To:	**Trust Board**
From:	**Chief Nurse/ Deputy Chief Executive**
Date:	**25 April 2013**
CQC regulation:	Outcome 16 – Assessing and Monitoring the Quality of Service Provision

Title:	**UHL BOARD ASSURANCE FRAMEWORK (BAF) 2012/13**

Author/Responsible Director: Chief Nurse/Deputy Chief Executive

Purpose of the Report:
To provide the Board with an updated BAF for assurance and scrutiny.

The Report is provided to the Board for:

Decision		Discussion	**X**
Assurance	**X**	Endorsement	

Summary / Key Points:

- 11 actions were due for completion in March 2013 and of these, 8 have been completed and 3 have deadlines that have been extended.

- There have been no changes to BAF risk scores since the previous month, however following delivery of the £46k year end surplus (subject to accounts sign-off by Internal Audit) the Board is asked to advise as to whether the score assigned to risk 8 (failure to achieve financial sustainability) should be reduced from 25.

- Following recommendations from RSM Tenon the Board is asked to advise of any other relevant external sources of assurance that could be included on future iterations of the BAF.

- A further recommendation asks the Board to consider and advise whether ranking the BAF risks by strategic objective would add any more value than retaining the current risk score ranking system.

- Board members are invited to review the following risks:
  Risk 2: Business Continuity.
  Risk 4: Failure to transform the emergency care system.
  Risk 12: Inadequate reconfiguration of buildings and services.

Recommendations

Taking into account the contents of this report and its appendices the Board is invited to:

(a) review and comment upon this iteration of the BAF, as it deems

appropriate:

(b) note the actions identified within the framework to address any gaps in either controls or assurances (or both);

(c) identify any areas in respect of which it feels that the Trust's controls are inadequate and do not, therefore, effectively manage the principal risks to the organisation meeting its objectives;

(d) identify any gaps in assurances about the effectiveness of the controls in place to manage the principal risks; and consider the nature of, and timescale for, any further assurances to be obtained, in consequence;

(e) identify any other actions which it feels need to be taken to address any 'significant control issues' to provide assurance on the Trust meeting its principal objectives;

(f) With reference to section 2.4 of this report; to advise as to whether the current risk score of 25 assigned to risk number 8 should be reduced.

Previously considered at another corporate UHL Committee? **No**	
Strategic Risk Register **Yes**	**Performance KPIs year to date** **No**
Resource Implications (e.g. Financial, HR) **N/A**	
Assurance Implications **Yes**	
Patient and Public Involvement (PPI) Implications **Yes.**	
Equality Impact **N/A**	
Information exempt from Disclosure **No**	
Requirement for further review? **Yes. Monthly at Executive Team and Board meetings.**	

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST

REPORT TO: **TRUST BOARD**

DATE: **25 APRIL 2013**

REPORT BY: **CHIEF NURSE/ DEPUTY CHIEF EXECUTIVE**

SUBJECT: **UHL BOARD ASSURANCE FRAMEWORK (BAF) 2012/13**

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1. INTRODUCTION

1.1 This report provides the Board with:-

a) A copy of the Board Assurance Framework (BAF) as of 31 March 2013.
b) A heat map of risk movements from the previous month.
c) A summary of progress of actions due for completion in the reporting period.
d) Suggested parameters for scrutiny of the BAF.

2. POSITION AS OF 31 MARCH 2013

2.1 An updated version of the BAF is attached at appendix 1 with changes from the previous report highlighted in red text.

2.2 A heat map to show the trend of BAF risk scores from the previous month is attached at appendix 2.

2.3 There are 11 actions that were due for completion in March 2013 and of these, 8 have been completed and 3 have had deadlines extended. (See appendix 3 for further details).

2.4 Following the delivery of the £46k year end surplus (subject to accounts sign-off by Internal Audit) the Board is asked to advise as to whether the current risk score assigned to risk 8 (failure to achieve financial sustainability) should be reduced from its score of 25.

2.5 A key element of the BAF is to assure the Board that control mechanisms are effective and the assurances provided are designed to demonstrate this. A recommendation from the RSM Tenon governance review is to *'provide a greater range of assurances for inclusion in the BAF. Assurances should include wherever possible external audits, clinical audits, reports from external inspectorates, etc'*. The Risk and Assurance Manager has included a number of external sources of assurance in this iteration of the BAF such as:

- PbR audit and Information Governance Toolkit audits in relation to accuracy of clinical coding,
- UHL involvement in eligible national audits and national confidential enquiries (100% involvement during 2012/13).
- Review of SHMI and other mortality data by Boston Consultancy Group.

The Board are asked to advise of any other relevant external sources of assurance that could be included on future iterations of the BAF.

2.6 A further recommendation from RSM Tenon asks the Trust to *'consider renaming the SRR/BAF the BAF and ranking risks by strategic goal or objective rather than by risk rating'.* The renaming of the BAF has been agreed however the Board are asked to consider and advise whether ranking the risks by strategic objective would add any more value than retaining the current risk score ranking system.

2.7 To provide scrutiny of BAF risks on a cyclical basis, Board members are invited to review the following risks against the parameters listed in appendix 4.

Risk 2: Business Continuity.
Risk 4: Failure to transform the emergency care system.
Risk 12: Inadequate reconfiguration of buildings and services.

NB. In light of continued pressure within the Emergency Department (ED) risk number 4 is being submitted for review outside of its normal sequencing.

3. RECOMMENDATIONS

3.1 Taking into account the contents of this report and its appendices the Board is invited to:

(a) review and comment upon this iteration of the BAF, as it deems appropriate:

(b) note the actions identified within the framework to address any gaps in either controls or assurances (or both);

(c) identify any areas in respect of which it feels that the Trust's controls are inadequate and do not, therefore, effectively manage the principal risks to the organisation meeting its objectives;

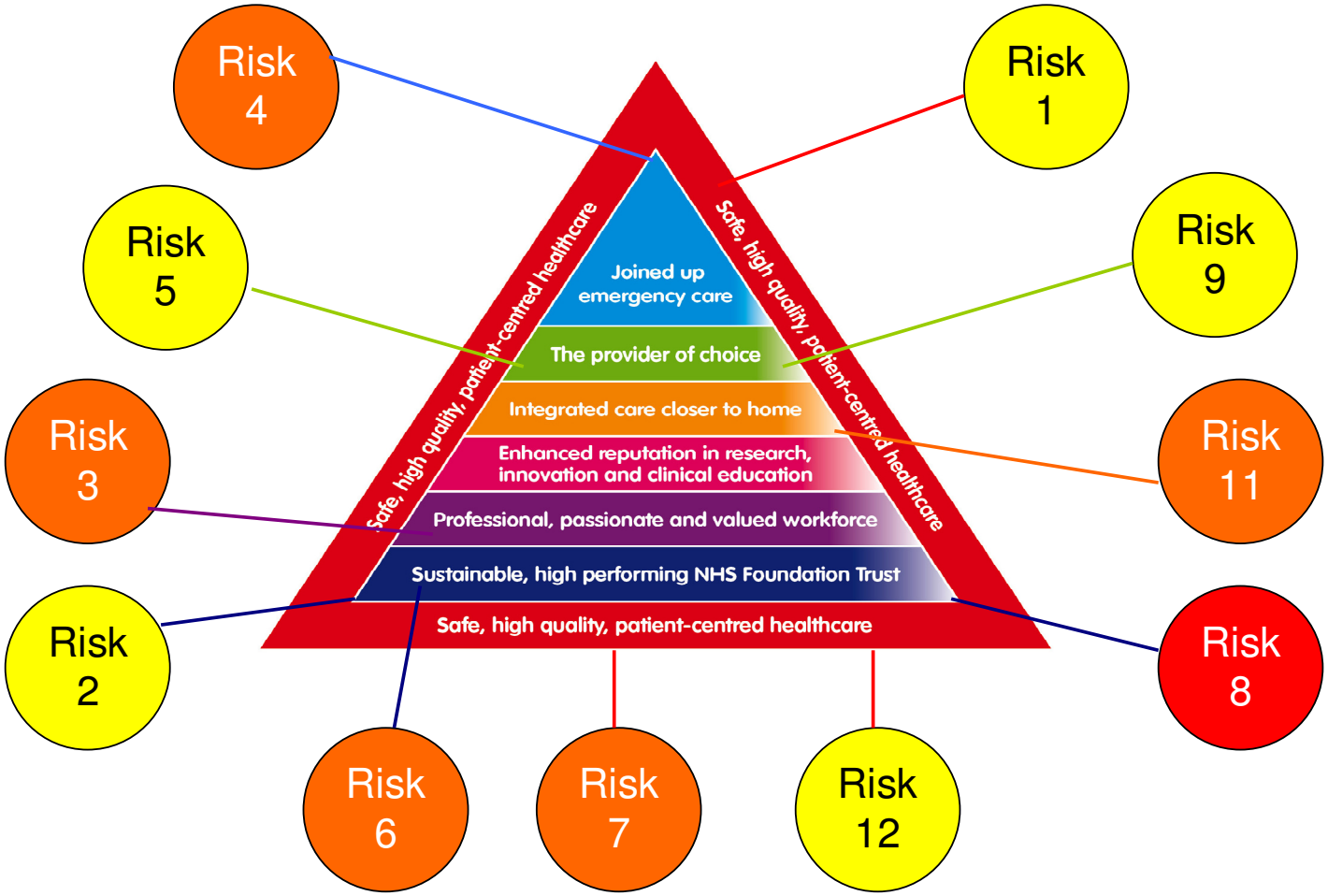
(d) identify any gaps in assurances about the effectiveness of the controls in place to manage the principal risks; and consider the nature of, and timescale for, any further assurances to be obtained, in consequence;

(e) identify any other actions which it feels need to be taken to address any 'significant control issues' to provide assurance on the Trust meeting its principal objectives;

(f) With reference to section 2.4 of this report; to advise as to whether the current risk score of 25 assigned to risk number 8 should be reduced.

Peter Cleaver,
Risk and Assurance Manager,
18 April 2013.

BOARD ASSURANCE FRAMEWORK - MARCH 2013



N.B. Action dates are end of month unless otherwise stated

PERIOD: 1 MARCH – 31 MARCH 2013

RISK TITLE	STRATEGIC OBJECTIVE	CURRENT SCORE	TARGET SCORE
Risk 8 – failure to achieve financial sustainability	g - To be a sustainable, high performing NHS Foundation Trust	25	12
Risk 4 – failure to transform the emergency care system	b - To enable joined up emergency care	20	12
Risk 3 – inability to recruit, retain, develop and motivate staff	f - To maintain a professional, passionate and valued workforce e - To enjoy an enhanced reputation in research, innovation and clinical education.	16	12
Risk 7 – ineffective organisational transformation	a - To provide safe, high quality patient-centred health care	16	12
Risk 6 – failure to achieve FT status	g - To be a sustainable, high performing NHS Foundation Trust	16	12
Risk 11 – failure to maintain productive relationships	d - To enable integrated care closer to home	15	10
Risk 9 – failure to achieve and sustain operational targets	c - To be the provider of choice	12	12
Risk 12 – inadequate reconfiguration of buildings and services	a - To provide safe, high quality patient-centred health care	12	9
Risk 1 - reducing avoidable harms	a - To provide safe, high quality patient-centred health care	12	6
Risk 5 – patient experience/ satisfaction	c - To be the provider of choice	12	6
Risk 2 – business continuity	g - To be a sustainable, high performing NHS Foundation Trust	9	6

STRATEGIC OBJECTIVES:-

a. To provide safe, high quality patient-centred health care.
b. To enable joined up emergency care.
c. To be the provider of choice.
d. To enable integrated care closer to home.
e. To enjoy an enhanced reputation in research, innovation and clinical education
f. To maintain a professional, passionate and valued workforce
g. To be a sustainable, high performing NHS Foundation Trust.

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST – BOARD ASSURANCE FRAMEWORK

RISK NUMBER/ TITLE:	**RISK 8 – FAILURE TO ACHIEVE FINANCIAL SUSTAINABILITY**
LINK TO STRATEGIC OBJECTIVE(S)	**To be a sustainable, high performing NHS Foundation Trust.**
EXECUTIVE LEAD:	Director of Finance and Business Services

Principal Risk (What could prevent the objective(s) being achieved)	**What are we doing about it?** **(Key Controls)** What control measures or systems we have in place to assist secure delivery of the objective (describe process rather than management group)	**Current Score I x L**	**How do we know we are doing it?** **(Key Assurances of controls)** Provide examples of recent reports considered by Board or committee where delivery of the objectives is discussed and where the board can gain evidence that controls are effective.	**What are we not doing?** **(Gaps in Controls C) / Assurance (A)** What gaps in systems, controls and assurance have been identified?	**How can we fill the gaps or manage the risk better?** **(Actions to address gaps)**	**Target Score I x L**	**Timescale** When will the action be completed?
Failure to achieve financial sustainability including:	Overarching financial governance processes including PLICS process and expenditure controls	5X5=25	Monthly /weekly financial reporting to Exec Team, F&P Committee and Board Cost centre reporting and monthly PLICS reporting Annual internal and external audit programmes Comparison with PLICS benchmarking against other NHS organisations Prior to accounts sign-off by Audit, the year end surplus of £46K has been achieved.			4x3=12	
Failure to achieve CIP	Strengthened CIP governance structure		Progress in delivery of CIPs is monitored by CIP Programme Board (meeting fortnightly) and reported to ET and Board.	(c) CIP shortfall of £4.6m.			
Locum expenditure	Workforce plan to identify effective methods to recruit to 'difficult to fill' areas Reinstatement of weekly workforce panel to approve all new posts. STAFFflow for medical locums saving £130k of every £1m expenditure		The use of locum staff in 'difficult to fill' areas is reported to the Board on a monthly basis via the Quality and Performance report. A reduction in the use of such staff would be an assurance of our success in recruiting substantive staff to 'difficult to fill' areas. Increase in substantive staff of 200wte to Oct 12. Saving in excess of £0.6m 5 weeks after 'go live' date	(c) Failure to reduce locum spend. 587 wte locum staff currently used			

Loss of income due to tariff/tariff changes (including referral rate for emergency admissions – MRET)	Contract meetings with Commissioners Negotiations with Commissioners concluded at a transactional level		Monthly /weekly financial reporting to Finance and Performance (F&P) Committee and Board	(c) Failing to manage marginal activity efficiently and effectively			
Ineffective processes for Counting and Coding	Clinical coding project		Ad-Hoc reports on annual counting and coding process. PbR clinical coding audit Jan 2013 (final report awaited). IG toolkit audit (sample of 200 General Surgery episodes).	(c) Error rates identified as: Primary diagnoses incorrect 8.0% › Secondary diagnoses incorrect 3.6% › Primary procedure incorrect 6.4% › Secondary procedure incorrect 4.5%			
Loss of liquidity	Liquidity Plan		Monthly /weekly financial reporting to Finance and Performance (F&P) Committee and Board				
Lack of robust control over non-pay expenditure	Non-pay action plan (agreed by F&P Committee) Catalogue control project		Monthly /weekly financial reporting to Finance and Performance (F&P) Committee and Board. Ongoing Monitoring via F&P Committee	(c) Failing to control adverse trends in non-pay (running ahead of activity growth). YTD non-pay expenditure £15.7m adverse to plan			Mar 2013 Director of Finance and Business Services
Commissioner fines against performance targets	Contract meetings with Commissioners Negotiations with Commissioners concluded at a transactional level		Monthly /weekly financial reporting to Finance and Performance (F&P) Committee and Board	(c) Failing to reduce readmission trends. YTD readmission rate 7.8% (M10 7.6%)	Divisions to develop plans and trajectories to be monitored at monthly C&C meetings		April 2013 Director of Operations
Use of readmission monies	Contract meetings with Commissioners Negotiations with Commissioners concluded at a transactional level		Monthly /weekly financial reporting to Finance and Performance (F&P) Committee and Board	(c) Failing to reduce readmission trends			
Ineffective organisational transformation	See risk 7		See risk 7	See risk 7	See risk 7		

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST – BOARD ASSURANCE FRAMEWORK

RISK NUMBER/ TITLE:	**RISK 3 – INABILITY TO RECRUIT, RETAIN, DEVELOP AND MOTIVATE STAFF**
LINK TO STRATEGIC OBJECTIVE(S))	**To maintain a professional, passionate and valued workforce** **To enjoy an enhanced reputation in research, innovation and clinical education**
EXECUTIVE LEAD:	Director of Human Resources

Principal Risk (What could prevent the objective(s) being achieved)	**What are we doing about it?** **(Key Controls)** What control measures or systems we have in place to assist secure delivery of the objective (describe process rather than management group)	**Current Score I x L**	**How do we know we are doing it?** **(Key Assurances of controls)** Provide examples of recent reports considered by Board or committee where delivery of the objectives is discussed and where the board can gain evidence that controls are effective.	**What are we not doing?** **(Gaps in Controls C) / Assurance (A)** What gaps in systems, controls and assurance have been identified?	**How can we fill the gaps or manage the risk better?** **(Actions to address gaps)**	**Target Score I x L**	**Timescale** When will the action be completed?
Inability to recruit, retain, develop and motivate suitably qualified staff leading to inadequate organisational capacity and development.	Leadership and talent management programmes to identify and develop 'leaders' within UHL	4x4=16	Development of UHL talent profiles	No gaps identified	No actions required	4x3=12	
			Talent profile update reports to Workforce and OD Committee	No gaps identified	No actions required		
	Substantial work program to strengthen leadership contained within OD Plan			No gaps identified	No actions required		
	Organisational Development (OD) plan		A central enabler of delivering against the OD Plan work streams will be adopting, 'Listening into Action (LiA)' and progress reports on the LiA will be presented to the Trust Board on a quarterly basis.	(a) A potential measure of the number of applicants received for advertised posts may be a useful future assurance of the success of the OD plan	To develop a monitoring and reporting process		Jun 2013 Director of HR
	Workforce and OD Committee to monitor progress and oversee implementation of OD plan A central enabler of delivering against the OD Plan work streams will be adopting, 'Listening into Action (LiA)'. A Sponsor Group personally led by our Chief Executive and including, Executive Leads and other key clinical influencers has been established.		Quarterly progress reports to Board via Workforce and OD Committee Progress reports on the LiA will be presented to the Trust Board on a quarterly basis.	No gaps identified No gaps identified	No actions required No actions required		

	Staff engagement action plan encompassing six integrated elements that shape and enable successful and measurable staff engagement		Results of National staff survey and local patient polling reported to Board via Workforce and OD Committee on a six monthly basis. Improving staff satisfaction position. Staff sickness levels may also provide an indicator of staff satisfaction and targets for staff sickness rates are close to being achieved (3.8% at Month 11, 3.4% over a rolling 12 month period)	No gaps identified No gaps identified	No actions required No actions required		
	Appraisal and objective setting in line with UHL strategic direction		Appraisal rates reported monthly to Board via Quality and Performance report. Current rates 91.1% at end of month 11 (increase of 0.6% over previous month). Results of quality audits to ensure adequacy of appraisals reported to the Board via the Workforce and OD Committee. Quality Assurance Framework to monitor appraisals on an annual cycle (next due March 2013).	No gaps identified No gaps identified No gaps identified	No actions required No actions required No actions required		
	Workforce plan to identify effective methods to recruit to 'difficult to fill areas). Divisions and Directorates 2013/14 Workforce Plans		The use of locum staff in 'difficult to fill' areas is reported to the Board on a monthly basis via the Quality and Performance report. A reduction in the use of such staff would be an assurance of our success in recruiting substantive staff to 'difficult to fill' areas.	No gaps identified	No actions required		
	Reward /recognition strategy and programmes (e.g. salary sacrifice, staff awards, etc)			(a) Reward and recognition strategy requires revision to include how we will provide assurance in the future that reward and recognition programmes are making a difference to staffing recruitment/ retention/ motivation.	Revise strategy		Jun 2013 Director of HR
	UHL Branding – to attract a wider and more capable workforce. Includes development of recruitment literature and website, recruitment events, international recruitment. This includes a recently held nurse recruitment day (Jan 2013)		Evaluate recruitment events and numbers of applicants. Reports issued to Nursing Workforce Group (last report 4 Feb). Report to Workforce and OD Committee in March. Positive feedback from nurse recruitment day on 26 Jan 2013	(a) Better baselining of information to be able to measure improvement. (c) Lack of engagement in production of website material	Take baseline from January and measure progress now that there is a structured plan for bulk recruitment. Identify a lead from each professional group to develop and encourage the production of fresh and up to date material		Dec 2013 Director of HR

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST – BOARD ASSURANCE FRAMEWORK

RISK NUMBER/ TITLE:	**RISK 4 – FAILURE TO TRANSFORM THE EMERGENCY CARE SYSTEM**
LINK TO STRATEGIC OBJECTIVE(S)	**To enable joined up emergency care.**
EXECUTIVE LEAD:	Director of Operations

Principal Risk (What could prevent the objective(s) being achieved)	**What are we doing about it?** **(Key Controls)** What control measures or systems we have in place to assist secure delivery of the objective (describe process rather than management group)	**Current Score I x L**	**How do we know we are doing it?** **(Key Assurances of controls)** Provide examples of recent reports considered by Board or committee where delivery of the objectives is discussed and where the board can gain evidence that controls are effective.	**What are we not doing?** **(Gaps in Controls C) / Assurance (A)** What gaps in systems, controls and assurance have been identified?	**How can we fill the gaps or manage the risk better?** **(Actions to address gaps)**	**Target Score I x L**	**Timescale** When will the action be completed?
Failure to transform emergency care system leading to demands on ED and admissions units continuing to exceed capacity.	LLR emergency Care Network Project to reduce emergency attendances and ensure maximum use of the Urgent care centre.	4x5=20	Monthly report to Trust Board in relation to Emergency Dept (ED) flow.	ED performance UHL (+ UCC) Type 1 and 2 = 92.6% YTD (M11). UHL Type 1 and 2 = 90.7% YTD (M11) In month (M 11) UHL (+ UCC) Type 1 and 2 = 86.1%. UHL Type 1 and 2 = 82.2%		4x3=12	
	Increased recruitment of ED Medical and nursing staff.		Monthly Quality and Performance summary report to TB including use of locum staff.	(c) Difficulties are being encountered in filling vacancies within the emergency care pathway. Agency and bank requests continue to increase in response to increasing sickness rates, additional capacity, and vacancies.	Continued fortnightly meetings with HR to highlight delays and solutions in the recruitment process. Continue to advertise for permanent and locum consultant positions.		Review of progress May 2013 Director of Operations Review of progress May 13 Director of Operations
	LLR Emergency Plan to ensure that delays to transfer of care are minimised.		Monthly report to Trust Board in relation to Emergency Dept (ED) flow. 169 delayed episodes of transfer of Care (M11). Reduction of 111 from M10.	(c) Lack of availability of rehabilitation beds for increasing numbers of patients			
	Emergency Care Pathway Programme to enable a comprehensive and co-ordinated approach to the design and implementation of process improvements across the end-to-end patient flow for our ED attendees and medical non-elective patients.		Monthly report to Trust Board in relation to Emergency Dept (ED) flow.	(c) ED performance against target not being sustained. *'What is not working'* key themes are Resourcing, Clinical Leadership, Untimely flow onto base wards and Entrenched behaviours.	Via key stakeholders (medical, nursing and managerial) enforce steps to address the core issues:		Director of Operations Apr 2013

	Metrics in place in relation to AMU assessment process.		'Time to see consultant' metric included in National ED quarterly indicator.	No gaps identified	No actions required		

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST – BOARD ASSURANCE FRAMEWORK

RISK NUMBER/ TITLE:	**RISK 7 – INEFFECTIVE ORGANISATIONAL TRANSFORMATION**
LINK TO STRATEGIC OBJECTIVE(S)	**To provide safe, high quality patient-centred health care.**
EXECUTIVE LEAD:	Director of Finance and Business Services

Principal Risk (What could prevent the objective(s) being achieved)	**What are we doing about it?** **(Key Controls)** What control measures or systems we have in place to assist secure delivery of the objective (describe process rather than management group)	Current Score I x L	**How do we know we are doing it?** **(Key Assurances of controls)** Provide examples of recent reports considered by Board or committee where delivery of the objectives is discussed and where the board can gain evidence that controls are effective.	**What are we not doing?** **(Gaps in Controls C) / Assurance (A)** What gaps in systems, controls and assurance have been identified?	**How can we fill the gaps or manage the risk better?** **(Actions to address gaps)**	Target Score I x L	**Timescale** When will the action be completed?
Ineffective organisational transformation preventing the development of safer, more effective and productive services. Among other consequences this will impact on the Trust's FT timeline.	Clinical strategy	4x4=16	CIP Programme Board monitors project plans associated with clinical strategy to ensure achievement of key milestones. Good progress in development of 2013/14 CIP plans.	(c) Shortfall on delivery of projects in 2012/13	Interim transformation resources	4x3=12	Apr 2013 Director of Finance and Business Services
	Transformation Board/ team including Interim Director of Service Development						
	Managed Business Partner for IM&T services to deliver IT that will be a key enabler for our clinical strategy.		MBP programme board monitors defined KPIs for 'Lot 1 services'. Non-compliance with KPIs reported to Board	(c) New systems (lot 2) not yet specified	'Lot 2' systems replacement plan to be developed		2013/14 Director of Finance and Business Services
	Development of lean processes improvement capability to deliver more efficient and effective services and greater patient / staff satisfaction. Head of Process Improvement now in post (Jan '13)		Board monitoring of patient and staff survey results. Improved levels of patient / staff satisfaction are expected when lean processes are embedded	(c) Slow start to process improvement initiatives	Board level sponsorship and Leadership		Apr 2013 Director of Finance and Business Services
	Estates Strategy including award of FM contract to private sector partner to deliver an Estates solution that will be a key enabler for our clinical strategy in relation to clinical adjacencies		Facilities Management Co-operative (FMC) will monitor FM contract against agreed KPIs to provide assurance of successful service	No gaps identified	No actions required		

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST – BOARD ASSURANCE FRAMEWORK

RISK NUMBER/ TITLE:	**RISK 6 – FAILURE TO ACHIEVE FT STATUS**
LINK TO STRATEGIC OBJECTIVE(S)	**To be a sustainable, high performing NHS Foundation Trust.**
EXECUTIVE LEAD:	Chief Executive Officer

Principal Risk (What could prevent the objective(s) being achieved)	**What are we doing about it?** **(Key Controls)** What control measures or systems we have in place to assist secure delivery of the objective (describe process rather than management group)	**Current Score I x L**	**How do we know we are doing it?** **(Key Assurances of controls)** Provide examples of recent reports considered by Board or committee where delivery of the objectives is discussed and where the board can gain evidence that controls are effective.	**What are we not doing?** **(Gaps in Controls C) / Assurance (A)** What gaps in systems, controls and assurance have been identified?	**How can we fill the gaps or manage the risk better?** **(Actions to address gaps)**	**Target Score I x L**	**Timescale** When will the action be completed?
Failure to achieve Foundation Trust (FT) Status within specified timescale (April 2015)	FT Programme Board provides strategic direction and monitors the FT application programme	4x4=16	Monthly progress against the FT programme is reported to the Board to provide oversight.	No gaps identified	No actions required	4x3=12	
	FT Workstream group of Executive and operational Leads to ensure delivery of IBP and evidence to support HDD1 and 2 processes		Feedback from external assessment of application progress by SHA (readiness review meeting Dec 2012	No gaps identified	No actions required		
	FT application project plan / project team in place FT Integrated Development Plan		Achievement against the key milestones set out in UHL's TFA is reported to the Trust Board and Trust Development Authority (TDA) on a monthly basis through the trust over-sight self certification	(c) Development of LLR Clinical Strategy and Site and Service Reconfiguration Proposals not fully achieved	Collaborative delivery programmes; establishing robust governance structures (programme director and collaborative delivery teams) to be agreed at BCT Board meeting 18/4/13		Chief Executive Apr 2013

	Outcome of the LLR Better Care Together (BCT) economic modelling reported to all partner organisations.			(c)Confirmation of specific LLR reconfiguration priorities over a 3 year time horizon not fully achieved.	Collaborative delivery programmes to be agreed by the BCT Board / partner organisations		Chief Executive Apr 2013
				(c)Draft pre-consultation Business Case considered by Trust Boards not fully achieved.	Statutory consultation to commence Jun 2013 pending the output of the economic modelling and agreement of the resulting LLR wide plans		Chief Executive Jun 2013
					BCT communication and engagement plans to be developed for collaborative delivery programmes June/July 2013.		Chief Executive Jun/Jul 2013
				(c) Formal Consultation on LLR Reconfiguration Proposals not fully achieved	Consultation timescales to be agreed pending defining the scope of the delivery programmes.		Chief Executive Aug 2013
				(c)UHL Clinical Strategy developed but preferred options costs not yet identified	Service developments underpinning the Trust's Clinical Strategy will be costed as further iterations of the IBP / LTFM are Developed		Chief Executive Review May 2013
					Integrate outcome of the BCT economic modelling into UHL's improvement framework / future configuration of services		Chief Executive Jun 2013
			Feedback and recommendations from the independent reviews against the Quality Governance Framework and the Board Governance Framework	(c) Independent reports identify a number of recommendations	Action plans in place to address recommendations from independent reviews		Chief Executive Review Jun 2013
	Monitoring of KPIs in particular in relation to financial position and ED performance that are crucial for a successful FT application		Monthly Finance and Performance report to Board Achievement against the governance and finance risk rating based on Monitors Compliance Framework is reported to the Trust board and the TDA on a monthly basis through the trust oversight self certification.	c) Significant financial variance from plan (c) Underperformance in relation to ED targets	See actions associated with risk number 8 Transform emergency care system to reduce demand and increase footprint of ED (see risk 4)		During 2013/14 Chief Executive Officer

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST – BOARD ASSURANCE FRAMEWORK

RISK NUMBER/ TITLE:	**RISK 11 – FAILURE TO MAINTAIN PRODUCTIVE RELATIONSHIPS**
LINK TO STRATEGIC OBJECTIVE(S)	**To enable integrated care closer to home.**
EXECUTIVE LEAD:	Director of Communications and External Relations

Principal Risk (What could prevent the objective(s) being achieved)	**What are we doing about it?** **(Key Controls)** What control measures or systems we have in place to assist secure delivery of the objective (describe process rather than management group)	**Current Score I x L**	**How do we know we are doing it?** **(Key Assurances of controls)** Provide examples of recent reports considered by Board or committee where delivery of the objectives is discussed and where the board can gain evidence that controls are effective.	**What are we not doing?** **(Gaps in Controls C) / Assurance (A)** What gaps in systems, controls and assurance have been identified?	**How can we fill the gaps or manage the risk better?** **(Actions to address gaps)**	**Target Score I x L**	**Timescale** When will the action be completed?
Failure to maintain productive relationships with external partners/ stakeholders leading to potential loss of activity and income, poor reputation and failure to retain/ reconfigure clinical services	Stakeholder Engagement Strategy Regular meetings with external stakeholders and Director of Communications and member of Executive Team to identify and resolve concerns Regular stakeholder briefing provided by an e-newsletter to inform stakeholders of UHL news Leicester, Leicestershire and Rutland (LLR) health and social care partners have committed to a collaborative programme of change known as the 'Better Care Together' programme	5X3=15	Twice yearly GP surveys with results reported to UHL Executive Team	(a) No surveys undertaken to identify relationship issues. Anecdotal feedback only.	Productive relationships with CCGs are likely to improve further only if UHL performance around ED improves therefore the target score is dependent upon actions from other risks within this document being taken	5X2=10	Dependant upon actions associated with other risks

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST – BOARD ASSURANCE FRAMEWORK

RISK NUMBER/ TITLE:	**RISK 9 – FAILURE TO ACHIEVE AND SUSTAIN OPERATIONAL TARGETS**
LINK TO STRATEGIC OBJECTIVE(S)	**To be the provider of choice.**
EXECUTIVE LEAD:	Director of Operations

Principal Risk (What could prevent the objective(s) being achieved)	**What are we doing about it?** **(Key Controls)** What control measures or systems we have in place to assist secure delivery of the objective (describe process rather than management group)	**Current Score I x L**	**How do we know we are doing it?** **(Key Assurances of controls)** Provide examples of recent reports considered by Board or committee where delivery of the objectives is discussed and where the board can gain evidence that controls are effective.	**What are we not doing?** **(Gaps in Controls C) / Assurance (A)** What gaps in systems, controls and assurance have been identified?	**How can we fill the gaps or manage the risk better?** **(Actions to address gaps)**	**Target Score I x L**	**Timescale** When will the action be completed?
Failure to achieve and sustain operational targets leading to contractual penalties, patient dissatisfaction and poor reputation.	Backlog plans to recover 18 week referral to treatment (RTT) target	4x3=12	Monthly Q&P report to Trust Board showing 18 week RTT rates. RTT admitted and non-admitted rates favourable against target (91.9% and 96.9% respectively for month 11)	No gaps identified	No actions required	4x3=12	
	Referral pathways to decrease demand and ensure discharge to GP where appropriate			(a) Lack assurance in relation to performance metrics to show activity versus number of patients deferred onto a different care pathway.	Development of key metrics at a local level		Review Apr 13
	Transformational theatre project to improve theatre efficiency to 80 -90%		Monthly theatre utilisation rates	No gaps identified	No actions required		
	Emergency Care process redesign (phase 1) implemented 18 February 2013 to improve and sustain ED performance.		Monthly report to Trust Board in relation to Emergency Dept (ED) flow (including 4 hour breaches)	See risk number 4	See risk number 4		

	Each tumour site has developed action plans to achieve targets. (Expected that target of 85% to be delivered by April 2013)		Director of Operations receives reports from Cancer Manager and information included within Monthly Q&P report to Trust Board	62 day cancer target delivery 79.4% (M11). This equates to 7.5 breaches too many	Urgent assessment of the gap between what is required and what is provided. Planned care to perform urgent review of Cancer Centre management structure to ensure ownership of entire cancer pathway at tumour site level. Consider inviting NHS Interim Management and Support team to review and advise in relation to process.		Apr 2013 Director of Operations Apr 2013 Director of Operations Apr 2013 Director of Operations
	Ongoing monitoring of key performance indicators		Monthly Q&P report to Trust Board	No gaps identified	No actions required		
	Outpatient delivery plan to reduce cancellation rates has been developed and circulated to Divisions for inclusion in their CIP plans			(c) Not reducing cancellation rates for outpatients appointments	Continued monitoring of outpatient delivery plan		Review May 2013 Director of Operations

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST – BOARD ASSURANCE FRAMEWORK

RISK NUMBER/ TITLE:	**RISK 12 – INADEQUATE RECONFIGURATION OF BUILDINGS AND SERVICES**
LINK TO STRATEGIC OBJECTIVE(S)	**To provide safe, high quality patient-centred health care**
EXECUTIVE LEAD:	Chief Executive Officer

Principal Risk (What could prevent the objective(s) being achieved)	**What are we doing about it?** **(Key Controls)** What control measures or systems we have in place to assist secure delivery of the objective (describe process rather than management group)	**Current Score I x L**	**How do we know we are doing it?** **(Key Assurances of controls)** Provide examples of recent reports considered by Board or committee where delivery of the objectives is discussed and where the board can gain evidence that controls are effective.	**What are we not doing?** **(Gaps in Controls C) / Assurance (A)** What gaps in systems, controls and assurance have been identified?	**How can we fill the gaps or manage the risk better?** **(Actions to address gaps)**	**Target Score I x L**	**Timescale** When will the action be completed?
Inadequate reconfiguration of buildings and services leading to less effective use of estate and services.	Clinical Strategy	3x4=12		(a) Key measures to demonstrate success of strategy and reporting lines not yet identified	Key measures for gauging success of strategy to be developed by specialties as part of their 'mini-IBPs' and will be monitored via divisional and directorate boards.	3X3=9	December 2013 Medical Director
	Estates Strategy including award of FM contract to private sector partner to deliver an Estates solution that will be a key enabler for our clinical strategy in relation to clinical adjacencies		Facilities Management Co-operative (FMC) will monitor against agreed KPIs to provide assurance of successful outsourced service	(c) Estates plans not fully developed to achieve the strategy. (c) The success of the plans will be dependent upon capital funding and successful FT application	Ensure success of FT Application (see risk 6 for further detail) Secure capital funding		Apr 2015 Chief Executive Officer May 2013 Director of Finance and Business Services
	Divisional service development strategies and plans to deliver key developments		Progress of divisional development plans reported to Service Reconfiguration Board.	No gaps identified	No actions required		
	Service Reconfiguration Board			Requirement for more regular ET oversight and decision making	Establish monthly ET Strategy Session		Apr 2013
	Capital expenditure programme to fund developments		Capital expenditure reports reported to the Board via Finance and Performance Committee	No gaps identified	No actions required		
	Managed Business Partner for IM&T services to deliver IT that will be a key enabler for our clinical strategy		IM&T Board in place	(c) Need to link to wider transformational agenda	To be incorporated into Improvement and Innovation Framework		May 2013 Chief Executive

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST – BOARD ASSURANCE FRAMEWORK

RISK NUMBER / TITLE	**RISK 1 - REDUCING AVOIDABLE HARMS**
LINK TO STRATEGIC OBJECTIVE(S)	**To provide safe, high quality patient-centred health care**
EXECUTIVE LEAD:	Deputy Chief Executive/ Chief Nurse

Principal Risk (What could prevent the objective(s) being achieved)	**What are we doing about it?** **(Key Controls)** What control measures or systems we have in place to assist secure delivery of the objective (describe process rather than management group)	**Current Score I x L**	**How do we know we are doing it?** **(Key assurances of controls)** Provide examples of recent reports considered by Board or committee where delivery of the objectives is discussed and where the board can gain evidence that controls are effective.	**What are we not doing?** **(Gaps in Controls C) / Assurance (A)** What gaps in systems, controls and assurance have been identified?	**How can we fill the gaps or manage the risk better?** **(Actions to address gaps)**	**Target Score I x L**	**Timescale** When will the action be completed?
Failure to reduce avoidable harms and mortality and morbidity leading to decreasing patient experience/ patient satisfaction and loss of reputation	Policies and procedures	4x3=12	Hospital Standardised Mortality Indicators reported monthly to Trust Board via Quality and Performance (Q&P) report. HSMI 'within expected' for elective and non-elective activity Review of SHMI and other mortality data by Boston Consultancy Group	(a) Lack of mortality analysis out of hours/weekend (a) absence of community-wide mortality review	LLR Mortality Summit (interface review)	3x2=6	May/ June 2013
	Relentless attention to 5 Critical Safety Actions (CSA) initiative to lower mortality		Q&P report to Trust Board showing outcomes for 5 CSAs. 5 CSAs form part of local CQUIN monitoring. RAG rated green at end of quarter 2.	(c) Lack of a unified IT system in relation to ordering and receiving results means that many differing processes are being used to acknowledge/respond to results. Potential risk of results not being acted upon in a timely fashion.	Feasibility of a less cumbersome IT platform to be investigated by IBM.		Review May 2013 Chief Information Officer
	Learning lessons from incidents, complaints and claims to reduce the likelihood of recurrence.		Monthly patient safety report to Quality Assurance Committee (QAC) and Quality and Performance management Group (QPMG) Number of formal complaints received reducing (1.6 per 1000 attendances – M11)	No gaps identified	No actions required		
	Infection prevention plan to ensure hospital acquired infections are reduced		MRSA/C. Difficile rates reported to Trust board via monthly Q&P report. 0 MRSA cases reported to end of Feb 13. YTD MRSA cases = 2. Target = 6 C. Difficile currently below trajectory. 85 cases YTD to end of Feb 13 against full year target of 103.	No gaps identified	No actions required		

	Monthly patient experience monitoring 'Net Promoter'		Monthly patient experience report to Trust board included within Q&P report. Improving Net Promoter results (63.3% at month 11)	No gaps identified	No actions required		
	Implementation of UHL Quality and Safety Commitment' 2012 – 15 (launched Jan 13) Key priorities: Reducing harm, reducing mortality rates and improving the patient experience		Monitoring of CQUINS outcomes via monthly Q&P report to Trust Board Published SHMI = 105 (July 11 – Jun 12) 'within expected' range	(c) Resource to support the delivery of the 'Quality Ambition' is still to be identified. (c) Need wider engagement of CCG partners for health economy initiatives (c) Significant increase of newly acquired UTIs with catheter causing a reduction in the number of 'harm free' care episodes. 91.11% harm free care during M11 (reduced from 92.98)	Resource requirements identified and to be discussed at ET on 16/4/13 2013 CQUIN and quality negotiations. Infection Prevention team to review actions required in relation to patients acquiring a catheter acquired UTI (CAUTI) whilst an in-patient		Chief Nurse/ Dep CEO Review Apr 2013 Chief Nurse/ Dep CEO review Apr 2013 Chief Nurse/ Dep CEO May 2013
	NHS Safety thermometer utilised to measure the prevalence of harm and how many patients remain 'harm free' (Monthly point prevalence for '4 Harms')		Monthly outcome report of '4 Harms' is reported to Trust board via Q&P report New DoH definitions may see an increase in harm attributed to UHL to encourage closer working between primary and secondary care.	a) The collection of ST data at ward level is resource intensive. There is also a risk that some data may not be accurate due to complex DoH definitions of each harm in relation to whether it is community or hospital acquired.	Ongoing education from the operational leads for each harm during the monthly data collection and validation process Utilisation of CQUIN monies for 2013/14 to invest in data collection posts at ward level to improve data quality and release time of ward managers to focus on reducing harms.		Dep CEO / Chief Nurse Apr 2013 Dep CEO / Chief Nurse Apr 2013
	Measurement through clinical audit programme to identify adherence to practice standards and outcomes.		Bimonthly reports to UHL Clinical Audit Committee. Clinical audit dashboards presented at QAC, QPMG and divisional boards. 100% participation in eligible national clinical audits and national confidential enquiries (2012/13)	No gaps identified.	No actions required.		

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST – BOARD ASSURANCE FRAMEWORK

RISK NUMBER/ TITLE:	**RISK 5 – PATIENT EXPERIENCE/ SATISFACTION**
LINK TO STRATEGIC OBJECTIVE(S)	**To be the provider of choice.**
EXECUTIVE LEAD:	Deputy Chief Executive/ Chief Nurse

Principal Risk (What could prevent the objective(s) being achieved)	**What are we doing about it?** **(Key Controls)** What control measures or systems we have in place to assist secure delivery of the objective (describe process rather than management group)	**Current Score I x L**	**How do we know we are doing it?** **(Key Assurances of controls)** Provide examples of recent reports considered by Board or committee where delivery of the objectives is discussed and where the board can gain evidence that controls are effective.	**What are we not doing?** **(Gaps in Controls C) / Assurance (A)** What gaps in systems, controls and assurance have been identified?	**How can we fill the gaps or manage the risk better?** **(Actions to address gaps)**	**Target Score I x L**	**Timescale** When will the action be completed?
Levels of patient satisfaction/experience may deteriorate leading to poor reputation and deterioration in Net Promoter scores.	Patient experience plan and associated projects. Patient Experience Strategy incorporated into Goal 3 of the Quality & Safety Commitment 2012 - 2015	4x3=12	Patient experience progress reports to Quality Assurance Committee (QAC). Patient stories presented at Trust Board. Discharge project outcomes (i.e. delayed transfer of care) reported to the Discharge and Transfer of Care (DTOC) Group and monthly to the emergency Care Network and Clinical Quality Review Group (CQRG). Data included in monthly Quality and Performance report to Trust Board.	(c) Trust-wide communications of patient experience learning.		2x3=6	
	Net Promoter scores to identify key areas for focus.		Ongoing Patient Experience surveys Net Promoter scores reported monthly to Trust Board via Q&P report. Improving picture in relation to Net Promoter scores (63.34% @ M11).	No gaps identified.	No actions required.		
	Caring @its best, releasing time to care initiatives and implementation of UHL Quality and Safety commitment (launched Jan 13). Key priorities: Reducing harm, reducing mortality rates and improving the patient experience.		Caring @ its best awards Improving patient experience reports. Improved infection prevention outcomes. 0 MRSA cases reported to end of Feb 13. YTD MRSA cases = 2. Target = 6 C. Difficile currently below trajectory. 85 cases YTD to end of Feb 13 against full year target of 103.	(c) Lack of supervisory headroom for ward managers.	Develop proposal for the ward managers to have rostered supervisory time in line with Francis recommendations.		Apr 2013 Dep CEO/Chief Nurse

	Patient experience programme (across 85 clinical areas to gain feedback from patients relating to their experience of care) and national patient survey.		Ongoing Patient Experience surveys. Net Promoter scores reported monthly to Trust Board via Q&P report. Annual reporting to trust board of national patient survey.	No gaps identified. No gaps identified. (c) Absence of support facility at main entrance to respond to patient/public concerns.	No actions required. No actions required. Space to be identified for provision of PILS support and 3rd sector support		May 2013 Director of Comms/Director of Nursing
	Trust values instilled within UHL staff.		UHL staff awards demonstrating individuals who demonstrate the values. Ongoing Patient Experience surveys. Net Promoter scores reported monthly to Trust Board via Q&P report.	No gaps identified.	No actions required.		
	Patient Adviser engagement at divisional level to ensure consistent involvement in the development of services.		Patient Advisors meet bi-monthly and these meetings are minuted and as such their involvement is formally captured. Non-attendance at two or more meetings triggers contact from UHL to see if they are still active and engaged	(a) No current mechanism to monitor involvement Healthwatch to provide assurance of involvement/ engagement. (c) Evidence to suggest lack of PPI involvement in early stages of service developments.	Further work is required with Healthwatch to establish protocols and monitoring processes as they develop PPI strategy to be revised/ rewritten and launched via communication campaign. Integrated as part of the Quality & Safety Committment Develop PPI training programme and toolkit for managers. Review and refresh PPI leads post divisional restructure.		Sep 2013 Director of Comms and External Relations Sep 2013 Director of Comms and External Relations Oct 2013 Director of Comms and External Relations May 2013 Director of Comms and External Relations

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST – BOARD ASSURANCE FRAMEWORK

RISK NUMBER/ TITLE:	**RISK 2 – BUSINESS CONTINUITY**
LINK TO STRATEGIC OBJECTIVE(S))	**To be a sustainable, high performing NHS Foundation Trust**
EXECUTIVE LEAD:	Director of Operations

Principal Risk (What could prevent the objective(s) being achieved)	**What are we doing about it?** **(Key Controls)** What control measures or systems we have in place to assist secure delivery of the objective (describe process rather than management group)	**Current Score I x L**	**How do we know we are doing it?** **(Key Assurances of controls)** Provide examples of recent reports considered by Board or committee where delivery of the objectives is discussed and where the board can gain evidence that controls are effective.	**What are we not doing?** **(Gaps in Controls C) / Assurance (A)** What gaps in systems, controls and assurance have been identified?	**How can we fill the gaps or manage the risk better?** **(Actions to address gaps)**	**Target Score I x L**	**Timescale** When will the action be completed?
Inability to react /recover from events that threaten business continuity leading to sustained downtime and inability to provide full range of services	Major incident/business continuity/ disaster recovery and Pandemic plans developed and tested for UHL/ wider health community. This includes UHL staff training in major incident planning/ coordination and multi agency involvement across Leicestershire to effectively manage and recover from any event threatening business continuity.	3x3=9	Annual Emergency planning Report identifying good practice presented to the Governance and Risk Management Committee July 2012. External auditing and assurances to SHA, Business Continuity Self-Assessment, June 2010, completed by Richard Jarvis Completion of the National Capabilities Survey, November 2013 completed by Aaron Vogel. Results will be included in the annual report on Emergency Planning and Business Continuity to the QAC. Audit by Price Waterhouse Coopers LLP Jan 2013. Results being compiled and will be reported to Trust Board (date to be agreed)	(c) On-going continual training of staff to deal with an incident (a) Do not gain assurances from external service providers as to their ability to continue to provide services to the trust in the event of an incident within their organisation or/and within the Trust. (a) Do not consider realistic testing of different failure modes for critical IT systems to ensure IT Disaster Recovery arrangements will be effective during invocation.	Training Needs Analysis to be developed to identify training requirements for staff. Develop an appropriate training programme and supporting materials for staff involved in the planning and response to an incident. Training and education materials to be produced in line with ISO 22301 and National Occupational Standards Ensure that contracts awarded include reference to business continuity commitments and providing assurances to the Trust of their arrangements. Determine an approach to delivering a physical testing of the IT Disaster Recovery arrangements which have been identified as a dependency for critical services. Include assessment of the benefits of realistic testing of arrangements against the potential disruption of testing to operations.	2x3=6	Director of Operations Apr 2013 Director of Operations Apr 2013 Director of Operations Apr 2013 Chief Information Officer Apr 2013

	Emergency Planning Officer appointed to oversee the development of business continuity within the Trust		Outcomes from Price Waterhouse Coopers LLP audit identified that there is a programme management system in place through the Emergency Planning Officer to oversee. A year plan for Emergency Planning has been developed. Production/updates of documents/plans relating to Emergency Planning and Business Continuity aligned with national guidance have begun.	(c) Key documentation to ensure critical services are identified and plans to mitigate the impact of an incident are not consistently applied and available across the Trust.	All CBUs require a Business Impact Assessment to identify critical services Review IT service continuity arrangements against the recovery requirements determined by the BIAs to validate existing arrangements.		Director of Operations Apr 2013 Chief Information Officer Apr 2013
	New policy to identify key roles within the Trust of those responsible for ensuring business continuity planning /learning lessons is undertaken.		Minutes/action plans from Emergency Planning and Business Continuity Committee. Any outstanding risks/issues will be raised through the Director of Operations.	No gaps identified	No actions required		
			New Policy on InSite Emergency Planning and Business Continuity Committee ensures that processes outlined in the Policy are followed, including the production of documents relating to business continuity within the service areas. 3 incidents within the Trust have been investigated and debrief reports written, which include recommendations and actions to consider.	(c) Do not effectively communicate issues/lessons learnt that have been identified in service area disruptions and follow up actions	Issues/lesson will feed into the development of local plans and training and exercising events.		Director of Operations Aug 2014
				(c)Do not always consider the impact on business continuity and resilience when implementing new systems and processes.	Further processes require development, particularly with the new Facilities and IM&T providers to ensure resilience is considered/ developed when implementing new systems, infrastructure and processes.		Director of Operations Jul 2013

				(a) Lack of coordination of plans between different service areas and across the CBUs.	Emergency Planning Officer and Divisional BCM leads will ensure that plans developed are coordinated between service areas/CBUs/Divisions Training and Exercising events to involve multiple CBUs/Divisions to validate plans to ensure consistency and coordination.		Director of Operations Aug 2014 Director of Operations Aug 2014

APPENDIX TWO

UHL BOARD ASSURANCE FRAMEWORK SUMMARY REPORT – MARCH 2013

Risk No	Risk Title	Current Risk Score (Mar 13)	Previous Risk Score (Feb 13)	Target Risk Score and Final Action Date	Risk Owner	Comment
8	Failure to achieve financial sustainability	25	25	12 – Mar 13	Director of Finance and Business services	
3	Inability to recruit, retain, develop and motivate staff	16	16	12 – Dec 13	Director of HR	
4	Failure to transform the emergency care system	20	20	12 – Review May 13	Director of Operations	
7	Ineffective organisational transformation	16	16	12 – 2013/14	Director of Finance and Business Services	
6	Failure to achieve FT status	16	16	12 – Apr - 15	Chief Executive Officer	Deadline for authorisation of FT extended.
11	Failure to maintain productive relationships	15	15	10	Director of Comms and External Relations	
9	Failure to achieve and sustain operational targets	12	12	12 – Review Apr 13	Director of Operations	
12	Inadequate reconfiguration of buildings and services	12	12	9 - Apr-14	Chief Executive Officer	
1	Reducing avoidable harms	12	12	6 – Review May 13	Dep. Chief Executive/ Chief Nurse	
5	Patient experience/ satisfaction	12	12	6 – Oct 13	Dep. Chief Executive/ Chief Nurse	Timescale for completion extended to allow PPI elements to be addressed
2	Business continuity	9	9	6 – Aug 14	Director of Operations	
10	Loss of reputation			n/a	n/a	This risk has been deleted. Loss of reputation is a consequence of failure to control other risks

APPENDIX THREE

UHL BOARD ASSURANCE FRAMEWORK SUMMARY OF CHANGES TO ACTIONS – MARCH 2013

Risk No.	Action Description	Action Owner	Comment
1	Delivery of 3 clinical task groups to identify resource requirements	Chief Nurse/Deputy Chief Executive	**Complete.** Task Groups in place. Resource requirements identified. For discussion at ET on 16/4/13.
1	2013 CQUIN and quality negotiations.	Chief Nurse/Deputy Chief Executive	**Onging.** Final draft schedule in place. Awaiting confirmation on pay mechanism. For investment discussion at ET on 16/4/13. Deadline for further review April 2013.
3	Formation of OD executive group.	Director of Human Resources	**Complete.** A central enabler of delivering against the OD Plan work streams will be adopting, 'Listening into Action (LiA)'. A Sponsor Group personally led by our Chief Executive and including, Executive Leads and other key clinical influencers has been established. Progress reports on the LiA will be presented to the Trust Board on a quarterly basis. The next report is scheduled for the April meeting. We have also agreed on quarterly Trust Board reports to update on Workforce and OD developments (commencing June 2013). Kate Bradley and Jane Wilson will review all regular items of business on the Workforce and OD Committee agenda and map these across to UHL Committees.
4	Sustainable on-going delivery of ED targets.	Director of Operations	**Ongoing.** Action now reworded to *'Via key stakeholders (medical, nursing and managerial) enforce steps to address the core issues'*. Original wording indicated an outcome as opposed to an action. Deadline for completion extended to April 2013.
5	Identify monitoring mechanism for involvement of patient adviser/	Director of Communications	**Complete.** Patient Advisors meet bi-monthly and these meetings are minuted

APPENDIX THREE

UHL BOARD ASSURANCE FRAMEWORK SUMMARY OF CHANGES TO ACTIONS – MARCH 2013

	Healthwatch in order to provide assurance of involvement/ engagement.		and as such their involvement is formally captured. Non-attendance at two or more meetings triggers contact from UHL to see if they are still active and engaged. Further work is required with Healthwatch to establish protocols and monitoring processes as they develop.
6	LLR wide economic modelling is to commence on the 21st January and conclude by the 31st March 2013.	Chief Executive	**Complete.** Economic Modelling completed and being reported to BCT Programme Board on 18/4/13 with next steps.
6	Confirmation of specific LLR reconfiguration priorities over a 3 year time horizon to be determined by the BCT economic modelling.	Chief Executive	**Ongoing.** Process included in new BCT workstreams to be approved by BCT PB 18/4. Immediate UHL priorities agreed at ET Strategy Session 16/4/13. Deadline for further review April 2013.
7	Proposals in relation to taking forward transformation to be presented to Finance and performance Committee on 26/3/13.	Chief Executive	**Complete.** Recommendations to develop Improvement Framework approved by F&PC 26/3/13.
7	Implement FMC contract.	Director of Finance and Business Services	**Complete**
8	Recovery plan to be developed and monitored by Executive Team (ET)/ F&P Committee and Board.	Director of Finance and Business Services	**Complete** Recovery plan implemented and monitored by Executive Team, Finance & Performance Committee and Trust Board. Prior to accounts sign-off by Audit, the year end surplus of £46K has been achieved.
8	Implementation of catalogue control project.	Director of Finance and Business Services	**Complete.** Catalogue project has been implemented. Ongoing monitoring will be through the Finance & Performance Committee.

AREAS OF SCRUTINY FOR THE UHL BOARD ASSURANCE FRAMEWORK (BAF)

1) Are the Trust's strategic objectives S.M.A.R.T? i.e. are they :-

- **S**pecific
- **M**easurable
- **A**chievable
- **R**ealistic
- **T**imescaled

2) Have the main risks to the achievement of the objectives been adequately identified?

3) Have the risk owners (i.e. Executive Team) been actively involved in populating the BAF?

4) Are there any omissions or inaccuracies in the list of key controls?

5) Have all relevant data sources been used to demonstrate assurance on controls and positive assurances?

6) Is the BAF dynamic? Is there evidence of regular updates to the content?

7) Has the correct 'action owner' been identified?

8) Are the assigned risk scores realistic?

9) Are the timescales for implementation of further actions to control risks realistic?