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ID	Title	Risk Type	Gaps in Control	Risk action plan	Rating (current)	Risk level (current)	Manager	Lead management group
4175	Management of emergency demand (corporate)	Service disruption	Ambulance handovers and conveyance performance. Streaming to services co-locating or outside of the Emergency Department. ED staffing levels (reliance on agency) and process inefficiencies. Admissions areas and flow management issues. 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%). 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. 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. 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. 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	Brassington, Mr Mark	Performance Review Meeting
4383	Substantial unplanned expenditure or financial penalties (corporate)	Finances	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). 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. The financial plan assumes interest rates will reduce for both new and existing borrowing from August 2018.	20	Very high risk	Brown, Karen	Financial Turnaround Group
4382	Delivery of the Financial Recovery Programme (corporate)	Finances	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.	20	Very high risk	Brown, Karen	Financial Turnaround Group

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ID	Title	Risk Type	Gaps in Control	Risk action plan	Rating (current)	Risk level (current)	Manager	Lead management group
4362	Workforce capacity & capability (recruitment, retention & skills)	Service disruption	Substantial challenge to recruiting and retaining sufficient numbers of Registered Nurses (RNs) to maintain safely the full range of services across the Trust. High vacancy rates for consultants & middle grade doctors throughout the Trust. 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. 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. 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. Focus on medical staff engagement & structuring development pathways. Utilisation of alternative workforce models to reduce reliance on medical staff. 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. 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. 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	Rayson, Martin	PRM
3520	Compliance with fire safety regulations & standards (corporate)	Reputation / compliance	Fire Policy & related procedures are overdue for review. 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. Availability of sufficient capital resource to fund required improvement works.	Detailed action plan to address issues raised in the Fire Service Improvement Notice.	20	Very high risk	Boocock, Paul	Estates Investment & Environment Committee
4043	Non-compliance with clinical governance regulations & standards (corporate)	Reputation / compliance	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). The CQC have threatened to take action if compliance does not improve. Low levels of compliance with baseline assessments for NICE guidelines & Technology Appraisals. Inconsistencies in clinical governance arrangements at specialty level. Limited identification and sharing of learning from Serious Incident (including Never Event) investigations.	Application for a bespoke e-learning module to be added to Core Learning Plus, mandatory for all clinical staff; policy, guidance & letter templates to be revised; communication plan being implemented; performance focus for October 2018 (all divisions to develop action plans). Performance management of NICE guidelines backlog through PSC. TAs being managed through Medicines Optimisation (MOPS) & reported upwardly to PSC. Implementation of new Clinical Governance directorate structure to provide additional support to specialties. 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.	20	Very high risk	Hepburn, Dr Neill	Patient Safety Committee
3687	Delivery of an Estates Strategy aligned to clinical services (corporate)	Service disruption	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, ERIC data & Lord Carter's recommendations.	16	High risk	Boocock, Paul	Estates Strategy Group

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ID	Title	Risk Type	Gaps in Control	Risk action plan	Rating (current)	Risk level (current)	Manager	Lead management group
4146	Effectiveness of safeguarding practice (corporate)	Harm (physical or psychological)	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. Audit of the use of chemical sedation is raising concerns that the Trust policy is not consistently being adhered to: choice of drug; dose; route of administration. 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. 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. 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.	Clinical holding training commenced March 2018 and is scheduled for 2018/19 for identified staff; Debrief process being introduced; Staff encouraged to complete Datix IR1s so trends and themes can be identified; training compliance to be escalated through HoN and Site Operational Leads; audit of 5 security incidents per month from September 2018; Review of chemical sedation pathway. On call medical photography service being developed through additional appointments onto the Bank; Staff have been reminded of requirement to complete Datix when service has been unavailable to enable impact to be assessed. Development of an appropriate pathway for patients with learning disabilities: Plans currently made on an individual basis however this results in delays; task and finish group scoping extent of issues and to progress pathway development Commissioning gap – work being led by the CCG; external support being sourced as required for 1:1 supervision etc.; Additional support offered by safeguarding team; Development of log to evidence issues.	16	High risk	Rhodes, Michelle	Safeguarding Committee
4384	Substantial unplanned income reduction or missed opportunities (corporate)	Finances	Clinical coding & data quality issues. Operational ownership of income at directorate level. 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. Complete an income improvement plan for each Directorate & incorporate within performance review process. Continued engagement with Commissioners in the development & implementation of demand management schemes.	16	High risk	Brown, Karen	Financial Turnaround Group
4403	Compliance with electrical safety regulations & standards (corporate)	Reputation / compliance	Fixed electrical testing is not routinely being carried out due to interruption to services on wards & departments and lack of adequate resources at all sites. Non compliance with the IET wiring regulations (BS7671). In many areas of the estate emergency lighting is non-compliant with health & safety regulations.	Maintenance programme and site specific management of reported issues.	12	High risk	Boocock, Paul	Electrical Safety Group
4399	Compliance with health & safety regulations & standards (corporate)	Reputation / compliance	Quality Governance Committee raised issues with the effectiveness of the Trust Health & Safety Committee (only meets quarterly; disparity in engagement between sites; reporting assurance gaps raised concerns that full range of responsibilities are not being discharged). The Trust does not currently have in place a sustainable programme of manual handling training for staff.	Assurance issues identified by the Quality Governance Committee to be raised with the chair of the Health & Safety Committee. Future reports to cover all aspects of H&S management. Proposals to be developed for resourcing of a sustainable manual handling training programme.	12	High risk	Boocock, Paul	Health & Safety Committee
4157	Compliance with medicines management regulations & standards (corporate)	Reputation / compliance	The Trust currently uses a manual prescribing process across all sites, which is inefficient and presents challenges to auditing and compliance monitoring. 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. Compliance with Falsified Medicines Directive (FMD) legislation (Directive 2011/62/EU) is mandatory from February 2019, aiming to provide assurance to patients that the medicines they are supplied are not counterfeit or 'Falsified Medicines' that might contain ingredients, including active ingredients, which are not of a pharmaceutical grade or incorrect strength or indeed may contain no active ingredient. Falsified medicines are considered a major threat to public health with seizures by regulators increasing annually across the globe. We do not currently have a plan in place to ensure that we will comply with this legislation, and be able to robustly provide the necessary assurance to patients.	Planned introduction of an auditable electronic prescribing system across the Trust. Isolator cabinets replaced at PHB; LCH facility remains closed whilst awaiting necessary building works (not currently possible to reopen due to potential for contamination). The FMD legislation requires that a system be established to enable all pharmaceuticals to be tracked through the supply chain, from manufacturer, via wholesalers, to pharmacy and to end user, and will be facilitated through the use of 2D barcode scanning technology. The Trust will work regionally with wholesalers and pharmacy computer system providers. Funding for new equipment is likely to be needed.	12	High risk	Costello, Colin	Medicines Optimisation & Safety Committee

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3690	Compliance with water safety regulations & standards (corporate)	Reputation / compliance	Trust Water Safety Group not fully represented . Policy approved Dec 2017. Water Safety Plan draft prepared Dec 2017 and currently being reviewed for issue by April 2018. Lack of water safety training for competent persons. Lack of robust alarm monitoring systems and injectors approaching obsolescence. The planned maintenance regime necessary to satisfy statutory requirements is not sufficiently resourced. The site risk assessments are required to be reviewed against the water schematics which are currently being developed. 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).	Review of water safety plan and governance arrangements; implementation of planned maintenance programme and remedial works.	12	High risk	Boocock, Paul	Water Safety Group
4406	Critical failure of the medicines supply chain (corporate)	Service disruption	Update to sustainability strategy, policy & plan.	National preparations directed by the Dept of Health & Social Care to ensure at least 6 weeks supply of medicines in case imports to the UK are affected Planned introduction of an electronic prescribing system across the Trust. Senior pharmacist and medical staff to manage switch between immunoglobulin brands with advice from the responsible consultant. Where patients are not looked after by any consultant following retirement of consultant Immunologist, the patients will remain on existing brand until Immunology cover is available. Shortages of contract lines are reported centrally; shortages of non-contract lines rely on identification by Trust pharmacy staff. Where shortages are identified, aim to put in place an appropriate management plan, after liaison with relevant members of pharmacy staff or specialist clinicians. Information regarding the restrictions to use of VZIg and also the process for obtaining stock have been shared with all pharmacy staff. Stock will routinely be supplied on the next working day to the pharmacy or GP surgery. Clarification has been sought from PHE regarding out of hours emergency access.	12	High risk	Costello, Colin	Medicines Optimisation & Safety Committee
3720	Electrical infrastructure failure (corporate)	Service disruption	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 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. Street lighting and car park lighting cables at PHB are suffering from multiple faults due to their age.	Maintenance programme and site specific management of reported issues.	12	High risk	Boocock, Paul	Electrical Safety Group
3722	Energy performance and sustainability (corporate)	Finances	Issues with insulation; lighting and waste management across LCH, PHB and GDH sites.	Site specific action plans to address identified issues.	12	High risk	Boocock, Paul	Energy & Sustainability Group
4179	Major cyber security attack (corporate)	Service disruption	A structured framework approach to cyber security would provide more reliable assurance that existing measures are effective and support any necessary improvement work. 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. Digital business continuity & recovery plans are in place but need to be updated with learning from the 'Wannacry' incident (May 2017) and routinely tested.	The Trust is working towards compliance with the Cyber Essential Plus framework and EU Network Security Directive. Prioritisation of available capital and revenue resources to essential projects through the business case approval process. 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	Gay, Nigel	Information Governance Committee

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4368	Management of demand for outpatient appointments (corporate)	Service disruption	Potential for failure to meet national targets of 52 weeks for clinic waiting times due to patients not appearing on PTL & Business Units occasionally lacking visibility of long waiting patients. Capacity to record e-outcomes onto Medway in a timely manner; Consultants not taking ownership of completing e-outcomes. May lead to Missing Outcomes not being completed & consequent delayed treatment. Capacity gaps within individual specialities, and with outpatients from a staffing / estates perspective increase the potential for appointment delays due to issues with the management of overdue new referrals; Appointment Slot Issues (ASIs); and the Partial Booking Waiting List (PBWL) for management of Overdue follow-ups. Overdue new appointments may be incorrectly added / unvalidated on the Open Referrals worklist . The New Booking team identify 'other' new patient referrals added to the Open Referral worklist by other parties in BU's. As the New Booking Team did not make the entry they are unable to validate the referral.	Information Support team to develop further reports to minimised number of patients not been visible in PTL. Short term solution offer overtime to reduce the number of patients outstanding in the report to within 48hours. Business case to be investigated and written to allow e-outcomes to update Medway with the outcomes. Clinical Directorates providing trajectories for recovery plans - monitored at fortnightly RTT Recovery and Delivery Groups. Detailed plans are in place at speciality level. C&A manually drawing down referrals from ASI list. The Trust is required to be fully compliant with an electronic booking system with a target set by NHSI of June 2018.	12	High risk	Rinaldi, Dr Ciro	Performance Review Meeting
4176	Management of planned care (corporate)	Service disruption	Too much inappropriate activity defaults to ULHT. Sustainability of a number of specialties due to workforce constraints. Availability of physical assets & resources (e.g. diagnostic equipment; outpatient space; inpatient beds). ASR / STP not agreed / progressing at required pace (left shift of activity).	System-wide planned care group setting up referral facilitation service & 100 day improvement programme, amongst other projects. Local mitigations in place including locum workforce; recruitment & retention premium; altering the model of working. Strategic direction to be outlined in fragile services paper to Trust Board. Capital plan for estate development, space utilisation and medical equipment. Progression of 2021 Strategy. Engagement in local Acute Services Review (ASR) & Sustainability & Transformation Partnership (STP).	12	High risk	Brassington, Mr Mark	Performance Review Meeting
3721	Mechanical infrastructure failure (corporate)	Service disruption	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. 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. Lack of resilience in mechanical infrastructure (e.g. ventilation, steam, cold water, heating, medical gas pipeline systems and lifts).	Maintenance programme and site specific management of reported issues.	12	High risk	Boocock, Paul	Mechanical Infrastructure Group
4300	Medical device & equipment management (corporate)	Service disruption	Gaps in service history recorded on central equipment inventory. Resource constraints (insufficient funds available to deliver against identified equipment requirements). 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. Prioritisation by Medical Device Group through Capital & Revenue Investment Board. 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	Hepburn, Dr Neill	Patient Safety Committee

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4145	Non-compliance with safeguarding regulations & standards (corporate)	Reputation / compliance	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. Not yet consistently achieving 90% compliance with safeguarding training requirements. 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. The Trust is not yet fully compliant with recommendations made following the Savile and Bradbury inquiries (e.g. Chaperone Policy and Safer Recruitment).	Increased visibility of SG team who are providing advice, support and supervision to staff to bridge theory practice gap; Monthly audits to monitor progress which are reported through operational group and committee; Benchmarking data being explored. Safeguarding training completion is included in performance framework and compliance reviewed and managers held to account through operational performance management reviews; individual accountability managed through appraisal process. Areas for more efficient working identified and being implemented; work progressing to develop an integrated SG model for Lincolnshire that will deliver optimum benefits for SG across the county and ultimately deliver improved safeguarding outcomes for adults, children and young people in receipt of an holistic service: minimal duplication and gaps in provision (including transitions); greater innovation as future need is better anticipated; smooth patient hand-over and movement across organisational boundaries; urgent advice available via the Local Authority. Outstanding actions from Savile & Bradbury incorporated into Safeguarding QSIP plan as priorities for 2018/19; Task and finish group reviewing chaperone policy; Existing chaperone posters displayed in clinical areas; Risk assessments for areas unable to comply with policy; More information to be made available for patients about availability of chaperones; 3 yearly DBS checks to be implemented – process being explored by HR.	12	High risk	Rhodes, Michelle	Safeguarding Committee
4081	Quality of patient experience (corporate)	Reputation / compliance	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). There is significant cynicism amongst staff, which will not be resolved until they see action alongside the words.	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.	12	High risk	Rayson, Martin	
3688	Quality of the patient environment (corporate)	Reputation / compliance	Issues with the quality of the patient environment across the Trust identified through PLACE audits.	Detailed site specific action plans to address identified issues.	12	High risk	Boocock, Paul	Patient Environment Group
4156	Safe management of medicines (corporate)	Harm (physical or psychological)	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. 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. 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. Inappropriate storage of refrigerated medicinal products (fridges constantly going above 8 degrees) due to lack of fridge(s) space. Periods of time where storage requirements are compromised has the potential to affect the stability of the products and therefore could have impact on patient treatment. Inadequate and unsecure storage and stock accountability of medical gas cylinders at all sites. Modifications required to meet standards and improve security.	Planned introduction of an electronic prescribing system across the Trust, to eliminate some of the risks associated with manual prescribing. Routine monitoring of compliance with electronic discharge (eDD) policy. Request for funding to support additional pharmacy resources for involvement in discharge medicine supply. 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. Temperatures being monitored continuously. Additional fridges required in order to ensure appropriate storage and product quality and comply with standards. Business case to request additional funding for fridges completed and approved. Fridges being purchased. Risk to be assessed with local security management specialist; recommendations will include new lighting to storage buildings, surveillance cameras, effective alarm system and new doors to replace weak hinges and stronger locks.	12	High risk	Costello, Colin	Medicines Optimisation & Safety Committee

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4138	Safety & effectiveness of medical care (corporate)	Harm (physical or psychological)	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. Issues with consistent and timely completion of electronic discharge documents (eDDs), which can lead to medication inaccuracies on discharge and delayed handover to GPs. Inconsistent compliance with initiation and completion of sepsis bundle, particularly initial screening (currently below 70%). Inconsistent compliance with e-observation policy. 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. eDD Committee to oversee compliance and implementation of improvement plans. Sepsis Committee to oversee compliance and implementation of improvement plans. E-obs system audits all inpatients each month. Ward Accreditation has a deteriorating patient standard with the aim of driving improvement. 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	Hepburn, Dr Neill	Patient Safety Committee
4083	Workforce engagement, morale & productivity (corporate)	Reputation / compliance	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. 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. 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	Rayson, Martin	
4082	Workforce planning process (corporate)	Service disruption	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	Rayson, Martin	
3689	Compliance with asbestos management regulations & standards (corporate)	Reputation / compliance	Asbestos Policy is overdue for review. Asbestos Management Plan still to be fully developed. Availability of sufficient capital funding to remove Asbestos; or other higher risk competing priorities depleting capital resources. Appointed Person not yet in place; Asbestos Management Structure to be agreed Continuity of contractors appointment requires resourcing and managing; verification of contractors training required. No Access areas still to be surveyed. Potentially inaccurate survey data due to restricted access to areas.	Development & impplementation of the asbestos management plan, supported by a revised policy & resource allocation.	8	Moderate risk	Boocock, Paul	Asbestos Management Group
4389	Compliance with corporate governance regulations & standards (corporate)	Reputation / compliance	Board committee terms of reference and work programmes are not up to date or fully reflective of the role of the committees. The Board Assurance Framework (BAF) needs to be aligned with strategic objectives and the corporate risk register and integrated with work programmes of Board committees.	Terms of Reference and work programmes for all Board committees to be reviewed and updated. The BAF to be refreshed, aligned with strategic objectives and the corporate risk register and integrated with the work programmes of Board committees.	8	Moderate risk	Brown, Karen	

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4398	Compliance with environmental and energy management regulations & standards (corporate)	Reputation / compliance	Lack of up to date strategy, policy & plan for sustainability. LCH Vacuum plant is non -compliant with HTM 02-01. This was highlighted by the Trust's Authorising Engineer on his site assessment carried out in October 2015.	Update to sustainability strategy, policy & plan.	8	Moderate risk	Boocock, Paul	Energy & Sustainability Group
4351	Compliance with equalities and human rights regulations, standards & contractual requirements (corporate)	Reputation / compliance	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. In 2019 it is anticipated that a new contractual NHS Workforce Disability Equality Standard (WDES) will be introduced, which the Trust will need to prepare to comply with. Monitoring of equality KPIs & data is still in draft. NHS England has published a new Sexual Orientation Monitoring Standard, but its implementation date has not yet been mandated.	AIS: Implementation of the Hybrid Mail System project. Preparatory work to support compliance with the new WDES (similar to requirements for WRES). Establishment of a disability staff network. Complete implementation of KPI monitoring. Dataset prepared. Awaiting confirmation of implementation date in order to activate changes to patient information systems and train and equip staff.	8	Moderate risk	Rayson, Martin	Equality & Inclusion Forum
4402	Compliance with regulations and standards for mechanical infrastructure (corporate)	Reputation / compliance	Grantham Hospital medical gas store is non compliant with HTM's and HSE Guidance. Racking is in a poor state of repair.	Maintenance programme and site specific management of reported issues.	8	Moderate risk	Boocock, Paul	Mechanical Infrastructure Group
4177	Critical ICT infrastructure failure (corporate)	Service disruption	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. 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. 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	Gay, Nigel	Information Governance Committee
4397	Exposure to asbestos (corporate)	Harm (physical or psychological)	Areas of LCH, PHB and GDH sites identified as being contaminated with asbestos.	Detailed remedial action plan by site to remove asbestos.	8	Moderate risk	Boocock, Paul	Asbestos Management Group
4404	Major fire safety incident (corporate)	Harm (physical or psychological)	Fire Policy & related procedures are overdue for review. 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. Availability of sufficient capital resource to fund required improvement works.	Updates to fire policy, procedures & training; planned programme of remedial works.	8	Moderate risk	Boocock, Paul	Fire Safety Group

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ID	Title	Risk Type	Gaps in Control	Risk action plan	Rating (current)	Risk level (current)	Manager	Lead management group
4003	Major security incident (corporate)	Harm (physical or psychological)	Insufficient security provision to safely cover all sites; issues with the provision of body armour to security officers. Not all areas of Trust sites are covered by CCTV and CCTV is not monitored across all sites. Security staff are currently using outdated radio communication systems. 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. LCH access control system - maintenance company is sole UK provider of key processor equipment.	Review of security management arrangements, equipment and resourcing.	8	Moderate risk	Boocock, Paul	Security Management Group
4141	Non-compliance with infection prevention & control regulations & standards (corporate)	Reputation / compliance	Sub-optimal cleaning standards in many areas increase the likelihood that the Trust will breach the yearly Clostridium difficile threshold set by NHS England. Insufficient housekeeping resource to provide and maintain a clean and appropriate environment and poor cleaning audit compliance with the Infection Code of Practice.	Matrons reviewing cleanliness standards during golden hour walk rounds; increased supervisory support for housekeepers being rolled out. To progress housekeeping plan & business case for further investment in housekeeping resources (centralisation and coordination of all Trust housekeeping resources).	8	Moderate risk	Rhodes, Michelle	Infection Prevention & Control Committee
4044	Non-compliance with information governance regulations & standards (corporate)	Reputation / compliance	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). Compliance with mandatory IG training remains below the required level of 95% and is therefore assessed as unsatisfactory in the national toolkit submission. Issues with achieving compliance with the Freedom of Information Act timescales, due to gaps in the Information Asset Register and lack of knowledge of how to apply exemptions. The data protection / privacy impact assessment process is not consistently followed at the start of a system change project, therefore results may not be available to inform decision-making.	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. IG mandatory training to be comprehensively revised & brought up to date with GDPR, then re-launched in October 2018. The method used to calculate compliance is to be reviewed to ensure the Trust is not under-reporting compared with peers. Review of Freedom of Information Act management processes and introduction of regular compliance reporting to the IGC. Review of the data protection / privacy impact assessment process.	8	Moderate risk	Gay, Nigel	Information Governance Committee
4154	Opportunities to participate in major clinical research projects (corporate)	Harm (physical or psychological)	ULH has not been successfully attracting research grants. There is an identified need and an opportunity for the Trust to drive rural health research. 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. ULH is leading a new initiative to set up a Centre for Rural Health and Care. Development of new, dedicated accommodation for a joint Lincolnshire Clinical Research Facility to support formal recognition by the NIHR as a registered CRF.	8	Moderate risk	Hepburn, Dr Neill	
4352	Public consultation & engagement (corporate)	Reputation / compliance	Current arrangements for collaboration with other teams across Lincolnshire are not formalised in a service level agreement. Lack of formal governance arrangements for public involvement in decision making increases the potential for major decisions to be made without adequate public consultation & engagement.	Development of a combined Communications & Engagement team across the Lincolnshire area. Escalation of public engagement governance issues to Ch Executive & Trust Secretary.	8	Moderate risk	White, Paul	

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4180	Reduction in data quality (corporate)	Reputation / compliance	Information requirements and flows need to be better understood to improve core data quality. Multiple sources are used to provide information to the Trust Board and its committees. The is currently no assurance mechanism for KPIs that they are correct, valid, QA'd and signed off by an appropriate person.	Quality and Safety Improvement Plan project to include: - Core data quality improvement - information requirements and flow mapping - Development of the InPhase system as the single source of governance information - Development of a quality assurance mechanism for KPIs throughout the Trust	8	Moderate risk	Caig, Shaun	Information Governance Committee
4353	Safe use of medical devices & equipment (corporate)	Harm (physical or psychological)	Lack of clarity over corporate responsibility for medical equipment management Trust-wide. Inventory of 'in use' medical equipment is incomplete. No formal SOP for distribution of Safety Alerts & oversight of actions. Limited records of staff competency in equipment use or evidence that equipment is impact assessed to determine training priorities. Information on safe use of medical equipment is not routinely part of specialty governance arrangements. Potential for equipment management process to vary between sites - requires standardisation. Prioritisation process for capital investment in equipment requires clarification. 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	Moderate risk	Hepburn, Dr Neill	Patient Safety Committee
4142	Safety & effectiveness of nursing care (corporate)	Harm (physical or psychological)	Issues have been identified with the accuracy and reliability of patient falls data; understanding patient risk; use of evidence-based interventions and resource availability. Issues have been identified with the accuracy and reliability of pressure ulcer data; understanding patient risk; use of evidence-based interventions and resource availability. 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. 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. 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	Moderate risk	Rhodes, Michelle	Patient Safety Committee
4401	Safety of the hospital environment (corporate)	Harm (physical or psychological)	Road lining (including both white and yellow) is in a poor state; road and footway surfaces uneven and 'pot holed' leading to claims for slips, trips and falls; major deterioration of the condition of roads. Road crossings on the internal roads on the site are poorly lit and road markings are poor across the Trust. No up-to-date glazing survey and an insufficient maintenance regime has led to a deterioration in the condition of windows and glazing throughout the estate. Rotting windows in the Maternity Block at LCH; despite planned maintenance being carried out, a window could fail causing glass to fall.	Planned maintenance programme and action plans to address specific issues identified on each site.	8	Moderate risk	Boocock, Paul	Health & Safety Committee
4400	Safety of working practices (corporate)	Harm (physical or psychological)	Insufficient low friction slides sheets. Inappropriate use of not fit for purpose products for patient handling. Patient hoists could fail when being used to move a patient as they are no longer serviceable from Sept 2018; 19 Passive Hoists and 10 active hoist are discontinued, 4 passive Hoists are beyond there serviceable life and 15 other passive hoists are just beyond their manufacturers expected life.	Site H&S Leads to encourage the use of best practice slide sheet products; departments to order these slide sheets or each site to have a central stock. Patient hoiist replacement programme - Business case for 21 replacement passive hoists and 6 active hoists (cost around £115,000).	8	Moderate risk	Boocock, Paul	Health & Safety Committee

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4181	Serious breach of confidentiality (corporate)	Reputation / compliance	Compliance with mandatory IG training was 86% in 2017/18, which suggests a potential vulnerability in terms of staff knowledge of IG requirements. Unencrypted patient data held on dictation machines is not secure and could be lost due to encryption states not being enabled and inadequate storage. 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. Implementation of electronic dictation upgrade project. 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	Moderate risk	Gay, Nigel	Information Governance Committee
4144	Uncontrolled outbreak of serious infectious disease (corporate)	Service disruption	ULHT does not currently have any fully 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. 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. 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. At present an outbreak would be managed ass an individual incident in its own right, without a defined corporate approach.	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. Pathlinks working to rectify alert organism surveillance issue but may be some time before data is available in a format to allow easy access. Estates have action plan to replace doors on all bays in MEAU and awaiting opportunity to complete this work once operational pressures allow. Development of an outbreak management plan for the response to infectious outbreaks across any site.	8	Moderate risk	Rhodes, Michelle	Infection Prevention & Control Committee
4277	Adverse media or social media coverage (corporate)	Reputation / compliance			4	Low risk	White, Paul	
4385	Compliance with financial regulations, standards & contractual requirements (corporate)	Reputation / compliance			4	Low risk	Brown, Karen	Financial Turnaround Group
4363	Compliance with HR regulations & standards (corporate)	Reputation / compliance			4	Low risk	Rayson, Martin	
4388	Compliance with procurement regulations & standards (corporate)	Reputation / compliance			4	Low risk	Brown, Karen	
4386	Critical failure of a contracted service (corporate)	Service disruption			4	Low risk	Brown, Karen	
4387	Critical supply chain failure (corporate)	Service disruption			4	Low risk	Brown, Karen	
4061	Financial loss due to fraud (corporate)	Finances			4	Low risk	Brown, Karen	
4155	Safety of research project participants (corporate)	Harm (physical or psychological)	Current management processes do not include regular audit of research projects for compliance with requirements. Current risk assessment methodology is due for review.	Review of capacity to build in annual compliance audit of 10% of research projects. Review of research project risk assessment methodology.	4	Low risk	Hepburn, Dr Neill	Patient Safety Committee