**Appendix I - Corporate Risk Register - September 2018**

| Risk | Type | Lead directorate | Weaknesses or gaps in control | Risk action plan | Rating (current) | Risk level (current) | Lead management committee |
|---|---|---|---|---|---|---|---|
| Management of emergency demand (corporate) | Service disruption | Operations | Ambulance handovers and conveyance performance.<br><br>Streaming to services co-locating or outside of the Emergency Department.<br><br>ED staffing levels (reliance on agency) and process inefficiencies.<br><br>Admissions areas and flow management issues.<br><br>Bed configuration issues across the Trust. | Ambulance Handovers and Conveyance: Actions are on track and performance continues to improve. SSG continue to support, the scheme is on track to deliver 2nd quartile national performance and <1% 120 minute delays by end of July 2018 (June 1.5%, July to date 1.2%).<br><br>Streaming to Services Co-Locating or outside of the Emergency Department: Remains poor despite recent additional actions, increasing diagnostics. ULHT requesting to review the service model at next governance meeting with a view to re-looking at who does the streaming. At risk.<br><br>PHB and LCH ED Staffing and Process Improvements; Rotas still heavily dependent on agency especially PHB. RAIT process and ACP developing on track, but risk of not recruiting staffing is very high.<br><br>Admissions areas and flow management; Red2Green Marketplace is in place and maturing, System MFFD SOP not yet in place due in June, however pilot schemes have begun on Carlton Coleby, awaiting results. At risk.<br><br>Large Scale Trust Bed-Reconfiguration; Programme manager in place, governance in place, plan signed off estates work timescales shortened, on track. SOC for Expansion of Resus Facilities at LCH and PHB; approved at CRIB, now forming part of bid for ETTF funding as part of wider urgent care strategy including Urgent Treatment Centres, on track. | 20 | Very high risk | Executive Team (ET) |
| Substantial unplanned expenditure or financial penalties (corporate) | Finances | Finance, Procurement & Corporate Affairs | Continued reliance upon a large number of temporary agency and locum staff to maintain the safety and continuity of clinical services across the Trust, at substantially increased cost (at the end of Q1 pay expenditure was £0.8m adverse to plan).<br><br>Trusts in Special Measures are charged a punitive interest rate of 6%. At the point the financial plan was submitted, NHSI had indicated that interest rates would be reduced to 3.5% if the Trust could achieve plan in three consecutive periods. | Range of recruitment & retention initiatives as part of the People Strategy, to fill substantive posts and reduce reliance on temporary staff.<br><br>The financial plan assumes interest rates will reduce for both new and existing borrowing from August 2018. | 20 | Very high risk | Financial Turnaround Group (FTG) |
| Workforce capacity & capability (recruitment, retention & skills) | Service disruption | Human Resources & Organisational Development | Substantial challenge to recruiting and retaining sufficient numbers of Registered Nurses (RNs) to maintain safely the full range of services across the Trust.<br><br>High vacancy rates for consultants & middle grade doctors throughout the Trust.<br><br>A significant proportion of the current clinical workforce are approaching the age at which they could retire, which may increase skills gaps and vacancy rates.<br><br>The Trust continues to employ a significant number of staff from the European Union; at present there is not systematic communication and engagement with these employees, due to capacity issues.<br><br>The Trust is dependent on Deanery positions to cover staffing gaps with medical trainees; there have been issues also with the effectiveness of the Guardians of Safe Working Practice; shortages in the medical recruitment team will impact on the next rotation if not resolved. | Focus on nursing staff engagement & structuring development pathways; use of apprenticeship framework to provide a way in to a career in nursing; exploration of new staffing models, including nursing associates; continuing to bid for SafeCare live funding.<br><br>Focus on medical staff engagement & structuring development pathways. Utilisation of alternative workforce models to reduce reliance on medical staff.<br><br>Workforce plans are identifying the potential risk due to the age profile in more detail, by year and service area; People Strategy includes mitigating actions; using HEE funding to bring additional capacity into OD in order to make progress on this project in 2018/19. Target date for completion is September 2018.<br><br>Communication with EU staff and their managers, to ensure that they are aware of the position in respect of their employment rights and we are aware of their concerns and the actions we can take to reassure them and keep them at ULHT.<br><br>The Education Director has developed an action plan in relation to the issues raised.; two HEE fellows are currently looking at issues relating to engagement with the juniors; issues with the effectiveness of the Guardians to be addressed by the Medical Director. | 20 | Very high risk | Executive Team (ET) |

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| Risk | Type | Lead directorate | Weaknesses or gaps in control | Risk action plan | Rating (current) | Risk level (current) | Lead management committee |
|---|---|---|---|---|---|---|---|
| Delivery of planned objectives within the Estates Strategy (corporate) | Finances | Estates & Facilities | Estates Strategy not yet approved; lack of clarity over local health community (STP) clinical services strategy to inform estates strategy; no identified resource to develop Estates Strategy & limited availability of capital and revenue resource to fund planned developments; lack of awareness of cost of space to the user / service and assumption that the Trust has space readily available and fit for purpose. | Develop, review and implement Estates Strategy (aligned to capital investment programme) with reference to STP & Lord Carter's recommendations. | 16 | High risk | Estates Infrastructure & Environment Committee (EIEC) |
| Compliance with fire safety regulations & standards (corporate) | Reputation / compliance | Estates & Facilities | Fire Policy & related procedures are overdue for review.<br><br>Failure to maintain & routinely test the fire safety infrastructure (fire alarms; extinguishers; fire dampers; fire doors; emergency lighting; compartmentation, mechanical & electrical infrastructure); lack of a sustainable fire safety training programme.<br><br>Availability of sufficient capital resource to fund required improvement works.<br><br>*Specific risk locations to be documented in separate risk assessment and attached to Datix.* | Review and update Fire Policy and Procedures.<br><br>Development & Implementation of Fire Safety Action Plan to address issues raised in Enforcement Notice numbers 29/5059/EN and 01/2508/EN.<br><br>Resources application to NHSI for additional capital and revenue support and deployment of Trust Estates Backlog Capital to mitigate risk. | 16 | High risk | Estates Infrastructure & Environment Committee (EIEC) |
| Delivery of the Financial Recovery Programme (corporate) | Finances | Finance, Procurement & Corporate Affairs | Deliverable FRP schemes do not cover the extent of savings required. Financial plan for 2018/19 includes an efficiency programme of £25m; as of the end of Q1 the FRP was approx £0.5m adverse to plan. | New Turnaround Director to oversee all planned FRP schemes & implement changes to support increased pace of delivery. | 16 | High risk | Financial Turnaround Group (FTG) |
| Substantial unplanned income reduction or missed opportunities (corporate) | Finances | Finance, Procurement & Corporate Affairs | Clinical coding & data quality issues.<br><br>Operational ownership of income at directorate level.<br><br>Commissioners have a combined shortfall to contract of c£5m. This could result in demand management schemes that the Trust cannot pull the costs out of at the same rate or aggressive in year fines and penalties. | Appointment of Grant Thornton to carry out short-term income review project .<br><br>Complete an income improvement plan for each Directorate & incorporate within performance review process.<br><br>Continued engagement with Commissioners in the development & implementation of demand management schemes. | 16 | High risk | Financial Turnaround Group (FTG) |
| Paediatric services at Pilgrim Hospital, Boston (Women & Children's Services) | Service disruption | Women & Children's Services | Issues with recruiting and retaining sufficient numbers of middle grade doctors to safely maintain paediatric services at PHB.<br><br>Concerns about limited supervisory resource for trainee doctors at PHB could result in withdrawal of trainees by HEE.<br><br>Long term service model not yet agreed; until this is agreed and in place the service remains vulnerable to staffing and demand management issues. Current demand is lower than expected (for reasons unknown). | Interim paediatrics service model in place; dependent upon locum staffing and therefore vulnerable and not cost effective or sustainable.<br><br>Interim arrangements in place to provide sufficient supervision in order to maintain supply of trainee doctors. Sustainable position is dependent upon agreement and resourcing of long-term service model.<br><br>Development of sustainable long-term model for paediatrics at PHB, through the STP. | 12 | High risk | Executive Team (ET) |
| Major cyber security attack (corporate) | Service disruption | ICT | Availability of sufficient funds to support required hardware & software upgrades & deliver the digital strategy, with increasing scale of threat which may leave the network vulnerable to attack.<br><br>Digital business continuity & recovery plans are in place but need to be updated with learning from the 'Wannacry' incident (May 2017) and routinely tested. | Prioritisation of available capital and revenue resources to essential projects through the business case approval process.<br><br>Digital business continuity & recovery plans to be updated & tested at STP level. ICT plan to engage an independent security consultant to advise on any further action required. | 12 | High risk | Information Governance Committee |

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| Risk | Type | Lead directorate | Weaknesses or gaps in control | Risk action plan | Rating (current) | Risk level (current) | Lead management committee |
|---|---|---|---|---|---|---|---|
| Medical device & equipment management (corporate) | Service disruption | Clinical Governance | Gaps in service history recorded on central equipment inventory.<br><br>Resource constraints (insufficient funds available to deliver against identified equipment requirements).<br><br>Current contractual arrangements for bed frames and mattresses (with ARJO) have expired and continue on a 6 month rolling basis; the current contract model may not represent the best value for money. Bed management processes lack corporate oversight and effective control. | Departments to be given system access to update central equipment inventory.<br><br>Prioritisation by Medical Device Group through Capital & Revenue Investment Board.<br><br>Appointment of a dedicated project manager to coordinate development of a revised bed / mattress operational model and contract review. Option to work collaboratively with LCHS and LPFT. | 12 | High risk | Patient Safety Committee |
| Compliance with water safety regulations & standards (corporate) | Reputation / compliance | Estates & Facilities | Trust Water Safety Group not fully represented .<br><br>Policy approved Dec 2017. Water Safety Plan draft prepared Dec 2017 and currently being reviewed for issue by April 2018.<br><br>Lack of water safety training for competent persons.<br><br>Lack of robust alarm monitoring systems and injectors approaching obsolescence.<br><br>The planned maintenance regime necessary to satisfy statutory requirements is not sufficiently resourced.<br><br>The site risk assessments are required to be reviewed against the water schematics which are currently being developed.<br><br>Lack of assurance that flushing regime is carried out by ward and department staff (including 3rd parties) (despite the returns being submitted from wards and departments).<br><br>*Specific risk locations to be documented in separate risk assessment and attached to Datix.* | Non-attendance at meetings to be escalated to IPCC.<br><br>Water Safety Plan to be approved by Estates Environment & Investment Committee.<br><br>Implement a formal water safety training programme for competent persons as part of 18/19 revenue compliance resource allocation.<br><br>Requirements and costs for alarm monitoring systems and replacement injectors to be identified and implemented.<br><br>Establish and implement capital water safety improvement allocation 18/19 alongside comprehensive planned maintenance regime utilising additional compliance funding.<br><br>Complete the production of site water schematics and engineering drawings (by Oakleaf).<br><br>Introduce standard exception reporting format.<br>Additional resources bid for in Financial Plan. Reminders being issued to 3rd parties to highlight their responsibilities under HSE ACOP L8 | 12 | High risk | Estates Infrastructure & Environment Committee (EIEC) |
| Critical estates infrastructure failure (corporate) | Service disruption | Estates & Facilities | Mechanical and electrical infrastructure is in poor condition and needs significant investment to eliminate backlog maintenance, reduce maintenance costs, maintain capacity of the estate to deliver clinical activity<br><br>The majority of the high voltage switchgear and transformers on all three site are oil filled & 25-40 years old; these are typically replaced with vacuum and SF6 switchgear to reduce fire risks due to oil and maintenance costs.<br><br>Lack of resilience in mechanical infrastructure (e.g. ventilation, steam, cold water, heating, medical gas pipeline systems and lifts).<br><br>*Specific risk locations to be documented in separate risk assessment and attached to Datix.* | Regular inspections to identify urgent repairs required; identification of bakclog maintenance & capital funding through Facilities capital allocation.<br><br>Funding required for programme of switchgear replacement (£500k+); Pilgrim should be the first site to be addressed.<br><br>Develop and update Medical Gas pipeline services policy and procedures; develop and implement compliance testing plan. | 12 | High risk | Estates Infrastructure & Environment Committee (EIEC) |
| Patient satisfaction with the quality of the hospital environment (corporate) | Reputation / compliance | Estates & Facilities | Issues with the quality of the patient environment across the Trust identified through PLACE audits.<br><br>*Specific risk locations to be documented in separate risk assessment and attached to Datix.* | Funding required to enable environmental quality improvement works to be carried out. | 12 | High risk | Estates Infrastructure & Environment Committee (EIEC) |

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| Risk | Type | Lead directorate | Weaknesses or gaps in control | Risk action plan | Rating (current) | Risk level (current) | Lead management committee |
|---|---|---|---|---|---|---|---|
| Workforce engagement, morale & productivity (corporate) | Service disruption | Human Resources & Organisational Development | Impact of the cost reduction programme & organisational change on staff morale. The national staff survey results for 2017 shows that the impact of the Trust going into special measures for both quality and finance is being felt by staff. Morale has declined significantly, pride in working for ULHT has gone down and staff feel that decisions are taken on the basis of finance, rather than patient experience and safety and to the detriment of staff (e.g. increase in car parking charges & controls over travel and training). There is significant cynicism amongst staff, which will not be resolved until they see action alongside the words.<br><br>Relationships with staff side representatives is challenged by the scale of organisational change required and the extent to which staff side wish to protect the status quo. There are disagreements amongst staff side representatives and not all meetings have taken place as scheduled. | Shaping a response to the staff survey results which will inform the revised People Strategy and the 2021 Programme. One of the key themes will be creating a strategic narrative which gives hope for the future and addresses the issue that quality and money are not incompatible. Improvement methodology work provides means for staff to make efficiency and patient experience improvements. FAB programme will emphasise what is possible. Directorates will be tasked with also addressing staff survey issues at a local level. The actions proposed provide the mitigation, but we have to recognise that this remains a tough environment in which to drive up morale. Staff survey predated launch of 2021, but there is a need to tackle vacancy gaps as well.<br><br>Reviewing the current recognition agreement to modernise it and ensure it is fit for purpose. It is based on the Sandwell model and seeks to ensure proper debate, without giving staff side the capacity to prevent us moving beyond the status quo. Intention is to write to staff side to propose a further partnership meeting. Formal consultation around the new recognition agreement will begin shortly. | 12 | High risk | Executive Team (ET) |
| Workforce planning process (corporate) | Service disruption | Human Resources & Organisational Development | Capacity within the business to support the process and recognition of its priority is an inhibiting factor, which is less within the direct control of HR. | KPMG are providing additional capacity and capability. Created temporary team to take forward work aligned to CSR. Business partners to be appointed. Skill-building planned at STP level, where we also have continued support from WSP. Escalation to FRG if necessary. | 12 | High risk | Executive Team (ET) |
| Compliance with medicines management regulations & standards (corporate) | Reputation / compliance | Clinical Support Services (Pharmacy) | The Trust currently uses a manual prescribing process across all sites, which is inefficient and presents challenges to auditing and compliance monitoring.<br><br>Significant areas of non-compliance with national standards for aseptic preparation of injectable medicines have been identified. Key issues are the inadequacy of current staffing resources & skills mix and the condition of the facilities. | Planned introduction of an auditable electronic prescribing system across the Trust.<br><br>Isolator cabinets replaced at PHB; LCH facility remains closed whilst awaiting necessary building works (not currently possible to reopen due to potential for contamination). | 12 | High risk | Medicines Optimisation & Safety Committee |
| Effectiveness of safeguarding practice (corporate) | Harm (physical or psychological) | Corporate Nursing | Agitated patients may receive inappropriate sedation, restraint, chemical restraint or rapid tranquilisation; policies are now in place and training is in the process of being rolled out across the Trust.<br><br>The Trust employs a part time medical photographer which covers 2 days per week and also provides an on-call service; there is currently no cover for absence, which may result in inability to provide evidence to police & social care in support of legal / criminal proceedings.<br><br>The Trust has no agreed pathway for referring clinicians, both internal and external, for patients with significant learning disabilities and challenging behaviours and no pathway to achieve a General Anaesthetic for procedures such as blood tests/ MRI, etc. This can lead to sub-optimal care and delays in diagnosis or treatment.<br><br>National shortage of specialist learning disability / mental health beds for children and young people with challenging behaviours, which can result in inappropriate admissions and increased length of stay. | Complete Trust-wide roll-out of clinical holding and restraint; training compliance to be monitored through Safeguarding Committee and monthly audits of chemical sedation logs.<br><br>Proposed contingency - employment of bank medical photographer to cover absence.<br><br>Development of an appropriate pathway for patients with learning disabilities.<br><br>Development of a clinical pathway for staff to escalate concerns regarding children and young people with learning disability / mental health needs to the Safeguarding team and support early escalation to and support from the CCG and other relevant agencies. | 12 | High risk | Safeguarding Committee |

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| Risk | Type | Lead directorate | Weaknesses or gaps in control | Risk action plan | Rating (current) | Risk level (current) | Lead management committee |
|---|---|---|---|---|---|---|---|
| Non-compliance with clinical governance regulations & standards (corporate) | Reputation / compliance | Clinical Governance | Low levels of compliance with Duty of Candour (verbal and written). CCGs can impose fines for failure to achieve agreed levels for verbal compliance (which occurred in several months of 2017/18).<br><br>Low levels of compliance with baseline assessments for NICE guidelines & Technology Appraisals.<br><br>Inconsistencies in clinical governance arrangements at specialty level.<br><br>Limited identification and sharing of learning from Serious Incident (including Never Event) investigations. | Internal audit review of Duty of Candour commissioned to inform action plan. Systems, processes, training, communication and performance management to be reviewed.<br><br>Performance management of NICE guidelines backlog through PSC. TAs being managed through Medicines Optimisation (MOPS) & reported upwardly to PSC.<br><br>Implementation of new Clinical Governance directorate structure to provide additional support to specialties.<br><br>SOP introduced to ensure Board members are informed of all Never Events once declared and a monthly report is provided to QGC. Improved learning processes to be developed through the Safer Care work-stream of the QSIP. | 12 | High risk | Patient Safety Committee |
| Non-compliance with infection prevention & control regulations & standards (corporate) | Reputation / compliance | Corporate Nursing | Sub-optimal cleaning standards in many areas increase the likelihood that the Trust will breach the yearly Clostridium difficile threshold set by NHS England.<br><br>Insufficient housekeeping resource to provide and maintain a clean and appropriate environment and poor cleaning audit compliance with the Infection Code of Practice.<br><br>Reduced staffing capacity within the Infection Control Team (due to maternity leave, vacancies and sickness absence) impacts on the consistent achievement of compliance with the Hygiene Code of Practice. | Matrons reviewing cleanliness standards during golden hour walk rounds; increased supervisory support for housekeepers being rolled out.<br><br>To progress housekeeping plan & business case for further investment in housekeeping resources (centralisation and coordination of all Trust housekeeping resources).<br><br>Cover arrangements with Pharmacy for antimicrobial pharmacist. Explore ways of increasing microbiologist support either through NLAG or internally. Business case for increased resources. | 12 | High risk | Infection Prevention & Control Committee |
| Non-compliance with safeguarding regulations & standards (corporate) | Reputation / compliance | Corporate Nursing | Inconsistent compliance with Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLs) and Trust safeguarding policy requirements (e.g. Failure to recognise the need to assess capacity & make a DoLS application) picked up by regular audits.<br><br>Not yet consistently achieving 90% compliance with safeguarding training requirements.<br><br>Capacity within the Safeguarding team affecting the ability to fulfil all statutory responsibilities of their roles (e.g. Domestic Homicide and Serious Case Reviews) and deliver proactive support to front-line staff.<br><br>The Trust is not yet fully compliant with recommendations made following the Savile and Bradbury inquiries (e.g. Chaperone Policy and Safer Recruitment). | Safeguarding audit findings are shared with clinical areas, to prepare action plans. Continue to monitor delivery and hold heads of nursing to account through Safeguarding Committee.<br><br>Continue to monitor Core Learning training compliance and hold heads of nursing to account through Safeguarding Committee.<br><br>Local health service providers conducting a safeguarding review to look at new / integrated ways of working, with the aim of potentially releasing capacity.<br><br>Outstanding actions from Savile & Bradbury incorporated into Safeguarding QSIP plan for 2018/19; delivery to be monitored through Quality & Safety Improvement Board. | 12 | High risk | Safeguarding Committee |
| Safe management of medicines (corporate) | Harm (physical or psychological) | Clinical Support Services (Pharmacy) | The Trust currently uses a manual prescribing process across all sites, which is vulnerable to human error that increases the potential for delayed or omitted dosages; moving of charts from wards; and medicines not being ordered as required.<br><br>Pharmacy is not sufficiently involved in the discharge process or medicines reconciliation, which increases the potential for communication failure with primary care leading to patients receiving the wrong continuation medication from their GPs.<br><br>The Trust routinely stores medicines & IV fluids on wards in excess of 25 degrees (& in some areas above 30 degrees). This is worse in summer months. These drugs may not be safe or effective for use.<br><br>Aseptic facility at LCH is not currently fit for purpose due to its age and condition which increases potential for contamination of products (including chemotherapy; nutrition and antimicrobials). | Planned introduction of an electronic prescribing system across the Trust, to eliminate some of the risks associated with manual prescribing.<br><br>Routine monitoring of compliance with electronic discharge (eDD) policy. Request for funding to support additional pharmacy resources for involvement in discharge medicine supply.<br><br>Introduction of electronic temperature monitoring systems for all drug storage areas to enable central monitoring. Capital investment required. Contingency - ward monitoring of temperatures & escalation of issues.<br><br>Aseptic facility at LCH temporarily closed whilst awaiting required building works, due to potential for contamination. | 12 | High risk | Medicines Optimisation & Safety Committee |

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|---|---|---|---|---|---|---|---|
| Safety & effectiveness of medical care (corporate) | Harm (physical or psychological) | Clinical Governance | Areas of Hospital Standardised Mortality Ratio (HSMR) primary diagnosis outside of Dr Foster confidence intervals for the period April 2017 to March 2018: Septicemia (except in labour); Other perinatal conditions; Aortic peripheral and visceral artery aneurysms.<br><br>Issues with consistent and timely completion of electronic discharge documents (eDDs), which can lead to medication inaccuracies on discharge and delayed handover to GPs.<br><br>Inconsistent compliance with initiation and completion of sepsis bundle, particularly initial screening (currently below 70%).<br><br>Inconsistent compliance with e-observation policy.<br><br>An adult patient with suspected sepsis or high risk criteria who fails to respond within 1 hour of initial antibiotic and/or intravenous fluid resuscitation may not have a consultant attend in person (especially out of hours), as recommended by NICE Guideline NG51 Sepsis: recognition, diagnosis and early management. Funding and potential recruitment issues represent a barrier to increasing consultant resources. | HSMR: Sepsis task and finish group to review alerts; perinatal mortality to be added to QSIP; review of aortic peripheral and visceral artery aneurysms underway.<br><br>eDD Committee to oversee compliance and implementation of improvement plans.<br><br>Sepsis Committee to oversee compliance and implementation of improvement plans.<br><br>E-obs system audits all inpatients each month. Ward Accreditation has a deteriorating patient standard with the aim of driving improvement.<br><br>Patients with suspected sepsis may be seen by CCOT and by senior decision makers below consultant level (ST/ middle grades); however this may not always be within 1 hour out of hours. There are also consultants on call 24/7, who could attend dependent upon availability. Further work required to understand the extent of residual risk to patients. | 12 | High risk | Patient Safety Committee |
| Quality of patient experience (corporate) | Reputation / compliance | Human Resources & Organisational Development | Impact of the cost reduction programme on staff morale. The national staff survey results for 2017 shows that the impact of the Trust going into special measures for both quality and finance is being felt by staff. Morale has declined significantly, pride in working for ULHT has gone down and staff feel that decisions are taken on the basis of finance, rather than patient experience and safety and to the detriment of staff (e.g. increase in car parking charges & controls over travel and training). | Shaping a response to the staff survey results which will inform the revised People Strategy and the 2021 Programme. One of the key themes will be creating a strategic narrative which gives hope for the future and addresses the issue that quality and money are not incompatible. Improvement methodology work provides means for staff to make efficiency and patient experience improvements. FAB programme will emphasise what is possible. Directorates will be tasked with also addressing staff survey issues at a local level. | 12 | High risk | Patient Experience Committee |
| Critical ICT infrastructure failure (corporate) | Service disruption | ICT | Availability of sufficient funds to support required hardware & software upgrades & deliver the digital strategy, with increasing demands which may leave the network vulnerable to overload.<br><br>Local service / site specific vulnerabilities which may not be prioritised and addressed by the relevant management teams. | Prioritisation of available capital and revenue resources to essential projects through the business case approval process.<br><br>Comprehensive risk assessment to be completed and distributed to relevant managers for inclusion within their own risk registers and implementation of required actions. | 8 | Moderate risk | |
| Management of planned care (corporate) | Service disruption | Operations | Too much inappropriate activity defaults to ULHT.<br>Sustainability of a number of specialties due to workforce constraints.<br>ASR / STP not agreed / progressing at required pace (left shift of activity). | Engagement in local Acute Services Review (ASR)<br>Engagement in Sustainability & Transformation Partnership (STP)<br>100 day improvement programme. | 8 | Moderate risk | |
| Reduction in data quality (corporate) | Reputation / compliance | Information Services | Data quality issues are identified, reviewed and impact RAG rated. However, all recent issues are RAG rated Green with a risk score of 1, which does not enable the IG Committee to be assured that issues are prioritised appropriately.<br><br>The IG Committee now receives and reviews the SUS+ data quality dashboard. Areas of DQ risk are highlighted but require further interpretation and identification of any mitigating actions required.<br><br>The is currently no assurance mechanism for KPIs that they are correct, valid, QA'd and signed off by an appropriate person. | Review of the methodology used to priories / RAG rate data quality issues.<br><br>Further development of the DQ dashboard report to IG Committee to highlight areas of risk and mitigating actions.<br><br>Development of a quality assurance mechanism for KPIs throughout the Trust. | 8 | Moderate risk | |

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| Major security incident (corporate) | Harm (physical or psychological) | Estates & Facilities | Insufficient security provision to safely cover all sites; issues with the provision of body armour to security officers.<br><br>Not all areas of Trust sites are covered by CCTV and CCTV is not monitored across all sites.<br><br>Security staff are currently using outdated radio communication systems.<br><br>Inadequate control of site boundaries (e.g. dwellings adjacent to GDH); no lockdown management procedure in place in the event of a major security incident.<br><br>LCH access control system - maintenance company is sole UK provider of key processor equipment. | Independent security review and development of security specification for the Trust.<br><br>Capital investment required to upgrade current CCTV capability and increase CCTV coverage.<br><br>Survey of current security radio equipment across all sites. ICT involvement required to determine the most appropriate system.<br><br>Task & Finish Group review of site lockdown procedures & public rights of way.<br><br>Engagement of alternative provider to establish if they can support the current system, or if it is possible to migrate to an alternative system. | 8 | Medium risk | |
| Major fire safety incident (corporate) | Harm (physical or psychological) | Estates & Facilities | Fire Policy & related procedures are overdue for review.<br><br>Failure to maintain & routinely test the fire safety infrastructure (fire alarms; extinguishers; fire dampers; fire doors; emergency lighting; compartmentation, mechanical & electrical infrastructure).<br><br>Lack of a sustainable fire safety training programme.<br><br>Availability of sufficient capital resource to fund required improvement works. | Review and update Fire Policy and Procedures.<br><br>Development & Implementation of Fire Safety Action Plan to address issues raised in Enforcement Notice numbers 29/5059/EN and 01/2508/EN.<br><br>Resources application to NHSI for additional capital and revenue support and deployment of Trust Estates Backlog Capital to mitigate risk. | 8 | Medium risk | |
| Energy performance and sustainability (corporate) | Finances | Estates & Facilities | Lack of up to date strategy, policy & plan for sustainability.<br><br>*Specific risk locations to be documented in separate risk assessment and attached to Datix.* | Develop and update Sustainability Policy and procedures; develop and implement sustainable development management plan (SDMP); promote planning and strategy in respect of Trusts energy performance. | 8 | Medium risk | |
| Compliance with asbestos management regulations & standards (corporate) | Reputation / compliance | Estates & Facilities | Asbestos Policy is overdue for review.<br><br>Asbestos Management Plan still to be fully developed.<br><br>Availability of sufficient capital funding to remove Asbestos; or other higher risk competing priorities depleting capital resources.<br><br>Appointed Person not yet in place; Asbestos Management Structure to be agreed<br><br>Continuity of contractors appointment requires resourcing and managing; verification of contractors training required.<br><br>No Access areas still to be surveyed.<br><br>Potential ly inaccurate survey data due to restricted access to areas.<br><br>*Specific risk locations to be documented in separate risk assessment and attached to Datix.* | Asbestos Policy to be reviewed, updated and approved by Estates Environment & Investment Committee.<br><br>Complete development of Asbestos Management Plan.<br><br>Involvement with Trust Capital prioritisation process to make case for Estates backlog maintenance.<br><br>Agree Appointed Person & structure for Asbestos management.<br><br>Review of contractors appointment & verification of training.<br><br>Re-Inspection Programme to be completed.<br><br>Periodic review of site survey data to ensure current and upto date; Micad to go live with the Asbestos Module. | 8 | Medium risk | |
| Compliance with equalities and human rights regulations, standards & contractual requirements | Reputation / compliance | Human Resources & Organisational Development | The Trust has scope to improve its compliance with the NHS Accessible Information Standard (AIS) by my consistently tailoring its communications to meet individual needs.<br><br>In 2019 it is anticipated that a new NHS Workforce Disability Equality Standard (WDES) will be introduced, which the Trust will need to prepare to comply with.<br><br>Monitoring of equality KPIs & data is still in draft. | AIS: Implementation of the Hybrid Mail System project.<br><br>Preparatory work to support compliance with the new WDES (similar to requirements for WRES). Establishment of a disability staff network.<br><br>Complete implementation of KPI monitoring. | 8 | Moderate risk | ED&I Operational Group |

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|---|---|---|---|---|---|---|---|
| Non-compliance with information governance regulations & standards (corporate) | Reputation / compliance | ICT | Introduction of new UK data protection legislation that brought into effect the EU General Data Protection Regulation (GDPR) from May 2018 - the Trust is not yet fully compliant with the new laws and is awaiting further guidance from the ICO on some key aspects (including consent).<br><br>Compliance with mandatory IG training remains below the required level of 95% and is therefore assessed as unsatisfactory in the national toolkit submission.<br><br>Issues with achieving compliance with corporate records management codes of practice. | GDPR - Task & Finish Group set up to oversee initial implementation of compliance action plan; outstanding actions now moved to 'business as usual' under the IGC work programme.<br><br>IG mandatory training to be comprehensively revised & brought up to date with GDPR, then re-launched.<br><br>Additional resources (deputy) to be identified to support the Trust Secretary with corporate records management. | 8 | Medium risk | Information Governance Committee |
| Opportunities to participate in major clinical research projects (corporate) | Harm (physical or psychological) | Clinical Governance | ULH has not been successfully attracting research grants.<br><br>There is an identified need and an opportunity for the Trust to drive rural health research.<br><br>There is an opportunity for LCRF to be recognised by the NIHR to attract further funding. | ULH research funding can be increased by ULH clinicians/nurses/AHPs attracting their own or collaborative research grants.<br><br>ULH is leading a new initiative to set up a Centre for Rural Health and Care.<br><br>Development of new, dedicated accommodation for a joint Lincolnshire Clinical Research Facility to support formal recognition by the NIHR as a registered CRF. | 8 | Medium risk | Patient Safety Committee |
| Safe use of medical devices & equipment (corporate) | Harm (physical or psychological) | Clinical Governance | Lack of clarity over corporate responsibility for medical equipment management Trust-wide.<br>Inventory of 'in use' medical equipment is incomplete.<br>No formal SOP for distribution of Safety Alerts & oversight of actions.<br>Limited records of staff competency in equipment use or evidence that equipment is impact assessed to determine training priorities.<br>Information on safe use of medical equipment is not routinely part of specialty governance arrangements.<br>Potential for equipment management process to vary between sites - requires standardisation.<br>Prioritisation process for capital investment in equipment requires clarification.<br>Incident reporting & management processes (Datix) for equipment related safety incidents. | Project on 'Safe Use of Medical Equipment' included in Quality & Safety Improvement Plan 2018/19, to address all identified weaknesses in control. | 8 | Medium risk | Patient Safety Committee |
| Safety & effectiveness of nursing care (corporate) | Harm (physical or psychological) | Corporate Nursing | Issues have been identified with the accuracy and reliability of patient falls data; understanding patient risk; use of evidence-based interventions and resource availability.<br><br>Issues have been identified with the accuracy and reliability of pressure ulcer data; understanding patient risk; use of evidence-based interventions and resource availability.<br><br>The Trust has consistently reported a relatively high contaminated blood culture rate which could lead to delayed diagnosis and therefore timely and effective treatment resulting in avoidable patient deterioration. | Delivery of the Corporate Pressure Falls Plan (attached to Datix), monitored through the Trust Falls Group. Directorates will also have local action plans linked to ward accreditation.<br><br>Delivery of the Corporate Pressure Ulcer Action Plan (attached to Datix), monitored through the Trust Pressure Ulcer Group. Directorates will also have local action plans linked to ward accreditation.<br><br>Recruit to sepsis nurse post permanently; develop a teaching package; progress site improvement plans; develop a business case for a team to take blood cultures as per Worcestershire model. | 8 | Medium risk | Patient Safety Committee |
| Serious breach of confidentiality (corporate) | Reputation / compliance | ICT | Compliance with mandatory IG training was 86% in 2017/18, which suggests a potential vulnerability in terms of staff knowledge of IG requirements.<br><br>Unencrypted patient data held on dictation machines is not secure and could be lost due to encryption states not being enabled and inadequate storage.<br><br>The Audit functionality within the current release of Medway is lacking in a number of areas and doesn't meet with the IG and other national requirements. Some audit detail can be obtained through workarounds. Other detail has to be obtained through contact with SystemC. Users that only read an entry, and make no changes are not currently able to be audited as the data is not stored. | IG training to be reviewed and updated in line with new GDPR requirements and re-launched.<br><br>Implementation of electronic dictation upgrade project.<br><br>Plan to upgrade to Medway version 4.8.x, but have been advised that some audit functions are still not fixed in this release either. | 8 | Medium risk | Information Governance Committee |

**Appendix I - Corporate Risk Register - September 2018**

| Risk | Type | Lead directorate | Weaknesses or gaps in control | Risk action plan | Rating (current) | Risk level (current) | Lead management committee |
|---|---|---|---|---|---|---|---|
| Uncontrolled outbreak of serious infectious disease (corporate) | Harm (physical or psychological) | Corporate Nursing | ULHT does not currently have any compliant negative pressure rooms on any of its hospital sites. This may incur the risk of transmission of infectious pathogens if patients with suspected/ known highly infectious conditions are cared for within existing side rooms at ULHT for any period of time.<br><br>Potential for failure to identify alert organisms in a timely manner due to the fact that data presentation has been changed to accommodate for new catalogue features on Apex software.<br><br>A lack of bay doors on wards including MEAU has been identified at the Lincoln Site. This may impact service provision due to lack of capacity to cohort nurse affected patients during an outbreak, leading to increased bed or ward closures. | In line with the current risk assessment, any patients with suspected / known MDR-TB are transferred immediately to a healthcare provider in another county. There are negative pressure facilities available within the trust however they do not fully meet the required HBN 04-01 (Isolation facilities for infectious patients in acute settings). They are still the preferred option for isolation of patients with high risk infectious pathogens and priority would be given to inpatients with these risks.<br><br>Pathlinks working to rectify alert organism surveillance issue but may be some time before data is available in a format to allow easy access.<br><br>Estates have action plan to replace doors on all bays in MEAU and awaiting opportunity to complete this work once operational pressures allow. | 8 | Medium risk | Infection Prevention & Control Committee |
| Compliance with equalities regulations, standards & contractual requirements | Reputation / compliance | Human Resources & Organisational Development | The Trust has scope to improve its compliance with the NHS Accessible Information Standard (AIS) by my consistently tailoring its communications to meet individual needs.<br><br>In 2019 it is anticipated that a new NHS Workforce Disability Equality Standard (WDES) will be introduced, which the Trust will need to prepare to comply with. | AIS: Implementation of the Hybrid Mail System project.<br><br>Preparatory work to support compliance with the new WDES (similar to requirements for WRES). Establishment of a disability staff network. | 8 | Medium risk | Equality, Diversity & Inclusion Operational Group |
| Safety of research project participants (corporate) | Harm (physical or psychological) | Clinical Governance | Current management processes do not include regular audit of research projects for compliance with requirements.<br><br>Current risk assessment methodology is due for review. | Review of capacity to build in annual compliance audit of 10% of research projects.<br><br>Review of research project risk assessment methodology. | 4 | Low risk | Patient Safety Committee |
| Critical supply chain failure (corporate) | Service disruption | Finance, Procurement & Corporate Affairs | | | 4 | Low | Emergency Planning Committee |
| Compliance with financial regulations, standards & contractual requirements (corporate) | Reputation / compliance | Finance, Procurement & Corporate Affairs | | | 4 | Low | Financial Turnaround Group (FTG) |
| Compliance with procurement regulations & standards (corporate) | Reputation / compliance | Finance, Procurement & Corporate Affairs | | | 4 | Low | Executive Team (ET) |
| Compliance with HR regulations & standards (corporate) | Reputation / compliance | Human Resources & Organisational Development | | | 4 | Low risk | Executive Team (ET) |