an initial review of EPR 'Plan B' a follow up to assess how the programme is progressing using a diagnostic 'Twelve elements of programme management excellence' – Audit review completed May 2018 – High risk - progress with actions tracked via the e-Hospital Board, delays against plan but expected to complete by Mar 19. • ISO 27001:2013 – The MBP maintains an accreditation (in 2017) – due for review in 2018/19. • NHS digital Health Check – cyber security audit – Jan 2018 – remediation plan agreed. • NHS IT Maturity Index – Completed Q1 2018/19 - scores for UHL higher on all domains than national average.	• **Investment resource** to finance the acceleration of the Trust's IT service including desktop replacement project – *Secure adequate resources to fund 18/19 IT strategy* – Financial plan confirmed by CIO July 18 for eMeds. Plan to recruit in progress. Project priorities resource plan to the end of Mar19 will be taken to eHospital Board Nov 18. • **Paperless Hospital engagement** - *Deliver support to the quality commitment by identifying priority work that can be undertaken on existing systems, i.e. nervecentre or ICE as per the agreed UHL annual priorities. For 2018/19 will involve the following 5 areas (Responsible Officers MD & CIO):* ➢ *Replacing old computing/mobile hardware- roll-out started Aug 18* ➢ *Nervecentre- in progress, assessment forms being deployed Q3* ➢ *PACS – in progress go live due Nov18* ➢ *ICE– in progress- Implement in Cardiology and ENT Dec 18* ➢ *E-Prescribing – in progress roll-out to start Oct 18* • **Information Governance plan** for implementation of **GDPR** – gap analysis by Internal Auditors identified there are a number of gaps with regard to the new regulation commenced in May 2018. Mitigating actions include undertaking a Corporate Records Audit by Mar 2019 (CIO). • **Cyber security** – raising awareness to reduce risk of **human factors** and on-going **medical equipment** challenges – IM&T awareness campaigns including IM&T newsletter and new GDPR training - Commenced Oct 18 (CIO). • **External IT supplier preparedness -** UHL to seek assurance from external providers about their system resilience arrangements. CIO linking with CMGs HoOs to request they liaise with their external providers (requested 06/08/18) – Q2 2018/19 (CIO).

DATE: @ Sept 2018	Director:	DEF	Executive Board:	ESB	TB Sub Committee:	AC / QOC
Linked Objective	To progress our strategic enabler… to deliver safe, high quality, patient centred, healthcare					
BAF Principal Risk: 6 – Estates	If the Trust does not adequately develop and maintain its estate to meet statutory compliance obligations and minimise the potential for critical infrastructure failure, ***caused by a lack of resources to address the backlog maintenance programme, insufficient clinical decant capacity and the sheer volume of technical work to address ageing buildings***, then it may result in an increased risk of failure of critical plant, equipment and core critical services leading to compliance issues, risk of regulatory intervention, impact upon business and patient critical infrastructure and adverse publicity.				**Current Risk & Assurance Rating (I x L):**	**5 x 3 = 15**

BAF Ratings	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	JAN	FEB	MAR
Exec Team:	5 x 3 = 15	5 x 3 = 15	5 x 3 = 15	5 x 3 = 15	5 x 3 = 15	5 x 3 = 15						

Primary Controls	Detective Risk Indicators
• Estates & Facilities directorate governance structure to deliver effective estates and facilities services. • Estates Strategy - directs investment and resources how the Trust will maintain a fit for purpose estate that enables delivery of high quality, safe and effective care (in line with CQC core standards: Safety and suitability of premises; Safety, availability and suitability of equipment; Cleanliness and infection control), including Clinical Strategy priorities and the organisation's wider five year plan. • Prioritised Annual and Five-Year capital programme developed in consultation with CMGs and Trust Exec Team. • Statutory Compliance monitoring programme provides assurance that statutory obligations are met. The Compliance Assessment Audit System (CAAS) is used to monitor compliance rate and assist UHL in evidencing its Premises Assurance Model (PAM) position. The PAM dashboard is reported to Exec Team. Independent Authorising Engineer annual reports to measure conformance against HTM / HBN guidance. • Estates & Facilities Risk Management Process – monthly multi-disciplinary Estates & Facilities Capital Risk Management Group review new and existing E&F risks prior to reporting for scrutiny to the E&F SMT. Significant risks are escalated to the UHL Risk Register, thus providing a consistent governance approach to monitoring and review in-line with the Trust risk plan. • Backlog Maintenance & maintainability surveys and business continuity and condition surveys. • Reactive maintenance capability and 24/7 emergency call out arrangements across all sites. • Infection Prevention and Control programme embedded in Estates including policies / procedures; staff training; environmental cleaning audits and inspections. • Estates & Facilities Help Desk provides single focal point for all works requests. • Patient-led Assessments of the Care Environment (PLACE). • All key projects are taken through a rigorous business case process to ensure they deliver benefits based on the situation at the time of their development.	• Key Estates & Facilities Performance Indicators: ➢ Model Hospital benchmark. ➢ Carter Indices. ➢ Naylor recommendations for E&F. ➢ Internal KPIs and performance thresholds (hard and soft FM) ➢ Premises Assurance Model Reports ➢ CAAS Reports ➢ Specialist Reports and verifications ➢ DoH acceptance of Trust ERIC submission

Internal Assurances	External Assurances	Gaps Identified & Pending Actions
• Risk Assessments identify significant risks are reviewed by E&F Senior Management Team on a quarterly basis, prior to being put onto the Trust Risk Register. • Risk action plans/action notes are generated and monitored and reviewed in accordance with Trust risk management policy. • Data from Backlog maintenance & maintainability (age & replacement parts), business continuity and condition surveys ensures highest identified risks are prioritised and considered for funding. • For September achieved 100% in the delivery of Statutory Maintenance tasks in the month. • For the Non-Statutory tasks (69%) completion of the monthly schedule is subject to the volume of reactive calls and the shortage of engineers to carry out tasks and administration personnel to close them down on the system.	• Backlog maintenance – reported in the ERIC return to the Department of Health and benchmarked against other NHS Trusts annually. • Premises Assurance Model – current rating: 'Steady State'. • External audit for Piped Medical Gases carried out by an Independent Authorising Engineer, annually. • Electrical Low Voltage, High Voltage and Lifts audited by an Independent Authorising Engineer, annually. • Water audit carried out by an Independent Authorising Engineer, six monthly. • External audit for Specialist Ventilation carried out by an Independent Authorising Engineer, annually. • Patient-led Assessments of the Care Environment (PLACE) report benchmarking, • **Internal Audit 2017/18:** ➢ Backlog maintenance – Audit action plan monitored and reviewed at UHL Audit Committee. • **Internal Audit 2019/20:** ➢ Capital Programme (TBC) - a review of the prioritisation process for developing the capital programme, how resources are allocated across the key areas and the monitoring / reporting around the programme.	• Insufficient funding allocated to fully implement the Sustainable Development Management Plan and reconfigure the estate in-line with clinical and estates strategy. A five-year backlog maintenance reduction programme with Trust Board backing is required. • Detailed build-up of capital costs to provide an overall 5 year capital programme to ensure appropriate finances are allocated to implement the changes required. • A full asset list of all plant and equipment is required. • LLR STP funding position to be updated for a 2019/20 bid and put forward to NHS Improvement and NHS England. This includes backlog and infrastructure investment. • Confirmation of planning assumptions and service model which will lead to refinements in the proposed DCP design solutions – Further revision of the DCPs based the current level of information and forecasts. • Identify appropriate level of upgrade works; to be informed by the latest condition survey and linked to the Galliford Try review. • Recruitment and retention of key operational and maintenance E&F staff challenges, resulting in gaps in service delivery and standards – DEF to review following a change in E&F trajectory as a result of not moving to the planned E&F Subsidiary model. • Recruitment and Retention of Estates Specialist Services Authorised Person (AP) specialists identified as a potential threat to Capital Development schemes as AP support is key to quality & safety in the delivery of capital schemes – DEF to review 18/19.

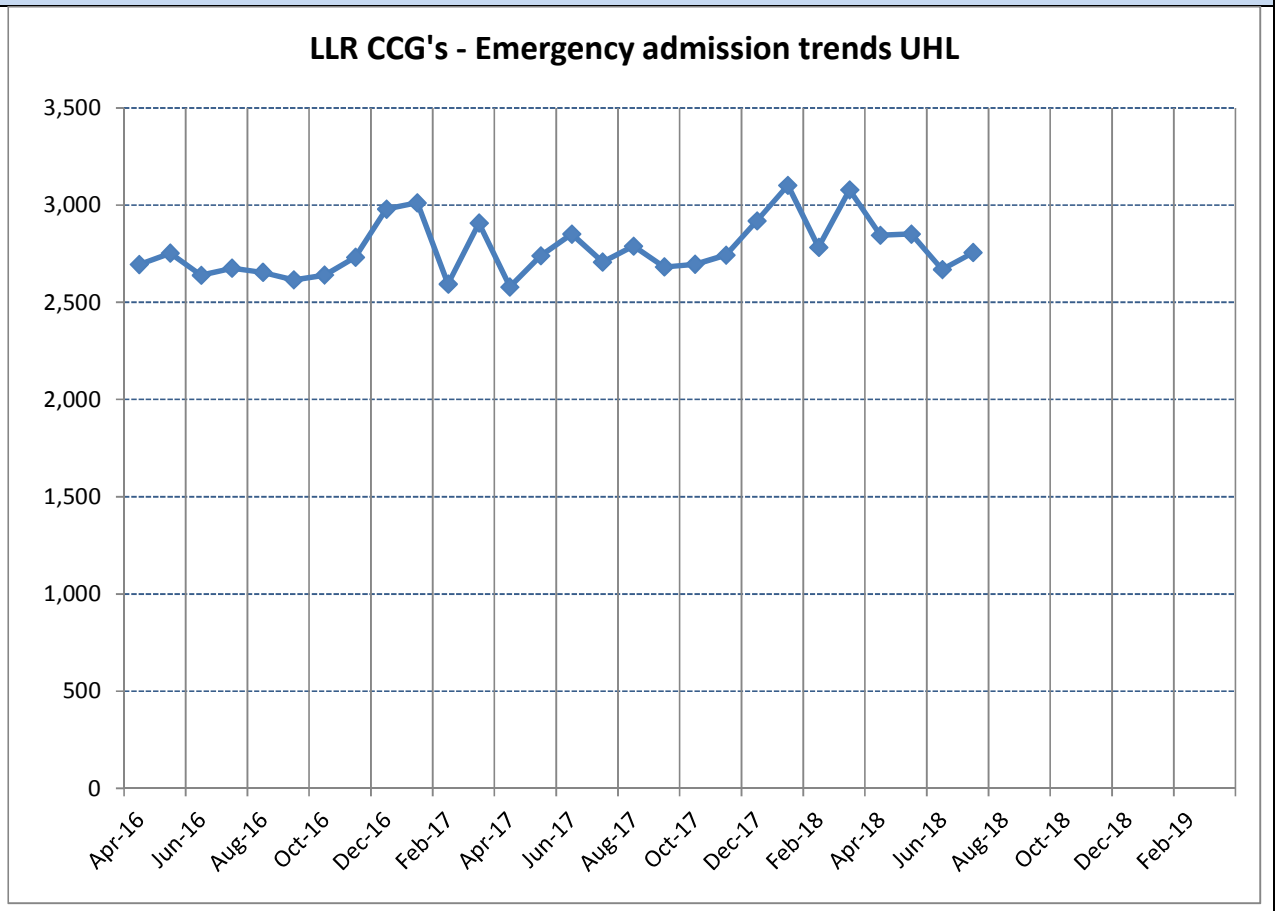
DATE: @ Sept 2018	Director:	DSC	Executive Board:	ESB	TB Sub Committee:	AC / PPPC
Linked Objective	To develop more integrated care in partnership with others					
BAF Principal Risk: 7 – Partnerships	If the Trust is unable to work collaboratively with partners to secure the support of community and STP stakeholders, ***caused by breakdown of relationships amongst partners and ineffective clinical service strategies of the local population***, then it may result in disruption to transforming sustainable clinical services, affecting business (finance) and reputation (breach in regulatory duty / adverse publicity).				**Current Risk & Assurance Rating (I x L):**	**4 x 4 = 16**

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

Primary Controls

- Attendance and active participation in:
  - All STP work streams at senior strategic level and at operational level where relevant.
  - Health and wellbeing Boards across City and County.
  - Active engagement with primary care across city and county.
- Revised Trust objectives and annual priorities agreed for 2018/19.
- Frailty programme, AE Delivery Board and internal flow metrics.
- LLR Frailty Checklist agreed by health and social care. This is a single page reminding professionals to check that vaccinations, falls assessments, medication reviews etc. have been completed.
- Clinical Frailty Scale score has been built into Nerve Centre with a tailored training package for all EF staff.
- Active Clinical input and leadership across key STP work streams such as planned care, urgent care, Integrated Locality teams, and Home First.
- System wide PMO including: Project and programme management; Specialist Support e.g. business intelligence, strategic planning; Change Management and Transformation Function.
- Readmissions working group set up to analyse data at specialty level (inc. benchmarking) and assess the actions needed.

Detective Risk Indicators



Internal Assurances	External Assurances	Gaps Identified & Pending Actions
• Internal self-assessment reviews about the efficacy of the controls for this risk have been reported to ESB; Stakeholder meetings; Trust Board sub-committees and have identified gaps in active participation in several related STP work streams – this has been rectified from June 2018, with operations and strategy attendance at key STP meetings. • UHL Trust Board briefed on the LLR Frailty programme in August 2018. • Multiple CMGs and services now involved in improving this system of care for frail and multi-morbid patients internally and with external partners. Positive engagement noted to date (as at Aug 2018). • UHL Consultants Conference (Sept 2018) – symposium held on frailty to identify how to make UHL 'frailty friendly'. • Planned care: ➢ System wide LiA events for key specialties continue to take place. 5 have been completed so far, with working groups in place to inform transformed models of care for each specialty. ➢ Next set of 5 planned for September 2018.	• Review of the LLR STP has shown that this risk is not fully mitigated as assurance of efficacy of the partnership working is limited at this point. This tells us that the current governance processes are not yet fit for purpose and will not fully mitigate the risk as presented. • The work will be referenced in LLR escalation meetings with NHS England and NHS Improvement. • New Out of Hospital Board formed, covering the duplicative work of the Integrated Locality Teams and the Home First STP work streams. UHL fully engaged at strategic and operational level. Outcomes being aligned to those of the Frailty programme.	• First new Out of Hospital Board met in October 2018 but with limited progress made on action plan. DCOO attended for UHL. Action to review progress in November 2018 and escalate via SLT and CLG if required.

Appendix 2 UHL Risk Register Dashboard (15+) as at 30 Sep 18

Risk ID	CMG / Corporate	Risk Description	Current Risk Score	Target Risk Score	Risk Cause
1149	CHUGGS	If there is an increase to cancer patients waiting times, caused by competing priorities between cancer targets, patient compliance, capacity and administration processes then we may breach waiting time targets resulting in delays in patient diagnosis and treatment.	20	9	Demand & Capacity
2264	CHUGGS	If an effective solution for the nurse staffing shortages in CHUGGS at LGH and LRI is not found, then the safety and quality of care provided will be adversely impacted.	20	6	Workforce
2565	CHUGGS	If capacity is not increased to meet demand, then delivery of national targets in General Surgery, Gastro and Urology will be compromised resulting in delays in patient treatment pathways.	20	9	Demand & Capacity
3139	CHUGGS	If the ageing and failing decontamination equipment in both Endoscopy and theatres is not improved / replaced, then the service may fail to meet national guidelines, diagnostic targets and decontamination and Infection Control requirements, resulting in increased risk of harm to both patients and staff, increasing waiting list size and failure to secure JAG approval.	20	3	Equipment
3183	RRCV	If Cardiac Surgery is unable to operate on elective patients due to winter pressures and/or availability of ward and ITU beds, there is a risk that patients' conditions could deteriorate, resulting in a need for urgent admission or more complex surgery with greater risk of complications.	20	15	Demand & Capacity
3186	RRCV	If the CMG fails to achieve the allocated financial control total then this could result in an deterioration in the Trust overall financial deficit.	20	9	Finance
2354	RRCV	If the capacity of the Clinical Decisions Unit is not expanded to meet the increase in demand, then will continue to experience overcrowding resulting in potential harm to patients.	20	9	Demand & Capacity
2149	ESM	If we do not recruit and retain into the current Nursing vacancies within SM, then patient safety and quality of care may be compromised resulting in potential delayed care.	20	6	Workforce
2804	ESM	If the ongoing pressures in medical admissions continue, then Specialist Medicine CMG bed base will be insufficient thus resulting in the need to out lie into other speciality/CMG beds affecting quality and safety of patient care.	20	12	Demand & Capacity
3077	ESM	If there are delays in the availability of in-patient beds, then both Emergency Care performance and safety of patients within the Emergency Department at Leicester Royal Infirmary could be adversely affected, resulting in overcrowding in the Emergency Department and an inability to accept new patients from ambulances.	20	15	Demand & Capacity
3114	ITAPS	If we are unsuccessful in recruiting ITU medical and nursing staff to agreed establishment, then we are at risk of not being able to deliver a safe and effective service, resulting in delay in treatment to patients and deterioration in performance.	20	6	Workforce
3115	ITAPS	If there is an IT infrastructure failure or delay in accessing systems due to out of date and obsolete hardware and software in theatres and other clinical areas, then clinical teams will not be able to access essential patient information or imaging in a timely manner resulting in potential for patient harm.	20	4	IT
3120	ITAPS	If there is a continued mismatch between capacity and demand for access to emergency theatres we are at risk of cat 2 and 3 patients not receiving surgery within the NCEPOD timeframes and increased requirement for out of hours working.	20	12	Demand & Capacity
2333	ITAPS	If we do not recruit into the Paediatric Cardiac Anaesthetic vacancies, then we will not be able to maintain a WTD compliant rota resulting suboptimal patient treatment.	20	8	Workforce
3113	ITAPS	If the infrastructure in our ITU's is not updated and expanded to meet current standards and demand, then clinical teams will not be able to provide safe care to all patients requiring level 2 or 3 care resulting in deterioration in clinical outcomes benchmarked against other centres (ICNARC).	20	8	Estates
3200	ITAPS	If the practices, workforce, estate and facilities in LRI ITU are not compliant to current standards and expectations Caused by staffing shortages, inadepquate capacity for demand and an aging estate with suboptimal environment for critical care patients then clinical teams will not be able to provide safe care to all patients requiring level 2/3 care due to an increased risk of cross contamination	20	10	Policy & Procedures
3119	ITAPS	If there is a deterioration in our theatre staff vacancies and we are unsuccessful in recruiting ODP's to agreed establishment; then we are at risk of not being able to deliver a safe and effective service.	20	6	Workforce
3083	W&C	When gaps on the Junior Doctor rota reach a critical level there are not enough Junior Doctors to staff the Neonatal Units at both the LRI and LGH; resulting in a substantial risk to patient care, quality of service and reputation to the unit and Trust. The number of gaps will vary but for July 2018 are at a critical level.	20	3	Workforce
2777	Comms	If fundraising targets for the Charity fundraising campaign do not reach target charitable income	20	8	Demand & Capacity
3054	Human Resources	If the Trust's Statutory and Mandatory Training data can no longer be verified on the new Learning Management System, HELM, then it is not possible to confirm staff training compliance which could result in potential harm to patients, reputation impact, increased financial impact and non-compliance with agreed targets.	20	3	IT
3148	Corporate Nursing	If the Trust does not recruit the appropriate staff with the right skills in the right numbers then we may not be able to deliver safe, high quality, patient centred, efficient care and reduce our current nursing vacancy levels resulting in potential increased clinical risk to our patients and poor patient experience	20	12	Workforce
2404	Corporate Nursing	If the process for identifying patients with a centrally placed vascular access (CVAD) device within the trust are not robust, then this could result in increased morbidity and mortality.	20	16	Policy & Procedures
3298	Corporate Nursing	If the outbreak of Carbapenem-resistant Organisms (CRO) continues, we are at risk of under achieve ment of key clinical standards and a decrease in bed capacity for emergency admissions so reducing our ability to continue to provide an acceptable level of health service resulting in potential harm to patients, adverse reputation and service delivery impact.	20	5	Policy & Procedures
3222	ESM	If a member of the public is violent or agrresive outside ED, or in Ed receptions/waiting rooms, then staff or members of the public may be harmed, equipment may be damaged	20	10	Policy & Procedures
3109	RRCV	If additional capacity, resource and support is not provided for the Respiratory Consultant Pharmacist then there is a risk of patient harm as they will be unable to deliver current commitments, service requirements or meet the future demands of the CMG due to the significant gaps in resource versus demand in this highly specialised role.	16 ← 12	8	Demand & Capacity
3181	RRCV	If the Prescribing Administration and Monitoring of Oxygen in Adults (B27/2010) Policy is to be adhered to, Then the e-obs system settings must be adjustable for Cardio-Respiratory patients, Resulting in in improved patient care or chronic hypoxic conditions and for patients who do not have Type 2 respiratory failure.	16	6	Policy & Procedures
3040	RRCV	If there are insufficient medical trainees in Cardiology, then there may be an imbalance between service and education demands resulting in the inability to cover rotas and deliver safe, high quality patient care.	16	9	Workforce
2820	RRCV	If a timely VTE risk assessments is not undertaken on admission to CDU, then we will be breach of NICE CCG92 guidelines resulting patients being placed at risk of harm.	16	3	Policy & Procedures
3198	ESM	If there is a Failure to administer insulin safely and monitor blood glucose levels accurately, in accordance with any prescriber's instructions and at suitable times then this may lead to patients not having their diabetes appropriately monitored/managed resulting in a risk of prolonged length of stay, severe harm	16	4	Policy & Procedures

Risk ID	CMG / Corporate	Risk Description	Current Risk Score	Target Risk Score	Risk Cause
3275	ESM	If the aging Neurophysiology investigative/diagnostic systems are not replaced, then the EMG, EP, EEG services, including Telemetry, Ambulatory, OP & IP and Portable across UHL and community may become unsustainable resulting in an inability to diagnose patients disorders of the function of nervous system.	16	6	Equipment
3203	ESM	If Dermatology is not adequately resourced, then we will be unable to provide high quality and timely care to our patients and recruitment of staff will be affected, resulting in threat of not meeting RTT and skin cancer targets.	16	4	Demand & Capacity
3025	ESM	If there continues to be high levels of qualified nursing vacancies and issue with nursing skill mix across Emergency Medicine, then quality and safety of patient care could be compromised.	16	4	Workforce
3121	ITAPS	If operating theatres' ventilation systems fail due to lack of maintenance, then the affected theatres cannot be used to provide patient care resulting in reduced theatre capacity and pressure on other theatres to meet demand and may lead to patient cancellations	16	9	Estates
2191	MSS	If workforce constraints within the ophthalmology service are not addressed, then backlogs and delays could result in serious patient harm.	16	8	Workforce
2989	MSS	If we do not recruit into the T&O Wards nursing vacancies, then patient safety and quality of care will be placed at risk	16	4	Workforce
2955	CSI	If system faults attributed to EMRAD are not expediently resolved, then we will continue to expose patients to the risk of harm	16	4	IT
3205	CSI	If the breast screening round length is not reduced, caused by a multitude of factors including workforce gaps, implementation of new PACS EMRAD, lack of unit space and unplanned equipment downtime, then the PHE performance indicator may not be met leading to delays with patients three yearly breast screening appointments impacting early cancer diagnosis.	16	8	Demand & Capacity
3128	CSI	If unfated blood components previously issued (2015 to 2017) are not evidenced then BSQR 2005 legal requirement of 100% traceability will not be met resulting in regulatory implications and delay in providing blood and blood components.	16	4	Policy & Procedures
3129	CSI	If a 100% traceability (end fate) of blood components is not determined Then BSQR 2005 legal requirement of 100% traceability will not be met Resulting in legal implications and delay in providing blood and blood components	16	4	Policy & Procedures
3206	CSI	If staff are not appropriately trained on the usage of POC medical device equipment then this may lead to improper use that may result in inaccurate diagnostic test results affecting patient care and leading to potential harm to the patient.	16	6	Policy & Procedures
3286	CSI	If continual failure in meeting key performance indicators for urgent blood cancer diagnostic testing, caused by limited Consultant Immunologist availability then this will result in delayed diagnosis and treatment of acute leukaemia patients and withdrawal of weekend standby service	16	6	Workforce
3008	W&C	If the paediatric retrieval and repatriation teams are delayed mobilising to critically ill children due to inadequately commissioned & funded provision of a dedicated ambulance service, then this will result in failure to meet NHS England standards, delayed care, potential harm and inability to free-up PICU capacity.	16	5	Demand & Capacity
2153	W&C	If the high number of vacancies of qualified nurses working in the Children's Hospital is not addressed, then there will be a shortfall in the nurse to patient ratio which could impact on the quality of patient care.	16	8	Workforce
3201	Communications	If the Mac desktop computers fail/break down or the shared server fails, then there is a loss of service to the Trust because photographers and/or graphics are unable to do their job and potential loss of work products that are saved/stored on there. There is no IM&T support for these machines and no IM&T support or management of this server.	16	2	IT
2237	Corporate Medical	If a standardised process for requesting and reporting inpatient and outpatient diagnostic tests is not implemented, then the timely review of diagnostic tests will not occur.	16	8	Policy & Procedures
3138	Estates & Facilities	If there are insufficient management controls in place to meet Regulation 4 of the Control of Asbestos Regulations (CAR), then there is an increased risk of enforcement action by the HSE, resulting in prosecution, and/or significant financial impact and reputational damage.	16	4	Policy & Procedures
3140	Estates & Facilities	If sufficient 'downtime' for Planned Preventative Maintenance and corrective maintenance is not scheduled into the theatre annual programmes, then functional defects will emerge and evolve in specialist ventilation systems, resulting in potential risk of microbiological contamination in the theatre environment.	16	8	Demand & Capacity
3141	Estates & Facilities	If the integrity of fire compartmentation is compromised, then during a real fire event the rate of fire and/or smoke spread will accelerate through the building limiting the ability to utilise horizontal and/or vertical evacuation methods, resulting in potential life safety concerns and loss of areas / beds / services.	16	8	Equipment
3143	Estates & Facilities	If sufficient capital funding is not committed to reduce backlog maintenance across the estate there will be an increasing risk of key/critical failures in buildings, building services and infrastructure impacting on service provision and patient care.	16	6	Finance
3145	Estates & Facilities	If there is not a significant investment to upgrade electrical infrastructure across the UHL, then there will be an increased risk of a loss of 'normal' electrical supply and potential failures in generator stand-by electrical supply leading to interruption to patient care, key electrical equipment breakdown, and provision of normal patient care and support services resulting in adverse impacts to patient care and non-clinical services.	16	6	Finance
3137	Estates & Facilities	If calls made to the Switchboard via '2222' are not recorded, then there is a risk that vital/critical information passed verbally between caller and call handler cannot be verify if the emergency response is not appropriate for the reported situation.	16	4	Policy & Procedures
3191	IM&T	If the Trust is unable to demonstrate 95% compliance with IG training, then the Trust may lose level 2 IG accreditation, resulting in potential loss of research status and difficulties with forging future collaborative working arrangements with prospective business partners which could adversely impact on the delivering strategic aims.	16	12	IT
3180	IM&T	If fragility in the underlying UHL IM&T infrastructure is not addressed, then there may be limited or no access to Trust IM&T critical systems, resulting in service disruption and impacting provision of care	16	6	IT
3155	IM&T	If the PABX system fails then the telephone system will not work for a range of telephone numbers resulting in significant service disruption and potential patient harm.	16	4	IT
2621	CHUGGS	If recruitment and retention to vacancies on Ward 22 at the LRI does not occur, then patients may be exposed to harm due to poor skill mix on the Ward.	15	6	Workforce
3211	RRCV	If Additional appropriately trained sedationists are not provided in Angiocatheter suite. Then Patients undergoing cardiology procedures may receive an inadequate level of monitoring during conscious sedation.	15	8	Workforce
3047	RRCV	If the service provisions for vascular access at GH are not adequately resourced to meet demands, then patients will experience significant delays for a PICC resulting in potential harm.	15	6	Demand & Capacity
2837	ESM	If migration to an automated results monitoring system is not introduced, Then follow-up actions for patients with multiple sclerosis maybe delayed resulting in potential harm.	15	2	IT
3317	CSI	If breast care services are unable to consistently deliver the 2WW demand, due to high volumes of vacancies, lack of equipment and adequate space to house the service, then patients may experience delayed appointment time and treatment, resulting in harm	15	9	Demand & Capacity

Risk ID	CMG / Corporate	Risk Description	Current Risk Score	Target Risk Score	Risk Cause
2615	CSI	Integrity and capacity of containment level 3 laboratory facility in Clinical Microbiology	15 ← 20	2	Demand & Capacity
2973	CSI	If the service delivery model for Adult Gastroenterology Medicine patients is not appropriately resourced, then the quality of care provided by nutrition and dietetic service will be suboptimal resulting in potential harm to patients.	15	6	Workforce
3262	CSI	If the pressure on the Cellular Pathology Urology service caused by the continuing increase in cases from external sources is not effectively matched with appropriate resources then the service will become unsustainable potentially leading to reporting errors and impacting on patient safety.	15	3	Demand & Capacity
2965	CSI	If we do not address Windsor pharmacy storage demands, then we may compromise clinical care and breach statutory duties	15	6	Estates
3093	W&C	If there is insufficient Midwifery establishment to achieve the recommended Midwife to Birth ratio, in view of increased clinical acuity, then patient care may be delayed resulting in potential increase in maternal and fetal morbidity and mortality rates	15	6	Workforce
3023	W&C	There is a risk that the split site Maternity configuration leads to impaired quality of Maternity services at the LGH site	15	6	Workforce
3084	W&C	Due to the current split site Consultant cover of the Neonatal Units at the LRI and LGH; there is a risk to patient care, quality of service and reputation to the unit and Trust. This may also result in the withdrawal of the neonatal service from the LGH site impacting significantly the Maternity Service.	15	5	Workforce
2394	Comms	If a service agreement to support the image storage software used for Clinical Photography is not in place, then we will not be able access clinical images in the event of a system failure.	15	3	IT
3079	Corporate Medical	If there is insufficient capacity with the administrative support for the Learning from Deaths Framework and the Specialty M&M Structured Judgment Review process which is not addressed and substantive funding is not identified for an additional Bereavement Support Nurses, then this will lead to a delay with screening all deaths, undertaking Structured Judgment Reviews, and speaking to bereaved relatives, resulting in failure to learn from deaths in a timely manner and non-compliance with the internal QC and external NHS England and Statutory Quality Account requirement	15	6	Workforce
3172	IM&T	If systems and services provided by IM&T are not continuously maintained to ISO accredited standard, then our systems may be vulnerable to potential cyber attack resulting in in significant service disruption, harm to patients and financial loss	15	15	IT
2434	IM&T	If computers operating on Windows XP are not upgraded, then we may experience significant service disruptions in the event of a cyber attack.	15	6	IT
1615	IM&T	If flooding occurs at the LRI, then the Servers and Network equipments in our Data Centre may become damaged resulting in Trust-wide service disruption and potential harm to patients.	15	6	IT
3289	Operations (Corporate)	If the Trust fails to improve its emergency preparedness, resilience and response (EPRR) arrangements, caused by a lack of appropriate time and resources to develop them, then there is a risk that the Trust is not adequately prepared to respond to a business continuity, critical or major incident.	15	6	Policy & Procedures