To:	**Trust Board**
From:	**Rachel Overfield - Chief Nurse**
Date:	**27 March 2014**
CQC regulation:	Outcome 16 – Assessing and Monitoring the Quality of Service Provision

Title:	**UHL RISK REPORT INCORPORATING THE BOARD ASSURANCE FRAMEWORK (BAF) 2013/14**

Author/Responsible Director: Chief Nurse

Purpose of the Report:
The report provides the Board with an updated BAF and oversight of any new extreme and high risks opened within the Trust during the reporting period. The report includes:-

a) A copy of the BAF as of 28 February 2014.
b) An action tracker to monitor progress of BAF actions
c) New extreme and/ or high risks opened during the reporting period.

The Report is provided to the Board for:

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

Summary :

Work has commenced on the revision of risk one and will be presented at the UHL Finance and Performance Committee in March for endorsement before being presented to the TB in April 2014.

- The contents of risk eight will be reordered following discussions at the March 2014 EQB meeting and reported to the April 2014 TB.
- Risk 13 has increased its score from 12 (moderate) to 16 (high)
- Action 10.6 (on-going from previous BAF report) now has an extended deadline of June 2014
- Risk 12 (failure to exploit IM&T) had previously achieved its target risk score however, following discussion by the ET, has been significantly revised by the Chief Information Officer
- The Director of Strategy is asked to provide the TB with a verbal update of progress in relation to action number 4.1.
- The following three BAF entries are suggested for review against the parameters listed in appendix three.
  - Risk 2 – Failure to transform the emergency care system.
  - Risk 3 – Inability to recruit, retain develop and motivate staff.
  - Risk 4 – Ineffective organisational transformation.
- One new high risk has opened during February 2014.

Recommendations:
Taking into account the contents of this report and its appendices the Board are 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 which it feels that the Trust's controls are inadequate and do not, therefore, effectively manage the principal risks to the organisation achieving 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;

(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) receive a verbal update in relation to action 4.1 from the Director of Strategy.

Board Assurance Framework Yes	**Performance KPIs year to date** N/A
Resource Implications (eg 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 review by the Board	

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST

REPORT TO: **TRUST BOARD**

DATE: **27 MARCH 2014**

REPORT BY: **RACHEL OVERFIELD - CHIEF NURSE**

SUBJECT: **UHL RISK REPORT INCORPORATING THE BOARD ASSURANCE FRAMEWORK (BAF) 2013/14**

---

1. INTRODUCTION

1.1 This report provides the Board with:-

a) A copy of the BAF as of 28 February 2014.
b) An action tracker to monitor progress of BAF actions.
c) Notification of any new extreme or high risks opened during the reporting period.

2. BAF POSITION AS OF 28 FEBRUARY 2014

2.1 A copy of the BAF is attached at appendix one with changes to narrative since the previous version shown in red text. A summary to show the movement of risk scores since the previous report is now included at page 3 of the BAF.

2.2 The progress of actions associated with the BAF is monitored by reference to the action tracker attached at appendix two. Actions completed prior to February 2014 have been removed from the tracker however a full audit trail of these is available by reference to previous documents.

2.3 The Board is asked to note the following points:

a. The Interim Director of Financial Strategy (IDFS) previously advised that risk one requires significant revision as the risk has already materialised (i.e. a forecast deficit £39.8 million). Work has commenced on this and will the BAF entry be presented at the UHL Finance and Performance Committee in March for endorsement before being presented to the TB in April 2014.

b. The Chief Nurse and Medical Director have discussed the content of risk eight at the March 2014 EQB meeting. The content will be reordered and presented to the TB in April 2014.

c. Risk 13 has increased its score from 12 (moderate) to 16 (high) reflecting challenges to recruitment and retention of medical staff in relation to this risk.

d. Action 10.6 (on-going from previous BAF report) now has an extended deadline of June 2014 reflecting the need to ensure that activities required to develop a Strategic Outline Case (SOC) are appropriately sequenced.

e. Risk 12 (failure to exploit IM&T) had previously achieved its target risk score however, following discussion by the ET, has been significantly

revised by the Chief Information Officer to reflect additional strategic IM&T issues and the current risk score increased to 12 (moderate).

f. No action tracker updates have been received from the Director of Strategy in relation to action number 4.1 and the Director of Strategy is asked to provide the TB with a verbal update of progress.

g. In instances where action completion dates have slipped from those originally agreed there are no increased risks.

2.4 In order to provide an opportunity for more detailed scrutiny the following three BAF entries are suggested for review against the parameters listed in appendix three.

- Risk 2 – Failure to transform the emergency care system.
- Risk 3 – Inability to recruit, retain develop and motivate staff..
- Risk 4 – Ineffective organisational transformation.

3 EXTREME AND HIGH RISK REPORT.

3.1 The TB is asked to note that one new high risk has opened during February 2014 as described below. The detail of this risk is included at appendix four.

Risk ID	Risk Title	Risk Score	CMG/Corporate Directorate
2307	The Forensic Toxicology service will fail resulting in a substantial loss of income and prestige for the Department/Empath	16	CSI

4. RECOMMENDATIONS

4.1 Taking into account the contents of this report and its appendices the TB 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);

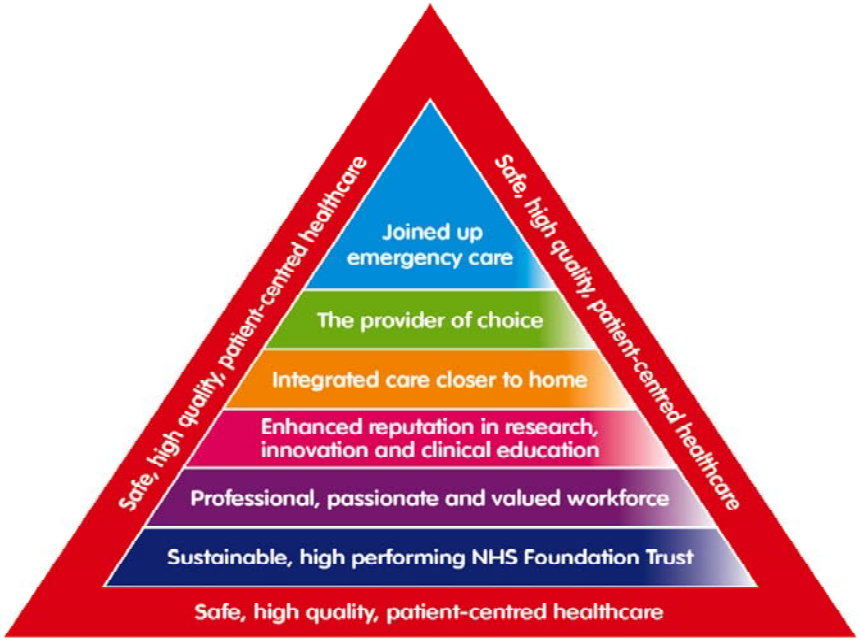
(c) identify any areas which it feels that the Trust's controls are inadequate and do not, therefore, effectively manage the principal risks to the organisation achieving its objectives;

(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;

(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) Receive a verbal update in relation to action 4.1 from the Director of Strategy.

Peter Cleaver - Risk and Assurance Manager
20 March 2014.


Safe, high quality, patient-centred healthcare
Safe, high quality, patient-centred healthcare
Joined up emergency care
The provider of choice
Integrated care closer to home
Enhanced reputation in research, innovation and clinical education
Professional, passionate and valued workforce
Sustainable, high performing NHS Foundation Trust
Safe, high quality, patient-centred healthcare

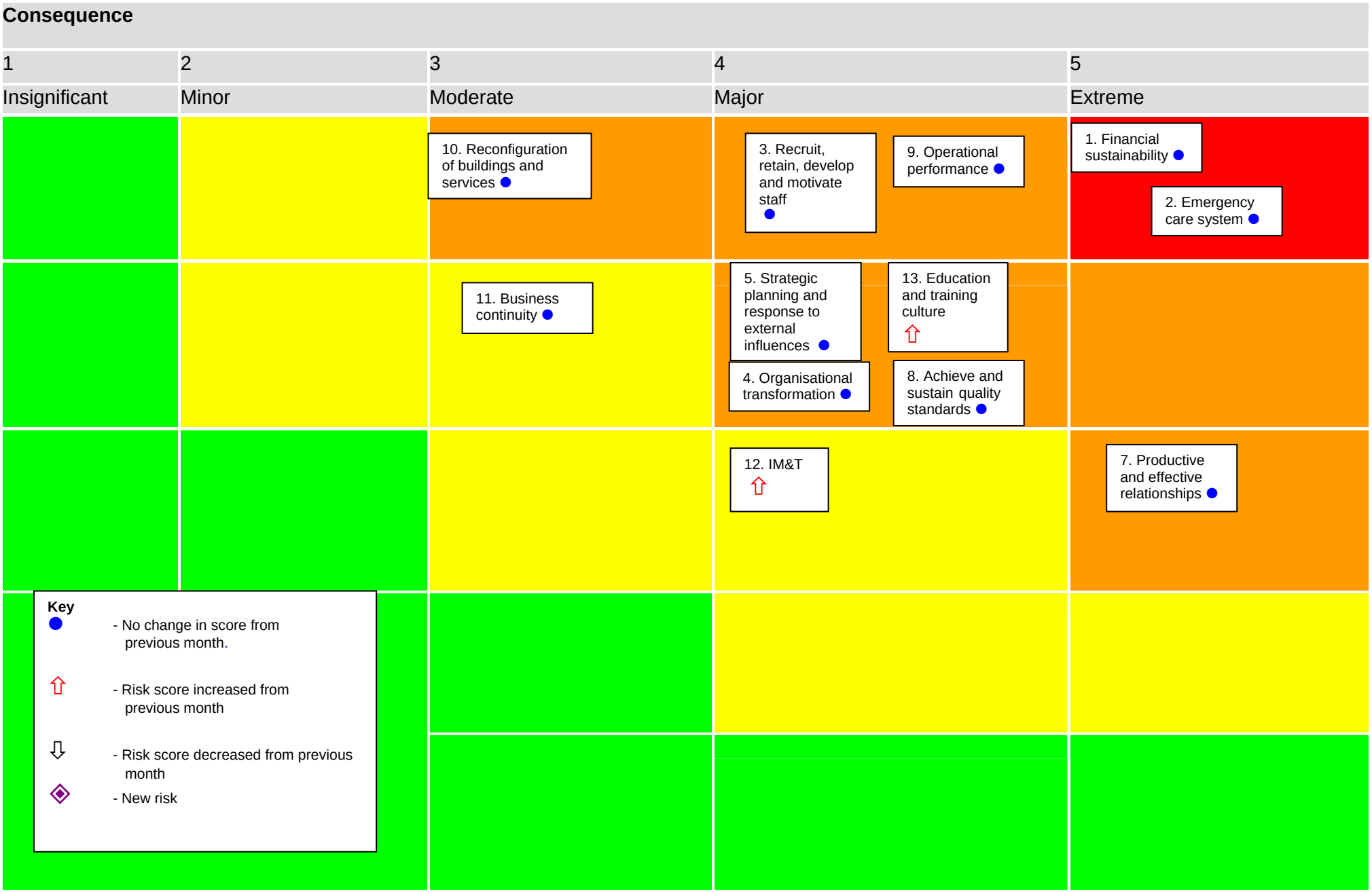
UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST – BOARD ASSURANCE FRAMEWORK FEBRUARY 2014

PERIOD: FEBRUARY 2014

RISK TITLE	STRATEGIC OBJECTIVE	CURRENT SCORE	TARGET SCORE
Risk 1 – Failure to achieve financial sustainability	g - To be a sustainable, high performing NHS Foundation Trust	25	12
Risk 2 – Failure to transform the emergency care system	b - To enable joined up emergency care	25	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.	20	12
Risk 4 – Ineffective organisational transformation	a - To provide safe, high quality patient-centred health care c - To be the provider of choice d - To enable integrated care closer to home	16	12
Risk 5 – Ineffective strategic planning and response to external influences	a - To provide safe, high quality patient-centred health care c - To be the provider of choice g - To be a sustainable, high performing NHS Foundation Trust	16	12
Risk 6 – **Risk deleted from BAF following approval of Trust Board**	**Not applicable**	**N/A**	**N/A**
Risk 7 – Failure to maintain productive and effective relationships	c - To be the provider of choice d - To enable integrated care closer to home f - To maintain a professional, passionate and valued workforce	15	10
Risk 8 – Failure to achieve and sustain quality standards	a - To provide safe, high quality patient-centred health care c - To be the provider of choice	16	12
Risk 9 – Failure to achieve and sustain high standards of operational performance	a - To provide safe, high quality patient-centred health care	20	12
Risk 10 – Inadequate reconfiguration of buildings and services	a - To provide safe, high quality patient-centred health care	15	9
Risk 11– Loss of business continuity	g - To be a sustainable, high performing NHS Foundation Trust	12	6
Risk 12 – Failure to exploit the potential of IM&T	a - To provide safe, high quality patient-centred health care d - To enable integrated care closer to home	12	6
Risk 13 - Failure to enhance education and training culture	e – To enjoy an enhanced reputation in research, innovation and clinical education	16	6

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

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST – BOARD ASSURANCE FRAMEWORK FEBRUARY 2014



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

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST – BOARD ASSURANCE FRAMEWORK FEBRUARY 2014

RISK NUMBER/ TITLE:	**RISK 1 – FAILURE TO ACHIEVE FINANCIAL SUSTAINABILITY**
LINK TO STRATEGIC OBJECTIVE(S)	**g. - To be a sustainable, high performing NHS Foundation Trust.**
EXECUTIVE LEAD:	Interim Director of Financial Strategy

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. Revised variance analysis and reporting metrics especially for the ETPB Self-assessment and SLM baseline exercise completed and project manager identified Finalised SLM Action plan Full information has now been received on UHL allocations from all the no-recurrent funding streams including transformation monies. This information is being incorporated into the financial forecasts.	5X5=25	Monthly /weekly financial reporting to Exec Team Performance Board, F&P Committee and Board. Cost centre reporting and monthly PLICS reporting. Monthly confirm and challenge processes at specialty and CMG level. Annual internal and external audit programmes. Monthly meetings with the NTDA and the CCG Contract Performance Meeting	(c) SLM programme not fully implemented	ESB will continue to meet every 6 weeks to ensure implementation of SLM across the Trust (expected Mar 2014) (1.19)	4x3=12	Mar 2014 IDFS
Failure to achieve CIP.	Strengthened CIP governance structure including appt of Head of CIP programme		Progress in delivery of CIPs is monitored by CIP Programme Board (meeting fortnightly) and reported to ET and Board.	(c) Under-delivery of CIP programme			

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 Financial Recovery plans developed Non Contractual Payments are discussed at monthly CMG meetings Confirm and Challenge Meetings All CMGs (by specialty) have produced premium spend trajectories and associated plans until March 2014 Weekly Staff Bank data reports are issued for medical and nursing (qualified and unqualified) staff Action plan to increase bank staff capacity and drive down agency nurse expenditure.		The use of locum staff in 'difficult to fill' areas reported monthly to the Board via the Q&P report. A reduction in the use of locums would be an assurance of success in recruiting substantive staff to 'difficult to fill' areas. Increase in contracted staff numbers of medical and nursing professions of 252wte since Mar 12. Saving in excess of £0.6m 5 weeks after 'go live' date Monthly Q&P report to TB Monthly confirm and challenge meetings Non contractual payments (premium spend) are reported monthly to the Finance and Performance Committee A weekly report is presented to ET. Weekly meetings with HoNs and DHR to monitor progress.	(c) Further investigation required as to the increase in Consultant numbers by 41wte (7.7%)			
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. Ongoing discussions with commissioners about planned re-investment of the MRET deductions.		Monthly /weekly financial reporting to Finance and Performance (F&P) Committee and Board.	(c) Failing to manage marginal activity efficiently and effectively. This is being addressed via ongoing discussions with Commissioners			

Ineffective processes for Counting and Coding.	Clinical coding project. Clinical coding to be included as a 2nd wave LIA pioneering team to involve clinicians.		Ad-Hoc reports on annual counting and coding process. PbR clinical coding audit Jan 2013 (final report received 29 May 2013). IG toolkit audit (sample of 200 General Surgery episodes).	(c) Error rates in audit sample could be indicative of underlying process issues. (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 F&P Committee and Board. Detailed cash management plans presented at August 2013 F&P committee.				
Lack of robust control over pay and non-pay expenditure.	Pay and Non-pay recovery action plan in place and monitored monthly. Catalogue control project.		Monthly /weekly financial reporting to F&P Committee and Board. Non-pay management plan presented at July F&P committee. Ongoing Monitoring via F&P Committee.				
Commissioner fines against performance targets.	Contract meetings with Commissioners and negotiations with Commissioners concluded at a transactional level. Plans and trajectories developed to reduce admission rates that are monitored at monthly C&C meetings.		Monthly /weekly monitoring of action plans, key performance target, and financial reporting to F&P Committee and Board.				
Use of readmission monies.	Contract meetings with Commissioners Negotiations with Commissioners concluded at a transactional level Ownership of readmissions work streams in divisions clarified.		Monthly /weekly financial reporting to F&P Committee and Board.				
Ineffective organisational transformation.	See risk 4		See risk 4.	See risk 4.	See risk 4.		See risk 4

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST – BOARD ASSURANCE FRAMEWORK FEBRUARY 2014

RISK NUMBER/ TITLE:	**RISK 2 – FAILURE TO TRANSFORM THE EMERGENCY CARE SYSTEM**
LINK TO STRATEGIC OBJECTIVE(S)	**b. - To enable joined up emergency care.**
EXECUTIVE LEAD:	Chief Operating 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 transform emergency care system leading to demands on ED and admissions units continuing to exceed capacity.	Health Economy has submitted response plan to NHSE requirements for an Emergency Care system under the A&E Performance Gateway Reference 00062.	5x5=25	Once plan agreed with NTDA, it will be circulated to the Board.	No gaps	No actions	4x3=12	
	Emergency Care Action Team formed. Chaired by Chief executive to ensure Emergency Care Pathway Programme actions are being undertaken in line with NHSE action plan and any blockages to improvement removed. Development of action plan to address key issues.		Action Plan circulated to the Board on a monthly basis as part of the Report on the Emergency Access Target within the Quality and Performance Report.	Gaps described below	Actions described below		
	A new plan has been submitted detailing a clear trajectory for performance improvement and includes key themes from plan: Single front door.		Project plan developed by CCG project manager Risks from 'single front door' to be escalated via ECAT and raised with CCG Managing Director as required.	No gaps	No actions		
	ED assessment process is being operated.		Forms part of Quality Metrics for ED reported daily update and part of monthly board performance report.	No gaps	No actions		
	Recruitment campaign for continued recruitment of ED medical and nursing staff including fortnightly meetings with HR to highlight delays and solutions in the recruitment process.		Vacancy rates and bank/agency usage reported to Trust Board on a monthly basis. Recruitment plan being led by HR and monitored as part of ECAT.	(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. (c) Staffing vacancies for medical and nursing staff remain high.	Continue with substantive appts until funded establishment is achieved. (2.7)		Review Mar 2014 COO

	Formation of an EFU and AFU to meet increased demand of elderly patients.		'Time to see consultant' metric included in National ED quarterly indicator.	No gaps	No actions		
	Maintenance of AMU discharge rate above 40%.		Reported to Operational Board twice monthly and will be included in Emergency Care Update report in Q&P Report.	No gaps	No actions		
	New daily MDT Board Rounds on all medical wards and medical plans within 24hrs of admission.		Reported to Operational Board twice monthly and will be included in Emergency Care Update report in Q&P Report.	No gaps	No actions		
	EDDs to be available on all patients within 24 hours of admission. Review built in to daily discharge meetings to check accuracy of EDDs (from 2/09/13).		Monitored and reported to Operational Board twice monthly and will be included in Emergency Care Update report in Q&P report.	No gaps	No actions		
	Maintain winter capacity in place to allow new process to embed.		All winter capacity beds are to be kept open until the target is consistently met.	No gaps	No actions		
	DTOCs to be kept to a minimal level by increasing bed capacity. 24 Additional beds available from December 2013.		Forms part of the Report on Emergency Access in the Q&P Report.	No gaps	No actions		

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST – BOARD ASSURANCE FRAMEWORK FEBRUARY 2014

RISK NUMBER/ TITLE:	**RISK 3 – INABILITY TO RECRUIT, RETAIN, DEVELOP AND MOTIVATE STAFF**
LINK TO STRATEGIC OBJECTIVE(S))	**e. - To enjoy an enhanced reputation in research, innovation and clinical education** **f. - To maintain a professional, passionate and valued workforce**
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.	4x5=20	Development of UHL talent profiles.	No gaps identified.	No actions required.	4x3=12	
			Talent profile update reports to Remuneration 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.	No gaps identified.	No actions required.		
	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.	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 on a six monthly basis. Improving staff satisfaction position.	No gaps identified.	No actions required.		
			Staff sickness levels may also provide an indicator of staff satisfaction and performance. Staff sickness rate is 4.48% for M10.	No gaps identified	No actions required.		

	Appraisal and objective setting in line with UHL strategic direction. Local actions and appraisal performance recovery plans/ trajectories agreed with CMGs and Directorates Boards.		Appraisal rates reported monthly to Board via Quality and Performance report. Appraisal performance features on CMG / Directorate Board Meetings to monitor the implementation of agreed local actions.				
	Summary of quality findings communicated across the Trust; to identify how to improve the quality of the appraisal experience for the individual and the quality of appraisal meeting recording.		Results of quality audits to ensure adequacy of appraisals reported to the Board via the quarterly workforce and OD report.	No gaps identified.	No actions required.		
			Appraisal Quality Assurance Findings reported to Trust Board via OD Update Report June 2013 Quality Assurance Framework to monitor appraisals on an annual cycle (next due March 2014).	No gaps identified.	No actions required.		
	Workforce plans to identify effective methods to recruit to 'difficult to fill areas). CMG and Directorates 2013/14 Workforce Plans. Active recruitment strategy including implementation of a dedicated nursing recruitment team. Programme of induction and adaptation for international pool of nurses.		Nursing Workforce Plan reported to the Board in September 2013 highlighting demand and initiatives to reduce gap between supply and demand. The use of locum staff in 'difficult to fill' areas is reported to the Board on a monthly basis via the Q&P report. Reduction in the use of such staff would be an assurance of our success in recruiting substantive staff.	(c) Risks with employing high number from an International Pool in terms of ensuring competence	Develop an employer brand and maximise use of social media (3.9).		April 2014 DHR
	Reward /recognition strategy and programmes (e.g. salary sacrifice, staff awards, etc). Recruitment and Retention Premia for ED medical and nursing staff.				Development of Pay Progression Policy for Agenda for Change staff (3.3).		Review April 2014 DHR
	UHL Branding – to attract a wider and more capable workforce. Includes development of recruitment literature and website, recruitment events, international recruitment. Recruitment progress is measured now there is a structured plan for bulk recruitment. Leads have been identified to develop and encourage the production of fresh and up to date recruitment material. Reporting and monitoring of posts with 5 or less applicants.		Evaluate recruitment events and numbers of applicants. Reports issued to Nursing Workforce Group (last report 4 Feb). Reporting will be to the Board via the quarterly workforce an OD report. Quarterly report to senior HR team and to Board via quarterly workforce and OD report.	(a) Better baselining of information to be able to measure improvement. (c) Lack of engagement in production of website material.			

	Statutory and mandatory training programme for 9 key subject areas in line with National Core Skills Framework.		Monthly monitoring of statutory and mandatory training uptake via reports to TB and ESB against 9 key subject areas (currently showing month on month improvements (72% at M11).	(c) Compliance against the 9 key subject areas is 72% (February 2013) (a) Potentially there may be inaccuracies of training data within the e-UHL system.	Ensure Statutory and Mandatory training is easy to access and complete with 75% compliance by reviewing delivery mode, access and increasing capacity to deliver against specific subject areas (3.5). Update e-UHL records to ensure accuracy of reporting on a real time basis (3.7).		Mar 2014 DHR Mar 2014 DHR

RISK NUMBER/ TITLE:	**RISK 4 – INEFFECTIVE ORGANISATIONAL TRANSFORMATION**						
LINK TO STRATEGIC OBJECTIVE(S)	**a. - To provide safe, high quality patient-centred health care.** **c. - To be the provider of choice.** **d. - To enable integrated care closer to home**						
EXECUTIVE LEAD:	Director of Strategy						
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 put in place a robust approach to organisational transformation, adequately linked to related initiatives and financial planning/outputs.	Development of Improvement and Innovation Framework (IIF). Outputs from this transformation programme will drive the implementation of the clinical strategy.	4x4=16	Monthly progress reports to Exec Strategy Board and F&P Committee. Approval of framework and operational arrangements due at Trust Board June 2013. Monitoring of overall Framework will be via IIF Board and F&P Ctte and monitoring of financial outputs (CIPs) will be via CIP Delivery Board, Exec Performance Board and F&P Committee. Delivery of whole hospital change programmes requires alignment with the whole local Health Economy change programme – currently described through the Better Care Together programme.	(c) Gaps are evident in the alignment of transformational process between UHL and principle partners – this is being raised through the Better Care Together Programme structures.	Review outputs from Chief Officers Group and strategic Planning Group to ensure gaps in current processes are being addressed (4.1).	4x3=12	Review Feb 2014 DS

RISK NUMBER / TITLE	**RISK 5 - INEFFECTIVE STRATEGIC PLANNING AND RESPONSE TO EXTERNAL INFLUENCES**
LINK TO STRATEGIC OBJECTIVE(S)	**a. - To provide safe, high quality patient-centred health care.** **c. - To be the provider of choice.** **e. - To enjoy an enhanced reputation in research innovation and clinical education.** **g. - To be a sustainable, high performing NHS Foundation Trust**
EXECUTIVE LEAD:	Director of Strategy

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 put in place appropriate systems to horizon scan and respond appropriately to external drivers. Failure to proactively develop whole organisation and service line clinical strategies.	Appointment of Strategy Director.	4x4=16	Plan agreed by Remuneration Committee.	None identified.	Not applicable.	4x3=12	N/A
	Allocation of market intelligence responsibility to Director of Marketing and Communications.		Agreed by Remuneration Committee.	None identified.	Not applicable.		N/A
	Co-ordinated approach to business intelligence gathering and response via Clinical Management Groups. Workshop 'hosted by the Director of Strategy 'delivering our strategic direction' held in November with all CMGs to set the external context within which we will need to develop a LLR Integrated 5-yaer plan, within which our 2-yaer operational plans will sit. CMG Strategy Leads now engaged in the BSST meetings to improve engagement, alignment and teamwork. ESB forward plan reflecting a 12 month programme aligned with: • the development of the IBP/LTFM • the reconfiguration programme • the development of the next AOP • The TB Development Programme The TB formal agenda		Weekly strategic planning meetings in place – cross CMG and corporate team attendance with delivery led through the Strategy Directorate. Development of a clear, clinically based 5 year strategic will provide assurance that strategic planning is taking place. Reports to ESB. Regular reports to TB reflecting progress of 12 month programme.	None identified. None identified.	Not applicable. Not applicable.		

RISK NUMBER/ TITLE:	**RISK 7– FAILURE TO MAINTAIN PRODUCTIVE AND EFFECTIVE RELATIONSHIPS**
LINK TO STRATEGIC OBJECTIVE(S)	**c. - To be the provider of choice.** **d. - To enable integrated care closer to home.** **f. – To maintain a professional, passionate and valued workforce.**
EXECUTIVE LEAD:	Director of Marketing and Communications

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 ('Better Care Together').	5X3=15	Twice yearly GP surveys with results reported to UHL Executive Team. Latest survey results discussed at the April 2013 Board and showed increasing levels of satisfaction… a trend which has now continued for 18 months. Annual Reputation / Relationship survey to key professional and public stakeholders Nov 13.	(c) No external and 'dispassionate' professional view of stakeholder / relationship management activity.	Invite PWC (Trust's Auditors) to offer opinion on the plan / talk to a selection of stakeholders. (7.3)	5X2=10	Mar 2014 DCM

RISK NUMBER/ TITLE:	**RISK 8 – FAILURE TO ACHIEVE AND SUSTAIN QUALITY STANDARDS**
LINK TO STRATEGIC OBJECTIVE(S)	**a. – To provide safe, high quality patient-centred health-care**
EXECUTIVE LEAD:	Chief Nurse (with Medical Director)

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 quality standards leading to failure to reduce patient harm with subsequent deterioration in patient experience/ satisfaction/ outcomes, loss of reputation and deterioration of 'friends and family test' score.	Standardised M&M meetings in each speciality.	4x4=16	Routine analysis and monitoring of out of hours/weekend mortality at CMG Boards.	No gaps.	No action needed.	4x3=12	
	Systematic speciality review of "alerts" of deterioration to address cause and agree remedial action by Mortality Review Committee. Reports to Executive Quality Board, QAC, and by exception to ET and TB. All deaths in low risk groups identified. Working with DFI to ensure data has been recorded accurately.		Quality and Performance Report and National Quality dashboard presented to ET and TB. Currently SMHI "within expected" (i.e. 106). UHL now subscribes to the Hospital Evaluation Dataset (HED) which is similar to the Dr Foster Intelligence clinical benchmarking system but also includes a 'SHMI analysis tool'.	(a) UHL risk adjusted perinatal mortality rate above regional and national average.			
	Robust implementation of actions to achieve Quality Commitment (save 1000 extra lives in 3 years).		HSMI 107 (based on HSCIC data from July 12 to June 13) Independent analysis of mortality review performed by Public Health. Results reported at November 2013 TB meeting.	No gaps identified.	No action needed.		
	Agreed patient centred care priorities for 2013-14: - Older people's care - Dementia care - Discharge Planning		Quality Action Group meets monthly. Achievement against key objectives and milestones report to Trust board on a monthly basis. A moderate improvement in the older people survey scores has been recorded.	No gaps identified.	No action needed.		
	Multi-professional training in older peoples care and dementia care in line with LLR dementia strategy.		Quality Action Group monitoring of training numbers and location.	No gaps identified.	No action needed.		
	Protected time for matrons and ward sisters to lead on key outcomes.		CMG/ specialty reporting on matron activity and implementation or supervisory practice.	(c) Present vacancy levels prevent adoption of supervisory practice.	Active recruitment to ward nursing establishment so releasing ward sister –for supervisory practice (8.5).		Sep 2014 CN
	To promote and support older people's champion's network and new dementia champion's network.		Monthly monitoring of numbers and activity.	No gaps identified.	No action needed.		

	Targeted development activities for key performance indicators - answering call bells - assistance to toilet - involved in care - discharge information		Monthly monitoring and tracking of patient feedback results. Monthly monitoring of Friends and Family Test reported to the TB (71.8% at M10). England average 71%. Older Peoples Quality Outcomes: all scores increased from M7 to M8 Discharge: All scores except for the question on being informed of problems/dangers signals increased from M7 to M8.				
	Quality Commitment 2013 – 2016: • Save 1000 extra lives • Avoid 5000 harm events • Provide patient centred care so that we consistently achieve a 75 point patient recommendation score.		Quality Action Groups monitoring action plans and progress against annual priority improvements. A Quality Commitment dashboard has been developed to present updates to the TB on the 3 core metrics for tracking performance against our 3 goals. These metrics will be tracked up to 2015. Impressive drops in fall numbers have been observed in Datix reports and in the Safety Thermometer audit.				
	Relentless attention to 5 Critical Safety Actions (CSA) initiatives to lower mortality.		Q&P report to TB showing outcomes for 5 CSAs. 4CSAs form part of local CQUIN monitoring. There is a risk to Q3 CQUIN full compliance from the delay in implementing the ward round documentation for the Senior Clinical Review, Ward Rounds and Notation action. All the other actions have achieved full compliance for Q3 against agreed action plans.	(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.	Implementation of Electronic Patient Record (EPR). (8.10)		2015 CIO

	NHS Safety thermometer utilised to measure the prevalence of harm and how many patients remain 'harm free' (Monthly point prevalence for '4 Harms'). Monthly meetings with operational/clinical and managerial leads for each harm in place.		Monthly outcome report of '4 Harms' is reported to Trust board via Q&P report. The percentage of Harm Free Care for M10 was 93.8 % reflecting a reduction in the number of patients with newly acquired harms. There are no areas of concern in relation to the prevalence of New Harms.	(a) There is some concern that the revised DH monitoring tool is still not an effective measure to produce accurate information. Local actions to resolve this are not practicable.			

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST – BOARD ASSURANCE FRAMEWORK FEBRUARY 2014

RISK NUMBER/ TITLE:	**RISK 9 – FAILURE TO ACHIEVE AND MAINTAIN HIGH STANDARDS OF OPERATIONAL PERFORMANCE**
LINK TO STRATEGIC OBJECTIVE(S)	**a. - To provide safe, high quality patient-centred health-care** **c. - To be the provider of choice.** **g. - To be a sustainable, high performing NHS Foundation Trust.**
EXECUTIVE LEAD:	Chief Operating 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 and sustain operational targets leading to contractual penalties, patient dissatisfaction and poor reputation.	Referral to treatment (RTT) backlog plans (patients over 18 weeks) and operational performance of 90% (for admitted) and 95 % (for non-admitted). Further recovery plans for RTT performance agreed by Commissioners Use of independent sector for key specialties. Reissue across UHL of cancelled operations policy	4x5=20	Key specialities in weekly performance meetings with COO to implement plans. Weekly patient level reporting meeting for all key specialties. Monthly Q&P report to Trust Board showing 18 week RTT performance. Daily RTT performance and prospective reports to inform decision making. Monthly monitoring of RTT performance recovery plans	(c) Inadequate elective capacity. (c) Capacity issues created by emergency demand causes cancellations of operations.	Implementation of recovery action plan (including specialty level action plan / recovery trajectory at Trust and speciality level of RTT standards). (9.13)	4x3=12	March 2014 COO
	Transformational theatre project to improve theatre efficiency to 80 -90%.		Monthly theatre utilisation rates. Theatre Transformation monthly meeting. Transformation update to Board.	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). 4 hour wait performance 90.1%	See risk number 2.	See risk number 2.		

	Cancer 62 day performance - Tumour site improvement trajectory agreed and each tumour site has developed action plans to achieve targets. Senior Cancer Manager appointed. Lead Cancer Clinician appointed. Action plan to resolve Imaging issues implemented.		Cancer action board established and weekly meetings with all tumour sites represented. Monthly trajectory agreed and Cancer action plan agreed with CCGs in June 2013 and reported and monitored at Executive Performance board. Chief Operating Officer receives reports from Cancer Manager and 62 day performance included within Monthly Q&P report to Trust Board. The ongoing management of cancer performance is carried out by a weekly cancer action board to provide operational assurance. Performance against 62 day standard has been achieved for the past 6 months. Commissioners have formally removed the contract performance notice in relation to 62 day standard.	No gaps identified.	No actions required.		

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST – BOARD ASSURANCE FRAMEWORK FEBRUARY 2014

RISK NUMBER/ TITLE:	**RISK 10 – INADEQUATE RECONFIGURATION OF BUILDINGS AND SERVICES**
LINK TO STRATEGIC OBJECTIVE(S)	**a. - To provide safe, high quality patient-centred health care**
EXECUTIVE LEAD:	Director of Strategy

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.	3x5=15	Trust Board development session on development of approach to strategic planning and development of SOC. This outlined the methodology being used to ensure any changes in configuration are specifically designed to deliver optimum quality of care. Ongoing monitoring of service outcomes by MRC to ensure outcomes improve. Improvement in health outcomes and effective Infection Prevention and Control practices monitored by Executive Quality Board (Q+P report) with escalation to ET, QAC and TB as required.	(a) Service specific KPIs not yet identified for all services.	Iterative development of strategic plans with specialities. This is monitored by CMG and Executive Boards. Work continues with DS and CMGS to prioritise key areas for delivery within the clinical strategy. Further workshops planned for Jan/Feb 2014. (10.5)	3X3=9	March 2014 MD
	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. Reconfiguration Programme working with clinicians to develop a 'preferred' way forwards' with regards to the alignment of the future estate with clinical strategy.		Facilities Management Collaborative (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 approval by the NTDA.	Reconfiguration programme to develop a strategic outline case which will inform the future estate strategy (10.6) Secure capital funding. (10.3)		June 2014 DS Mar 2014 IDFS
	CMG 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.		Monthly ET Strategy session to provide oversight of reconfiguration.	No gaps identified.	No actions required.		

	Capital expenditure programme to fund developments.		Capital expenditure reports reported to the Board via F&P 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 incorporated into Improvement and Innovation Framework.		IM&T Board in place.	No gaps identified.	No actions required.		

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST – BOARD ASSURANCE FRAMEWORK FEBRUARY 2014

RISK NUMBER/ TITLE:	**RISK 11 – LOSS OF BUSINESS CONTINUITY**
LINK TO STRATEGIC OBJECTIVE(S))	**g. - To be a sustainable, high performing NHS Foundation Trust.**
EXECUTIVE LEAD:	Chief Operating 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?
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. Tailored training packages for service area based staff. All priority IT systems have disaster recovery testing completed as part of the change approvals for major upgrades or at least once per year if no upgrade is planned within a financial year. Contingency plans developed to manage loss of critical supplier and how we will monitor and respond to incidents affecting delivery of critical supplies.	3x4=12	Annual Emergency planning Report identifying good practice presented to the GRMC July 2012. Training Needs Analysis developed to identify training requirements for staff supported by appropriate training packages for Senior Managers on Call. 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 included in the annual report on Emergency Planning and Business Continuity to the QAC. Audit by PwC Jan 2013. Completed Jan 2014. Documented evidence from key critical suppliers has been collected to ensure that contracts include business continuity arrangements.	(c) On-going continual training of staff to deal with an incident. (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. c) Not all the critical suppliers questioned provided responses. (c) Contracts aren't assessed for their potential BC risk on the Trust.	Training and Exercising events to involve multiple specialties/CMGs to validate plans to ensure consistency and coordination (11.13). Finance and procurement staff to be trained how to assess the BC risk to a contract and utilise the tools developed. (11.14)	2x3=6	Aug 2014 COO Mar 2014 COO

	Emergency Planning Officer appointed to oversee the development of business continuity within the Trust.		Outcomes from PwC 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 developed and updated annually. Production/updates of documents/plans relating to Emergency Planning and Business Continuity aligned with national guidance have begun. Including Business Impact Assessments for all specialties. Plan templates for specialties now include details/input from Interserve. 2014/2015 work plan based on priority tasks to undertake and plans to review	(c) Local plans for loss of critical services not completed due to change over of facilities provider. (c) Plans have not been provided by Interserve as to how they would respond or escalate issues to the Trust. (c) A number of plans are out of date and risk being inadequate for a response due to operational changes. (c)Call out system designed to notify staff of a major incident and activate the plan is not suitable.	Further work required to develop escalation plans and response plans for Interserve. (11.11) Review and consider options for an automated system to reduce time and resources required to initiate a staff call out (11.16).		Mar 2014 COO April 2014 COO
	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 COO.	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. Incidents within the Trust are investigated and debrief reports written, which include recommendations and actions to consider. Issues/lessons feed into the development of local plans and training and exercising events.				

			Head of Operations and Emergency Planning Officer are consulted on the implementation of new IM&T projects that will disrupt user's access to IM&T systems.	(c) Do not always consider the impact on business continuity and resilience when implementing new systems and processes. (c) End users aren't always consulted adequately prior to downtime of a system.	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. (11.8)		Review Mar 2014 COO
				(a) Lack of coordination of plans between different service areas and across the specialties.	Training and Exercising events to involve multiple specialties/CMGs to validate plans to ensure consistency and coordination. (11.10)		Aug 2014 COO

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST – BOARD ASSURANCE FRAMEWORK FEBRUARY 2014

RISK NUMBER/ TITLE:	**RISK 12 FAILURE TO EXPLOIT THE POTENTIAL OF IM&T**
LINK TO STRATEGIC OBJECTIVE(S))	**a. - To provide safe, high quality patient-centred health care.** **d. - To enable integrated care closer to home**
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 integrate the IM&T programme into mainstream activities.	IM&T is required to be part of the short/medium and long term planning processes	4x3=12	Strategic IM&T Board in place. Quarterly reports to Trust Board IM&T represented on key groups such as ESB, capital planning etc…	(c) late notice of significant changes that have a material impact on M&T provision (c) lack of uptake of IM&T opportunities within the planning processes	Ensure that there is further integration of IM&T within planning groups (12.9) Ensure that there are no unforeseen IM&T requirements coming out of the 2014-2016 planning phase. (12.10)	3x2=6	May 2014 CIO Apr 2014 CIO
	Creation of an exciting portfolio of opportunities for UHL to use within its delivery and reporting activities		A clear plan for 2014/15 exists, within the IM&T strategic framework. Work with directly affected areas has commenced	(c) lack of a fully signed off five year plan for IMT (c) a clear communications and engagement plan to inform all stakeholders of these opportunities	Work with the DOF and the capital group to ensure a coherent 5 year plan is in place for the delivery of the core IM&T components (12.11) Work with specialists from UHL and IBM to better define the communications and engagement strategy. (12.12) Review and reissue the IM&T strategy (12.13)		May 2014 CIO May 2014 CIO Jun 2014 CIO
	Engagement with the wider clinical communities (internal) including formal meetings of the newly created advisory groups/ clinical IT. Improved communications plan incorporating process for feedback of information.		CMIO(s) now in place, and active members of the IM&T meetings The joint governance board monitors the level of communications with the organisation.	(c Whilst there is increased clinical engagement this is still not flowing through the anticipated cascade methodology	To review the means by which we communicate to clinical teams, including reviewing working models from successful organisations. (12.14)		Apr 2014 CMIO

	Engagement with the wider clinical communities (External). UHL CMIOs are added as invitees to the meetings, as are the clinical (IM&T) leads from each of the CCGs.		UHL membership of the wider LLR IM&T board	(c) no involvement of external stakeholders on our significant internal projects	Review any relevant groups and engage our external stakeholders for membership (12.15)		May 2014 CIO/CMIO
Benefits are not well defined or delivered	Appointment of IBM to assist in the development of an incentivised, benefit driven, programme of activities to get the most out of our existing and future IM&T investments. Initial engagement with key members of the TDA to ensure there is sufficient understanding of technology roadmap and their involvement. The development of a strategy to ensure we have a consistent approach to delivering benefits. Increased engagement and communications with departments to ensure that we capture requirements and communicate benefits. Standard benefits reporting methodology in line with trust expectations.		Minutes of the joint governance board, the transformation board and the service delivery board. Benefits are part of all the projects that are signed off by the relevant groups.	(a) Not all projects are fully reporting on the benefits realised. (c) Ownership of benefits delivery is being overlooked when a project, from IM&T's perspective, is finished. (c) Requirements within projects are moving significantly from the time a project specification is signed off.	Ensure that all teams working on IM&T projects work to the required standards. (12.16) Post project benefit realisation plans and ownership is identified at pre-commencement phase to ensure the total work is identified. (12.17) Requirements and benefits are fully signed off prior to any work commencing (12.18)		Apr 2014 CIO
Major programmes of work do not deliver on time and budget	A joint Programme and project methodology is in place between UHL and IBM for managing and tracking activities.		Weekly and Monthly reports are in place to track both at a programme level and at an individual project level	(c) sufficient feedback to individual CMGs on both the progress, benefits and further opportunities from their IM&T projects	Re-establish monthly meetings with a nominated lead to discuss projects and overall performance with the CMGs (12.19) Enhance the communications with the CMGs to include new opportunities that they could consider within their planning processes going forward (12.20)		Apr 2014 CIO Apr 2014 CIO
	External factors such as CCG alignment and NTDA approval are in place to ensure smooth passage of approvals		Bi monthly LLR meetings are in place to ensure alignment across all healthcare stakeholders in Leicestershire	(a) more early engagement with the NTDA is required to ensure visibility of the IM&T programme (c) Agree LLR joint priorities for 2014	To provide a plan/dates to the relevant NTDA bodies of the expected business case release plan (12.21) Further work through the IM&T strategy board is required to refine the large set of requirements into a realistic deliverable plan (12.22)		Mar 2014 CIO May 2014 CIO

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST – BOARD ASSURANCE FRAMEWORK FEBRUARY 2014

RISK NUMBER/ TITLE:	**RISK 13 – FAILURE TO ENHANCE MEDICAL EDUCATION AND TRAINING CULTURE**
LINK TO STRATEGIC OBJECTIVE(S)	**e - To enjoy an enhanced reputation in research, innovation and clinical education.**
EXECUTIVE LEAD:	Medical Director

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 implement and embed an effective medical training and education culture with subsequent critical reports from commissioners, loss of medical students and junior doctors, impact on reputation and potential loss of teaching status.	Medical Education Strategy and Action Plan.	4x4=16	Strategy approved by the Trust Board. Strategy monitored by Operations Manager and reviewed monthly in Full team Meetings. Favourable Deanery visit in relation to ED Drs training.	(c) Lack of engagement/awareness of the Strategy with CMGs.	Meetings to discuss strategy with CMGs (13.1).	3x2 = 6	Mar 2014 MD
	UHL Education Committee. 'Doctors in Training' Committee established. Education and Patient Safety. Links with LEG/ QUAC and QPMG		Professor Carr reports to the Trust Board. Reports submitted to the Education Committee. Terms of reference and minutes of meetings.	(c) Attendance at the Committee could be improved. (c) Improved trainee representation on Trust wide committees. (c) Improve engagement with other patient safety activities/groups.	Relevance of the committee to be discussed at specialty/ CMG meetings (13.2).		Mar 2014 MD
	Quality Monitoring. Engagement with specialties to share findings from education and training dashboards		Quality dashboard for education and training (including feedback from GMC and LETB visits) monitored monthly by Operations Manager, Quality Manager and Education Committee. Education Quality Visits to specialties. Exit surveys for trainees. Monitor progress against the Education Strategy and GMC Training Survey results.	(a) Do not currently ensure progress against strategic and national benchmarks. (c) Inadequate educational resources.	Monitor UHL position against other trusts nationally. (13.7) New Library/learning facilities to be developed at the LRI .(13.8)		Review Mar 2014 MD Apr 2014 MD

	Educational project teams to lead on education transformation projects.		Project team meets monthly. Favourable outcome from Deanery visit in relation to ED Drs training.				
	Financial Monitoring.		SIFT monitoring plan in place.	(c) Poor engagement with specialties in relation to implication of SIFT.	Need to engage with the specialties to help them understand the implication of SIFT and their funding streams. (13.10)		Mar 2014 MD

Appendix two

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST
ACTION TRACKER FOR THE 2013/14 BOARD ASSURANCE FRAMEWORK (BAF)

Monitoring body (Internal and/or External):	Executive Team
Reason for action plan:	Board Assurance Framework
Date of this review	**February 2014**
Frequency of review:	Monthly
Date of last review:	January 2014

REF	ACTION	SENIOR LEAD	OPS LEAD	COMPLETION DATE	PROGRESS UPDATE	STATUS
1	**Failure to achieve financial sustainability**					
1.19	ESB will continue to meet every 6 weeks to ensure implementation of SLM across the Trust (expected Mar 2014)	IDFS		March 2014	On track.	4
2	**Failure to transform the emergency care system**					
2.7	Continue with substantive appts until funded establishment within ED is achieved.	COO	HO	Review ~~Sept~~ ~~Nov 2013~~ ~~Jan 2014~~ March 2014	Still on track to recruit to funded establishment. International recruitment has been successful.	4
3	**Inability to recruit, retain, develop and motivate staff**					
3.3	Development of Pay Progression Policy for Agenda for Change staff.	DHR	DDHR	~~October~~ ~~November~~ ~~December 2013~~ ~~February 2014~~ ~~Review~~ April 2014	A number of amendments need to be made to the Policy for the JSCNC on 12.03.14. It is unlikely agreement will be reached on all of the proposed measures and staff side will deliver their intentions at the JSCNC on 12.03.14. Implementation of the Policy will be delayed as a result and sufficient time for training and development needs to be made available. In response to the Listening Events on the proposal for 8C 8D and 9, an updated proposal will be developed for initial sharing at the JSCNC on 12.03.14. Timescale for action completion adjusted to reflect this.	3

Status key:	5	Complete	4	On track	3	Some delay – expect to completed as planned	2	Significant delay – unlikely to be completed as planned	1	Not yet commenced	0	Objective Revised

3.5	Ensure Statutory and Mandatory training is easy to access and complete with 75% compliance by reviewing delivery mode, access and increasing capacity to deliver against specific subject areas.	DHR	ADLOD	March 2014	Performance improved to 72%. (2% ahead of trajectory) at the end of February. All 10 newly designed e-learning packages have been completed and are available for staff to complete.	4
3.7	Update e-UHL records to ensure accuracy of reporting on a real time basis	DHR	ADLOD	March 2014	System performance issues continue to be worked on with interface between OCB Media and eUHL strengthened as required for accurately recording learner completion. Team Builder Guidance circulated to all members of the Leadership Community.	4
3.9	Develop an employer brand and maximise use of social media to describe benefits of working at UHL	DHR		April 2014	First meeting of task and finish group taken place. Use of Linked-In and staff good news stories to describe benefits of working at UHL. Group has expanded membership to broader range of staff groups. Action Plan in development, focused on three elements of employment cycle – attraction, retaining existing staff and understanding why individuals exit.	4
4	**Ineffective organisational transformation**					
4.1	Review outputs from Chief Officers Group and strategic Planning Group to ensure gaps in current processes are being addressed	DS		Review February 2014	On track	4
5	**Ineffective strategic planning and response to external influences**					
7	**Failure to maintain productive and effective relationships**					
7.3	Invite PWC (Trust's Auditors) to offer opinion on the plan / talk to a selection of stakeholders.	DMC		~~January 2014~~ March 2014	Meeting held to scope the work, however delays in sending the raw data to PWC have delayed this action. Timescale for completion adjusted to reflect this.	3

Status key:	5	Complete	4	On track	3	Some delay – expect to completed as planned	2	Significant delay – unlikely to be completed as planned	1	Not yet commenced	0	Objective Revised

8	**Failure to achieve and sustain quality standards**					
8.5	Active recruitment to ward nursing establishment so releasing ward sister for supervisory practice.	CN		September 2014	On going recruitment process in place and is likely to take 12 -18months. Deadline extended to reflect this.	4
8.10	Implementation of Electronic Patient Record (EPR)	CIO		2015	Currently developing the procurement strategy for the EPR solution	4
9	**Failure to achieve and sustain high standards of operational performance**					
9.11	Agree recovery action plan with commissioners to recover Referral to Treatment Performance within required operational standards	COO	Head of Performance Improvement	February 2014	**Compete.** Action plan agreed with commissioners , awaiting formal notification 28/2/14	5
9.12	Re launch of cancelled operations policy	COO		Review February 2014	**Complete.** Cancelled operations policy re-issued to CMGs	5
9.13	Implementation of recovery action plan (including speciality level action plan / recovery trajectory at Trust and speciality level of RTT standards).	COO		March 2014	Significant details to be worked through re beds / theatre and outpatient and staffing capacity. To be presented to ET 11th March 2014	3
10	**Inadequate reconfiguration of buildings and services**					
10.3	Secure capital funding to implement Estates Strategy.	IDFS		~~May 2013~~ ~~December 2013~~ March 2014	Work underway on capital planning around reconfiguration – SOC due for completion in March 2014 which will be the key vehicle to agree availability of capital funding.	3
10.5	Iterative development of strategic plans with specialities. This is monitored by CMG and Executive Boards. Work continues with DS and CMGS to prioritise key areas for delivery within the clinical strategy. Further workshops planned for Jan/Feb 2014. *(Action reworded December 2013 to incorporate action 10.1)*	MD		March 2014	On track	4

Status key:	5	Complete	4	On track	3	Some delay – expect to completed as planned	2	Significant delay – unlikely to be completed as planned	1	Not yet commenced	0	Objective Revised

10.6	Reconfiguration programme to develop a strategic outline case which will inform the future estate strategy	DS		June 2014	A decision was made at the Reconfiguration Board of 12th that, to ensure that we place the activities to progress the SOC in the correct sequence and develop a robust plan, we need to refresh the programme structure, work stream ownership and governance arrangements. Deadline extended to reflect this.	3
11	**Loss of business continuity**					
11.8	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.	COO	EPO	~~July~~ ~~August~~ Review ~~October~~ ~~November 2013~~ ~~December 2013~~ March 2014	Lack of progress with Interserve escalated via NHS Horizons; however still no formal assurance from Interserve of the BCM policy/process/plans. Chief Nurse has emailed Managing Director of LLRFMC to elicit a response.	2
11.10	Training and Exercising events to involve multiple CMGs/specialties to validate plans to ensure consistency and coordination.	COO	EPO	August 2014	BCM training and exercising programme has been developed.	4
11.11	Further work required to develop escalation plans and response plans for Interserve.	COO	EPO	~~October~~ ~~December 2013~~ March 2014	Lack of response from Interserve escalated via NHS Horizons; however still no formal assurance from Interserve of the BCM policy/process/plans. Chief Nurse has emailed Managing Director of LLRFMC to elicit a response.	2
11.13	Training and Exercising events to involve multiple CMGs/ specialties to validate plans to ensure consistency and coordination	COO	EPO	August 2014	On track	4
11.14	Finance and procurement staff to be trained how to assess the BC risk to a contract and utilise the tools developed.	COO	EPO	March 2014	On track	4

Status key:	5	Complete	4	On track	3	Some delay – expect to completed as planned	2	Significant delay – unlikely to be completed as planned	1	Not yet commenced	0	Objective Revised

11.15	Review all the plans and identify priority for updating and work into 2014/2015 year plan	COO	EPO	March 2014	**Complete.** 2014/2015 work plan based on priority tasks to undertake and plans to review	5
11.16	Review and consider options for an automated system to reduce time and resources required to initiate a staff call out	COO	EPO	April 2014	On track	4
11.17	Policy and terms of reference require updating to reflect organisational restructuring	COO	EPO	February 2014	**Complete.**	5
12	**Failure to exploit the potential of IM&T**					
12.9	Ensure that there is further integration of IM&T within planning groups (12.9)	CIO		May 2014	On track	4
12.10	Ensure that there are no unforeseen IM&T requirements coming out of the 2014-2016 planning phase.	CIO		April 2014	On track	4
12.11	Work with the DOF and the capital group to ensure a coherent 5 year plan is in place for the delivery of the core IM&T components	CIO		May 2014	On track	4
12.12	Work with specialists from UHL and IBM to better define the communications and engagement strategy.	CIO		May 2014	On track	4
12.13	Review and reissue the IM&T strategy	CIO		June 2014	On track	4
12.14	To review the means by which we communicate to clinical teams, including reviewing working models from successful organisations.	CMIO		April 2014	On track	4
12.15	Review any relevant groups and engage our external stakeholders for membership	CIO/ CMIO		May 2014	On track	4
12.16	Ensure that all teams working on IM&T projects work to the required standards.	CIO		April 2014	On track	4

Status key:	5	Complete	4	On track	3	Some delay – expect to completed as planned	2	Significant delay – unlikely to be completed as planned	1	Not yet commenced	0	Objective Revised

12.17	Post project benefit realisation plans and ownership is identified at pre-commencement phase to ensure the total work is identified.	TBA		TBA	On track	4
12.18	Requirements and benefits are fully signed off prior to any work commencing	TBA		TBA	On track	4
12.19	Re-establish monthly meetings with a nominated lead to discuss projects and overall performance with the CMGs	CIO		April 2014	On track	4
12.20	Enhance the communications with the CMGs to include new opportunities that they could consider within their planning processes going forward	CIO		April 2014	On track	4
12.21	To provide a plan/dates to the relevant NTDA bodies of the expected business case release plan	CIO		March 2014	On track	4
12.22	Further work through the IM&T strategy board is required to refine the large set of requirements into a realistic deliverable plan	CIO		May 2014	On track	4
13	**Failure to enhance education and training culture**					
13.1	To improve CMG engagement facilitate meetings to discuss Medical Education Strategy and Action Plans with CMGs.	MD	AMD	~~December 2013/January 2014~~ March 2014	Meetings held with – ES Medicine, O&G, MSS, ITAPS, and discussion with CMG Leads from CHUGS and CSI Meeting with RRC tbc	3
13.2	Relevance of the UHL Education Committee to be discussed at CMG Meetings in an effort to improve attendance.	MD	AMD	~~December 2013/January 2014~~ March 2014	Meetings held with – ES Medicine, O&G, MSS, ITAPS, and discussion with CMG Leads from CHUGS and CSI Meeting with RRC tbc	3
13.4	Build relationships with CBU Quality Leads and establish links with LEG/QAC and QPMG in an effort to improve engagement with other patient safety activities/groups.	MD	AMD	~~December 2013/January 2014~~ February 2014	**Complete.** Contributing to LEG, QAC and Medical Director reports to QPMG re patient safety issues	5
13.6	**Action deleted. Same as 13.1**					

Status key:	5	Complete	4	On track	3	Some delay – expect to completed as planned	2	Significant delay – unlikely to be completed as planned	1	Not yet commenced	0	Objective Revised

13.7	Monitor UHL position against other trusts nationally to ensure progress against strategic and national benchmarks.	MD	AMD	Review ~~October 2013~~ March 2014	Following further discussions with the LETB this data is not readily available. LETB to investigate how we can acquire this data.	2
13.8	New Library/learning facilities to be developed at the LRI to help resolve inadequate educational resources.	MD	AMD	~~October 2013~~ April 2014	A Project Manager is now in place. Odames Ward will be handed over on 1st February for work to start on 1st April 2014.	4
13.9	Dr Hooper in post for Acute Medicine to implement project and improve Acute Medicine progress.	MD	AMD	February 2014	**Complete.**	5
13.10	Need to engage with the CMGs to help them understand the implication of SIFT and their funding streams.	MD	AMD	~~December 2013/January 2014~~ March 2014	Meetings held with – ES Medicine, O&G, MSS, ITAPS, and discussion with CMG Leads from CHUGS and CSI Meeting with RRC tbc	3

Key

CEO	Chief Executive Officer
IDFBS	Interim Director of Financial Strategy
MD	Medical Director
AMD	Assistant Medical Director
COO	Chief Operating Officer
DHR	Director of Human Resources
DDHR	Deputy Director of Human Resources
DS	Director of Strategy
ADLOD	Asst Director of Learning and Organisational Development
DMC	Director of Marketing and Communications
CIO	Chief Information Officer
CMIO	Chief Medical Information Officer
EPO	Emergency Planning Officer
HPO	Head of Performance Improvement
HO	Head of Operations
CD	Clinical Director
CMGM	Clinical Management Group Manager
DDF&P	Deputy Director Finance and Procurement

Status key:	5	Complete	4	On track	3	Some delay – expect to completed as planned	2	Significant delay – unlikely to be completed as planned	1	Not yet commenced	0	Objective Revised

FTPM	Foundation Trust Programme Manager
HTCIP	Head of Trust Cost Improvement Programme
ADI	Assistant Director of Information
FC	Financial Controller
ADP&S	Assistant Director of Procurement and Supplies
HoN	Head of Nursing
TT	Transformation Team
CN	Chief Nurse

Status key:	5	Complete	4	On track	3	Some delay – expect to completed as planned	2	Significant delay – unlikely to be completed as planned	1	Not yet commenced	0	Objective Revised

Appendix three

University Hospitals of Leicester NHS Trust

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?

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST

NEW RISKS SCORING 15 OR ABOVE FOR THE PERIOD ENDING 28/02/2014

REPORT PRODUCED BY: UHL CORPORATE RISK MANAGEMENT TEAM

Key

Red	Extreme risk (risk score 25)
Orange	High risk (risk score 15 - 20)
Yellow	Moderate risk (risk score 8 - 12)
Green	Low risk (risk score below 8)

Risk ID	CMG	Specialty	Risk Title	Opened	Review Date	Description of Risk	Risk subtype	Controls in place	Impact	Likelihood	Current Risk Score	Action summary	Target Risk Score	Risk Owner	Div/Exec Director	Strategic risk No.
2307	Clinical Support and Imaging	Special Biochemistry	The Forensic Toxicology service will fail resulting in a substantial loss of income and prestige for the Department/empath	17/02/2014	02/05/2014	**Causes:** The Coronial Forensic Toxicology workload will treble in January after the appointment of a new consultant Toxicologist. Work previously analysed in Sheffield will transfer to Leicester in January 2014. - insufficient qualified and experienced staff to perform analysis and interpret and report findings. - insufficient analytical platforms to perform analysis and address workload. - insufficient staff and time to administer increased workload **Consequences:** There are no resources in place for our Forensic Toxicology department to be able to process this workload in a timely manner. We will fail the agreed targets with our current users of the service. Failure to address the above will result in loss of current Toxicology contracts.with a large loss of income. Loss of prestiege will compromise our ability to win new contracts in the future.	Patients	Staff are working extra sessions and overtime at weekends but this is not sustainable in the long term. This doesn't address the lack of analytical time available on the current equipment.	Major	Likely	16	Recruitment/Transfer of staff -02.05.2014 Procure additional LCMS platform - 02.06.2014 Procure Forensic LIMS - 02.05.2014	4	BDI		