Appendix 2: BAF Report

ID	675
Manager	Screaton, Mrs Maura
Handler	Randall, Ms Kathy
Opened	11/06/2014
Consequence (current)	Major - 4
Likelihood (current)	Likely - 4
Risk level (current)	Extreme Risk
Risk level (Target)	High Risk
Rating (current)	16
Description	If we fail to ensure good Infection prevention and control practices then the Trust may fail to protect patients, staff and others from un-necessary harm from Hospital acquired infections such as MRSA, C. difficile & E coli Blood stream infection and fail to stay within ceiling trajectories for Healthcare Associated Infections. This could lead to illness, financial penalties and loss of reputation (SSI)
Controls in place	• Weekly in-patient ward meetings. • 6 weekly in-patient critical care meetings with review of all cases via Root Cause Analysis (RCAs). • Monthly reporting on hygiene code. • Monthly Directorate balanced scorecard. • Quarterly report to Cardiac Clinical Management Group.• Monthly reporting and monitoring through Infection Prevention & Control Committee • Avoidable Actions • Scrutiny panels for all C-Diff and MRSA • Microbiology clinical ward round in CCA twice a week • ED Environmental rounds • Infection Control Nurse ward rounds four times a week. • Managing lab results and advising on isolation precautions/treatment • Monitoring for trends pockets of increased infection and taking appropriate action • The hospital has a closed ventilated air system. Throughout our clinical areas the enhanced ventilation is tailored to meet the requirements of our patients. •SSI priority safety and quality focus for the Trust. •Harm reviews for all deep and organ space infections •Focus on essential IPC practices with increase in audits and improvement actions. •ED led environment rounds. •SSI stakeholder group. •deep cleaning programme for theatres •Peer review carried out by Mr Simon Kendall and recommendations being carried forward by IPC and SSI stakeholder groups •Ventilation safety group in place. •Water safety group continues. •12/4/23 SSI stakeholder group meeting bimonthly chaired by CN/MD. •NICE guidance for prevention of SSI's in place •Reduced footfall and movement within operating theatres •Introduction of mini vac TNP for all patients at higher risk of infection. •Daily •MDT environment and clinical practise e.g. hand washing conduct on ward rounds. •NHSE/ICB external supportive review 12/6 and 13/6/2023. •Peer review of audit processes in theatre - actions being followed up through new governance structure. •10/10/23 Recommendations and actions from NHSE in implementation phase - progress against actions reviewed at SSI stakeholder group.Updates on reviews due 13/2/24. •UKHSA SSI team presented comparative data to SSI clinical group, actions being taken forward for review 27/3/24 •8/5/24 Alternative sterilisation and decontamination contract now in place since 1/4 and being positively received. mini vac dressings and endoscopic vein harvesting continued for patients at high risk of SSI. Continued enhanced governance structure to provide oversight continues. •05/7/24 Daily IMT, cohorting of positive patients, separation of staff, enhanced patient screening, enhanced cleaning, staff communications. •8/8/24 Proportionate controls remain in place , admission and weekly screening of patients, double chlorine cleaning of patient environment on discharge, enhanced audits of compliance.
Risk Assessors recommended actions to further reduce the risk	Continued close monitoring and involvement of infection control team. Continue with RCA and scrutiny panel. RCA for MRSA bacteraemia and internal scrutiny panel. Update and review all infection control policies and procedures, including the over-arching policy DN15. DIPC has close oversight on all actions to gain assurance. Further external scrutiny requested e.g. external assessor and different approach to audits, external DIPC contacted to invite and review, theatre expert visit and opinion requested. Governance of SSI stepped up to allow greater assurance on actions and monitoring improvements. 10/10/23 Focused work on decolonisation treatment pre and post operatively, cleaning and decontamination audit actions and focus on resourcing diabetic care pre operatively. 11/12/23 Focus on environment L5 cleaning standards, theatre footfall and CC cleaning and decontamination in view of micro organism profiling.Complete 8/1/25 Air sensors placed in theatres as part of ventilation study. Meeting held with UKHSA re further support / advice. Review of data underway due 13/2/24 8/4/24 Ventilation study data now analysed and presentation due to be presented to the SSI clinical practise group by 30/4/24. Theatre footfall plan and standards agreed by theatre users. Specific actions in order to comply currently being implemented. Update on progress and audit of practise due to SSI clinical group 23/4/24.Pre operative decolonisation compliance has improved from 20% to 90% in March. 6/6/24 Compliance with IPC standards and practise demonstrates improvement. SSI rates remain circa 5% above UKHSA benchmark. SSI summit to be arranged for wider engagement and discussion. SSI summit held on 08 August 2024. 5/7/24 Numbers of CPE positive patients reducing. Elective activity paused until Monday 8th July 2024 to allow for cleaning. 8/8/24 No new cases of CPE identified since July 22nd indicating confidence in control measures. Control measures as above being regularly reviewed and adjusted.
Assurance	Mandatory IPC training for all staff. IPC policy, procedures and guidelines in place. IPCC committee meetings. Quality & Safety Management Group. CQC Outcome 8. Enhanced Surveillance scheme (MESS). Q&R Committee minutes. Audit high impact interventions as reported to the Commissioners. Recording all nosocomial infections in PIPR so that the Board has oversight. Review of all IPC National Guidance and ensure that we are compliant with these. The Trust has significant controls in place which are reported to the Board monthly and monitoring of all nosocomial infections has been added to Board reporting through PIPIR. SSI Governance has been revised to allow greater assurance on actions and monitoring improvements via SSI dashboard. Visit to Liverpool heart and chest hospital 5.9.23 and learning shared with SSI subgroups. This has now formed part of the SSI workplan. NHSE peer review of IPC measures undertaken in June 2023 and recommendations agreed. Numbers of positive CPE cases.
Gaps in Assurance	Measures are taken to manage any new and emerging infection risks however due to the evolving nature of these it is difficult to provide complete assurance that all mitigations are in place and this is kept under constant review.
Levels of Assurance (182)	Adequate
BAF risks - Does this risk have an action plan on Datix? (179)	Yes
Progress notes	[Screaton, Mrs Maura - 07/10/2024] CPE closure meeting held on 2/10/24. Proposed ongoing CPE screening protocol discussed and supported. One case of ESBL transmission in CC identified in September. Internal IMT held with actions in place for further screening and enhanced audit of practise. as of 6/10/24 no further cases of transmission identified further review planned 14/10/24. Q1 SSI rates finalised as 5.4% which is a reduction from previous but remains above UKHSA benchmark. There has been a reduction in deep and organ space infection. Continued focus remains in respecting the theatre environment and footfall attention to the essentials of IPC, optimisation of ventilation system and management of diabetes.Review of timeline of interventions in respect to reducing SSI's to be discussed at SSI stakeholder group on 7/10/24.This is to understand if there are any correlations with interventions and a reduction in infections.
Committee Responsible for the Risk	Infection Control Pre & Perioperative Committee, Quality & Risk Committee, The Board
Date last reviewed	07/10/2024
Review date	07/11/2024
Directorate	Trust wide - All Directorates Involved
Trust Objectives 2022-24	1. Deliver clinical excellence, 6. Achieve sustainability

ID	678
Manager	McEnroe, Harvey
Handler	Speed, Jane
Opened	11/06/2014
Consequence (current)	Major - 4
Likelihood (current)	Certain - 5
Risk level (current)	Extreme Risk
Risk level (Target)	High Risk
Rating (current)	20
Description	IF the Trust fails to meet the constitutional reporting standards of RTT and cancer waiting targets THEN this could result in poor patient outcomes, poor patient experience, damage the Trust's reputation and reduce its income.
Controls in place	• All patients being prioritised for access based on the national priority codes rather than waiting time alone to ensure patients are safely managed while waiting. • Review of waiting time on a weekly basis including the weekly PTL, daily review of IHU waits and Trust capacity. • Remedial action plans are in place for all divisions to reduce the number of patients waiting over 40 weeks. • The theatre transformation plan is delivering performance and productivity improvements with trajectory to return to 5.5 theatre model by September 23. (achieved as per plan) • Harm reviews are in place and take place at 35 and 52 weeks. Action is now being taken to reduce patients above 40 week in line with national programme for recovery. These Patient Safety Initiatives (PSI) are focused on clearing +40 week waiting. these commenced on the 17/09 and will run for 3 months. 15.11.23 PSI lists now embedded within the divisions. Positive impacted on patients over 52 weeks and improvements in patients over 40 weeks. Dedicated operational support for cancer pathway. 14.02.24 PSI lists continue albeit at a slower rate that Q4 2023/24. 17.05.2024 Additional weekly scrutiny of waiting lists has been introduced, Chaired by the COO. Focus patients over 52 weeks and 40 weeks.
Risk Assessors recommended actions to further reduce the risk	Trust productivity improvement programme (Flow programme) proposed to deliver following in support of achieving reduced waiting lists: 1.Reduce length of stay and improve discharge profile. 2.Improved theatre utilisation. 3.Reduce DNAs. 4.Reduce overall waits, waiting list and longest waits. 5.Deliver capacity and demand analysis. 6.Support maintenance of diagnostic performance. 7.Deliver alternative models of care. 8.Improve cancer performance. 9.Improve day case utilisation. Actions will be reviewed by the Performance Committee on a monthly basis.
Assurance	IHU review and sign off daily by the COO and reported to the weekly senior operational oversight meeting. Recovery plan in place for Cancer waiting times with target trajectory which is monitored through the Trust Access meeting. Weekly PTL and Access meetings well established and oversee recovery plans. Additional, 40 week wait weekly meeting in place, focusing on 52 week waiters TCI dates, 40 week trends and developing plans to address. Use of PSI's to create additional capacity as and when required. 2nd line assurance vis monthly PIPR.
Gaps in Assurance	There are no gaps noted at present
Levels of Assurance (182)	Adequate
BAF risks - Does this risk have an action plan on Datix? (179)	Yes
Progress notes	[Walker, Wendy - 14/10/2024] Flow Programme continues and update will be presented to October Performance Committee. Enhance recovery Unit fully open to 10 bed in the week, positive impact on flow through unit and theatres. Good progress being made on CT backlog recovery. New project on improving referral pathways being included with the Programme.
Committee Responsible for the Risk	Performance Committee, The Board
Date last reviewed	14/10/2024
Review date	14/11/2024
Directorate	Trust wide - All Directorates Involved
Trust Objectives 2022-24	1. Deliver clinical excellence

ID	742
Manager	Screaton, Mrs Maura
Handler	Screaton, Mrs Maura
Opened	30/01/2015
Consequence (current)	Major - 4
Likelihood (current)	Unlikely - 2
Risk level (current)	High Risk
Risk level (Target)	High Risk
Rating (current)	8
Description	If the Trust fails to meet safer staffing for nursing (85% fill rates) and other staff groups e.g. pharmacy and radiography THEN this may impact on quality of clinical care, capacity to treat and completion of other Trust duties.
Controls in place	• Three times daily site safety meetings using safe care to aid nurse deployment; nurse:patient ratios, patient acuity and skill mix reported for all inpatient areas. • Escalation process in place when staffing concerns are raised. Process in place for activity adjustment if required. • Monthly reports to CPAC on roster effectiveness and safe staffing metrics • Monthly Trust wide recruitment events Comprehensive action plan to recruit and retain nursing staff • Monitoring of quality and safety patient safety incident reports where staffing levels have an impact. • Monitoring of Friends and family tests. 4/2/22 Nursing Establishment setting policy approved at Q and R Safer nursing care tool training completed and data for establishment setting being collected. 8/2/23 Nurse to patient ratios and staffing red flags being monitored shift by shift with use of safe care and mitigation's, including staff redeployment, being put in when required to maintain safety. 10/10/23 Weekly look ahead staffing meetings in place that identify gaps and ensure plans are in place to mitigate. This oversight also now reviews and monitors red flag events to ensure red flag incidences are closed. Bi annual roster review meeting with wards and departments. Red flags reported weekly to EDs. 8/5/24 Pharmacy workforce compromised due to vacancies, pharmacists particularly vulnerable. Agency staffing agreed where available. Prioritisation of workload in place - discussed and supported by clinicians through CDC. Monitoring clinical incidents and delays in providing TTO's. Pharmacy mentoring support for newly appointed critical care pharmacist being provided by CUH 17/6/2024 5/7/24 Recruitment to vacant roles in progress with positive appointments. Business support role in place to allow trained pharmacists and leaders to concentrate on specialist work. 5/7/24 all urgent imaging activity will be protected. 8/8/24 Improvement in pharmacy recruitment.
Risk Assessors recommended actions to further reduce the risk	Continue to monitor vacancies. Twice a year staffing review due. 8/2/23 Outcome measures being regularly reviewed to identify any early warning signs of adverse effects of reduced fill rates. 12/6/23 Deep dive into fill rates and identification of improvements. Unregistered vacancy rate much improved with slightly higher fill rates. 10/10/23 BDO audit on safe staffing processes and data quality completed and discussed at audit committee. Actions in place to address assurance gaps. This will be further monitored by workforce committee. Presented to workforce committee 25/1/24 Registered fill rates to be within target range by 1/3/24 Unregistered fill rates to be within range 1/4/24 Supervisory sister/charge nurse time to incrementally improve month on month with target of 90% to be achieved by 08/08/24 Pharmacy staffing review completed and ATIR in progress to ensure safe staffing levels. Its envisaged that the posts requested will be attractive to potential candidates. Investment group 13/5/24 Pharmacy business support officer post advertised to release qualified pharmacists time from some administrative duties. Aim to appoint 11/5/24 Role profiles for new pharmacy roles in process with aim to advertise by 1/7/24 5/7/24 Roles advertised with positive applications and recruitment 5/7/24 New radiographers appointed to vacancies - awaiting start dates and period of induction
Assurance	• Safer staffing Unify submission report with commentary on areas of non-compliance. • Minutes of clinical profession advisory group monthly • Monthly PIPR report – Safe domain • Vacancy and recruitment activity tracked monthly – PIPR • Joint Staff Council, changes to workforce minuted • Establishment reviews are aligned to NICE Guidance and NQB 2016 best practice standards and have been taken for review to Q&R • Nursing Establishment Escalation policy in place • Patient experience reports and surveys
Gaps in Assurance	
Levels of Assurance (182)	Adequate
BAF risks - Does this risk have an action plan on Datix? (179)	Yes
Progress notes	[Screaton, Mrs Maura - 14/10/2024] 14/10/24 Safe staffing fill rates for registered nurses and HCSW have been consistently > 85% for the past 6 months. The pipeline of new starters is robust and will meet any predicted vacancies over coming months. Recruitment to pharmacy staffing vacancies has been very positive with almost all vacancies now appointed to. Risk reviewed at executive directors meeting on 8/10/24 following proposal to place the risk on the corporate risk register from the BAF. Supervisory sister/charge nurse time remains below target but improving trajectory.
Committee Responsible for the Risk	Workforce Committee, The Board
Date last reviewed	14/10/2024
Review date	14/11/2024
Directorate	Chief Execs
Trust Objectives 2022-24	1. Deliver clinical excellence, 2. Grow pathways with partners, 3. Offer positive staff experience, 4. Share and educate, 6. Achieve sustainability

ID	858
Manager	Raynes, Andrew
Handler	Page, Mr Simon
Opened	01/02/2016
Consequence (current)	Major - 4
Likelihood (current)	Unlikely - 2
Risk level (current)	High Risk
Risk level (Target)	High Risk
Rating (current)	8
Description	"If" the Trust's EPR is not being actively developed and a pathway to migrate to a replacement system cannot be achieved in a timely manner, “Then” there a strategic risk to the organisation as the EPR may not support corporate objectives, impacting productivity, clinical safety, benefits realization, and overall ambitions for data as part of the digital strategy “Ultimately” leading to loss of competitive advantage for the organisation and potential patient safety issues
Controls in place	a)Continue to utilise current EPR to support trusts strategy through clinical engagement and governance structures b)Assess EPR developments utilising a benefits methodology, to drive benefits from current system c)Identification of future options for EPR, assessment of capability of future state EPR to understand potential new benefits and any gaps within any new system d)Contract and relationship management of Dedalus, to maximise this relationship e) Soft market analysis to understand cost of change and cost of ownership of any new system f)Engage with ICS and central teams to understand funding available to RPH to enable any transition to ether another Dedalus EPR or an EPR from another provider
Risk Assessors recommended actions to further reduce the risk	1)Increased clinical engagement to deliver local optimization of the EPR where possible to avoid losing technological ground to mitigate risks, 2)Assess optimisations that do not require input from Dedalus or that can be delivered outside the core EPR 3)Deep dive into Orbis functionality to ensure it is fully ready for use in UK - especially in EPMA space (this looks furthest from being ready). 4)Look to drive competitive advantage through the partnership by shaping the anglicisation of Orbis in specialty areas 5)Further indepth report and risk list for remaining on Lorenzo till end of current contract.
Assurance	a)Clinical safety case and ongoing work of Digital Clinical safety meeting which reports to QRMG b)Digital governance structures and groups which give strategic oversight on EPR c)Contract meetings with Dedalus to escalate EPR concerns, risks and develop plans to mitigate/manage these risks d)Partnership agreement and first of type offer from Dedalus that they will cover much of the RPH costs for migration to Orbis e)Soft intelligence regarding frontline digitisation funding to give open options to organisation of EPR, agreement from central team to downgrade RPH from class 3 not applicable for funding to level 2 which would allow some funding (approx. £6m), this funding is not certain and would require ICS support f)Review of the Orbis evaluation by Gartner and HIC both suggested the methodology of assessment was sound and concurred with initial recommendations that Orbis looked like a system that would fit in the financially envelope and deliver a usable system.
Gaps in Assurance	Dedalus decision to stop development of Lorenzo Clinical, Anglicization gap for Orbis, is it ready for UK market
Levels of Assurance (182)	Adequate
BAF risks - Does this risk have an action plan on Datix? (179)	Yes
Progress notes	[Page, Mr Simon - 14/10/2024] Risk reduced based on OBC progress and independent affordability clarification in the absence of FD funding
Committee Responsible for the Risk	Digital Strategic Board, Strategic Projects Committee, The Board
Date last reviewed	14/10/2024
Review date	14/11/2024
Directorate	Digital
Trust Objectives 2022-24	1. Deliver clinical excellence, 2. Grow pathways with partners, 3. Offer positive staff experience

ID	1021
Manager	Raynes, Andrew
Handler	Bardell, Chris
Opened	17/02/2016
Consequence (current)	Catastrophic - 5
Likelihood (current)	Likely - 4
Risk level (current)	Extreme Risk
Risk level (Target)	High Risk
Rating (current)	20
Description	"IF" the trust is underprepared for a cyber-attack and/or lacks cyber resilience "THEN" the risk of a major cyber event increases. "ULTIMATELY" This event could cause data loss across key systems (clinical and non-clinical), and disruption at not only an organisation level but regional and national level. The impact may last for a prolonged period, necessitating cancellations and delays to treatment. Additionally, it poses a risk to the Trust's reputation, in the patient care that can be given and in rare cases even loss of life.
Controls in place	The Trust has multiple layers of protection: 1. Patching as per national best practice guidelines 2. A rolling plan to update servers and replace end user devices that are out of warranty 3. A plan to bring all software to fully supported versions, where not excluded by being part of a medical device. 4. Application of cyber security notifications from NHS England and the National Microsoft Defender for Endpoint tenant. These are discussed on receipt and actioned. All completed actions are reported back to the NHS England Cyber Responding Service or the NHS England ATP service. 5. Ongoing work to achieve Cyber Essentials level certification 6. Rolling Server replacement program 7. We regularly provide Cyber Security messages to staff via All Staff Briefs, NewsBites and also through Screensavers. 8. All staff on a annual basis undertake Information Governance mandatory training which incorporates Cyber Security. 9. Regular Simulation Phishing exercises are undertaken which is followed up with targeted training to inform staff and promote awareness. 10. Annual Penetration Testing which is undertaken by a external company and any recommendations which are picked up are mitigated. 11. We employ a Cyber Security Analyst which protects and monitors the organisation from Cyber attacks and mitigations against future attacks and ensures the organisation is aware of Cyber Security through campaigns, NewsBites, Simulated Phishing exercises. They also run vulnerabilities tests against the organisation and ensures remediation tasks are undertaken and implement security solutions. 12. The trust does not operate shared systems outside of those which are nationally provisioned, this gives a degree of circuit break in the system.
Risk Assessors recommended actions to further reduce the risk	1) Further work on the IT health dashboard to ensure all data is captured within this key assurance tool. - Ongoing 2) Commencement of formal apprenticeship for Cyber Analyst - Ongoing 3) Setting up quarterly meetings with NHS-E cyber lead for east off England, to improve knowledge of best practice. Completed Aug 24 4) Review role of MFA (multi-factor authentication) on-site and off-site in light of national guidance Completed July 24 5) Carry out back-ups to ensure these remain a safe restore point - Ongoing 6) Further work on the National Microsoft Defender to ensure all endpoints and servers are onboarded onto the platform for enhanced monitoring and protection. - Ongoing 7) Introduction of a Cyber Security & Security Additions roadmap 8) Cyber Awareness Comms Plan (NewsBites, The Brief, Screensavers & Simulated Phishing Exercises) 9) Retirement of legacy and/or out of support Operating Systems - Ongoing under BAU 10) Removal of legacy/out of support software - Ongoing under BAU 11) Taking advantage of national provided offerings from NHS England 12) Accreditations such as Cyber Essentials and Cyber Essentials +, ISO27001 and NIST2 will happen at a later time Expected to take 2-3 years to complete. 13) Purchasing and implementation of a Internet of Medical Devices Software to help harden and protect medical devices which are on the IT network by end of Quarter 4 in 2024/2025 depending on funding availability and procurement process 14) Purchasing and implementation of a Privileged Access Management Software to secure allow third parties and venders to access our network by end of Quarter 4 in 2024/2025 depending on funding availability and procurement process 15) Information Security Management System was purchased and implemented to collate all security data in September 2024 16) Purchasing of a Vulnerability Management software to scan all devices for potential issues and recommend remediation tasks depending on revenue funding availability. The timeline can be provided once the procurement process and funding is agreed 17) Re-configuration of existing Cyber IT enabled software ensuring the latest security features are applied we are taking advantage of all features, which is an ongoing activity 18) The introduction of Windows 11 - October 2025 19) Adopt EPRR National Guidance for best practices - Ongoing activity
Assurance	• DSP Toolkit and audit • Annual PEN testing of estate • IT Health dashboard with overview of estate • Business continuity planning in conjunction with EPRR • Ongoing work towards cyber essentials • AI based treat detection and isolation application, monitoring all traffic • EDR Soluton to detect and automatically act against certain detections • Quarterly cyber reports detailing patch compliance, OS compliance and treat detection rates • Monthly reporting to Information Governance Steering Group with Cyber oversight. • Security information and event management to collect all logs from endpoints and servers and to alert anomalies. • Vulnerability/Cyber alert information from NHS England • Passive (view only) device monitoring to the National Microsoft for Endpoint Tenant • Updates to existing policies and processes to align with new trends and best practices
Gaps in Assurance	Lack of senior cyber specialists within organisation due to funding within Digital. An ongoing program of Cyber education and sharing between EOE trusts and NHS England to mitigate risk is currently in progress.
Levels of Assurance (182)	Adequate
BAF risks - Does this risk have an action plan on Datix? (179)	Yes
Progress notes	[Vaithamanithi, Raj -17/10/2024] Reviewed and updated
Committee Responsible for the Risk	Digital Strategic Board, IG Steering Group, Performance Committee, The Board
Date last reviewed	17/10/2024
Review date	17/11/2024
Directorate	Digital
Trust Objectives 2022-24	1. Deliver clinical excellence, 6. Achieve sustainability

ID	1853
Manager	Monkhouse, Oonagh
Handler	Howard-Jones, Larraine
Opened	27/04/2018
Consequence (current)	Catastrophic - 5
Likelihood (current)	Possible - 3
Risk level (current)	Extreme Risk
Risk level (Target)	High Risk
Rating (current)	15
Description	If turnover does not reduce and remain at or below target level then the Trust will lose key skills and reduce the levels of experience in the workforce, incur additional costs in the form of recruitment costs and temporary staffing spend, see a reduction in staff engagement and satisfaction and be unable to maintain safe staffing levels and achieve activity levels.
Controls in place	The Compassionate and Collective Leadership Programme is the vehicle for reducing turnover through improving staff engagement and building a positive and compassionate culture. The programme focuses on leadership, EDI, health and wellbeing and staff development. In July 21 we launched the Trust's revised values and behaviour framework. The Reciprocal Mentoring programme has been launched and commenced in June 22 and is a vehicle for addressing inequality and discrimination. We have significantly increased the H&WB support for staff in recognition and appreciation of the efforts of staff. In June 22 we introduced a Staff Support Scheme which provided subsidised travel and food for staff. We further increased these subsidises in October and paid a £100 payment to support in November 22 to help with increased cost of living. These subsidies were continued in 23/24 and have been approved for 24/25. We have continued to focus on communication and thanking staff for their contributions. The line management CCL Programme commenced in April 22. The purpose of this programme is to develop the skills of line managers to lead in a compassionate way. We have established a Resourcing and Retention Improvement Programme to provide a structured and systematic approach to working collaboratively on a range of projects to improve retention. The 23-25 Workforce Strategy has been approved by the Trust Board and the 24/25 workplan has been signed off. The workplan includes action to improve the quality of appraisals, updating of nursing job descriptions and review of bandings, development of nursing career pathways and improvements in talent management processes. A revised structure is being implemented in the Workforce Directorate which will include a dedicated team for talent management and career pathways. An improved process for collecting feedback from leavers is being implemented.
Risk Assessors recommended actions to further reduce the risk	To improve career pathways and development plans for staff to reduce the instances of staff having to leave to develop their careers. A revised structure is being implemented in the Workforce Directorate which will include a dedicated team for talent management and career pathways.
Assurance	Turnover rates are reported to the Trust Board monthly via PIPR and there are regular spotlights exploring trends. The quarterly pulse survey and the annual staff survey include questions on the intention of staff to stay with the organisation. These results are reported to the Workforce Committee and Trust Board. The key driver for turnover is staff engagement. The pulse survey and the national staff survey both track a number of metrics related to staff engagement. The results of these surveys are reported to the Board and Workforce Committee. Trust Workforce Strategy includes a set of metrics and goals for measuring impact of the plans to reduce turnover.
Gaps in Assurance	We do not have good information and data from staff exit interviews. Improving this is in the 23/24 Workforce Action plan.
Levels of Assurance (182)	Adequate
BAF risks - Does this risk have an action plan on Datix? (179)	Yes
Progress notes	[Monkhouse, Oonagh - 09/10/2024] Risk reviewed and no change to the rating.
Committee Responsible for the Risk	The Board, Workforce Committee
Date last reviewed	09/10/2024
Review date	09/11/2024
Directorate	Workforce
Trust Objectives 2022-24	1. Deliver clinical excellence, 3. Offer positive staff experience, 6. Achieve sustainability

ID	1854
Manager	Monkhouse, Oonagh
Handler	Howard-Jones, Larraine
Opened	27/04/2018
Consequence (current)	Major - 4
Likelihood (current)	Possible - 3
Risk level (current)	High Risk
Risk level (Target)	High Risk
Rating (current)	12
Description	If the Trust is unable to attract and recruit staff to meet its workforce plan, as defined by the annual workforce planning process, then it will be unable to ensure safe staffing levels, maintain levels of activity required by the recovery plan, achieve the levels of income required by our financial plan, contain pay spend within budgeted levels and staff engagement, wellbeing and retention will be negatively impacted.
Controls in place	There is good joint working between the Communications team and the Recruitment team to ensure that all possible opportunities to promote career opportunities within the Trust are maximised that bespoke campaigns are designed for specific areas as necessary. Our Values are reflected in our adverts and recruitment process. There is an ICS supply group which the Trust is an active participant in. We are utilising overseas recruitment for registered nursing staff and AHP roles. We have increased the resources in the Nurse Recruitment and Retention team to support the recruitment and retention of HSCWs. The Trust Board reviews, at each Board, vacancy rates via PIPR. The Workforce Committee oversee the implementation of the Compassionate and Collective Leadership Programme and the Resourcing and Retention Improvement Programme. We have a programme of open events and attending external recruitment events. The Resourcing and Retention Improvement Programme aims to provide a structured and systematic approach to working collaboratively on a range of projects to improve recruitment. We have procured a new electronic recruitment system which has now been implemented and time to hire is starting to reduce. An overseas recruitment plan for 24/25 has been agreed. A Workforce Strategy has been approved by the Trust Board which describes the recruitment action plan.
Risk Assessors recommended actions to further reduce the risk	No additional recommendations noted
Assurance	Work with ICS partners to utilise educational and recruitment supply routes to meet projected demand and promote the NHS as the place to have a fulfilling and rewarding career Trust Workforce Strategy 2023-25 has been approved by the Trust Board which includes a 23/24 action plan and metrics Internal Monitoring • DWOD reports to Board on a monthly basis. The Workforce Committee has agreed regular reporting across: • Implementation of Compassionate and Collective Leadership Programme. - Implementation of the Workforce Strategy - Implementation of the Resourcing and Retention Programme • Development of networks to support our staff: BAME, LGBTQ+, Disability and Difference, Women's networks. • Annual monitoring of WRES and WDES data. • Annual review of our Gender Pay Gap report. • Workforce KPIs including vacancy rates are reported to Board through PIPR and reviewed monthly at Q&R and Performance Committees. External Assurance Measures: • Monitoring of our staff recommender score through the National Staff Survey (annual) with quarterly feedback through the Pulse survey. The output of the NHS Staff Survey is reviewed at a divisional and departmental level.
Gaps in Assurance	No gaps noted at present
Levels of Assurance (182)	Adequate
BAF risks - Does this risk have an action plan on Datix? (179)	Yes
Progress notes	[Monkhouse, Oonagh - 09/10/2024] Risk reviewed by Executive Team and in light of sustained reduction in vacancy rates across a number of departments/staff groups and healthy pipelines, the current likelihood rating has been reduced to possible taking the overall rating to 12.
Committee Responsible for the Risk	The Board, Workforce Committee
Date last reviewed	09/10/2024
Review date	09/11/2024
Directorate	Workforce
Trust Objectives 2022-24	1. Deliver clinical excellence, 3. Offer positive staff experience, 6. Achieve sustainability

ID	1929
Manager	Monkhouse, Oonagh
Handler	Howard-Jones, Larraine
Opened	23/07/2018
Consequence (current)	Major - 4
Likelihood (current)	Likely - 4
Risk level (current)	Extreme Risk
Risk level (Target)	High Risk
Rating (current)	16
Description	If there is no good staff engagement then staff turnover, recruitment, sickness absence, staff morale and team working will be negatively impacted. The evidence also shows that poor staff engagement negatively impacts on patient outcomes and experience and on confidence in the organisation and its financial performance.
Controls in place	The Compassionate and Collective Leadership Programme encompasses a number of workforce programmes to improve staff engagement and ensure a high care quality culture. In 2021 we launched revised values and a behaviour framework to support staff and leaders with role modelling the behaviour that engenders a compassionate and collective workplace culture. Workshops to embed this framework commenced Feb 22 and all staff are being encouraged to attend these. We have a number of support mechanisms in place to enable staff to work safely and to receive support for their health and wellbeing. We have implemented a Staff Support Scheme to support staff with the cost of transport and food. There is a monthly all staff briefing and weekly managers briefings to keep staff informed and provide the opportunity to recognise and appreciate the contribution of staff/teams. A weekly digital newsletter has been introduced which provides the opportunity to focus on particular items in more detail. The BME, LGBT, Womens and Disability Staff Networks provide the forum for proactively working with staff to improve engagement and inclusivity. The Reciprocal Mentoring Programme commenced in June 22 and a second cohort started in Sep 23. Good line management is an important aspect of building high staff engagement and the line managers development programme commenced in April 2022. One of the workstreams within the STA Improvement Programme, which has the lowest levels of staff engagement across the Divisions/Directorates is focused on improving culture and staff engagement across the departments within the division. The Workforce Strategy has been approved by the Trust Board and describes the approach to improving staff engagement and metrics for tracking progress. The Trust Board held development sessions in Dec 23 and March 24 to consider and review their strategic approach and leadership of EDI and culture. A further session took place in June 2024 to develop a vision for inclusive leadership and how this can be brought to life across the organisation. An event for the whole Trust leadership is in the planning for September 2024. In May 2024 a project commenced to review the job descriptions, banding and career progression for nursing roles in the Trust in order to proactively address the concerns being raised by Trade Unions.
Risk Assessors recommended actions to further reduce the risk	Support teams who are experiencing difficulties to improve and support a strong sense of belonging for all team members. Improve the quality of appraisals across the hospital.
Assurance	• Monitoring of our staff recommender score through the National Staff Survey (annual) with quarterly feedback through the Pulse survey. The output of the NHS Staff Survey is reviewed at a divisional and departmental level. •56% response rate to the 2023 NHS Staff Survey • Monthly monitoring of compliance of staff with a current IPR at a departmental level with Trust wide reporting in PIPR. • Weekly managers briefings held which ensure focus on issues raised by our staff using a 'you said we did' approach. • Monthly All Staff briefings. • Implementation of Compassionate and Collective Leadership Programme. • Development of networks to support our staff: BAME, LGBTQ+, Disability and Difference, Women's networks. • Annual monitoring of WRES and WDES data. • Annual review of our Gender Pay Gap report. • Implementation of the Reciprocal Mentoring Programme. Third cohort commencing Jan 25. . Workforce Strategy approved by Trust Board and annual action plan. - Vision for inclusive leadership and Leadership Behaviour Framework developed and launched.
Gaps in Assurance	We are below average against our peer group in all of the key themes in the NHS Staff survey 2023.
Levels of Assurance (182)	Adequate
BAF risks - Does this risk have an action plan on Datix? (179)	
Progress notes	[Monkhouse, Oonagh - 09/10/2024] Risk reviewed and the launch of the new leadership vision and leadership behaviour framework has been noted in the actions being taken to improve staff engagement. No change has been made to the risk rating.
Committee Responsible for the Risk	The Board, Workforce Committee
Date last reviewed	09/10/2024
Review date	09/11/2024
Directorate	Trust wide - All Directorates Involved
Trust Objectives 2022-24	1. Deliver clinical excellence, 3. Offer positive staff experience, 6. Achieve sustainability

ID	2829
Manager	Harrison, Sophie
Handler	Harrison, Sophie
Opened	23/02/2021
Consequence (current)	Major - 4
Likelihood (current)	Unlikely - 2
Risk level (current)	High Risk
Risk level (Target)	High Risk
Rating (current)	8
Description	IF the Trust does not achieve financial balance in the current year and beyond THEN the Trust (and ICS) will be subject to regulatory action which will impact on the Trust's ability to provide high quality, sustainable services to patients now and in the future.
Controls in place	Monthly reporting of cash, I&E and activity position through Performance Committee and Trust Board - Daily cash flow forecasting over rolling 12 month period - Part-block clinical income contracts with NHSE and key ICB partners - Activity recovery plans being implemented where necessary through operational and service teams. These plans are being monitored through Performance Committee - Cost investment controls through weekly vacancy control panel, monthly Investment Group and Performance Committee cycles - Long term financial modelling updates - CFCO involvement in ICB Finance forum - Trust working with specialised commissioning on future funding frameworks and strategy for NHSE - Potential for utilisation of non-recurrent financial recovery initiatives to support breakeven position - Current national funding mechanism is providing additional support through the Trust's fixed income arrangements to mitigate the 24/25 position - EPR replacement programme ongoing with business case process expected to clarify the financial implications as well as possible mitigations - Development of proposals for the growth of private care to support longer term financial sustainability - Strengthening of control environment for agency and temporary staffing - Number of linked actions in relation to industrial relations described under risk BAF 3261
Risk Assessors recommended actions to further reduce the risk	Greater clarity on the net cost impact of the EPR programme. This is expected following OBC and FBC completion. This may include securing additional funding to support the costs of the programme.
Assurance	First line / Second line: - Monthly reporting of cash, I&E and activity position through Performance Committee and Trust Board - Cash flow forecasting over rolling 12 month period - Part-block clinical income contracts with NHSE and key ICB partners - Activity recovery plans being implemented where necessary through operational and service teams. These plans are being monitored through Performance Committee and Divisional groups - Cost investment controls through weekly vacancy control panel, monthly Investment Group and Performance Committee cycles - Long term financial modelling updates - CFCO involvement in ICB Finance forum and risk mitigation - Trust working with specialised commissioning on future funding frameworks and strategy for NHSE - Potential for utilisation of non-recurrent financial recovery initiatives to support breakeven position in 2023/24 - National funding mechanism change in 2023/24 (non-recurrent) is providing additional support through the Trust's fixed income arrangements to mitigate the 23/24 position - EPR replacement programme ongoing with business case process expected to clarify the financial implications as well as possible mitigations - Updates on NHS Financial Regime provided to Performance Committee, Divisions and Board - Oversight of business planning process through Performance Committee and Board - Papers outlining proposal for the development of private care to support longer term financial sustainability - Enhanced design and operation of temporary staffing controls Third line: - External audit - Internal audit - review of key financial controls on an annual basis. Assurance over the design and effectiveness of controls through this report and reviewed by Audit Committee. - Feedback from NHSE
Gaps in Assurance	Macroeconomic environment, including supply constraints, potential for unfunded pay awards or material changes in banding profiles for registered nursing staff, inflation and pressure on public sector finances may lead to additional financial pressure above funded levels or reduction in funding available to Trust. Ability to control these largely outside Trust's direct control.
Levels of Assurance (182)	Adequate
BAF risks - Does this risk have an action plan on Datix? (179)	
Progress notes	[Harrison, Sophie - 16/10/2024] Risk remains high overall to reflect the levels of uncertainty in the financial framework in the medium term. There is material uncertainty associated with the financial impact of the EPR replacement programme and the national picture over delegation of specialised commissioning. This is being balanced with the underlying surplus under the current framework and the targeted breakeven position for 24/25. Given these factors, no change is proposed to the scoring of this risk at present and the residual consequence of any potential future deficit. This will continue to be assessed as the EPR works through OBC and FBC sign off.
Committee Responsible for the Risk	Performance Committee, The Board
Date last reviewed	16/10/2024
Review date	16/11/2024
Directorate	Finance
Trust Objectives 2022-24	6. Achieve sustainability

ID	2904
Manager	Harrison, Sophie
Handler	Harrison, Sophie
Opened	11/05/2021
Consequence (current)	Major - 4
Likelihood (current)	Likely - 4
Risk level (current)	Extreme Risk
Risk level (Target)	High Risk
Rating (current)	16
Description	IF the ICS does not achieve financial balance in the current year and beyond THEN the ICS and Trust will be subject to regulatory action which will impact on the Trust's ability to provide high quality, sustainable services to patients now and in the future.
Controls in place	System CFO meeting regularly to escalate system financial risks and develop plans to mitigate/manage these risks. - Wider ICS governance structure includes senior oversight of ICS financial position. - Long term ICS financial modelling being developed to understand the scale of future challenges. - Ad-hoc modelling of national funding to support impact of Industrial Action or other key risks as and when relevant. - ICS wide productivity workstreams set up to explore opportunities for productivity gains and closer working across corporate services. - National and ICB approval of strategic business cases to ensure collective agreement to material investment decisions that could impact the financial position (e.g. EPR, capital strategic projects incl new hospital programme builds). - ICB CFO engagement in regional specialised commissioning forum governing delegation approach. - - Maximising out of system funding flows to support system financial position.
Risk Assessors recommended actions to further reduce the risk	Assessment of the impact of unmitigated financial risks in 2024/25 by system partners. Clarity on the financial implications of three EPR programmes on the medium term position and mitigations available.
Assurance	System CFO meeting regularly to escalate system financial risks and develop plans to mitigate/manage these risks - Wider ICS governance structure includes senior oversight of ICS financial position and the action plans in partner organisations. - Long term ICS financial modelling being developed to understand the scale of future challenges - Modelling of national funding in 23/24 to support impact of Industrial Action, national reforecast exercise undertaken November 2023 on the back of additional funding provided by government (reduction of elective targets and additional targeted funding). Additional work undertaken in January 2024 in response to strike action.
Gaps in Assurance	Macroeconomic environment, including supply constraints, potential for unfunded pay awards or material changes in banding profiles for registered nursing staff, inflation and pressure on public sector finances may lead to additional financial pressure above funded levels or reduction in funding available to Trust. Ability to control these largely outside system's direct control.
Levels of Assurance (182)	Adequate
BAF risks - Does this risk have an action plan on Datix? (179)	No
Progress notes	[Harrison, Sophie - 16/10/2024] No change since last risk assessment.
Committee Responsible for the Risk	Performance Committee, The Board
Date last reviewed	16/10/2024
Review date	16/11/2024
Directorate	Trust wide - All Directorates Involved
Trust Objectives 2022-24	2. Grow pathways with partners, 6. Achieve sustainability

ID	2985
Manager	Harrison, Sophie
Handler	Goodier, Mr Chris
Opened	18/08/2021
Consequence (current)	Catastrophic - 5
Likelihood (current)	Unlikely - 2
Risk level (current)	High Risk
Risk level (Target)	High Risk
Rating (current)	10
Description	IF the Trust is reliant on key suppliers to deliver commissioner requested services THEN the Trust has a higher likelihood of being exposed to financial and service delivery risks.
Controls in place	Contracts are entered into the Atamis Contract register and a classification is entered based on the Government Commercial Function tiering tool. Additionally, a risk score is assigned to each contract to indicate the level of risk to the Trust based on criticality of supply, ease of change and size of supply market. This determines the level of contract management that the lead stakeholder will need to apply. Contracts are managed at department level with spot checks to be carried out by Procurement to ensure that contract management is taking place.
Risk Assessors recommended actions to further reduce the risk	A supplier audit will allow the Trust to monitor the suppliers financial stability and service delivery standards so that the Trust can identify or examine risks before they become a problem. Supplier audits to be carried out by Trust contract managers on Gold contracts every 6 months and annually on silver contracts. Review dates to be added to the Atamis contract register and reminders sent out to all contract owners prior to review date. This audit shall include a review of the annual financial statements of the suppliers to monitor financial stability with assistance from the Trust finance business partners. For each new procurement cycle the Trust will need to carry out a strategic review of the services being delivered to determine the most appropriate strategy to apply to reduce the level of risk to the Trust.
Assurance	The Chief Finance and Commercial Officer is in dialogue with suppliers to resolve issues surrounding the commercial elements of proposed contracts.
Gaps in Assurance	The assurance is based on the continued desire of both parties to come to a resolution that will benefit the Trust and its suppliers
Levels of Assurance (182)	Adequate
BAF risks - Does this risk have an action plan on Datix? (179)	
Progress notes	[Goodier, Mr Chris - 07/10/2024] Checks ongoing, will be reported to Deputy CFO at the end of October 2024
Committee Responsible for the Risk	Performance Committee, The Board
Date last reviewed	07/10/2024
Review date	07/11/2024
Directorate	Trust wide - All Directorates Involved
Trust Objectives 2022-24	1. Deliver clinical excellence

ID	3009
Manager	Harrison, Sophie
Handler	Goodier, Mr Chris
Opened	23/09/2021
Consequence (current)	Major - 4
Likelihood (current)	Possible - 3
Risk level (current)	High Risk
Risk level (Target)	High Risk
Rating (current)	12
Description	IF there are challenges in the supply of consumables or services THEN this could result in a failure to provide continuity of services, resulting in the inability to operate on patients.
Controls in place	Contracts are entered into the Atamis Contract register and a classification is entered based on the Government Commercial Function tiering tool. Additionally, a risk score is assigned to each contract to indicate the level of risk to the Trust based on criticality of supply, ease of change and size of supply market. This determines the level of contract management that the lead stakeholder will need to apply. For each new procurement cycle the Trust carries out a market review of the goods/services being delivered to determine the most appropriate strategy to apply to reduce the level of risk to the Trust. This may include splitting the contract in to multiple parts so that there is not a reliance on a single provider.
Risk Assessors recommended actions to further reduce the risk	An assessment to be completed in conjunction with clinical engineering and department leads to understand and document the relationship between equipment and consumables so that those that are locked together are documented. The new Supply Chain Manager will be tasked with monitoring all Important Customer Notices issued by NHS Supply Chain and reviewing these against the Trust's product portfolio to ensure mitigating steps can be taken prior to any impact on the Trust. Spot checks of department Business Continuity Plans to be carried out by Procurement for all Gold and Silver contracts with results recorded in the Atamis Contract Register to ensure steps are being taken to understand risks and put in place preventative measures.
Assurance	Procurement contract database. Management of suppliers through regular contract meetings. Tender processes that consider resilience.
Gaps in Assurance	No gaps noted at present
Levels of Assurance (182)	Adequate
BAF risks - Does this risk have an action plan on Datix? (179)	No
Progress notes	[Goodier, Mr Chris - 07/10/2024] Business Continuity Plan (BCP) report updated for all 21 Digital and Estates Gold/Silver contracts. 12 Business Continuity and Disaster Recoverys (BCDRs) received, 6 not received, 3 marked as not-applicable Missing ones will be discussed with Deputy Head of Digital to understand when they may be expected. BCP report set up for Gold and Silver contracts which will be refreshed monthly to monitor status.
Committee Responsible for the Risk	Performance Committee, The Board
Date last reviewed	07/10/2024
Review date	07/11/2024
Directorate	Trust wide - All Directorates Involved
Trust Objectives 2022-24	1. Deliver clinical excellence

ID	3040
Manager	Screaton, Mrs Maura
Handler	Randall, Ms Kathy
Opened	29/09/2021
Consequence (current)	Catastrophic - 5
Likelihood (current)	Unlikely - 2
Risk level (current)	High Risk
Risk level (Target)	High Risk
Rating (current)	10
Description	If the measures (POU Filters and bottled water) that the Trust has put in place to control the spread of M.Abscessus in patients identified as clinically vulnerable to M.Abscessus are not in place at each point of care for identified vulnerable patients THEN patients may come to harm and ultimately may have an adverse effect on Trust performance and reputation.
Controls in place	Water treatments as recommended by the Water Safety Group. Point of Use filters on water supplies in ALL clinical areas. Identified at risk patients receive bottled drinking water. Newly diagnosed/identified patients have a timeline performed and presented to SIERP to identify level of harm and required duty of candour. Patients given advice on admission on the risk M.Abscessus. External visit from Duke University Hospital provided opportunity of peer review. Regular water and environmental sampling is in place. Website contains information for patients, staff and public on M.Abscessus. Executive oversight (quarterly) group in place-- multi agency and multi professional attendance from UKHSA, NHSE, CQC all invited. CQC kept updated. M Abscessus steering group meetings held monthly with an executive lead. Review/check and challenge meeting with NHSE principal engineer 4/11/21 - no obvious gaps in practice identified 8/12/21 Core group dedicated meeting to review current situation and identify management of actions going forward. 12/12/22 - Water safety group continue to meet regularly and adjust water safety treatments as required. Point of use filters remain in place in all areas. March 2023- Water safety plan agreed and in place. August- Monthly IPC audits in place. 08/08/23-New M.Abscessus Risk Assessment -Water sources and Potential NTM contamination of taps and water systems risk assessment and audit report (Oct 2022 audit completed) (finalised - signed off by water safety Group in January 2023. Reviewed at M.Abscessus steering group 11/08/2023. 8/5/24 Outstanding sequencing results for patient samples received from UKHSA - not related to outbreak strain. Alternative provider for performing sequencing testing now in place to ensure reliability of testing going forward. 10/9/24 Water safety group continue to test and monitor water safety. No issues identified.
Risk Assessors recommended actions to further reduce the risk	Despite the controls that are in place we continue to have a background incidence of M.Abscessus. There is continually evolving information and evidence that the Trust must consider and respond to using the control mechanisms that are in place. 9/12/21 Regular updating external stakeholders on position 8/3/22 media queries addressed with factual information. Regulators and BoD being updated 12/12/22 Recent inquest findings communicated with media staff and BoD 08/08/23-New M.Abscessus Risk Assessment -Water sources and Potential NTM contamination of taps and water systems risk assessment and audit report (Oct 2022 audit completed) (finalised - signed off by water safety Group in January 2023. Due to go to M.Abscessus steering group 11/08/2023. To follow recommendations of this completed assessment and risk assessment. 10/10/23 NHSE supporting Trust and risk around delays in obtaining more timely relatedness testing results.All measures remain in place in respect to protecting vulnerable patients. Review of water safety plan and measures. 11/12/23 Meeting held with UKHSA who are unable to support with ongoing routine relatedness testing. Awaiting specification of protocols to allow alternative provider to be sourced. UKHSA will support ad hoc until alternative is in place. 10/3/24 Alternative provider sourced and process being finalised 8/5/24 Last confirmed case of M abscessus August 2022 suggesting controls in place for protecting patients are adequate. 6/6/2024 No new cases of Mabscessus identified 10/9/24 awaiting sequencing results for 3 patients
Assurance	All staff have local mandatory training on M.Abscessus Monitoring of cases of M.Abscessus has seen a return to a baseline level Water Safety Group, M.Abscessus Steering Group with oversight from Executive Directors and reporting into Q&R and Board. Open dialogue with UKHSA, as well as national and international subject matter experts. Governance and oversight structure in place with external stakeholder panel which includes ICB, NHSE and CQC with clear reporting lines
Gaps in Assurance	Laboratory testing and analysis takes times (to grow the species and perform relatedness testing). Relatedness testing is not a routine test for M.Abscessus. The changing nature of this mycobacterium causes challenges in identification, consequences for patient and management of infection.
Levels of Assurance (182)	Adequate
BAF risks - Does this risk have an action plan on Datix? (179)	
Progress notes	[Screaton, Mrs Maura - 07/10/2024] Continue to await outstanding 3 relatedness results from UKHSA. Water safety group considering bottle water provision and how it may be reduced further in line with risk mitigations of filters on tap outlets and continued water testing results.
Committee Responsible for the Risk	Infection Control Pre & Perioperative Committee, Quality & Risk Committee, The Board, Water Quality Group
Date last reviewed	07/10/2024
Review date	07/11/2024
Directorate	Trust wide - All Directorates Involved
Trust Objectives 2022-24	1. Deliver clinical excellence, 4. Share and educate, 5. Research and innovate, 6. Achieve sustainability

ID	3074
Manager	Harrison, Sophie
Handler	Harrison, Sophie
Opened	16/11/2021
Consequence (current)	Major - 4
Likelihood (current)	Possible - 3
Risk level (current)	High Risk
Risk level (Target)	High Risk
Rating (current)	12
Description	IF the Trust fails to engage with the national reforms on commissioning THEN delivery of its strategy and future financial sustainability could be adversely effected through strategic shifts away from the Trust and changes in patient flows, resulting in a failure to sustain and improve services for regional patients and regulatory intervention and/or the recurrence of a financial deficit.
Controls in place	The local ICS system: Mitigated by the leadership roles that are being undertaken in the local ICS and delivery of the C&P Cardiovascular Strategy. ICB CFO is a member of the regional governance group of ICB CFOs that are overseeing the delegation. RPH is working with its partners at CUH in a collaborative approach to the risk through 24/25. (Linked risks: BAF 2904 Achieving financial balance at ICS level; CRR 2854 IF RPH does not engage in the ICS THEN we will not utilise our expertise to influence local strategy for cardiology) Regional activity and flows to RPH: Mitigated by close working with specialised service commissioners and our role in Regional Provider Collaborative. National activity flows and designations: Mitigated by using lobbying and influence at the national levels, DH and through our role in the Federation of Specialist Hospitals, as well as our relationships at strategic NHSE level. Devolution of specialised funding to a number of ICBs is happening from 1/4/24 however this is impacting different ICBs in different ways. NHSE in East of England have confirmed 24/25 arrangements will operate as per 23/24, with more material allocation shifts expected from 25/26.
Risk Assessors recommended actions to further reduce the risk	Our response to national and local system reforms will require ongoing review and response as the new ICS structures emerge and as new models of care develop. In the absence of any detail around ICB specialised strategies and the mixed approach to delegation nationally, the likelihood of the risk remains above target levels but there are no further actions the for the Trust at this stage. The Trust will assess clinical engagement in the EoE Specialised Collaborative as work on clinical strategies and new models of care progresses.
Assurance	The local ICS system: Mitigated by the leadership roles that are being undertaken in the local ICS and delivery of the Cambridgeshire & Peterborough Cardiovascular Strategy. (Linked risks: BAF 2904 Achieving financial balance at ICS level; CRR 2854 IF RPH does not engage in the ICS THEN we will not utilise our expertise to influence local strategy for cardiology) Regional activity and flows to RPH: Mitigated by close working with specialised service commissioners and our role in Regional Provider Collaborative (Chaired by RPH CEO). National activity flows and designations: Mitigated by using lobbying and influence at the national levels, DH and through our role in the Federation of Specialist Hospitals, as well as our relationships at strategic NHSE level. Devolution of specialised funding to a number of ICBs is happening from 1/4/24 however this is impacting different ICBs in different ways. NHSE in East of England have confirmed 24/25 arrangements will operate as per 23/24, with more material allocation shifts expected from 25/26.
Gaps in Assurance	Gaps in assurance currently rest outside of the Trust's direct control (e.g. strategy for specialised commissioning, national clarity on allocation delegation, differing arrangements by region etc).
Levels of Assurance (182)	Adequate
BAF risks - Does this risk have an action plan on Datix? (179)	No
Progress notes	[Harrison, Sophie - 16/10/2024] No change since previous assessment. Work ongoing at ICS and regional level. Trust strategy development will include clinical strategy review and consideration of changes in national strategic context and local care model development.
Committee Responsible for the Risk	Performance Committee, The Board
Date last reviewed	16/10/2024
Review date	16/11/2024
Directorate	Trust wide - All Directorates Involved
Trust Objectives 2022-24	2. Grow pathways with partners, 4. Share and educate, 6. Achieve sustainability

ID	3223
Manager	McEnroe, Harvey
Handler	Speed, Jane
Opened	22/07/2022
Consequence (current)	Major - 4
Likelihood (current)	Likely - 4
Risk level (current)	Extreme Risk
Risk level (Target)	High Risk
Rating (current)	16
Description	If the trust does not recover it's activity throughput and productivity to optimal levels then there is a risk that patients will wait extended periods for treatment, then this could cause patients' conditions to deteriorate, an increase in acuity, less positive patient outcomes, reputational impact and the financial stability of the trust and ICS could be adversely impacted.
Controls in place	An operational improvement plan (incorporated in to Flow Programme) has been developed to a deliver the following outcomes; Reduce length of stay and improve discharge profile. Improve theatre utilisation Reduce DNAs Assess capacity and demand Deliver alternative models of care. Increase day case utilisation. Ensure delivery of 23/24 operational plan. The programme will monitor progress against these objectives and report to the Performance Committee on a monthly basis. Activity delivered is monitored on a weekly basis against plan and 19/20 levels. Remedial action is identified proactively and escalated via the trust access meeting. STA CI programme focused on in day productivity (reporting via Performance Committee). Clinical Admin processes being reviewed re booking of theatre lists and closing down 2 weeks in advance with no cancellation 72 hours prior. PSI lists now embedded within the divisions. Dedicated operational support for cancer pathway.
Risk Assessors recommended actions to further reduce the risk	Reviewed by Execs and agreed that assurance can be moved up to adequate. This is because the systems and processes that we have in place should mitigate the risk, but that efforts are impacted by continued industrial action. The systems and governance that are in place are through the Flow Programme, weekly PTL, 642 and Access meetings. Industrial action and system bed pressures will affect ability to recover activity and the impact of IA is planned through the IA Group. IA is expected to continue in to Q4 2024 and beyond. System bed pressures are managed daily.
Assurance	Activity reports in month via the Patient Access meeting and via the Performance Committee. Performance is on plan for M4 except for IP elective activity where we are seeing the impact of industrial action (IA). In response we are looking at mitigations and to reset activity targets for the year in line with the update provided in BAF 678.
Gaps in Assurance	Workforce engagement and establishment levels as well as impact of Indutrial Action
Levels of Assurance (182)	Adequate
BAF risks - Does this risk have an action plan on Datix? (179)	
Progress notes	[Walker, Wendy - 14/10/2024] Risk reviewed and no further changes required.
Committee Responsible for the Risk	Performance Committee, The Board
Date last reviewed	14/10/2024
Review date	14/11/2024
Directorate	Trust wide - All Directorates Involved
Trust Objectives 2022-24	1. Deliver clinical excellence, 6. Achieve sustainability

ID	3261
Manager	Monkhouse, Oonagh
Handler	Howard-Jones, Larraine
Opened	09/09/2022
Consequence (current)	Major - 4
Likelihood (current)	Likely - 5
Risk level (current)	Extreme Risk
Risk level (Target)	High Risk
Rating (current)	20
Description	If industrial relations are negatively impacted as a result of discontent with national pay settlements and terms and conditions, including how the NHS Job Evaluation System operates, then this could lead to industrial action, low staff engagement, increased vacancies and turnover. A consequential reduction in workforce availability would impact our ability to provide services, increase access times for patients and have adverse financial implications.
Controls in place	We are liaising with local and regional Trade Union representatives to ensure effective lines of communication and exchange of information. - We have updated our protocols for managing industrial action and departments have updated their Business Continuity Plans. - The Trust established an Industrial Action Task Force to ensure that the organisation has a clear understanding of the impact of this action in each area and the actions needed to minimise the impact on services. - Activity recovery plans have been developed and a Patient Safety Initiative scheme has been implemented to incentivise staff to work additional hours to undertake additional activity out of normal hours of service. - May 24:A project to review and update registered nursing job descriptions and then the banding of roles has commenced. This will identify whether we have any roles incorrectly banded and provide the opportunity to determine whether we need to change the way we are deploying staff/our staffing model and/or managed the rebanding of roles. - The 24/25 pay award for AfC will be paid to AfC staff in the October payroll and November for Medical Staff - We are actively participating in developing a regional collaborative approach to addressing the risks linked to job evaluation and banding of roles.
Risk Assessors recommended actions to further reduce the risk	Capacity assessment for Job Evaluation and recommendations to increase capacity to be costed and presented to the Executive Team.
Assurance	Guidance for managers has been developed. An Industrial Action Taskforce chaired by the COO is established to ensure that the organisation has a clear understanding of the impact of this action in each area and the actions that are being taken to maintain services, and support decisions in relation to the reduction of services or redeployment of staff. Business Continuity Plans are in place. Elective Recovery Programme is in place and reporting to the Performance Committee. Review of nurse job descriptions and development of pathways underway in partnership with Trade Union colleagues which will report to the Workforce Committee. Working as part of regional HRD Network and with ICB partners to share best practice and identify areas of potential joint working.
Gaps in Assurance	Pay and terms and conditions are nationally set and a significant part of this lies outside of the control of the Trust. The national employee relations environment is not something within the control of the Trust but is determining the levels of discontent and challenge in relation to pay within NHS organisations.
Levels of Assurance (182)	Adequate
BAF risks - Does this risk have an action plan on Datix? (179)	
Progress notes	[Monkhouse, Oonagh - 09/10/2024] The risk was reviewed and no change has been made to the rating as national industrial relations are a key driver for this risk. We may be able to reduce it once we are confident that our job descriptions are up to date and appropriately banded and that we have assessed how staff are working against these job descriptions.
Committee Responsible for the Risk	Workforce Committee, The Board
Date last reviewed	09/10/2024
Review date	09/11/2024
Directorate	Workforce
Trust Objectives 2022-24	1. Deliver clinical excellence, 3. Offer positive staff experience, 6. Achieve sustainability

ID	3433
Manager	Smith, Dr Ian
Handler	Speed, Jane
Opened	08/11/2023
Consequence (current)	Major - 4
Likelihood (current)	Likely - 4
Risk level (current)	Extreme Risk
Risk level (Target)	Moderate Risk
Rating (current)	16
Description	If the CT reporting backlog does not improve back to the 4 week reporting KPI, then patient pathways will continue to be delayed whilst awaiting results ultimately resulting in potential patient harm
Controls in place	PACS Board re-initiated (now called Image Working Board) CT Backlog Operational Group initiated. Was meeting weekly. Then fortnightly. Now monthly via the COO Patient prioritisation across all divisions and specialties to ensure all patient reports are treated equitably Prioritisation given to reports for inpatients, clinically unwell or deteriorating patients and those on active cancer & RTT pathways. All other patients, including longterm surveillance patients, are prioritised in date order reporting the oldest first. Weekly reporting of backlog into Trust Access operational meeting Weekly reporting by email to the CT Backlog Group attendees Escalation into STA Division via monthly performance reporting Quarterly update into QRMG via quarterly reporting Locum shifts offered to medical staff to undertake additional reporting Confirmation of stats numbers by consultant are accurate to ensure monitoring, tracking and ensure all are meeting their job planned reporting quota. Numbers circulated fortnightly to the consultant team. Insourcing Company providing 4 radiologists to report on CTs ran between 20/1/24 and 31/3/24 to clear the backlog to within KPI. This succeeded with the simple CTs but still left quite significant waiting times for the complex reports. Reviewing reporting capacity against demand, identified the department is staffed to 2018/19 activity levels with no previous uplift until 2024 for the additional activity undertaken, further benchmarking underway to ascertain full activity gap between scanner activity and reporting time availability in the consultant team Further engagement with the Insourcing Company to commence 6/7/24 with 4 reporting shifts each weekend for 6 months, to be reviewed in September 2024, to support with covering the x4 consultant radiologist vacancies within the team.
Risk Assessors recommended actions to further reduce the risk	Full clinical engagement with any remedial plans for actioning the backlog as well as PACS Board and CT Backlog Operational Group.
Assurance	ED oversight and monthly reports to the Performance Committee Weekly reporting of backlog into CDC and Trust Access Escalation into STA Division
Gaps in Assurance	None at the moment
Levels of Assurance (182)	Adequate
BAF risks - Does this risk have an action plan on Datix? (179)	
Progress notes	[Rodriquez, Mrs Helen - 08/10/2024] Progress continues to be made against the backlog. Highlight reports continue to be provided to all previously stated forums. Reporting plan submitted to Chief Operating Officer on 1/10/24 for consideration outlining all options available for ongoing support for reporting. Await update or advice on this report.
Committee Responsible for the Risk	Performance Committee, Radiology Business Unit Meeting, STA Divisional meeting, The Board
Date last reviewed	08/10/2024
Review date	08/11/2024
Directorate	Radiology
Trust Objectives 2022-24	1. Deliver clinical excellence, 3. Offer positive staff experience

ID	3449
Manager	Harrison, Sophie
Handler	Morrish, Katie
Opened	21/12/2023
Consequence (current)	Major - 4
Likelihood (current)	Possible - 3
Risk level (current)	High Risk
Risk level (Target)	High Risk
Rating (current)	12
Description	If the Trust does not work effectively with its partners across the Cambridge Biomedical Campus, then this could result in missed opportunities to sustain and improve care for patients, both now and in the future. Failure to create capacity within the Trust and Campus partner organisations could result in failures to capitalise on opportunities to innovate and and support economic growth in life sciences in Cambridge and across the region. Ultimately this will impact on progression of strategic partnership working on the campus at a time where there is increased focus on leveraging the relationships between the two organisations.
Controls in place	Trust membership of CUHP. - Trust membership of CBC Ltd. CBC Strategy Group is undertaking public consultation on a vision for 2050, setting out how the Campus can bring together the right set of research, education, healthcare delivery and industry partners; and what opportunities and requirements this generates for transport and other infrastructure, people and skills. - Research and innovation recognised as priority within the Trust's Strategy with visibility at Board and Management Executive, regular reporting on progress against strategy. - Joint working with the University of Cambridge (UoC) to deliver new research infrastructure through the development and operation of the Victor Phillip Dahdaleh Heart and Lung Research Institute Clinical Research Facility (VPD-HLRI CRF). The Trust partners with the UoC through joint management groups and a joint strategic group to oversee the direction of the CRF, in support the Trust's wider research strategy. - Strategic partnership with CUH, governed through a Joint Strategic Board and Executive led sub groups / workstreams. Workstreams have been informed by an independent external reporting which outlined barriers to collaboration and areas for joint working. CUH and RPH programme managers supporting their respective executive teams meet every fortnight to review progress across both organisations regarding the six clinical pathways identified for collaboration. This remains a recurrent meeting to enable opportunities for informal discussions, escalations, and updates in order to facilitate and support clinical teams across both organisations to progress work. - Broadening partnerships with industry and the University. - Collaboration with UoC on Total Body Positron Emission Tomography (TB PET) bid. - Work starting with other trusts across the East of England on the specialist provider collaborative, focused on improving access to specialist care within the region, including exploring opportunities to collaborate on research and innovation.
Risk Assessors recommended actions to further reduce the risk	Further work with Campus neighbours to extend partnerships to new areas as part of wider CUHP and CBC vision, supporting Cambridge Life Science. Further work with CUH to progress clinical and non-clinical areas of collaboration, including decision on EPR and implications for joint programmes.
Assurance	Minutes of Joint CUH RPH Strategic Boards. Minutes, action logs, escalations from Joint Clinical Pathways Group feeding into Joint CUH RPH Strategic Board. Workstream reports part of Joint Strategy Board. - Regular updates to Board on CBC Ltd and CUHP. - Executives participating in CBC Ltd working group on Campus development proposals and appropriate ICS and regional NHS groups. - Joint strategy / management group with UoC re. VPD-HLRI / CRF. - External input / expertise from NHS, academic and industry partners to provide advice and challenge.
Gaps in Assurance	The capacity and commitment of partner organisations to make the most of our collective opportunities and how we jointly work through differences in priorities.
Levels of Assurance (182)	Adequate
BAF risks - Does this risk have an action plan on Datix? (179)	
Progress notes	[Morrish, Katie - 14/10/2024] Joint working groups on bronchoscopy, blood transfusion and Acute coronary syndrome (ACS) treat and return continue meeting regularly with executive oversight through the Joint Strategic Booard (JSB). Next JSB on 15 October 2024
Committee Responsible for the Risk	Strategic Projects Committee, The Board
Date last reviewed	14/10/2024
Review date	14/11/2024
Directorate	Trust wide - All Directorates Involved
Trust Objectives 2022-24	1. Deliver clinical excellence, 2. Grow pathways with partners

ID	3536
Manager	Raynes, Andrew
Handler	Wayne, Ford
Opened	20/06/2024
Consequence (current)	Possible - 3
Likelihood (current)	Possible - 3
Risk level (current)	High Risk
Risk level (Target)	High Risk
Rating (current)	9
Description	"IF" the trust is underprepared to recover from a digital incident. "THEN" the risk of recovering from the major incident event increases. "ULTIMATELY" This event could cause impact on accessing systems and cause disruption at organisation level that leads to delay in providing care to patients. The impact may last for days, necessitating cancellations and delays to treatment. Additionally, it poses a risk to patient care that can be given and in rare cases even loss of life.
Controls in place	The Trust has considered and taken the following set of activities to reduce the risk: 1. Critical systems are identified as per the business needs 2. Systems are backed up at regular intervals and tapes are also stored in a safe location and can be accessed when required 3. Disaster recovery plan is in place to ensure that data can be restored back to production systems. 4. Continuous review is being conducted to update business impact analysis and to maintain business continuity plan 5. Regular engagement and communication is being carried out between business, emergency response and digital teams 6. Staff are informed about Business Continuity Plan (BCP) process via monthly staff briefing and also messages are communicated to staff using intranet, NewsBites and through Screensavers.
Risk Assessors recommended actions to further reduce the risk	1.Ensure that trust adopts feasible, compatible backup procedures and facilities. 2.Train digital team to ensure that they are well prepared to implement the plan and to withstand disasters. 3.Establish regular meetings with digital team and emergency response team to ensure that best practices are followed.
Assurance	• Ongoing Work to create robust Disaster recovery Plan • Business continuity planning in conjunction with EPRR • Up to date fully functional Backup Strategy • Off site immutable Data storage
Gaps in Assurance	No real time Disaster recovery testing to ensure our plans work as expected.
Levels of Assurance (182)	Adequate
BAF risks - Does this risk have an action plan on Datix? (179)	
Progress notes	[Ford, Wayne - 09/10/2024] No Change. But work is continuing on creating the Digital BCP and the Cyber Response Policy
Committee Responsible for the Risk	Digital Strategic Board, IG Steering Group, Performance Committee, The Board
Date last reviewed	09/10/2024
Review date	09/11/2024
Directorate	Digital
Trust Objectives 2022-24	1. Deliver clinical excellence, 6. Achieve sustainability