INTEGRATED RISK AND ASSURANCE REPORT: JUNE 2018

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

Executive Summary

Context

The purpose of this paper is to enable the UHL Trust Board (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 meeting.

Questions

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

Conclusion

1. The principal risks have been identified and linked to Trust objectives. The principal risks relate to: PR1 – Quality standards; PR2 – Staffing levels; PR3 – Financial sustainability; PR4 – Emergency care pathway; PR5 – IM&T service; PR6 – Estates and Facilities service; PR7 – Partnership working. The highest rated principal risks (currently rated at 20) relate to staffing levels, emergency care pathway and financial sustainability.
2. There are 193 risks recorded on the organisational risk register (including 73 with a current rating of 15 and above). The Trust's risk profile continues to demonstrate active review across all CMGs and corporate services. Two new risks scoring 15 and above have been entered on the risk register.
3. Thematic Analysis of the CMG risks on the organisational risk register has identified the two key risk causation themes as gaps in staffing levels and demand against capacity. Financial pressures, including external funding and internal arrangements are recognised as key enablers to support the delivery of the Trust's objectives.

Input Sought

The Board are 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: [TB 6.9.18]

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

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

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST

REPORT TO: **UHL TRUST BOARD**

DATE: **2ND AUGUST 2018**

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

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

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1 INTRODUCTION

1.1 This integrated risk and assurance report will assist the Trust Board (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 achievement of the Trust's strategic objectives. The format of the BAF is designed to provide the Board with a simple but comprehensive method for the effective and focussed management of principal risks to the achievement of its strategic objectives. The purpose of the BAF is therefore to enable the 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 assurance.

2.2 The BAF remains a dynamic document and the principal risks have been reviewed by the lead Directors (to report June performance) and have been reported to their relevant Executive Boards during July 2018, where they have been scrutinised and the endorsed, and a final version is attached at appendix one.

2.3 The principal risk descriptions include, in italics, the key *threats* likely to increase the risk. The seven principal risks on the BAF relate to:

PR1A – Quality standards – clinical effectiveness;
PR1B – Quality standards – patient safety;
PR1C – Quality standards – patient experience;
PR2 – Staffing levels;
PR3 – Financial sustainability;
PR4 – Emergency care pathway;
PR5 – IM&T service;
PR6 – Estates and Facilities service;
PR7 – Partnership working.

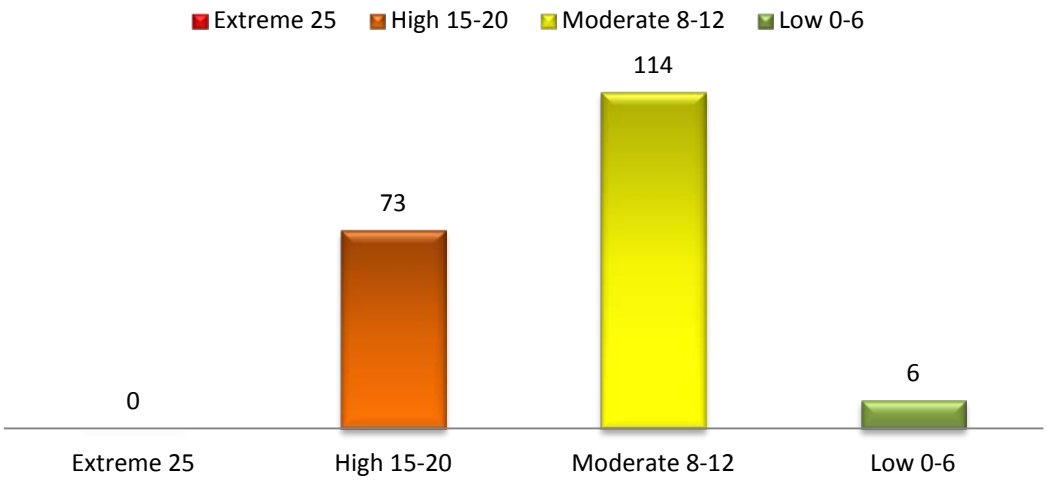
2.4 There has been no change to the principal risk scores on the BAF for this reporting period and the three highest rated principal risks, all with residual ratings of 20, relate to financial sustainability, emergency care pathway and staffing levels, and are described below:

Principal Risk Description	Risk Rating	Objective & Lead Director
PR2: If the Trust is unable to achieve and maintain 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).	20	Our People DPOD
PR3: If the Trust is unable to achieve and maintain financial sustainability***, caused through delivery of income, the control of costs or the delivery of cost improvement plans***, then it will result in a failure to deliver the financial plan, affecting business (finance) and reputation (breach in regulatory duty / adverse publicity).	20	Financial Stability CFO
PR4: If the Trust is unable to effectively manage the emergency care pathway***, caused by persistent unprecedented level of demand for services, primary care unable to provide the service required, ineffective resources to address patient flow, and fundamental process issues,*** then it may result in widespread instances of poor clinical outcomes for patients and sustained failure to achieve constitutional standards, affecting business (finance) and reputation (breach in regulatory duty / adverse publicity).	20	Organisation of Care COO

3. ORGANISATIONAL RISK REGISTER SUMMARY

3.1 The Trust risk register has been kept under review by the Executive Performance Board and CMG Boards during June and displays 193 risks. A dashboard of all risks rated 15 and above is attached at appendix two and figure 1, below, illustrates the Trust's risk profile by current residual risk rating.

Figure 1: UHL Risk Register profile - residual risk rating



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

CMG	Risk Description	Current Rating	Target Rating
3205	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
3201	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 any IM&T support or management of this server.	16	2

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

- Staffing shortages;
- Imbalance between demand and capacity.

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

4 RECOMMENDATIONS

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

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

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

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

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

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

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	4 x 3 = 12	NEW
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	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	4 x 3 = 12	NEW
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	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	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	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	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	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	4 x 4 = 16	↔

DATE: @ June 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:			**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 including 'safe' and 'caring' indicators reported to EPB 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 and participation in national clinical registries.
- 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	June-18	18/19 YTD
EFFECTIVE	E1	Readmissions <30 days – Discharge work stream – one month in arrears	Red >8.6%	May 9.2%	9.3%
	E2	Mortality (SHMI) – JJ	<=99	97	97
	E5	Crude Mortality – JJ	<=2.4%	1.90%	2%
	E6	#NOF <36 hours – CMG / ANDY CURRIE / Max Chauhan	Red <72%	53.5%	63.4%
	E7	Stroke – 90% stay on stroke unit – one month in arrears – CMGs/ S SNAP – RACHEL MARSH	Red <80%	May 87.3%	85.6
	E8	Stroke – TIA – RACHEL MARSH	Red <80%	77.7%	63.8%

Internal Assurances	External Assurances	Gaps Identified & Pending Actions
• UHL Quality Commitment components monitored at Exec Team and QOC, quarterly – Q1 performance due to be reported to the EQB in August. • 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 CAS alert compliance 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. • Externally reported SHMI and HSMR information – latest published SHMI continues to show UHL below 100 (97 and is within the threshold). • Latest Mortality report to QOC and Trust Board highlighted capacity constraints in the Learning from Deaths programme.	• 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:** ➢ Data Quality review – scheduled Q3; ➢ Learning from deaths – scheduled Q3; • **Internal Audit 2016/17:** ➢ Clinical Audit - medium risk (associated with CMG engagement).	• 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). • There has been an increase in the number of referrals to the TIA clinic; actions to reduce this include developing new pathways, better screening and redirecting some referrals to other clinics. This is essential if we are going to meet the criteria for low risk patients as well within the current clinic capacity. • #NOF Pathway agreed between ED, Trauma, Geriatrics and Theatres but followed inconsistently • At the end of 17/18 agreed that actions to prevent avoidable readmissions would be incorporated into the R2G work programme. Current discussions being held to confirm if this approach needs to be reviewed.

DATE: @ June 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**									

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.
- Incident reporting and investigation policy and procedures.
- 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.
- 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.
- Medical Examiner and Learning from Deaths reviews.
- GIRFT reports and NHSR scorecard.

Detective Risk Indicators

	Ref	Indicators	18/19 Target	June-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)	29 May	50
	S2	Serious Incidents - actual number escalated each month	<=37 by end of FY 18/19	6	14
	S8	Overdue CAS alerts	0	0	0
	S10	Never Events	0	2	4
	S11	Clostridium Difficile	61	5	21
	S12	MRSA Bacteraemias - Unavoidable	0	0	0
	S13	MRSA Bacteraemias (Avoidable)	0	0	0
	S14	MRSA Total	0	0	0
	S23	Falls per 1,000 bed days for patients > 65 years (1 month in arrears)	<6.6	6.1 May	6.7
	S24	Avoidable Pressure Ulcers Grade 4	0	0	0
	S25	Avoidable Pressure Ulcers Grade 3	<27	1	1
	S26	Avoidable Pressure Ulcers Grade 2	<84	7	18

Internal Assurances	External Assurances	Gaps Identified & Pending Actions
• Annual Governance statement providing assurance on the strength of internal control regarding risk management processes reported to Audit Committee (May 2018). • Report from DSR to EQB and QOC: ➢ Patient Safety Report (June 2018) : Two Never Events relating to wrong site surgery were reported in June, six serious incidents have been escalated, one Regulation 28 Coroner's letter was received and we continue to achieve 100% CAS compliance. There are fourteen approved incidents showing evidence gaps in Duty of Candour. ➢ Complaints Data report: An improved performance for 10, 25 day complaints and a decrease in performance for 45 days complaints. A decrease in the number of re-opened complaints this month. • 2 Never Events reported in June. The action plan has been revised to provide further interventions at corporate and ward level to improve management of Never Events in the Trust. • Support the proposal for the Medical Director, Chief Nurse, Director of Clinical Quality and Director of Safety and risk to review safety governance arrangements in light of the Gosport Report. • A recent NHSI letter invited Trusts to review their arrangements for signing off national patient safety alerts. Following review of our processes, national alerts will be received at EQB for approval prior to external sign-off.	• CQC comprehensive review in 2017/18 - inspectors have rated our Trust overall as Requires Improvement; rating us Good for being effective and caring, and Requires Improvement for being safe, responsive and well-led. Actions to be taken: ➢ The Trust must embed learning from never events in order to prioritise safety and reduce never events; ➢ The Trust did not always control infection risk well - Staff did not always adhere to trust policy in relation to cleaning of equipment, completing infection control risk assessments and hand hygiene. • CQC Warning notice issued following unannounced inspection in Nov 2017 – re the care given to diabetic patients in relation to the management of their insulin requires significant improvement. 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) & Q3 QC; ➢ 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 2018/19:** ➢ Quality Account with an unqualified audit opinion – May 2018. • **External Audit 2016/17:** ➢ Incident reporting and evidence of validation of grading of harm – outcome assured (safety nets in place and being monitored). • National Freedom to Speak up Guardian visit in Q3 2017 – positive verbal feedback received about systems and processes in place in UHL. • Parliamentary ombudsman enquires – only 1 partially upheld case in 17/18, reduced from 7 the previous year. • Healthwatch – independent complaints review panel – positive verbal feedback received during 2017 about complaints management and handling processes. • Commissioning review of the Emergency Department – report awaited.	• 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). • Audit of Patient Safety Alerts (reference NHS Improvement letter 1st June 2018) to strengthen governance arrangements and ensure embedding of Never Event preventative barriers – to be reported as part of Never Event action plan – Focus during Q2 2018/19 (MD / CN). • Overdue RCA actions require urgent attention from relevant CMGs (CMG CDs) – Escalated to CMG Boards monthly (DSR). • Improve culture and empower staff to 'Stop the Line' in all clinical areas – QC priority 2018/19 – Reviewed at EQB quarterly (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). Other actions are included in relevant BAF PR associated with: • IM&T systems and infrastructure – See PR5. • Workforce gaps – see PR2. • Demand and capacity imbalance – See PR4 .

DATE: @ June 2018	Director:	MD / CN. CR / 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:			**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.
- 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).

Detective Risk Indicators

	Ref	Indicators	18/19 Target	June-18	18/19 YTD
CARING	C2	Formal complaints rate per 1000 IP,OP and ED attendances	No Target	1.4	1.5
	C4	Published Inpatients and Daycase Friends and Family Test - % positive	97%	97%	97%
	C7	A&E Friends and Family Test - % positive	97%	92%	89%

Internal Assurances	External Assurances	Gaps Identified & Pending Actions
UHL Quality Commitment components monitored at Exec Team and QOC quarterly. 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.	• 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 (insulin) & Q3 QC; • **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).

DATE: @ June 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**									

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.

Detective Risk Indicators

	Ref	Indicators	Red RAG/ Exception Report Threshold (ER)	June-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%	60.3
	W8	Nursing Vacancies overall	Separate report submitted to QOC	14%	13.2%
	W10	Turnover Rate	Red = 11% or above ER = Red for 3 Consecutive Mths	8.4%	8.4%
	W11	Sickness absence (reported 1 month in arrears)	Red if >4% ER if 3 consecutive mths >4.0%	May 4%	4.1%
	W12	Temporary costs and overtime as a % of total paybill	TBC	11.8%	11.7%
	W13	% of Staff with Annual Appraisal (excluding facilities Services)	Red if <90% ER if 3 consecutive mths <90%	89.8%	89.8%
	W14	Statutory and Mandatory Training	95%	89%	89%
	W15	% Corporate Induction attendance	Red if <90% ER if 3 consecutive mths <90%	98%	97%
	W16	BME % - Leadership (8A – Including Medical Consultants)	4% improvement on Qtr 1 baseline	28%	28%
	W20	DAY Safety staffing fill rate - Average fill rate - registered nurses/midwives (%)	TBC	87.2%	87.7%
	W22	NIGHT Safety staffing fill rate - Average fill rate - registered nurses/midwives (%)	TBC	94.3%	94.5%

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 reports to Exec Board and PPPC. Draft strategic workforce plan circulated to Exec Team planning session on 27th June.
• 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:*
  ○ *Significantly BETTER on 3 questions*
  ○ *Significantly WORSE on 4 questions*
  ○ *The scores show no significant difference on 81 questions*
• *57% of staff would recommend the trust as place to work (from Pulse Check – March 2018).*
• Our latest national staff survey results for 2017 were not as good as the improving trend we saw in previous years.
• CMG Performance Review / Assurance Meetings – *all CMGs reviewed during April and appropriate action plans developed and being monitored.*
	• **Internal Audit 2018/19:**
	  ➢ 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 **–** *GMC survey results due in June 2018.*
	• HEEM quality management visits **-** *HEE re-visited Cardio-respiratory on May 4th 2018 to review progress against their action plan – formal report is awaited.*
	• Leicester Medical School feedback **–** *retention rate report awaited.*
	• Performance monitored by NIHR Central Commissioning Facility **–** *UHL are currently ranked 11th in league one and delivering 76% of trial to time and target (March 2018).*
	• East Midlands Clinical Research Network – *UHL remains the highest recruiting Trust within the East Midlands (March 2018).*
		• We will develop a sustainable 5 year outline workforce plan by the end of Q1 18/19, with a delivery plan to reduce our nursing and medical vacancy rates and reduce time to hire - Strategy to EWB in July 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.
		• Improve levels of employment from distinct populations/ communities to all levels of the Trust e.g. MOD veterans, disabled people, women, BAME, LGBT so they are representative of LLR population. Targets for each to be agreed at Diversity Board meeting in July 2018 to provide additional details.
		• Based on the feedback in the national staff survey, key themes to make improvements during 2018/19 are:
		  ○ Making appraisals more meaningful
		  ○ Treating our staff equally
		  ○ Looking after UHL – health and well-being
		  ○ Tackling behaviours
		Health & wellbeing annual plan to EWB in July 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.
		• Review of Undergraduate and Postgraduate medical education roles (including Educational Supervisors) to ensure identified time included in job plans.

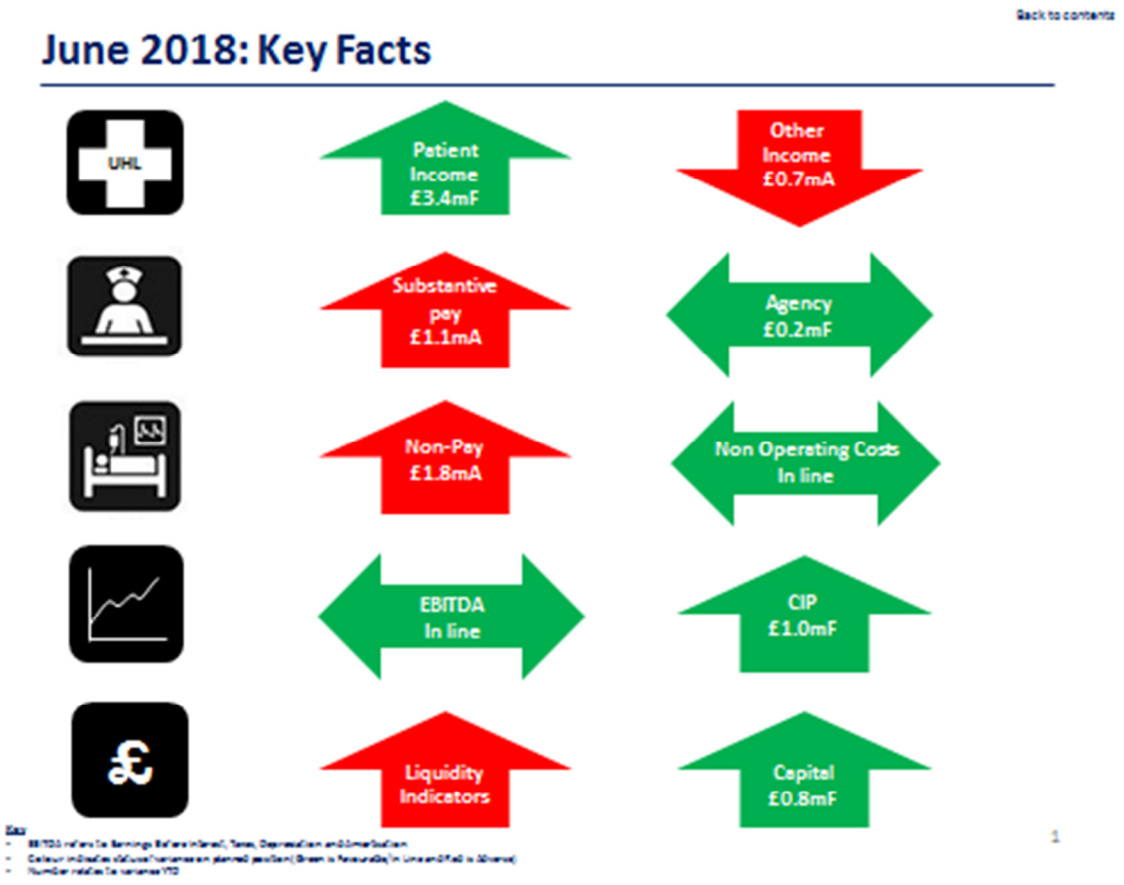
DATE: @ June 2018	Director:	CFO	Executive Board:	EPB	TB Sub Committee:	AC / FIC
Linked Objective	We will continue on our journey towards financial stability - deliver our target of £29.9m in 18/19					
BAF Principal Risk: 3 - Finance	If the Trust is unable to achieve and maintain financial sustainability, ***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**									

Primary Controls

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

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 3 relate to deliver of the planned deficit of £22.4m. The income position has over-preformed and a corresponding overspend within non-pay has been seen. The pay bill (both substantive and agency pay) is in-line with plan. Cost improvement plans have over-delivered against the month 3 plan although an element of the total annual requirement remains unidentified for future months. 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 3 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. • Alliance Contract. This quarterly review was discussed and reviewed at the Executive Quality Board in May.	• **External Audit of Financial Systems 2018/19:** ➢ Work programme for 2018/19 to be reviewed and approved at the relevant meeting of the Audit Committee. • **Internal Audit 2018/19:** ➢ Financial systems Q3 - financial systems controls work to meet the requirements of External Audit and to address specific risks identified by management. Work will include data analysis on specific areas of risk in order to identify trends/ anomalies and to direct our controls-based work. ➢ Review of cost improvement programme Q2 - will review the adequacy of arrangements for delivery of the CIP and the robustness of planning for future years. • NHSI Carter Corporate Service review: **-** *Carter Target for back office cost to be no more than 6% of turnover by March 2020.* The Trust's Director of Efficiency and CIP is leading this initiative, as part of the overall review of Model Hospital, and engaging across the Corporate Teams to ensure robust plans are in place to achieve the 2020 target.	**Gap:** Effectiveness of budget management and control at CMG and Corporate directorate levels**.** **Actions:** 2018/19 planning requires the delivery of a deficit of £29.9m inclusive of a £51m CIP programme. Each CMG and Corporate Directorate has an allocated budget totalling £29.9m however due to the current work in progress with respect of demand and capacity modelling CMGs are yet to sign-off a fully phased month by month budgetary control position in line with the accountability framework. This process has concluded with the exception of MSS and work will be completed by the end of July with this CMG. 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. There is currently a shortfall within the Cost Improvement Programme of £6.8m when compared to the target of £51m. Escalation meetings are in place to reduce this unidentified amount with fortnightly updates being presented to Executive Boards. Star chamber process (led by CEO) reviewing the new investment requirements. There is a significant shortfall in available funding compared to the complete list of investment requirements with the Star Chamber prioritising and approving spend. This process was forecast to be completed by the end of May 2018 and has concluded at the end of June. 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 may be required.

DATE: @ June 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**									

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.
  - 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 UHL CEO.
  - 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.

- **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)	June-18	18/19 YTD
Responsive	R1	**ED 4 Hour Waits UHL**	**95% or above**	Red if <85% Green 90%+	**82%**	**82.2%**
	R2	**ED 4 Hour Waits UHL + LLR UCC (Type 3)**	**95% or above**	Red if <85% Green 90%+	**87.1%**	**87.3%**
	R3	**12 hour trolley waits in A&E**	**0**	Red if >0 ER via ED TB report	**0**	**0**
	R12	**% Operations cancelled for non-clinical reasons on or after the day of admission UHL + ALLIANCE**	**0.8% or below**	Red if >0.8% ER if >0.8%	**1.2%**	**1.2%**
	R14	**Delayed transfers of care**	**3.5% or below**	Red if >3.5% ER if Red for 3 consecutive mths	**1.3%**	**1.3%**
	R15	**Ambulance Handover >60 Mins (CAD+ from June 15)**	**0**	Red if >0 ER if Red for 3 consecutive mths	**0.7%**	**1%**
	R16	**Ambulance Handover >30 Mins and <60 mins (CAD+ from June 15)**	**0**	Red if >0 ER if Red for 3 consecutive mths	**4%**	**4%**

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. Alternative skill mix models are being considered and have been implemented e.g. medical step down ward. • ED process: ➢ Time from arrival to decision to admit was 54.5% (average) in June ➢ Bed request to allocation in 60 mins was 77% (average) in June • DTOC: ➢ Remain below national average • Acuity: ➢ Plateaued 80+ admission age ➢ Decrease in super stranded • 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: 91 – 126/137. • NHSE June data - 4 hour performance = 82 % (UHL only). • 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); • 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 – ongoing 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). Urgent care action log has further details about the actions, owners and completion dates.

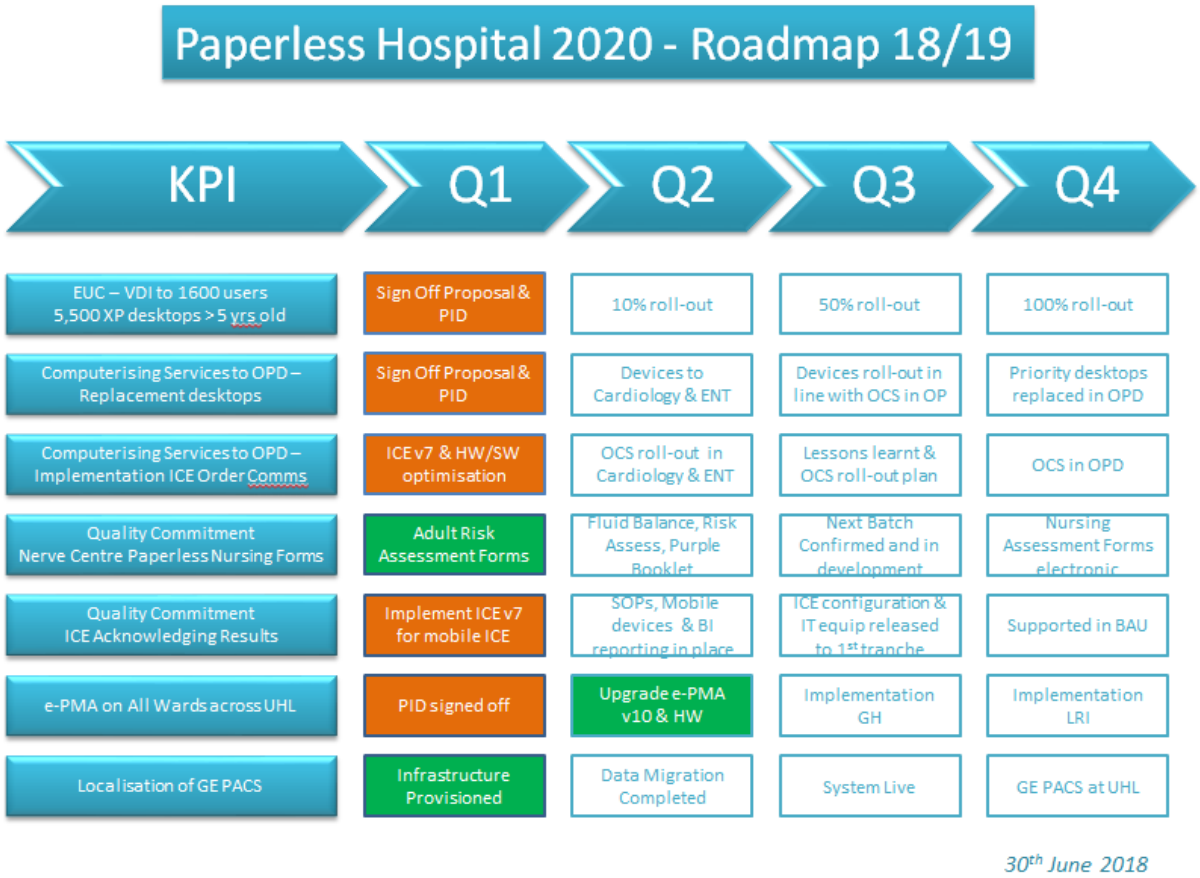
DATE: @ June 2018	Director:	CIO	Executive Board:	EIM&T (quarterly)/EPB	TB Sub Committee:	PPPC / AC
Linked Objective	To progress our strategic enabler – IM&T					
BAF Principal Risk: 5 – Information Technology	If the Trust is unable to deliver a fit for the future IM&T service, ***caused by inability to secure appropriate resources (including external capital and workforce), a critical infrastructure failure, ineffective system resilience and preparedness of an external IT supplier or an external shut-down attack***, then it may result in 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**									

Primary Controls

- IM&T Paperless hospital 2020 strategy including Board structure and clinical leads in place.
- Overarching 18/19 IM&T strategic plan.
- Cyber security measures in place including regular assessments and close working relationship with managed business partner.
- Information Governance arrangements including IG toolkit, IG Steering Group and GDPR plan.
- Working arrangements aligned with clinical strategies through clinical and medical workforce information officers.
- Disaster Recover plans in place for IM&T systems.
- IM&T governance and performance monitoring through IM&T Service Board reporting to Trust Board (via FIC/PPPC), Audit Committee and Executive (EMI&T).
- IT Network providers early warning notifications monitored.
- 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. • 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* – presented to EIM&T Board in May 2018 - No revenue funding available for 29.6 wte resources so IM&T capital will be used to fund some posts and additional pressure will fall to CMGs to effect the change programme. Budget shortfall for existing 4 wte clinical facilitators escalated to the PH2020 Board in Jun 18. Financial plan to be confirmed by CIO 31/07/18. Plan to recruit by 31/10/18, subject to internal recruitment controls (CIO). • **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:* ➢ *Replacing old computing/mobile hardware* ➢ *Nervecentre* ➢ *PACS* ➢ *ICE* ➢ *E-Prescribing* • **Information Governance plan** for implementation of **GDPR** – gap analysis by Internal Auditors identified there are a number of gaps with regard to the new regulation 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 - scheduled during Q2 2018/19 (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 – Q2 2018/19 (CIO).

DATE: @ June 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**									

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 reports to measure conformance against HTM / HBN guidance. • Estates & Facilities Risk Management Process – monthly multi-disciplinary Estates & Facilities Capital Risk Management Group review new and existing E&F risks prior to reporting for scrutiny to the E&F SMT. Significant risks are escalated to the UHL Risk Register, thus providing a consistent governance approach to monitoring and review in-line with the Trust risk plan. • Backlog Maintenance programme based on 6 Facet Condition Survey ensures highest identified risks are prioritised and considered for funding. • 24/7 reactive maintenance capability across all sites. • Infection Prevention and Control programme including policies / procedures; staff training; environmental cleaning audits and inspections. • Estates & Facilities Help Desk provides single focal point for all works requests. • 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

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

DATE: @ June 2018		Director:	DSC	Executive Board:	ESB	TB Sub Committee:	AC
Linked Objective	To develop more integrated care in partnership with others						
BAF Principal Risk: 7 – Partnerships	If the Trust is unable to work collaboratively with partners to secure the support of 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**									

Primary Controls

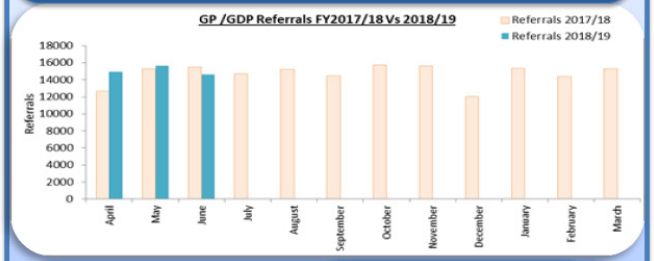
- Attendance and active participation in:
  - All STP work streams at senior strategic level and at operational level where relevant.
  - Health and wellbeing Boards across City and County.
  - Active engagement with primary care across city and county.
- Revised Trust objectives and annual priorities agreed for 2018/19.
- Frailty programme, AE Delivery Board and internal flow metrics.
- Active Clinical input and leadership across key STP work streams such as planned care, urgent care, Integrated Locality teams, and Home First.
- System wide PMO including: Project and programme management; Specialist Support e.g. business intelligence, strategic planning; Change Management and Transformation Function.

Detective Risk Indicators

UHL Activity Trends

University Hospitals of Leicester NHS
NHS Trust

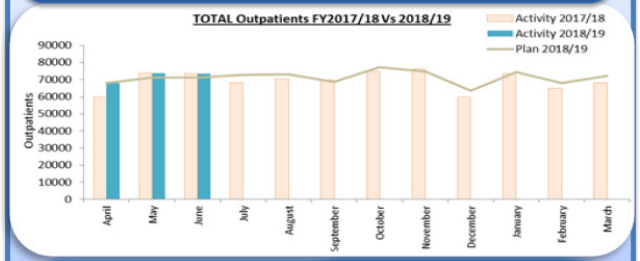
Referrals (GP)



YTD
18/19 Vs 17/18 +1793 +4.1%

Drop in GP referrals for June in comparison to the same period last year.

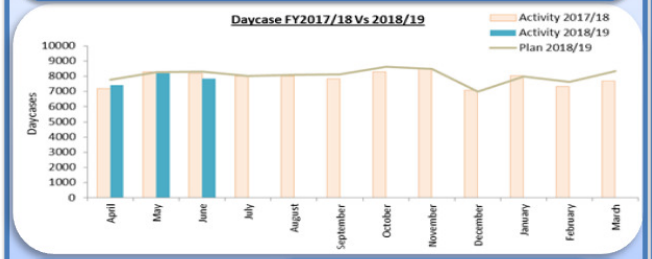
TOTAL Outpatient Appointments



YTD
18/19 Vs 17/18 +8,241 +4%
18/19 Vs Plan +4962 +2.4%

Dermatology, Integrated Medicine and Thoracic Medicine significantly higher than plan.

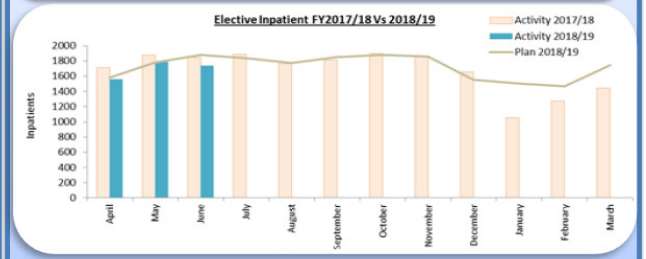
Daycases



YTD
18/19 Vs 17/18 -184 -0.8%
18/19 Vs Plan -842 -3.5%

Growth in Clinical Oncology and BMT against plan.
Medical Oncology and Urology Significantly lower than plan.

Elective Inpatient Admissions



YTD
18/19 Vs 17/18 -343 -6.3%
18/19 Vs Plan -155 -3%

ENT, Plastic Surgery, General Surgery and Urology lower than plan.

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. • 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.	• Review of the LLR STP has shown that this risk is not fully mitigated as assurance of efficacy of the partnership working is limited at this point. This tells us that the current governance processes are not yet fit for purpose and will not fully mitigate the risk as presented. • The work will be referenced in LLR escalation meetings with NHS England and NHS Improvement.	• A governance review is under way at LLR STP level – the Trust will feed in to this review robustly to ensure that relationships remain stable and the STP framework delivers the plans outlined – outcome of this review is planned for completion by the end of Q2 2018/19 through the STP programme. • Frailty/Home first/Integrated Locality Teams: ➢ The UHL internal frailty programme has begun to meet to deliver the internal requirements as per Trust priorities - to ensure delivery of a new model of care for frail patients by winter 18. ➢ External meeting structures and deliverables for frailty were agreed on May 17th 2018 at the Senior Leadership Team. The aim of the programme will be to have designed the system by July 2018, with key interventions implemented by Dec 2018. UHL CEO will chair this programme, with Head of Strategic Development as managerial lead.

Appendix 2 - Risk Register Dashboard 15+ (June Final)

Risk ID	CMG	Risk Description	Current Risk Score	Target Risk Score	Thematic Analysis of Risk Causation
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	Resource
3183	RRCV	If Cardiac Surgery is unable to operate on elective patients due to winter pressures and availability of ward and ITU beds, there is a risk that patients' conditions could deteriorate, resulting in a need for urgent admission or more complex surgery with greater risk of complications.	20	15	Demand & Capacity
3186	RRCV	If the CMG fails to achieve the allocated financial control total then this could result in an deterioration in the Trust overall financial deficit.	20	9	Finance
2354	RRCV	If the capacity of the Clinical Decisions Unit is not expanded to meet the increase in demand, then will continue to experience overcrowding resulting in potential harm to patients.	20	9	Demand & Capacity
2149	ESM	If we do not recruit and retain into the current Nursing vacancies within SM, then patient safety and quality of care may be compromised resulting in potential delayed care.	20	6	Workforce
2804	ESM	If the ongoing pressures in medical admissions continue, then Specialist Medicine CMG bed base will be insufficient thus resulting in 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
3122	ITAPS	If we are unsuccessful in controlling expenditure, finding efficiency savings and maximising income within ITAPS then the CMG is at risk of not achieving its set control total of £2,548k deficit and will under deliver further against the CIP	20	6	Finance
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	Process and Procedure
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	20	3	Workforce
2777	Communications	If fundraising targets for the Charity fundraising campaign do not reach target charitable income	20	8	Demand & Capacity

Risk ID	CMG	Risk Description	Current Risk Score	Target Risk Score	Thematic Analysis of Risk Causation
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
3172	IM&T	If systems and services provided by IM&T are not continuously maintained to ISO accredited standard, then our systems may be vulnerable to potential cyber attack resulting in in significant service disruption, harm to patients and financial loss	20	15	IT
3148	Corporate Nursing	If the Trust does not recruit the appropriate staff with the right skills in the right numbers then we may not be able to deliver safe, high quality, patient centred, efficient care and reduce our current nursing vacancy levels resulting in potential increased clinical risk to our patients and poor patient experience	20	12	Workforce
2404	Corporate Nursing	If the process for identifying patients with a centrally placed vascular access (CVAD) device within the trust are not robust, then this could result in increased morbidity and mortality.	20	16	Resource
3176	RRCV	If the current shortfall in nursing staff vacancies in RRCV is not addressed, then this will affect the ability to achieve appropriate Nurse to Patient ratio, resulting in increased clinical risk to our patients and poor patient experience	16	12	Workforce
3181	RRCV	If the Prescribing Administration and Monitoring of Oxygen in Adults (B27/2010) Policy is to be adhered to, Then the e-obs system settings must be adjustable for Cardio-Respiratory patients, Resulting in in improved patient care or chronic hypoxic conditions and for patients who do not have Type 2 respiratory failure.	16	6	Process and Procedure
3040	RRCV	If there are insufficient medical trainees in Cardiology, then there may be an imbalance between service and education demands resulting in the inability to cover rotas and deliver safe, high quality patient care.	16	9	Workforce
2820	RRCV	If a timely VTE risk assessments is not undertaken on admission to CDU, then we will be breach of NICE CCG92 guidelines resulting patients being placed at risk of harm.	16	3	Process and Procedure
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	Process and Procedure
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 nursing vacancies and issue with nursing skill mix across Emergency Medicine, then quality and safety of patient care could be compromised.	16	4	Workforce
2388	ESM	There is risk of delivering a poor and potentially unsafe service to patients awaiting MH admission &/or fruther MH assessment.	16	6	Demand & Capacity
3044	ESM	If under achievement against key Infectious Disease CQUIN Triggers (Hepatitis C Virus), then income will be affected.	16	8	Demand & Capacity
3121	ITAPS	If operating theatres' ventilation systems fail due to lack of maintenance, then the affected theatres cannot be used to provide patient care resulting in reduced theatre capacity and pressure on other theatres to meet demand and may lead to patient cancellations	16	9	Estates
2333	ITAPS	If we do not recruit into the Paediatric Cardiac Anaesthetic vacancies, then we will not be able to maintain a WTD compliant rota resulting in service disruption.	16	8	Workforce
2191	MSK & SS	If workforce constraints within the ophthalmology service are not addressed, then backlogs and delays could result in serious patient harm.	16	8	Workforce
3133	MSK & SS	If non compliant with MHRA guidance on the follow up of metal-on-metal (MoM) hip replacements, Then patients may be placed at risk of harm due to a lack of timely detection and intervention.	16	8	Process and Procedure
2989	MSK & SS	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
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
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

Risk ID	CMG	Risk Description	Current Risk Score	Target Risk Score	Thematic Analysis of Risk Causation
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	Process and Procedure
3129	CSI	If a 100% traceability (end fate) of blood components is not determined Then BSQR 2005 legal requirement of 100% traceability will not be met Resulting in legal implications and delay in providing blood and blood components	16	4	Process and Procedure
2673	CSI	If the bid for the National Genetics reconfiguration is not successful then there will be a financial risk to the Trust resulting in the loss of the Cytogenetics service	16	8	Demand & Capacity
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	9	Process and Procedure
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 then there is a loss of service to the Trust. Staff (photographers and/or graphics) are unable to do their job. There is no IM&T support for these machines. If the Mac shared server fails/breaks down then there is a loss of service and potential loss of work products that are saved/stored on there. There is 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	Process and Procedure
3138	Estates & Facilities	If there are insufficient management controls in place to meet Regulation 4 of the Control of Asbestos Regulations (CAR), then there is an increased risk of enforcement action by the HSE, resulting in prosecution, and/or significant financial impact and reputational damage.	16	4	Process and Procedure
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	Resource
3143	Estates & Facilities	If sufficient capital funding is not committed to reduce backlog maintenance across the estate there will be an increasing risk of key/critical failures in buildings, building services and infrastructure impacting on service provision and patient care.	16	6	Finance
3144	Estates & Facilities	If Estates & Facilities are unable to recruit and retain staff, or fund posts to deliver services to meet the Trust's expectations, then there is a risk of a service delays and interruption/failure to achieve required standards, resulting in adverse impacts to patient non-clinical services, environment, equipment and infrastructure.	16	9	Workforce
3145	Estates & Facilities	If there is not a significant investment to upgrade electrical infrastructure across the UHL, 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	Process and Procedure
3191	IM&T	If the Trust is unable to demonstrate 95% compliance with IG training, then the Trust may lose level 2 IG accreditation, resulting in potential loss of research status and difficulties with forging future collaborative working arrangements with prospective business partners which could adversely impact on the delivering strategic aims.	16	12	IT
3192	IM&T	If GDPR is not effectively implemented, then the Trust will be unable to demonstrate compliance resulting in potential enforcement action from the ICO and reputational damage	16	12	IT
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

Risk ID	CMG	Risk Description	Current Risk Score	Target Risk Score	Thematic Analysis of Risk Causation
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
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
3043	RRCV	If there is insufficient cardiac physiologists then it could result in reduced echo capacity resulting in diagnostics not being performed in a timely manner	15	6	Workforce
2837	ESM	If migration to an automated results monitoring system is not introduced, Then follow-up actions for patients with multiple sclerosis maybe delayed resulting in potential harm.	15	2	IT
2973	CSI	If the service delivery model for Adult Gastroenterology Medicine patients is not appropriately resourced, then the quality of care provided by nutrition and dietetic service will be suboptimal resulting in potential harm to patients.	15	6	Workforce
3173	CSI	If the transition from empath QMS to Pathology (UHL) QMS is not performed using a planned and controlled approach the Quality management system will be destabilised with a resultant risk to laboratory quality to quality processes and accreditation resulting in potential harm to patients, reputational damage, service delivery issues and loss of income to UHL	15	4	Process and Procedure
2965	CSI	If we do not address Windsor pharmacy storage demands, then we may compromise clinical care and breach statutory duties	15	6	Estates
2601	W&C	If the vacancies in the gynaecology services are not addressed, then there will be backlogs with typing patient correspondence, resulting in delays with patients receiving appointment letters and results	15	6	Workforce
3023	W&C	There is a risk that the split site Maternity configuration leads to impaired quality of Maternity services at the LGH site	15	6	Workforce
3093	W&C	If there is insufficient Midwifery establishment to achieve the recommended Midwife to Birth ratio, in view of increased clinical acuity, then patient care may be delayed resulting in potential increase in maternal and fetal morbidity and mortality rates	15	6	Workforce
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	Communications	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
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