RISK REPORT INCORPORATING THE BOARD ASSURANCE FRAMEWORK (BAF)

Author: Risk and Assurance Manager Sponsor: Medical Director Date: Trust Board 1 October 2015 paper I

Executive Summary

Context

The Board Assurance Framework (BAF) is the key source of evidence that links strategic objectives to risks, controls and assurances, and the main tool that the Trust Board (TB) should use in seeking assurance that those internal control mechanisms are effective. This report provides the TB with the UHL 2015/16 BAF and action tracker as of 31st August 2015 and notification of any new extreme or high risks opened during August 2015.

Questions

1. Does the BAF provide an accurate reflection of the principal risks to our strategic objectives?
2. Is sufficient assurance provided that the principal risks are being effectively controlled?
3. Have agreed actions been completed within the specified target dates?
4. Does the Board have knowledge of new significant risks reported within the reporting period?

Conclusion

1. Input from Executive owners of each strategic objective should have provided an accurate picture of our principal risks affecting the achievement of our objectives, however at time of writing no updates have been received from the Director of Strategy
2. Many of our assurance sources are based on internal monitoring and some may benefit from external scrutiny (e.g. via internal audit) to provide additional assurance that controls are effective.
3. No updates have been received in relation to actions 5.3 and 5.4. Seven actions have been completed within timescales and one action has had its deadline extended.
4. The board is provided with a summary of all new extreme and high risk that have been entered on the UHL risk register

Input Sought

We would welcome the board's input to consider the content of the BAF and

(a) Receive and note this report;
(b) review and comment upon this version of the 2015/16 BAF, as it deems appropriate;
(c) note the actions identified to address any gaps in either controls or assurances (or both);
(d) identify any areas which it feels that the Trust's controls are inadequate;
(e) identify any gaps in assurances about the effectiveness of the controls to manage the principal risks and consider the nature of, and timescale for, any further assurances to be obtained;

(f) identify any other actions necessary to address any 'significant control issues' in order to provide assurance on the Trust meeting its principal objectives

For Reference

Edit as appropriate:

1. The following objectives were considered when preparing this report:

Safe, high quality, patient centred healthcare	[Yes]
Effective, integrated emergency care	[Yes]
Consistently meeting national access standards	[Yes]
Integrated care in partnership with others	[Yes]
Enhanced delivery in research, innovation & ed'	[Yes]
A caring, professional, engaged workforce	[Yes]
Clinically sustainable services with excellent facilities	[Yes]
Financially sustainable NHS organisation	[Yes]
Enabled by excellent IM&T	[Yes]

2. This matter relates to the following governance initiatives:

Organisational Risk Register	[Yes]
Board Assurance Framework	[Yes]

3. Related Patient and Public Involvement actions taken, or to be taken: [None]

4. Results of any Equality Impact Assessment, relating to this matter: [None]

5. Scheduled date for the next paper on this topic: [05/11/15]

6. Executive Summaries should not exceed 1 page. [My paper does comply]

7. Papers should not exceed 7 pages. [My paper does not comply]

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST

REPORT TO: TRUST BOARD

DATE: 1 OCTOBER 2015

REPORT BY: ANDREW FURLONG – ACTING MEDICAL DIRECTOR

SUBJECT: RISK REPORT INCORPORATING THE BOARD ASSURANCE FRAMEWORK (BAF)

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1. INTRODUCTION

1.1 This report provides the Trust Board (TB) with:-

a) The UHL 2015/16 BAF and action tracker as of 31st August 2015.

b) Details of new extreme or high risks opened during August 2015.

2. 2015/16 BAF POSITION AS OF 31ST AUGUST 2015

2.1 A copy of the 2015/16 BAF is attached at appendix one with any changes highlighted in red text. A copy of the action tracker is attached at appendix two with changes also highlighted in red text for ease of reference.

2.2 In relation to the above, the TB is asked to note the following points:

a. No updates have been received in relation to actions 5.3 and 5.4. The Director of Strategy is invited to provide a verbal update to the TB if required.

b. Two actions (18.1 and 18.2 – Chief Information Officer) have moved to a red RAG rating due to delays by the DoH with granting approval to elements of the EPR programme.

c. One action due date has been extended (3.4) and six new actions have been created in respect of principal risks seven (7.5, 7.6 and 7.7) and nineteen (19.6, 19.7 and 19.8). The TB is asked to consider whether these changes impact upon the risk scores.

d. Seven actions have been completed during this reporting period, relating to principal risks seven (7.4), eleven (11.6), fourteen (14.2), sixteen (16.3) and nineteen (19.1, 19.3 and 19.5). The TB is asked to consider whether the completion of these actions has reduced the current risk scores.

e. In respect of principal risk three, the risk owner has reported that the action plan for the recovery of diagnostic 6 week standard in Endoscopy is showing an improvement.

f. There have been no changes to any of the current risks scores during this reporting period.

2.3 The role of the TB is to provide scrutiny and challenge in relation to the BAF to ensure that executive owners of each strategic objective have provided sufficient assurance that risks to the achievement of these are being

effectively controlled. As requested at the September 2015 TB meeting the following objective is submitted for scrutiny:

- ***'Enabled by excellent IM&T'*** (incorporating principal risks 18 and 19).

3. EXTREME AND HIGH RISK REPORT.

3.1 Two new high risks have opened during August 2015 as described below and details of these are included at appendix three for information.

Risk ID	Risk Title	Risk Score	CMG/ Directorate
2601	There is a risk of delay in gynaecology patient correspondence due to a backlog in typing	15	W&C
2591	Risk of increased demand in diabetes outpatient foot clinic leading to overbooked clinics which over run	16	ESM

4. RECOMMENDATIONS

4.1 The TB is invited to:

(a) Receive and note this report;

(b) review and comment upon this version of the 2015/16 BAF, as it deems appropriate;

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

(d) identify any areas which it feels that the Trust's controls are inadequate and do not effectively manage the principal risks to our objectives;

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

(f) identify any other actions necessary to address any 'significant control issues' in order to provide assurance on the Trust meeting its principal objectives;

Peter Cleaver
Risk and Assurance Manager
24th September 2015.

UHL BOARD ASSURANCE FRAMEWORK 2015/16

STRATEGIC OBJECTIVES

Objective	Description	Objective Owner(s)
a	**Safe, high quality, patient centred healthcare**	**Chief Nurse** /Medical Director
b	**An effective and integrated emergency care system**	**Chief Operating Officer/** Medical Director/ Chief Nurse
c	**Services which consistently meet national access standards**	**Chief Operating Officer**
d	**Integrated care in partnership with others**	**Director of Strategy**
e	**Enhanced delivery in research, innovation and clinical education**	**Medical Director**
f	**A caring, professional and engaged workforce**	**Director of Workforce and Organisational Development**
g	**A clinically sustainable configuration of services, operating from excellent facilities**	**Director of Strategy** / Director of Estates and Facilities
h	**A financially sustainable NHS Foundation Trust**	**Chief Financial Officer**
i	**Enabled by excellent IM&T**	**Chief Information Officer**

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST – BOARD ASSURANCE FRAMEWORK

PERIOD: AUGUST 2015

Risk No.	Link to objective	Risk Description	Risk owner	Current Score	Target Score
1.	**Safe, high quality, patient centred healthcare**	Lack of progress in implementing UHL Quality Commitment (QC).	CN	9	6
2.	**An effective and integrated emergency care system**	Demographic growth plus ineffective admission avoidance schemes may counteract any internal improvements in emergency pathway	COO	20	6
3.	**Services which consistently meet national access standards**	Failure to transfer elective activity to the community , develop referral pathways, and key changes to the cancer providers in the local health economy may adversely affect our ability to consistently meet national access standards	COO	9	6
4.	**Integrated care in partnership with others**	Existing and new tertiary flows of patients not secured compromising UHL's future more specialised status.	DS	15	10
5.		Failure to deliver integrated care in partnership with others including failure to: Deliver the Better Care Together year 2 programme of work Participate in BCT formal public consultation with risk of challenge and judicial review Develop and formalise partnerships with a range of providers (tertiary and local services) Explore and pioneer new models of care. Failure to deliver integrated care.	DS	15	10
6.	**Enhanced delivery in research, innovation and clinical education**	Failure to retain BRU status.	MD	9	6
7.		Clinical service pressures and too few trainers meeting GMC criteria may mean we fail to provide consistently high standards of medical education.	MD	9	4
8.		Insufficient engagement of clinical services, investment and governance may cause failure to deliver the Genomic Medicine Centre project at UHL	MD	9	6
9.		Changes in senior management/ leaders in partner organisations may adversely affect relationships / partnerships with universities.	MD	6	6
10	**A caring, professional and engaged workforce**	Gaps in inclusive and effective leadership capacity and capability , lack of support for workforce well- being, and lack of effective team working across local teams may lead to deteriorating staff engagement and difficulties in recruiting and retaining medical and non-medical staff	DWOD	16	8
11.	**A clinically sustainable configuration of services, operating from excellent facilities**	Insufficient estates infrastructure capacity and the lack of capacity of the Estates team may adversely affect major estate transformation programme	DS	20	10
12.		Limited capital envelope to deliver the reconfigured estate which is required to meet the Trust's revenue obligations	DS	12	8
13.		Lack of robust assurance in relation to statutory compliance of the estate	DS	12	8
14.		Failure to deliver clinically sustainable configuration of services	DS	12	8
15.	**A financially sustainable NHS Organisation**	Failure to deliver the 2015/16 programme of services reviews, a key component of service-line management (SLM)	DS	9	6
16		Failure to deliver UHL's deficit control total in 2015/16	CFO	15	10
17		Failure to achieve a revised and approved 5 year financial strategy	CFO	15	10
18	**Enabled by excellent IM&T**	Delay to the approvals for the EPR programme	CIO	16	6
19		Perception of IM&T delivery by IBM leads to a lack of confidence in the service	CIO	16	6

BAF Consequence and Likelihood Descriptors:

Impact/Consequence			**Likelihood**	
5	Extreme	Catastrophic effect upon the objective, making it unachievable	5	Almost Certain (81%+)
4	Major	Significant effect upon the objective, thus making it extremely difficult/ costly to achieve	4	Likely (61% - 80%)
3	Moderate	Evident and material effect upon the objective, thus making it achievable only with some moderate difficulty/cost.	3	Possible (41% - 60%)
2	Minor	Small, but noticeable effect upon the objective, thus making it achievable with some minor difficulty/ cost.	2	Unlikely (20% - 40%)
1	Insignificant	Negligible effect upon the achievement of the objective.	1	Rare (Less than 20%)

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST – BOARD ASSURANCE FRAMEWORK

Principal risk 1	Lack of progress in implementing UHL Quality Commitment (QC).	**Overall level of risk to the achievement of the objective**	**Current score 3x3=9**	**Target score 3x2=6**
Executive Risk Lead(s)	Chief Nurse			
Link to strategic objectives	Provide safe, high quality, patient centred healthcare			

Key Controls(What control measures or systems are in place to assist secure delivery of the objective)	**Assurance Source** (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).	**Gaps in Assurance (a)/ Control (c)** (i.e. What are we not doing - What gaps in systems, controls and assurance have been identified)	**Actions to Address Gaps**	**Timescale/ Action Owner**
Corporate leads agreed for each goal and identified leads for each work stream of the Quality Commitment (QC). Recruitment strategies for medical/ nursing staff in place	3 monthly and / or 6 monthly progress reports to EQB and QAC. Nursing recruitment monitored via NET and Medical recruitment via the Medical Workforce Group			
KPIs agreed and monitored for all parts of the Quality Commitment. High level KPIs include: UHL SHMI =/< 100 by March 2016 Reduction in harm events by 5% Trust level F&FT score to 97% by March 2016 Targeted work based on 'Box Plots'	Monthly Q&P Report to TB. 3 monthly and / or 6 monthly progress reports to EQB and QAC. Exception reporting where KPIs/ outcomes not achieved External validation and benchmarking data including: Dr Foster Intelligence Copeland Risk adjusted barometer (CRAB) Hospital Evaluation data Benchmarking against peer Trusts SHMI score fallen from 106 to 99 Nationally reported infection rates show improvement 97% positive for inpatients friends and family test Currently not all deaths are screened Safety walkabout programme	(a) Currently not all deaths are screened and there is a requirement to move to 100%.	Roll out plan to be developed (1.2) Audit support to be provided (1.3) Mortality database to be developed (1.5)	Sep 2015 MD Oct 2015 MD Oct 2015 MD
Clear work plans agreed and monitored for all parts of the Quality Commitment.	Action plans reviewed regularly at EQB and as a minimum annually reported to QAC. Annual reports produced. Internal audit review during 2014/15 for each arm of			

	QC CQC inspection during 2015/16 Commissioner review of work plans/ progress via CQUIN. Internal Audit.			
Robust governance and committee structures in place to ensure delivery of the quality agenda	Regular committee reports. Annual reports. Achievement of KPIs. Senior accountable individuals with appropriate support			

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST – BOARD ASSURANCE FRAMEWORK

<table>
<tr><td>Principal risk 2</td><td colspan="2">Demographic growth plus ineffective admission avoidance schemes may counteract any internal improvements in emergency pathway</td><td colspan="2">Overall level of risk to the achievement of the objective</td><td>Current score
4x5=20</td><td>Target score
3x2=6</td></tr>
<tr><td>Executive Risk Lead(s)</td><td colspan="6">Chief Operating Officer</td></tr>
<tr><td>Link to strategic objectives</td><td colspan="6">An effective and integrated emergency care system</td></tr>
<tr><td colspan="2">Key Controls(What control measures or systems are in place to assist secure delivery of the objective)</td><td colspan="2">Assurance Source (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).</td><td>Gaps in Assurance (a)/ Control (c)
(i.e. What are we not doing - What gaps in systems, controls and assurance have been identified)</td><td>Actions to Address Gaps</td><td>Timescale/ Action Owner</td></tr>
<tr><td colspan="2">Agreed set of metrics that measure internal and external emergency care performance</td><td colspan="2">Reported to UHL TB monthly
Reported to EPB monthly
Reported to UHL Emergency Quality Steering Group monthly
Performance reported at UHL Gold Command meeting daily
Reported to UCB and CCGs
National benchmarking of emergency care data</td><td>Attendance and admissions continue to increase (+5% and (+7%).</td><td>UHL is working with LLR colleagues to identify a more effective way of reducing attendances and admissions. Plan to achieve this to be presented to UCB (2.2)</td><td>Sep 2015
COO</td></tr>
<tr><td colspan="2">LLR Action plan to improve patient flow (i.e. admissions, reduction in discharge delays, making best use of existing ED capacity</td><td colspan="2"></td><td>(c) LLR action plan not fully implemented</td><td>Continue to implement and monitor progress of LLR action plan (2.1)</td><td>Review Sep 2015
COO</td></tr>
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UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST – BOARD ASSURANCE FRAMEWORK

Principal risk 3	Failure to transfer elective activity to the community , develop referral pathways, and key changes to the cancer providers in the local health economy may adversely affect our ability to consistently meet national access standards	**Overall level of risk to the achievement of the objective**	**Current score 3x3=9**	**Target score 3x2=6**
Executive Risk Lead(s)	Chief Operating Officer			
Link to strategic objectives	Services which consistently meet national access standards			

Key Controls(What control measures or systems are in place to assist secure delivery of the objective)	**Assurance Source** (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).	**Gaps in Assurance (a)/ Control (c)** (i.e. What are we not doing - What gaps in systems, controls and assurance have been identified)	**Actions to Address Gaps**	**Timescale/ Action Owner**
Agreed set of metrics that measure referrals activity and waiting times	Reported to EPB quarterly Reported to Trust Board monthly Reported to UHL Access meeting – weekly Reported to RTT Board weekly (with representation from TDA & CCGs) Weekly diagnostics meeting Engaged with Intensive Support Team (specialist services) Now delivering Admitted, non-admitted and incomplete 18 week RTT standards Theatre Waiting list Initiatives have reduced from 180 per month to 30 in July	Have yet to implement tools and processes that allow us to improve our overall responsiveness through tactical planning	Theatre productivity improvements driven through the cross-cutting work stream. (3.3)	Review Sep 2015 COO
		(c) Currently not delivering the 62 day and 31 day cancer access standard	Recovery of cancer standards - revised action plans with revised trajectory for 62 day compliance. (3.4)	Oct 2015 COO
		(c) Anticipated failure of diagnostic 6 week standard in June due to endoscopy overdue planned patients	Recovery of diagnostic 6 week standard - Medinet (outsource company) to provide additional capacity (3.5)	Sep 2015 COO

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST – BOARD ASSURANCE FRAMEWORK

Principal risk 4	Existing and new tertiary flows of patients not secured compromising UHL's future more specialised status.	**Overall level of risk to the achievement of the objective**	**Current score 5x3=15**	**Target score 5x2=10**
Executive Risk Lead(s)	Director of Strategy			
Link to strategic objectives	Integrated care in partnership with others.			
Key Controls(What control measures or systems are in place to assist secure delivery of the objective)	**Assurance Source** (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).	**Gaps in Assurance (a)/ Control (c)** (i.e. What are we not doing - What gaps in systems, controls and assurance have been identified)	**Actions to Address Gaps**	**Timescale/ Action Owner**
Appointment to Head of Tertiary Partnerships role to lead on formalising and securing existing pathways and developing new ones.	Monthly reporting to ESB as part of Director of Strategy report.	(c) Significant amount of partnership work being taken through ESB.	Considering options/benefits/risks of establishing UHL Partnership Board. (4.1)	Oct 2015 DS
Children's and Cancer Collaborative Groups established with NUH.	Monthly reporting to ESB as part of Director of Strategy report.	(c) Significant amount of partnership being taken through ESB.	As action 4.1	As action 4.1
Memorandum of Understanding (MoU) between NUH and UHL signed in 2011.	Monthly reporting to ESB as part of Director of Strategy report.	(c) MoU was intended to support establishment of EMPATH and should include wider partnership opportunities.	MoU to be reviewed by both organisations. (4.2)	Oct 2015 DS
Partnership Board for Specialised Services established in Northamptonshire. Membership includes Northants CCGs; NHS England; KGH; NGH and UHL.				
Meetings in place and planned at Director level with other provider organisations (regional and national) to explore partnership opportunities.	Monthly reporting to ESB as part of Director of Strategy report.	None	None	

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST – BOARD ASSURANCE FRAMEWORK

Principal risk 5	**Failure to deliver integrated care in partnership with others including failure to:** Deliver the Better Care Together year 2 programme of work; Participate in BCT formal public consultation with risk of challenge and judicial review; Develop and formalise partnerships with a range of providers; Explore and pioneer new models of care. Failure to deliver integrated care.	**Overall level of risk to the achievement of the objective**	**Current score 3x5=15**	**Target score 2x5=10**
Executive Risk Lead(s)	Director of Strategy			
Link to strategic objectives	An effective and integrated emergency care system; Services which consistently meet national access standards; A clinically sustainable configuration of services, operating from excellent facilities; A financially sustainable NHS Foundation Trust			

Key Controls(What control measures or systems are in place to assist secure delivery of the objective)	**Assurance Source** (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).	**Gaps in Assurance (a)/ Control (c)** (i.e. What are we not doing - What gaps in systems, controls and assurance have been identified)	**Actions to Address Gaps**	**Timescale/ Action Owner**
PLANNING • BCT Programme five year directional plan developed and agreed in June 2014. • Two-year operational plan approved in April 2014. • LLR BCT Strategic Outline Case approved and submitted centrally December 2014.	LLR BCT Partnership Board bi-monthly, attended by the chief executive and medical director. Ad hoc updates from the chief executive to Trust Board as part of the chief executive report			
GOVERNANCE - Robust BCT and UHL/BCT project governance structure: • LLR BCT Partnership Board - overarching responsibility for setting, implementing and reporting the BCT Programme • UHL/BCT Programme Board	Monthly UHL/BCT Programme Board progress reports to Executive Strategy Board LLR wide performance monitoring report presented to Trust Board			
DELIVERY - Robust system wide project delivery structure and organisational specific delivery mechanisms • LLR project delivery through LLR Implementation Group • Organisational delivery (UHL/BCT Programme Board) Project specific delivery (UHL Beds/theatres/OP etc.)	Monthly project specific highlight reports considered at UHL/BCT Programme Board	(a)LLR wide dashboard required so that performance can be monitored	A BCT Programme Dashboard is to be established and agreed with the BCT PMO. Dashboard to be aligned and consolidated to the UHL Reconfiguration Dashboard highlighting	Aug 2015 DS

	Monthly project specific highlight reports	(a) Lack of Triangulation and assurance of plans at organisational and system wide level.	progress/risks against the eight BCT work streams (5.3) BCT PMO to facilitate triangulation process (5.4)	Review Aug 2015 DS
PUBLIC CONSULTATION • Update on plans for Public consultation considered and approved by LLR BCT Partnership Board in March 2015. • The programme will carry out an overarching consultation for the whole system change, paying specific attention to areas of particular public interest and is targeted to take place in autumn 2015.	Monthly reports are submitted to the LLR BCT Partnership Board, last one submitted March 2015	(c)No detailed plans for overall change. These will form the basis for the narrative for formal consultation.	Plan for consultation including a full governance roadmap to be completed. (5.8)	Oct 2015 DMC
EXPLORING PIONEERING NEW MODELS OF CARE TO SUPPORT THE DELIVERY OF INTEGRATED CARE Proposal for proof of concept for a single Integrated Frail Older Person Service (LPT/UHL/GE Finnamore) prepared Proposed establishment of an Institute of Frail Older People Services Programme management arrangements in place (early April, 2015)	Verbal update to Executive Strategy Board (April 2015) Progress reports are to be submitted to the Executive Strategy Board on a monthly basis	Project plan and early progress not yet developed	Integrated Frail Older Person Service project plan to be developed (5.9)	Sep 2015 DS

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST – BOARD ASSURANCE FRAMEWORK

Principal risk 6	Failure to retain BRU status.	**Overall level of risk to the achievement of the objective**	**Current score 3x3=9**	**Target score 3x2=6**
Executive Risk Lead(s)	Medical Director			
Link to strategic objectives	Enhanced reputation in research, innovation and clinical education			

Key Controls(What control measures or systems are in place to assist secure delivery of the objective)	**Assurance Source** (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).	**Gaps in Assurance (a)/ Control (c)** (i.e. What are we not doing - What gaps in systems, controls and assurance have been identified)	**Actions to Address Gaps**	**Timescale/ Action Owner**
Maintaining relationships with key partners to support joint NIHR/ BRU infrastructure	Joint BRU Board (bimonthly) Annual Report Feedback from NIHR for each BRU (annual) UHL R&D Executive (monthly) R&D Report to Trust Board (quarterly)	(c) Requirement to replace senior staff and increase critical mass of senior academic staff in each of the three BRUs.	BRUs to re-consider theme structures for renewal, identifying potential new theme leads. (6.1) BRUs to identify potential recruits and work with UoL/LU to structure recruitment packages. (6.2)	Dec 2015 MD Dec 2015 MD
	Athena Swan Silver Status by University of Leicester and Loughborough University. (The Athena Swan charter applies to higher education institutions)	(c) Athena Swan Silver not yet achieved by UoL and Loughborough University. This will be required for eligibility for NIHR awards	UoL and LU to ensure successful applications for Silver swan status. Individual medical school depts. will need to separately apply for Athena Swan Silver status. (6.4)	Mar 2016 MD

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST – BOARD ASSURANCE FRAMEWORK

Principal risk 7	Clinical service pressures and too few trainers meeting GMC criteria may mean we fail to provide consistently high standards of medical education.	**Overall level of risk to the achievement of the objective**	**Current score 3 x 3 = 9**	**Target score 2 x 2 = 4**
Executive Risk Lead(s)	Medical Director			
Link to strategic objectives	Enhanced reputation in research, innovation and clinical education			

Key Controls(What control measures or systems are in place to assist secure delivery of the objective)	**Assurance Source** (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).	**Gaps in Assurance (a)/ Control (c)** (i.e. What are we not doing - What gaps in systems, controls and assurance have been identified)	**Actions to Address Gaps**	
Medical Education Strategy	Department of Clinical Education (DCE) Business Plan and risk register are discussed at regular DCE Team Meetings and information given to the Trust Board quarterly Oversight by Executive Workforce Board Bi-monthly UHL Medical Education Committee meetings (including CMG representation) Database of recognised Trainers required by GMC 2016 Appointment processes for Level 3 educational roles established Appraisal of Level 2 educational roles in UHL appraisal KPI are measured using the: • UHL Education Quality Dashboard • CMG Education Leads and stakeholder meetings • GMC Trainee Survey results • UHL trainee survey • HEEM accreditation visits	(c) Education facilities Identified as poor in external reports from HEEM and Leicester University c) Ineffective control of clinical service pressures, vacancies and loss of posts on rotas that adversely affect quality of training and added impact of	Continue to improve facilities i.e. to re-provide LRI Jarvis education centre in 1771 building, provide UHL Simulation facility and consider feasibility of Glenfield as an expanding training site (7.2) SPA time in job plans for training (7.5) CMG Education leads to develop action plans following findings from GMC National Trainee Survey and National Student	Nov 2015 MD Jan 2016 MD Aug 2016 MD

			Survey (7.6) All UHL trainers need to be recognised by GMC and included on a Trust database (7.7)	 July 2016 MD

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST – BOARD ASSURANCE FRAMEWORK

Principal risk 8	Insufficient engagement of clinical services, investment and governance may cause failure to deliver the Genomic Medicine Centre project at UHL	**Overall level of risk to the achievement of the objective**	**Current score** **3x3=9**	**Target score** **3x2=6**
Executive Risk Lead(s)	Medical Director			
Link to strategic objectives	Enhanced reputation in research, innovation and clinical education			

Key Controls(What control measures or systems are in place to assist secure delivery of the objective)	**Assurance Source** (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).	**Gaps in Assurance (a)/ Control (c)** (i.e. What are we not doing - What gaps in systems, controls and assurance have been identified)	**Actions to Address Gaps**	**Timescale/ Action Owner**
Genomic Medicine Centre project manager for UHL in place Nominated UHL GMC lead, with UHL leads for both cancer and rare diseases Trust GMC Steering Committee in place	GMC Report to UHL R&I Executive (bimonthly) R&I minutes (inc. GMC report) to ESB bimonthly Weekly NHS England/Genomics England: Reports to UHL GMC Steering Committee via Cambridge GMC Update in R&I Report to Trust Board (quarterly) Trust GMC Steering Committee minutes Local delivery monitoring against recruitment trajectory KPI via R&I Office when project live Delivery monitoring against recruitment trajectory KPI by Lead GMC Partner when project live	(c) Workforce education around genomics (c) Transformation in clinical services (c) Transformation in public attitudes towards genomic medicine	Work with AHSN, HEEM and GMC Lead organisation to develop appropriate training for clinical and non-clinical staff (8.1) Support CMGs with transformation of GMC project into clinical services (8.2) Work with AHSN and centre for BME Health to coordinate public engagement activity aimed at (i) raising expectation of participating in the GMC project and (ii) benefits to patients of genomic medicine (8.3)	Mar 2016 MD Mar 2016 MD June 2016 MD

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST – BOARD ASSURANCE FRAMEWORK

Principal risk 9	Changes in senior management/ leaders in partner organisations may adversely affect relationships / partnerships with universities.	**Overall level of risk to the achievement of the objective**	**Current score 3x2=6**	**Target score 3x2=6**
Executive Risk Lead(s)	Medical Director			
Link to strategic objectives	Enhanced reputation in research, innovation and clinical education			

Key Controls(What control measures or systems are in place to assist secure delivery of the objective)	**Assurance Source** (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).	**Gaps in Assurance (a)/ Control (c)** (i.e. What are we not doing - What gaps in systems, controls and assurance have been identified)	**Actions to Address Gaps**	**Timescale/ Action Owner**
Maintaining relationships with key academic partners. Developing relationships with key academic partners. Existing well established partners: • University of Leicester • Loughborough University Developing partnerships; • De Montfort University • University of Nottingham • University College London (Life Study) • Cambridge University (100k project)	Minutes of joint UHL/UoL Strategy meetings Minutes of Joint BRU Board Minutes of NCSEM Management Board Meetings of Joint UHL/UoL research office Life steering group meets monthly EM CLAHRC Management Board reports via R&D Exec to ESB	(c) Contacts with Universities could be developed more closely	Develop new 4 way strategy meeting with UHL, UoL, LU and DMU (9.2)	Mar 2016 MD

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST – BOARD ASSURANCE FRAMEWORK

<table>
<tr><td>Principal risk 10</td><td>Gaps in inclusive and effective leadership capacity and capability , lack of support for workforce well-being, and lack of effective team working across local teams may lead to deteriorating staff engagement and difficulties in recruiting and retaining medical and non-medical staff</td><td>Overall level of risk to the achievement of the objective</td><td>Current score
4x4 = 16</td><td colspan="2">Target score
4x2 = 8</td></tr>
<tr><td>Executive Risk Lead(s)</td><td colspan="5">Director of Workforce and Organisational Development</td></tr>
<tr><td>Link to strategic objectives</td><td colspan="5">A caring, professional and engaged workforce</td></tr>
<tr><td colspan="2">Key Controls(What control measures or systems are in place to assist secure delivery of the objective)</td><td>Assurance Source (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).</td><td>Gaps in Assurance (a)/ Control (c)
(i.e. What are we not doing - What gaps in systems, controls and assurance have been identified)</td><td>Actions to Address Gaps</td><td>Timescale/ Action Owner</td></tr>
<tr><td colspan="2">Organisational Development Plan</td><td>Reported to EWB quarterly
Reported to Trust Board quarterly
Internal Audit assurance via 2014/15 Programme
Key Performance Indicators included within OD plan
Progress against plan monitored monthly in CMGs</td><td></td><td></td><td></td></tr>
<tr><td colspan="2">LIA Programme</td><td>LIA Sponsor Group meet monthly
Reported to EWB quarterly
Reported to Trust Board quarterly (as part of the OD report).</td><td>(c) Analysis of LIA dataset has identified some key areas for improvement – coded as: Frustrations; Focus on Quality; Structures and leadership</td><td>Continue with the spread of LiA to enable staff to make contributions to changes and improvements at work (10.2)</td><td>Mar 2016
DWOD</td></tr>
<tr><td colspan="2">Workforce Planning</td><td>Reported to EWB quarterly
Reported to Trust Board quarterly (as part of OD plan)
Key Performance Indicators included in organisational health dashboard and NTDA submission and include:
Pay spend against plan
Staff number (wte) against plan
Safe staffing levels within clinical areas</td><td>(c) Affordability against workforce plan is an issue related to lack of substantive staff leading to increase in premium spend</td><td>CMGs to produce a trajectory of premium spend linked to recruitment with which will be monitored through the weekly CMG performance meetings and Cross Cutting Workforce Meeting. (10.3)</td><td>Mar 2016
DWOD</td></tr>
</table>

		(c) No national guidance currently in place in relation to nursing revalidation and therefore UHL plan based on draft/ consultation documents (c) Lack of resource for appraisals and third party confirmer processes and access to CPD for bank only nurses (c) registrants currently do not have time built into their shifts to complete revalidation requirements (approx. 8 hour per year per registrant required)	Once national guidance received we will need to identify the resources required to implement the nursing revalidation guidance and submit business cases for funding (10.13)	Mar 2016 CN
Medical Workforce Strategy Medical Workforce Group Medical Workforce Design and Recruitment group	Outputs reported to EWB (quarterly) and CQRG (bi-annually)	(c) Lack of effective processes for international recruitment. (c) Lack of a systematic approach to design by new teams around the patient. (c) Lack of clarity on gaps in junior Dr supply as a result of broadening foundation and redistribution	 Training for clinicians on role redesign and functional mapping (10.11) Work with HEEM to influence posts to be redistributed (10.12)	 Dec 2015 MD Mar 2016 MD
Leadership into Action Strategy	Reported to EWB quarterly	(c)Negative feedback	Improvements in	Mar 2016

	Reported to Trust Board quarterly (as part of OD plan) National staff survey responses Staff friends and family test responses LiA 'pulse check' responses East Midland Academy Board receives reports in relation to the monitoring of utilisation and quality of East Midlands Academy Board leadership programmes.	from surveys in relation to leadership issues	local leadership and the management of well led teams including holding to account for the basics (10.4)	DWOD
Equality Action Plan	Twice yearly progress report to Trust Board, EWB,EQB and Commissioners KPIs for monitoring are contained within the Public Sector Equality duty	(c) Low BME representation at band 7 or above	NED apprenticeship scheme to be implemented (10.5) Targeted interventions for BME band 5 and 6 to be developed and implemented (10.6)	Mar 2016 DMC Mar 2016 DMC
Compliance with national 'Freedom to Speak' standard including: 3636 concerns hotline Junior Dr 'gripe tool' Patients Safety walkabouts UHL intranet 'staff room' Clinical Senate Monthly 'Breakfast with the Boss' forums Whistleblowing' policy Anti-Bullying / harassment policy Director of Safety and Risk	Regular (quarterly) reporting to EQB in relation to 'whistleblowing 3636 hotline CQC Patient Safety Junior Dr 'gripe tool' Regular reports from Clinical senate	(c)Not yet appointed a 'Freedom to Speak' Guardian (a) No formal publication of actions taken as a consequence of concerns raised (c)Nominated managers for receipt of concerns not yet identified (c) Need better links with National helpline	Await national guidance in relation to this post (10.7) Undertake actions from 'Freedom to Speak' gap analysis (10.8) CMGs to nominate appropriate managers (10.9) TBA	Sep 2015 MD Sep 2015 MD Sep 2015 MD TBA MD

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST – BOARD ASSURANCE FRAMEWORK

Principal risk 11	Insufficient estates infrastructure capacity and the lack of capacity of the Estates team may adversely affect major estate transformation programme	**Overall level of risk to the achievement of the objective**	**Current score** 5x4=20	**Target score** 5x2=10
Executive Risk Lead(s)	Director of Facilities			
Link to strategic objectives	A clinically sustainable configuration of services, operating from excellent facilities			

Key Controls(What control measures or systems are in place to assist secure delivery of the objective)	**Assurance Source** (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).	**Gaps in Assurance (a)/ Control (c)** (i.e. What are we not doing - What gaps in systems, controls and assurance have been identified)	**Actions to Address Gaps**	**Timescale/ Action Owner**
Link the reconfiguration investment programme demands with current infrastructure, identifying future capacity requirements Current infrastructure details being gathered for all three acute sites identifying high risk elements of engineering and building infrastructure	Highlight reports developed monthly and reported to the UHL Reconfiguration Programme Board. Capital business cases meeting on a monthly basis which will ensure strategy/estates link and this group will feed into the reconfiguration board.	(c) A programme of infrastructure improvements is yet to be identified (c) Timescale issues for infrastructure works which could impact on the overall programme have not yet been identified and quantified in relation to risk	Assessment of current capacity being established (11.7) Develop a programme of works (11.2) Develop an operational risk register for the projects (11.3)	Sep 2015 DEF Sep 2015 DEF Sep 2015 DEF
Capital programme with ring fenced capital funding to support future infrastructure capacity demands	Capital Investments Monitoring Committee	(c) Currently no identified capital funding within 2015/16 programme and future years	Identification of investment required and allocation of capital funding (11.4)	Sep 2015 DEF/CFO
An established Estates and Facilities team with detailed knowledge of the estates and reconfiguration programme Estates work stream to support reconfiguration established which reports in UHL reconfiguration programme board to ensure alignment with all other reconfiguration projects.	Regular reports to Executive Performance Board (EPB) Monthly highlight reports completed and reported to EPB	(c) Conflicting responsibilities/roles of the estates and facilities team between UHL and the LLR estate	Define resource and skills gaps and agree an enhanced team structure to support the significant	Sep 2015 DEF

		and Facilities Management Collaborative	reconfiguration programme (11.5)	

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST – BOARD ASSURANCE FRAMEWORK

Principal risk 12	Limited capital envelope to deliver the reconfigured estate which is required to meet the Trust's revenue obligations	**Overall level of risk to the achievement of the objective**	**Current score** 4 x 3 = 12	**Target score** 4 x 2 = 8
Executive Risk Lead(s)	Director of Facilities			
Link to strategic objectives	A clinically sustainable configuration of services, operating from excellent facilities			

Key Controls(What control measures or systems are in place to assist secure delivery of the objective)	**Assurance Source** (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).	**Gaps in Assurance (a)/ Control (c)** (i.e. What are we not doing - What gaps in systems, controls and assurance have been identified)	**Actions to Address Gaps**	**Timescale/ Action Owner**
Five year capital plan agreed with individual business cases identified to deliver reconfiguration. The capital plan and overarching programme for reconfiguration is regularly reviewed by the executive team.	Capital Investment Monitoring Committee will monitor the overall programme of capital expenditure and early warning to issues. Monthly reports to ESB and IFPIC on progress of reconfiguration capital programme.	(c) Availability of external capital funding	On-going discussions between executive team and NTDA. (12.4) Consideration to be given to other avenues for sources of funding. (12.5)	Sep 2015 DEF / DOS / CFO
There are a series of capital business cases supporting reconfiguration. Each business case under development has its own project board in place to manage and monitor detailed schemes. Business case development is overseen by the strategy directorate, with responsibility for the estates annex part in the estates directorate. Both directorates work closely to ensure activities are tracked and aligned.	Highlight reports produced for each project board. This is then aggregated with all work streams, to provide an overall assurance picture of the reconfiguration for estates (last report 17.7) Estates work stream reporting to the UHL Reconfiguration Programme Board	(c) 'road map' requires development to provide the full picture and deliverability of the programme of change	PMO holding estates workshop and followed by a joint estates and strategy workshop (12.3)	Sep 2015 DEF/DS

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST – BOARD ASSURANCE FRAMEWORK

Principal risk 13	Lack of robust assurance in relation to statutory compliance of the estate	**Overall level of risk to the achievement of the objective**	**Current score 4x3=12**	**Target score 4x2=8**
Executive Risk Lead(s)	Director of Facilities			
Link to strategic objectives	A clinically sustainable configuration of services, operating from excellent facilities			

Key Controls(What control measures or systems are in place to assist secure delivery of the objective)	**Assurance Source** (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).	**Gaps in Assurance (a)/ Control (c)** (i.e. What are we not doing - What gaps in systems, controls and assurance have been identified)	**Actions to Address Gaps**	**Timescale/ Action Owner**
Outsourced facilities management contract performance managed by the Estates and Facilities Management Collaborative Defined KPI's which Interserve FM are measured against.	LLR FMC Board Monthly Contact Management Panel, and Service Review Meeting Assurance on IFM performance monitored via spot checks and deep dive analysis. In addition incident scenarios have been carried out to test IFM data, processes and systems the outcome of these are being reported to the Contract Management Panel with future scenarios planned bi-monthly On-going major incident scenarios developed and played out to identify any deficiencies in data, process and systems New Planet software system introduced by IFM in July now being evaluated	(a) A lack of electronic evidence by IFM on compliance (a) Limited contractual KPI's on compliance	 Develop improved software dashboard reporting (CASS) (13.2)	 Sep 2015 DEF

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST – BOARD ASSURANCE FRAMEWORK

Principal risk 14	**Failure to deliver clinically sustainable configuration of services**	**Overall level of risk to the achievement of the objective**	**Current score 4x3=12**	**Target score 4x2=8**
Executive Risk Lead(s)	Director of Strategy			
Link to strategic objectives	Clinically sustainable configuration of services, operating from excellent facilities			

Key Controls(What control measures or systems are in place to assist secure delivery of the objective)	**Assurance Source** (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).	**Gaps in Assurance (a)/ Control (c)** (i.e. What are we not doing - What gaps in systems, controls and assurance have been identified)	**Actions to Address Gaps**	**Timescale/ Action Owner**
Business case approvals: • Strategic capital business case work stream established within UHL reconfiguration programme governance. • Detailed programme plan which identifies key milestones for delivery of the capital plan over the coming years; business cases are differentiated between external funding/approval and internal approval. • Monitoring of business case timescales for delivery via established governance structure	A monthly highlight report is submitted to the UHL Reconfiguration Programme Delivery Board. Monthly aggregate reporting to ESB, IFPIC and Trust Board. (Last reporting, July 15). Monthly meetings with the NTDA to discuss the programme of delivery and identify new cases coming up for approval	(c) Lack of capacity within the NTDA to resource each of the business cases	NTDA to look at providing a management and financial lead for each business case (14.1)	Oct 2015 DS
Availability of transitional support: Requirements identified to deliver key projects and this is overseen by programme management office (PMO) to ensure delivery and ensure progress as outlined in project plan. Projects focus on reconfiguration/service transformation to support achievement of the UHL two acute site model, via: • Models of care • Future Operating Model • Strategic business cases • Enablers Project resources identified against each project, particularly for business cases. A resource management process has been approved through the reconfiguration board to monitor spend against agreed budgets and available resources.	PMO in place to track and monitor overall UHL reconfiguration delivery. Overall programme resources identified and system in place to manage/track spend relating to reconfiguration. Business case team oversee, manage and deliver cases for approval, including report on spend. A report is submitted to the UHL Reconfiguration Programme Delivery Board on a monthly basis that tracks progress to date, including financial assurance, risks with mitigations. Summary report provided to ESB each month.	No gaps currently identified		

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST – BOARD ASSURANCE FRAMEWORK

Consultation- • BCT Consultation programme established • Each of the appropriate BC have a consultation and engagement plans in place and work closely through the UHL communication and engagement lead to ensure continuity with the BCT Plan	The reconfiguration communication lead sits on key project boards and the BCT communications and engagement group. A monthly report is submitted to the UHL Reconfiguration Programme Delivery Board from the communication and engagement work stream. Last report Aug 15.			
A future operating model at speciality level which supports a two acute site footprint: Work stream exists to develop plans (bottom up) across beds, theatres, outpatients, diagnostics, and workforce with a series of workshops to map future capacity to inform reconfiguration.	Monthly reports submitted to UHL reconfiguration programme board. Models of care workshops set-up across the CMGs to further develop future state plans – led by Gino Distefano and Andrew Furlong as SRO. A work stream for the LGH has been established to support the estates delivery plan.	(a) Further work required, as part of future operating model, to look at the remaining acute services at the LGH to determine the gap in the current capital plan	Complete site survey at LGH and then to overlay future operating model outputs. (14.3). This will be done across estates/strategy to develop a future state delivery plan. Work stream established to support this.	Nov 15 DS
Ability to shift activity into out of hospital settings in order to support two site acute model: An out of hospital project has been established to develop and deliver plans to shift appropriate activity into the community.	Monthly reports submitted to UHL reconfiguration programme board. Last report Aug 15. Contract approved with transitional funding secured. Recruiting to positions (LPT lead) for an October phased start.	No gaps currently identified		

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST – BOARD ASSURANCE FRAMEWORK

Principal risk 15	Failure to deliver the 2015/16 programme of services reviews, a key component of service-line management (SLM)	**Overall level of risk to the achievement of the objective**	**Current score 3x3= 9**	**Target score 3x2=6**
Executive Risk Lead(s)	Director of Strategy			
Link to strategic objectives	A financially sustainable NHS Organisation			

Key Controls(What control measures or systems are in place to assist secure delivery of the objective)	**Assurance Source** (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).	**Gaps in Assurance (a)/ Control (c)** (i.e. What are we not doing - What gaps in systems, controls and assurance have been identified)	**Actions to Address Gaps**	**Timescale/ Action Owner**
Overarching project plan for service reviews developed	Service Review Update and Roll Out Plan considered by ESB.			
Governance arrangements established which includes: - Monthly highlight reporting process embedded (includes progress, risks, issues, and mitigation) - Monthly updates / assurance reported to Integrated Finance, Performance and Investment Committee (IFPIC) and EPB as part of the Cost Improvement Programme paper.	Monthly reporting to IFPIC and EPB as part of CIP report.			
Capacity bolstered through the appointment of: - Programme Support Officer appointed to coordinate the programme of service reviews, provide support to service leads, and to engage key stakeholders in the process e.g. heads of service, transformation managers, operational managers etc. - Transformation managers within CMGs who will support the facilitation of service reviews	N/A			
Service reviews to be considered as part of the Clinical Strategy work stream which reports into the BCT UHL Delivery Board (and PMO) to ensure alignment with wider provision of data and intelligence designed to inform new models of care / ways of working	Monthly reporting to BCT UHL Delivery Board (PMO)	N/A	N/A	N/A

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST – BOARD ASSURANCE FRAMEWORK

Principal risk 16	Failure to deliver UHL's deficit control total in 2015/16 (note this has officially changed by £2m to £34.1m)	**Overall level of risk to the achievement of the objective**	**Current score 5x3=15**	**Target score 5x2=10**
Executive Risk Lead(s)	Chief Financial Officer			
Link to strategic objectives	A financially sustainable NHS organisation			

Key Controls(What control measures or systems are in place to assist secure delivery of the objective)	**Assurance Source** (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).	**Gaps in Assurance (a)/ Control (c)** (i.e. What are we not doing - What gaps in systems, controls and assurance have been identified)	**Actions to Address Gaps**	**Timescale/ Action Owner**
Completion and delegation of final, detailed income and expenditure control totals each CMG and Department within UHL Following excess spend, particularly on premium pay in Q1 and the NTDA revision of the Trust's control total to £34.1m, a recovery/improvement plan submitted to NTDA	Final agreed financial plan including detailed budget book to IFPIC (draft in April 2015) in early May 2015 Full devolution of budgets to CMGs and Departments, clarity achieved by robust integrated planning process in advance of April 2015 Monthly reporting via Exec Performance Board, IFPIC and Trust Board			
Sign off and agreement of contracts with CCGs and NHSE including activity plans for all areas and the terms and conditions attached to the contracts in 2015/16	Detail of the agreed contracts to IFPIC (draft in April 2015) in early May 2015 Full devolution of activity and performance plans to CMGs and Departments, clarity achieved by robust integrated planning process in advance of April 2015 Monthly reporting via Exec Performance Board, IFPIC and Trust Board			
Finance and CIP delivery by CMGs at UHL	Weekly reviews between CFO/COO and all CMGs, covering key areas of performance including finance and CIPs Monthly reporting via Exec Performance Board, IFPIC and Trust Board			
UHL service and financial strategy (as per SOC and LTFM)	Updates and reporting to the BCT UHL Monthly			

	Delivery Group (chaired by DS or CFO), reporting into Executive Strategy Board, IFPIC and Trust Board			
Identification and mitigation of excess cost pressures	Robust process involving the CEO to identify and fund where necessary any unavoidable cost pressures in advance of the start of 2015/16 Monthly reporting via Exec Performance Board, IFPIC and Trust Board			

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST – BOARD ASSURANCE FRAMEWORK

Principal risk 17	Failure to achieve a revised and approved 5 year financial strategy	**Overall level of risk to the achievement of the objective**	**Current score 5x3=15**	**Target score 5x2=10**
Executive Risk Lead(s)	Chief Financial Officer			
Link to strategic objectives	A financially sustainable NHS organisation			

Key Controls(What control measures or systems are in place to assist secure delivery of the objective)	**Assurance Source** (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).	**Gaps in Assurance (a)/ Control (c)** (i.e. What are we not doing - What gaps in systems, controls and assurance have been identified)	**Actions to Address Gaps**	**Timescale/ Action Owner**
Overall strategic direction of travel defined through Better Care Together	The pending approval of the Better Care Together Strategic Outline Case (SOC) by TDA and NHSE			
Financial Strategy fully modelled and agreed by all parties locally and nationally	2015/16 financial plan (as per existing LTFM) approved by both Trust Board and TDA LTFM being revised for review by Trust Board in mid-May Approval of the LTFM by the TDA will be sought late May into June depending on TDA governance process	(c)LTFM not yet approved	Liaise with TDA to agree process for LTFM submission and sign-off (17.3)	Review Sep 2015 CFO
Cash required for capital and existing deficit support	Trust Board have approved UHL's working capital strategy (in April 2015) In principle, TDA are supportive of the 5 year strategy and the cash/loan support that is required This will be formalised through TDA approval of BCT SOC and the revised LTFM	(c)SOC not yet formally approved (c)LTFM not yet approved	As above Explore options for other (non-NHS) sources of capital funding(17.4)	 Sept 2015 CFO

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST – BOARD ASSURANCE FRAMEWORK

Principal risk 18	Delay to the approvals for the EPR programme		**Overall level of risk to the achievement of the objective**	**Current score 4x4 =16**	**Target score 2x3=6**
Executive Risk Lead(s)	Chief Information Officer				
Link to strategic objectives	Enabled by excellent IM&T				
Key Controls(What control measures or systems are in place to assist secure delivery of the objective)	**Assurance Source** (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).		**Gaps in Assurance (a)/ Control (c)** (i.e. What are we not doing - What gaps in systems, controls and assurance have been identified)	**Actions to Address Gaps**	**Timescale/ Action Owner**
Communications with key contacts throughout the external approvals chain	Weekly meeting to discuss progress and issues. Updates on the IM&T transformation Board, EPR programme Board and the joint Governance Board.		(c) Local TDA approval has been given and the project now sits with the Department of Health who are unable to give us a clear timetable	Further work with NTDA/DoH to progress a firm timetable to the ATP (18.1)	Oct 2015 CIO
Communications with key contacts throughout the Internal approvals chain	Weekly meeting to discuss progress and issues. Updates on the IM&T transformation Board, EPR programme Board and the joint Governance Board.		(c) Lack of confirmed planning, hindered by the external ATP steps, could lead to delays in the internal processing of the final FBC	Further work to expose the executive and the Trust board to the likely shape of the FBC and the required internal steps. (18.2)	Oct 2015 CIO

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST – BOARD ASSURANCE FRAMEWORK

Principal risk 19	Perception of IM&T delivery by IBM leads to a lack of confidence in the service	**Overall level of risk to the achievement of the objective**	**Current score 4x4=16**	**Target score 3x2=6**
Executive Risk Lead(s)	Chief Information Officer			
Link to strategic objectives	Enabled by excellent IM&T			

Key Controls(What control measures or systems are in place to assist secure delivery of the objective)	**Assurance Source** (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).	**Gaps in Assurance (a)/ Control (c)** (i.e. What are we not doing - What gaps in systems, controls and assurance have been identified)	**Actions to Address Gaps**	**Timescale/ Action Owner**
Review of contractual deliverable and quality of service	External reviews, PWC and ISO 27001 Audit in 2014 Monthly service delivery board, covering all aspects of service delivery	(a) VfM review has highlighted some improvements to the current deliverables	Develop a service improvement plan, created from contract review and LiA outputs, to ensure contract deliverables and expectations are in place (19.6)	Sept 2015 CIO
Communication to end users of the performance of IBM and IM&T in service delivery	Monthly service delivery board, covering all aspects of service delivery Performance reports are available on InSite Project performance is reported quarterly through the trust executive	(a) Demonstration of the improved communications approach	Review of the new communications strategy and deliverables (19.7)	Dec 2015 CIO
End user's service meets their requirements	Liaison with the CMGs to ensure we are meeting their requirements Monitoring of complaints around the service and it's delivery	(c) No formal process, post the contract award, to test the delivery principles	Following LiA Event in June, monitoring of the performance indicators in the improvement plan (19.8)	Dec 2015 CIO

Appendix two

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST

ACTION TRACKER FOR THE 2015/16 BOARD ASSURANCE FRAMEWORK (BAF)

Monitoring body (Internal and/or External):	UHL Executive Team
Reason for action plan:	Board Assurance Framework
Date of this review	**August 2015**
Frequency of review:	Monthly
Date of last review:	July 2015

REF	ACTION	BOARD LEVEL LEAD	OPS LEAD	COMPLETION DATE	PROGRESS UPDATE	STATUS
1	**Lack of progress in implementing UHL Quality Commitment (QC).**					
1.2	Roll-out plan to be developed to move to 100% screening of deaths	MD	HOE	September 2015	Process drafted and incorporated into policy. Being launched at M&M Lead's forum on 18th May.	4
1.3	Audit support to be provided.	MD	HOE	~~July 2015~~ October 2015	Funding approved. M&M Clerks and analyst recruitment process commenced. Job descriptions currently undergoing job panel evaluation. Deadline extended to reflect expected dates for roles to be filled	3
1.5	Mortality database to be developed.	MD/CN	HOE	~~Review July 2015~~ October 2015	Database scoping exercise being undertaken. Awaiting feedback from potential providers. Excel spread sheet database being used in the meantime.	3
2	**Demographic growth plus ineffective admission avoidance schemes may counteract any internal improvements in emergency pathway**					
2.1	Continue to implement and monitor progress of LLR action plan	COO		Review September 2015	Plan is reviewed through weekly EQSG and fortnightly UCB. The key problem remains inflow trend.	2
2.2	UHL is working with LLR colleagues to identify a more effective work of reducing attendances and admissions. Plan to achieve this to be presented to UCB in July	COO		~~June 2015~~ ~~July 2015~~ September 2015	Demand management is not proving to be as effective as had been hoped. Updated plan going to TB in September. Timescale extended to reflect this	2
3	**Failure to transfer elective activity to the community , develop referral pathways, and key changes to the cancer providers in the local health economy may adversely affect our ability to consistently meet national access standards**					

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

3.3	Theatre productivity improvements driven through the cross-cutting work stream.	COO		~~July 2015~~ September 2015	Theatre CCT is concentrating on reducing out of hours sessions at present. Waiting list initiatives have reduced from 180 per month to 30 in July. The next stage of the action is to improve theatres in hours utilisation. End point not yet defined therefore review of progress in September	3
3.4	Recovery of cancer standards	COO	W Monaghan / C Carr	~~September 2015~~ October 2015	Revised tumour site plans and trajectory. Appointment of 3 band 7's to support key tumour sites underway. New weekly executive cancer board on Tuesday afternoons to progress with recovery to trajectory.	3
3.5	Recovery of diagnostic 6 week standard	COO	W Monaghan / C Carr	September 2015	Main issue within endoscopy, Medinet IS provider starting additional capacity 1st week in July. Clear action plan in place Endoscopy improving.	4
4	**Existing and new tertiary flows of patients not secured compromising UHL's future more specialised status.**					
4.1	Consider options/benefits/risks of establishing UHL Partnership Board.	DS		~~July 2015~~ October 2015	Discussions are on-going to ensure members are aware on progress to date, the range of partnerships currently being explored and actions planned going forward a tertiary. It is anticipated that the feasibility of a UHL Partnership Board will be decided at meetings taking place in October. Deadline extended 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

4.2	Memorandum of Understanding (MoU) to be reviewed by both organisations.	DS		~~July 2015~~ October 2015	Positive discussions have started at Chief Executive level between UHL and NUH looking at ways of working and taking a more strategic leadership position across the East Midlands. Priorities include cancer services, children's services, spinal services and engagement with United Lincolnshire Hospitals Trust Discussions are on-going with meetings taking place in October. Deadline extended to reflect this	3
5	**Failure to deliver RTT improvement plan. Failure to deliver integrated care in partnership with others including failure to: Deliver the Better Care Together year 2 programme of work; Participate in BCT formal public consultation with risk of challenge and judicial review; Develop and formalise partnerships with a range of providers; Explore and pioneer new models of care. Failure to deliver integrated care.**					
5.3	LLR wide business intelligence group established. UHL dashboard in draft to be used to inform LLR wide dashboard.	DS		~~May 2015~~ ~~July 2015~~ August 2015	Awaiting update from action owner. UHL dashboard has been agreed and shared with the LLR BCT PMO team. Following June TB, a BCT Programme Dashboard is to be established and agreed with the BCT PMO. The dashboard is to be aligned and consolidated to the UHL Reconfiguration Dashboard highlighting progress/risks against the eight BCT work streams. The BCT dashboard to be presented to the August TB meeting.	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

5.4	BCT PMO to facilitate triangulation process for plans at an organisational and system level	DS		~~May 2015~~ ~~July 2015~~ Review August 2015	Awaiting update from action owner. In progress – series of presentations going to the BCT delivery board in May June and July. Deadline extended to reflect the sequencing of presentations Work continues. This action to be reviewed again at the end of August 2015	3
5.8	Plan for consultation including a full governance roadmap to be completed.	DMC		~~July 2015~~ October 2015	Draft plan complete. Awaiting outcomes of BCT Work stream 'Lock ins' taking place during August in order to finalise. Likely that the plan and narrative will be reviewed by BCT partners in Sept / Oct. timescale extended to reflect this	3
5.9	Project plan to be developed Integrated Frail Older Person Service Project plan to be developed	DS		~~May 2015~~ ~~July 2015~~ September 2015	The final report was presented to the August ESB, following ESB Chief Executive level discussions are to be taken with LPT before final agreement is reached.	3
6	**Failure to retain BRU status.**					
6.1	BRUs to re-consider theme structures for renewal, identifying potential new theme leads.	MD	Nigel Brunskill	~~June 2015~~ Dec 2015	On-going – Target date updated to align with schedule from NIHR	3
6.2	BRUs to identify potential recruits and work with UoL/ LU to structure recruitment packages.	MD	Nigel Brunskill	~~June 2015~~ Dec 2015	On-going – Target date updated to align with schedule from NIHR	3
6.4	University of Leicester (UoL) and Leicester University to ensure successful applications for Silver Swan status.	MD		March 2016	VC and President has re-constituted group leading Medical School Bid with appointment of new project manager.	4
7	**Clinical service pressures and too few trainers meeting GMC criteria may mean we fail to provide consistently high standards of medical education.**					

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

7.2	Continue to improve facilities i.e. to re-provide LRI Jarvis education centre in 1771 building, provide UHL Simulation facility and consider feasibility of Glenfield as an expanding training site	MD		~~Sept 2015~~ November 2015	Meetings held with facilities with Darryn Kerr, Nicky Topham July 2015 and outline education facilities strategy drafted. However, it is necessary to develop an inter-professional strategy and work with other academic partners to develop facilities for the longer term. Facilities strategy to be presented to Executive Workforce Board August.	3
7.4	Medical education quality dashboard, SPA time in job plans for training, support for CMG Medical Education leads and local faculty groups (College Tutors etc) to be developed	MD		August 2015	**Complete.**	5
7.5	SPA time in job plans for training	MD	Sue Carr	January 2016	Time for education roles remains to be reliably demonstrated in job plans and transparency of education expenditure is still an issue – CMGs will be visited over next 3 months	4
7.6	CMG Education leads to develop action plans following findings from GMC National Trainee Survey and National Student Survey.	MD	Sue Carr	August 2016	CMG Education leads have been asked to develop actions plan re learning culture and in particular giving feedback to trainees and students. We will take a trust wide approach to issues around learning culture, induction (Task & Finish group led by HR) and feedback. At present only 22.9% medical students choose Leicester as first choice for Foundation posts and discussions have been held with Leicester University about ways to improve this – a meeting will be held in October	4

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7.7	All UHL trainers need to be recognised by GMC and included on a Trust database	MD	Sue Carr	July 2016	To continue to train medical students and trainee doctors all Consultants will need to be appropriately trained and details recorded on a UHL database of trainers. Consultants with education SPA activity will need to demonstrate competence as a trainer and record this at appraisal. The GMC will visit Leicester in Nov 2016 and will request this information.	4
8	**Insufficient engagement of clinical services, investment and governance may cause failure to deliver the Genomic Medicine Centre project at UHL**					
8.1	Develop appropriate training for clinical and non-clinical staff		Nigel Brunskill	March 2016		4
8.2	Support CMGs with transformation of GMC project into clinical services		Nigel Brunskill	March 2016		4
8.3	Coordinate public engagement activity aimed at (i) raising expectation of participating in the GMC project and (ii) benefits to patients of genomic medicine		Nigel Brunskill	June 2016		4
9	**Changes in senior management/ leaders in partner organisations may adversely affect relationships / partnerships with universities.**					
9.2	Develop regular meeting with Universities	MD	Nigel Brunskill	March 2016	Develop new 4 way strategy meeting with UHL, UoL, LU and DMU	4
10	**Gaps in inclusive and effective leadership capacity and capability , lack of support for workforce well-being, and lack of effective team working across local teams may lead to deteriorating staff engagement and difficulties in recruiting and retaining medical and non-medical staff**					
10.2	Continue with the spread of LiA to enable staff to make contributions to changes and improvements at work	DWOD	B Kotecha	March 2016	Progress on track against LiA Year 3 Plan	4

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10.3	CMGs to produce a trajectory of premium spend linked to recruitment to be monitored through the CMG performance and Cross Cutting Workforce Meeting.	DWOD	B Kotecha	March 2016	Plans in place to reduce Premium Spend – implementation monitored by existing performance meetings (CIP/Workforce). Work is underway in populating the Workforce Modelling Tool with recruitment and workforce plans. Workforce tool is now being populated on a monthly basis and now plans are in place to monitor actions to reduce premium expenditure based on the DH toolkit. There are some challenges to accurate forecasting and a recommendation is to go to the Cross Cutting Theme Group on premium spend reports which are of most use to the CMGs and how information can be used to improve forecasting.	4
10.4	Improvements in local leadership and the management of well led teams including holding to account for the basics	DWOD	B Kotecha	March 2016	Progress on track against Trust Wide Action Plan	4
10.5	NED apprenticeship scheme to be implemented	DMC	D Baker	March 2016	Proposal drafted and discussed at the June NED meeting. Intention to report back on proposals at the September 2015 Board.	4
10.6	Targeted interventions for BME band 5 and 6 to be developed and implemented	DWOD	D Baker	March 2016	Graduate traineeship scheme under development focussed around recruitment at operational manager level. Communication Plan being developed in promoting leadership development opportunities to band 5 and 6 BME staff	4
10.7	Await national guidance in relation to the post of 'Freedom to Speak' Guardian	MD	DSR	September 2015		4
10.8	Undertake actions from 'Freedom to Speak' gap analysis	MD	DSR	September 2015		4

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10.9	CMGs to nominate appropriate managers to receive staff concerns	MD	DSR	September 2015		4
10.11	Training for clinicians on role redesign and functional mapping	MD	AMD	December 2015	Resource identified through Better Care Together Team. Pilot work being undertaken in RRC re 'How to Staff a Ward Differently'.	4
10.12	Work with HEEM to influence posts to be redistributed	MD	AMD	March 2016	Good clinical and education team engagement in discussions relating to redistribution.	4
10.13	Need to identify the resources required to implement the national nursing revalidation guidance and submit business cases for funding	CN		March 2016	Still awaiting confirmation from the NMC of launch date – update should have been circulated in July and will now be August	4
11	**Insufficient estates infrastructure capacity and the lack of capacity of the Estates team may adversely affect major estate transformation programme**					
11.2	Develop a programme of works for infrastructure improvements	DEF	Nigel Bond	September 2015	Work in progress	4
11.3	Develop an operational risk register for the projects	DEF	DEF	~~August 2015~~ September 2015	Work in progress	4
11.4	Identification of investment required and allocation of capital funding	DEF	Nigel Bond/ Richard Kinnersley	September 2015	Work in progress	4
11.5	Define resource and skills gaps and agree an enhanced team structure to support the significant reconfiguration programme	DEF		September 2015	Work in progress	4
11.6	Plans being developed and liaison between Estates and Strategy team programmed to ensure effective governance and oversight and scrutiny of investment programme demands	DEF/DS			**Complete.** There is now a capital business cases meeting on a monthly basis which will ensure strategy/estates link and this group will feed into the reconfiguration board.	5

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11.7	Assessment of current capacity of Estates infrastructure being established	DEF		September 2015		4
12	**Limited capital envelope to deliver the reconfigured estate which is required to meet the Trust's revenue obligations**					
12.3	PMO holding estates workshop and followed by a joint estates and strategy workshop to develop a 'road map' of deliverability and programme of change	DEF/DS		September 2015		4
12.4	On-going discussions between executive team and NTDA regarding availability of capital funding (this action now replaces previous 12.2)	DEF/ DOS/ CFO		September 2015	CFO continues to liaise closely with NTDA regarding external capital funding and the ITFF	4
12.5	Consideration to be given to other avenues for sources of funding.	DEF/ DOS/ CFO		September 2015	Discussions have commenced between the Trust and PwC and (separately) between the Trust and IBM	4
13	**Lack of robust assurance in relation to statutory compliance of the estate**					
13.2	Develop improved software dashboard reporting (CASS)	DEF	Mike Webster	September 2015	Supplier identified, quotation accepted and plans to commence work in July Population of software commenced in August. New Planet software system introduced by IFM in July now being evaluated	4
14	**Failure to deliver clinically sustainable configuration of services**					
14.1	NTDA to look at providing a management and financial lead for each of the business cases	DS		October 2015	Initial meeting was held on the 12.05.15 with the NTDA where they recognised the need for NTDA resource	4
14.2	Work stream to be established to identify gaps in the current capital plan	DS			**Complete.**	5
14.3	Complete site survey at LGH and then to overlay future operating model outputs.	DS		November 2015	Work underway	4
15	**Failure to deliver the 2015/16 programme of services reviews, a key component of service-line management (SLM)**					
16	**Failure to deliver UHL's deficit control total in 2015/16**					

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16.3	CFO to lead production of recovery plan internally and revised plan submission to NTDA	CFO			**Complete.** Revised plan submission returned to NTDA on 11th September 2015. Recovery plan in place with required internal control totals set in October 2015	5
17	**Failure to achieve a revised and approved 5 year financial strategy**					
17.3	Liaise with TDA to agree process for LTFM submission and sign-off	CFO		~~July 2015~~ Review September 2015	Revised financial strategy and LTFM submitted to NTDA in early August 2015 as part of ITFF funding application. Awaiting NTDA feedback. Review in September 2015	3
17.4	Explore options for other (non-NHS) sources of capital funding	CFO		September 2015	Explore options for other (non-NHS) sources of capital	4
18	**Delay to the approvals for the EPR programme**					
18.1	Further work with NTDA to progress a firm timetable to the ATP	CIO	E. Simons	~~May 2015~~ ~~June 2015~~ ~~August 2015~~ October 2015	Further reviews have happened with the NTDA. The recommendation has gone to, and been approved by, the local NTDA Capital investment Group in June 2015 The plan is now sitting with the DoH for their approval. No formal timetable for this has been given.	2
18.2	Further work to expose the executive and the Trust board to the likely shape of the FBC and the required internal steps.	CIO	E. Simons	~~July 2015~~ ~~August 2015~~ October 2015	Plan is currently being finalised for this action, as above 18.1	2
19	**Perception of IM&T delivery by IBM leads to a lack of confidence in the service**					
19.1	Engage third party, as per contract, to asses and review VfM	CIO	T. Hind		**Complete.** Service improvement plan is now in place	5
19.3	Production of a quarterly newsletter available to all staff	CIO	T. Webb		**Complete.** Plans are in place. Newsletter is now targeted at all staff rather than through a cascade.	5

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19.5	The creation of a credible delivery plan to address the key concerns highlighted through the LIA process.	CIO	IM&T/J. Spiers		**Complete**. Programme of work is underway. First deliverables are now in place i.e. new desktop devices on the pioneering wards	5
19.6	Develop Service Improvement Plan from contract review and LIA outputs	CIO	IM&T	September 2015		4
19.7	Review of the new communications strategy and deliverables	CIO	IM&T	December 2015		4
19.8	Following LiA Event in June 2015, monitoring of KPIs in the improvement plan	CIO	IM&T	December 2015		4

Key

CEO	Chief Executive
CFO	Chief Financial Officer
MD	Medical Director
DoF	Director of Finance
DEF	Director of Estates and Facilities
DP&I	Director of Performance and Improvement
COO	Chief Operating Officer
DWOD	Director of Workforce and Organisational Development
DS	Director of Strategy
DMC	Director of Marketing and Communications
CIO	Chief Information Officer
CN	Chief Nurse
AMD (CE)	Associate Medical Director (Clinical Education)
HOE	Head of Outcomes and Effectiveness
DSR	Director of Safety and Risk
AMD	Associate Medical Director

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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
2591	Emergency and Specialist Medicine		Risk of increased demand in diabetes outpatient foot clinic leading to overbooked clinics which over run	24/08/2015	30/09/2015	Causes: Increased volume of patients referred in from primary care needing MDT assessment. Majority of referrals are urgent due to high risk nature of patients. No increase in staffing capacity, therefore clinics are overbooked and over run. Inability to urgently transfer systemically unwell patients to be admitted to ESM due lack of transport. Consequences: Risk of patient harm (ulceration/amputation/sepsis) due to lack of capacity to see high risk patients urgently. Risk of delays in clinics. Risk of breaching national guidelines. Increasing workload of MDT foot team leading to stress and risk of mistakes. Risk to patients and staff when patients have to wait for transport to LRI when being admitted.	Patients	The diabetes foot team follow NICE/FDUK Guidance for treating high risk foot patients Patients are triaged in accordance with LLR Diabetes Foot care Pathway. CCGs aware of increase in referrals from primary care Clinics are consistently over booked to attempt to accommodate increased demand Service review of Foot care undertaken including review of Podiatry SLA	Major	Likely	16	Recruitment of Diabetes Specialist Nurse - 30/10/15 Recruitment of Consultant - 30/11/15 Additional foot clinic to commence (inc additional podiatry session) - 30/09/15 Arrangement to be agreed to access urgent transport (Use of CMG specific ambulance being explored to transfer high risk patients in a timely manner) - 30/09/15	8	JSPI

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2601	Women's and Children's	Gynaecology	There is a risk of delay in gynaecology patient correspondence due to a backlog in typing	24/08/2015	30/09/2015	Causes: An increase in the number of referrals to gynaecology services. 1.0 wte vacancy of an audio typist. Bank and Agency staff being used to reduce typing backlog are not consistent especially during holiday periods. In addition delays can occur due to Consultants working cross-site and not accessing results promptly in order for the letters to be completed. Consequences: Delay in timely appointment letters to patients Delay in patients receiving results Delay in patients receiving follow up appointments Breach in the Trust standard for typing and sending out of patients letters (48 hours maximum time from date of dictation) As at 21/08/15 - there is a delay in gynaecology correspondence to the patient of: - 8 weeks following a general gynaecology appointment at LRI - 8 weeks for 1st appointment letters for Colposcopy at LRI - 1 week and 5 days for colposcopy result letters at LRI - 10 days for communication to GP with regards to the patient.	Quality	2 week wait clinics or any letters highlighted on Windscribe in red are typed as urgent. Weekly admin management meeting standing agenda item: typing backlog by site also by Colposcopy and general gynaecology. Using Bank & Agency Staff. Protected typing for a limited number of staff.	Moderate	Almost certain	15	Introduce template letters for 1st colposcopy appts - due 31/10/15 Clearance of backlog of letters - due 30/09/15 Introduction of new transcription service within gynaecology - due 31/10/15	6	DMAR