RISK REPORT INCORPORATING THE BOARD ASSURANCE FRAMEWORK (BAF)

Author: Risk and Assurance Manager Sponsor: Medical Director Date: Thursday 2nd July 2015

Executive Summary

Trust Board Paper O

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 should use in discharging its overall responsibility for internal control. This report provides the Trust Board (TB) with:-

a) The UHL 2015/16 BAF and action tracker as of 31st May 2015.
b) Notification of any new extreme or high risks opened during May 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?

Conclusion

1. Input from Executive owners of each strategic objective should have provided an accurate picture of our principal risks.
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 actions have breached their due dates however there are four actions where the original timescale for completion has been extended due to delays.

Input Sought

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

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

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

(c) 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;

(d) 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: [06/08/15]

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: **2ND JULY 2015**

REPORT BY: **ANDREW FURLONG – 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 May 2015.

b) Notification of any new extreme or high risks opened during May 2015.

2. 2015/16 BAF POSITION AS OF 31ST MAY 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. Four actions (5.4, 5.9, 15.2 – Director of Strategy, and 18.1 – Chief Information Officer) have moved to an amber rating in response to delays affecting the completion dates.

b. All actions associated with principal risk eight have been completed and the TB is asked to consider whether the completion of these actions has closed the associated gaps in control/ assurance.

c. An increase in current risk score in relation to principal risk 10 (from 12 – 16) as requested at the June TB meeting

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. The strategic objective below is therefore submitted for scrutiny: *'Integrated Care in Partnership with Others' (incorporating* principal risk numbers four and five).

3. EXTREME AND HIGH RISK REPORT.

No new risks scoring 15 or above have been opened during the reporting period.

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,
25 June 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 Human Resources**
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**	**Director of Finance**
i	**Enabled by excellent IM&T**	**Chief Information Officer**

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST – BOARD ASSURANCE FRAMEWORK

PERIOD: MAY 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	DHR	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	DF	15	10
17		Failure to achieve a revised and approved 5 year financial strategy	DF	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).	3 monthly and / or 6 monthly progress reports to EQB and QAC.	Vacancies within clinical staff will affect implementation of QC	Nurse and medical workforce recruitment strategies (1.1)	Milestone review Jul 2015 MD&CN
KPIs agreed and monitored for all parts of the Quality Commitment.	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	Currently only 30% of deaths are screened and there is a requirement to move to 100%. Vacancies within clinical staff grades may adversely affect our ability to implement this.	Roll out plan to be developed (1.2) Audit support to be provided (1.3) Monitor uptake (1.4) Mortality database to be developed (1.5) As action 1.1	Sep 2015 MD July 2015 MD Milestone review Jul 2015 MD&CN As action 1.1
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	(a) Internal audit review awaited	Implement actions from review as required	June 2015 CN

	QC CQC inspection during 2015/16 Commissioner review of work plans/ progress via CQUIN.			
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			

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Principal risk 2	Demographic growth plus ineffective admission avoidance schemes may counteract any internal improvements in emergency pathway	**Overall level of risk to the achievement of the objective**	**Current score 4x5=20**	**Target score 3x2=6**
Executive Risk Lead(s)	Chief Operating Officer			
Link to strategic objectives	An effective and integrated emergency care system			

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 internal and external emergency care performance	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	Attendance and admissions continue to increase (+5% and (+7%).	UHL is working with LLR colleagues to identify a more effective work of reducing attendances and admissions. Plan to achieve this to be presented Plan to be presented to UCB (2.2)	Jun 2015-COO
LLR Action plan to improve patient flow (i.e. admissions, reduction in discharge delays, making best use of existing ED capacity		(c) LLR action plan not fully implemented	Continue to implement and monitor progress of LLR action plan (2.1)	Review Sep 2015 COO

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 non-admitted, incomplete 18 week RTT standards	(c) Currently not delivering the 62 day and 31 day cancer access standard 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)	Jul 2015 COO

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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)	Jul 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)	Jul 2015 DS
Partnership Board for Specialised Services established in Northamptonshire. Membership includes Northants CCGs; NHS England; KGH; NGH and UHL.		(a) Does not feed into UHL Governance Structure.	Future minutes to be included DS report to ESB. (4.3)	Jul 2015 DS
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	

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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	(a) Regular LLR wide performance monitoring report required for presentation to Trust Board	BCT PMO establishing a master plan (5.2)	Jun 2015 DS
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 Monthly project specific highlight reports	(a)LLR wide dashboard required so that performance can be monitored (a) Lack of Triangulation and assurance of plans	LLR wide business intelligence group established. UHL dashboard in draft to be used to inform LLR wide dashboard. (5.3) BCT PMO to facilitate	Jul 2015 DS Jul2015 DS

		at organisational and system wide level.	triangulation process (5.4)	
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)	Jul 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)	Jul 2015 DS

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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) UHL to use RCF to pump prime appointments if possible and LU planning new academic appointments to support lifestyle BRU. (6.3)	Jun 2015 MD Jun 2015 MD Jun 2015 MD
	Athena Swan Silver Status by University of Leicester and Loughborough University. (The Athena Swan charter applies to higher	(c) Athena Swan Silver not yet achieved by UoL and Loughborough	UoL and LU to ensure successful applications for	Mar2016 MD

	education institutions)	University. This will be required for eligibility for NIHR awards	Silver swan status. Individual medical school depts will need to separately apply for Athena Swan Silver status. (6.4)	

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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 • Health Education East Midlands	(c) Education facilities Identified as poor in external reports from HEEM and Leicester University (a) Lack of accountability and transparency of educational funding income and expenditure (c) Ineffective control of clinical service pressures, vacancies and loss of posts on rotas that adversely	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) Engagement with CMGs in ensuring education expenditure matches income (7.3) Medical education quality dashboard, SPA time in job plans for training, support for CMG	Sep 2015 MD Aug 2015 MD Aug 2015 MD

	Accreditation visits	affect quality of training and added impact of	Medical Education leads and local faculty groups (College Tutors etc) (7.4)	

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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 (?best reporting route – ?via W&C CMG board) 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) Need for sufficient funding to CMG to support delivery of recruitment trajectory (c) Need for key staff to consent/recruit/data entry (c) Need UHL IT solution to deliver and monitor recruitment trajectory – under development	‘	

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 DMU could be developed more closely	Develop regular meeting with DMU (9.2)	Jun 2015 MD

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Principal risk 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	**Overall level of risk to the achievement of the objective**	**Current score 16**	**Target score 8**
Executive Risk Lead(s)	Director of Human Resources			
Link to strategic objectives	A caring, professional and engaged workforce			

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**
Organisational Development Plan	Reported to EWB quarterly Reported to Trust Board quarterly Internal Audit assurance via 2014/15 Programme Key Performance Indicators included within OD plan	(a) Lack of scrutiny of the Organisational Health Dashboard at CMG level	Scrutinise at CMG level the organisational health dashboard at quarterly intervals (10.1)	Sep 2015 DHR
LIA Programme	LIA Sponsor Group meet monthly Reported to EWB quarterly Reported to Trust Board quarterly (as part of the OD report).	(c) Analysis of LIA dataset has identified some key areas for improvement – coded as: Frustrations; Focus on Quality; Structures and leadership	Continue with the spread of LiA to enable staff to make contributions to changes and improvements at work (10.2)	Mar 2016 DHR
Workforce Planning	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	(c) Affordability against workforce plan is an issue related to lack of substantive staff leading to increase in premium spend	CMGs to produce a trajectory of premium spend linked to recruitment with which will be monitored through the weekly CMG performance meetings and Cross	Mar 2016 DHR

			Cutting Workforce Meeting. (10.3)	
		(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	Training for clinicians on role redesign and functional mapping (10.11) Work with HEEM to influence posts to be redistributed	Dec 2015 MD Mar 2016 MD

		broadening foundation and redistribution	(10.12)	
Leadership into Action Strategy	Reported to EWB quarterly 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.	(c)Negative feedback from surveys in relation to leadership issues	Improvements in local leadership and the management of well led teams including holding to account for the basics (10.4)	Mar 2016 DHR
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 Programme Board	(a) Effective governance arrangements for oversight and scrutiny of this work are yet to be agreed. PMO developing reporting format (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	 Develop a programme of works (11.2) Develop an operational risk register for the projects (11.3)	 Sep 2015 DEF Sep 2015 DEF
Capital programme with ring fenced capital funding to support future capacity demands	Capital Investments Monitoring Committee	(c) Currently no identified capital funding within 2015/16 programme and future	Identification of investment required and allocation of capital	Sep 2015 DEF/DoF

		years	funding (11.4)	
An established Estates and Facilities team with detailed knowledge of the estates and reconfiguration programme	Regular reports to Executive Performance Board (EPB)	c) Conflicting responsibilities/roles of the estates and facilities team between UHL and the LLR estate and Facilities Management Collaborative	Define resource and skills gaps and agree an enhanced team structure to support the significant reconfiguration programme (11.5)	Sep 2015 DEF

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**
Individual project boards in place to manage and monitor schemes Merging of strategic clinical change projects into the Estates an Facilities Directorate	Project boards report to UHL Better Care Together (BCT) working group via monthly highlight reports Estates work stream reporting to the UHL – BCT Programme Board			
5 year plan agreed with individual annual programmes developed each year	Capital Investment Monitoring Committee will monitor the overall programme of capital expenditure and early warning to issues	(c) Lack of Contingency funding	Discussions between D. Kerr and P. Traynor to identify funding (12.2)	Sep 2015 DEF

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	(a) A lack of electronic evidence by IFM on compliance (a) Limited contractual KPI's on compliance	Additional assurance to be identified through spot checks and deep dive analysis (13.1) Develop improved software dashboard reporting (CASS) (13.2)	July 2015 DEF 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**
Agreed capital programme with NTDA identified what resources the NTDA need to commence their approval processes	Monthly meetings with the NTDA to discuss the programme of delivery and identify new cases coming up for approval A monthly highlight report is submitted to the BCT-UHL Programme Delivery Board.	(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)	Sep 2015
UHL structure and resources identified for delivery of the key projects • ITU • Vascular • Emergency Floor • Planned Treatment Centre • Maternity • Children's Hospital • Theatres • Beds • multi-storey car park Business Case Project resources identified against each project	A report is submitted to the BCT-UHL Programme Delivery Board on a monthly basis that tracks progress to date, including financial assurance, risks with mitigations	(a) Further work required looking at the remaining acute services at the LGH to determine the gap in the current capital plan	Work stream to be established to identify gaps (14.2)	Sep 2015 DS
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 communication lead for the business cases for women's sits on the wider BCT consultation work stream. This is led by UHL Director of Communications and Marketing. A monthly report is submitted to the BCT-UHL Programme Delivery Board from the communication and engagement work stream.			

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 Finance			
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.	(c) Alignment with CIP and future operating model.	Discuss with the Director of CIP the Future Operating Model and that through this we will cement delivery (15.1)	Jul 2015 DS
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.	(a) Monthly updates to ESB	High level updates to be included in the Director of Strategy's monthly report for ESB. (15.2)	Jul 2015 DS
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	(c) Capacity and level of clinical engagement determines when service reviews can happen and how many can run at any given time	Approach and scheduling of service reviews to be reviewed to ensure process remains viable and/or to identify resource requirement. (15.3)	July 2015 DS
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	**Overall level of risk to the achievement of the objective**	**Current score 5x3=15**	**Target score 5x2=10**
Executive Risk Lead(s)	Director of Finance			
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	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 DoF/COO and all CMGs, covering key areas of performance including finance and CIPs Monthly reporting via Exec Performance Board, IFPIC and Trust Board	(c) CIP plans for 2015/16 do not total £43m (100%) as yet	Full population of CIP plans by end May 2015 (16.2)	June 2015 COO/DoF
UHL service and financial strategy (as per SOC and LTFM)	Updates and reporting to the BCT UHL Monthly			

	Delivery Group (chaired by DS or DoF), 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)	Director of Finance			
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	(c) SOC not yet approved	Approval currently being sought (17.1)	CEO Date TBA
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	Production of revised LTFM and submission for approval to TDA (17.2) Liaise with TDA to agree process for LTFM submission and sign-off	Jun 2015 DoF Jul 2015 DoF
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 approved (c)LTFM not yet approved	As above	

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) No final approvals date can be given the recommendation is likely to go to the Local (NTDA) Capital Investment Group in June but they cannot give any clear timetable for the DH part of the approval.	Further work with NTDA to progress a firm timetable to the ATP (18.1)	Jun 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)	July 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	Engage third party, as per contract, to asses and review VfM (19.1)	Aug 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	(c) Communication about successes is not sufficiently robust	Production of a quarterly newsletter available to all staff (19.3)	Aug 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	LiA event to surface any issues with the service delivery and the delivery model (19.4)	Jun 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	**May 2015**
Frequency of review:	Monthly
Date of last review:	April 2015

REF	ACTION	BOARD LEVEL LEAD	OPS LEAD	COMPLETION DATE	PROGRESS UPDATE	STATUS
1	**Lack of progress in implementing UHL Quality Commitment (QC).**					
1.1	Nurse and medical workforce recruitment strategies	MD/CN		Review July 2015		4
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	Funding approved. M&M Clerks and analyst recruitment process commenced.	4
1.4	Monitor uptake of screening.	MD/CN	HOE	Review July 2015	Mortality death report revised to facilitate monitoring. HOE and Bank M&M Clerk meeting with M&M leads to agree monitoring process	4
1.5	Mortality database to be developed.	MD/CN	HOE	Review July 2015	Database scoping exercise being undertaken. Awaiting feedback from potential providers. Excel spread sheet database being used in the meantime	4
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		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

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 Plan to be presented to UCB	COO		June 2015		
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**					
3.1	Develop performance improvement framework for failing specialties driven by the DP&I	COO	DP&I	May 2015	**Complete.**	5
3.2	Development and implementation of intelligence led recovery plan and trajectories.	COO	DP&I	July 2015	**Complete**	5
3.3	Theatre productivity improvements driven through the cross-cutting work stream.	COO		July 2015		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	Discussions continue	4
4.2	Memorandum of Understanding (MoU) to be reviewed by both organisations.	DS		July 2015	Work is on-going	4
4.3	Future minutes of Partnership Board for Specialised Services to be included DS report to ESB.	DS		July 2015	A process has been put in place to ensure the minutes come to ESB under the strategy update	4
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.**					
5.1	BCT PMO to establish project plan	DS		May 2015	**Complete.** The programme plan went to the Board in May, the BCT PMO are now developing a roadmap.	5

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

5.2	BCT PMO establishing a master plan for regular LLR wide performance monitoring.	DS		June 2015	Work is in progress	4
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	UHL dashboard has been agreed and shared with the LLR BCT PMO team. The LLR dashboard is not yet finished as the capacity and activity planning process has taken priority. Realistically this is more likely be July and therefore timescale for completion adjusted accordingly	4
5.4	BCT PMO to facilitate triangulation process for plans at an organisational and system level	DS		~~May 2015~~ July 2015	In progress – series of presentations going to the BCT delivery board in May June and July. Deadline extended to reflect the sequencing of presentations	3
5.6	Results of the engagement programme will be summarised and used to inform the consultation planning.	DMC		May 2015	**Complete.**	5
5.7	Analysis of results of engagement programme to be provided to partnership Board.	DMC		May 2015	**Complete.**	5
5.8	Plan for consultation including a full governance roadmap to be completed.	DMC		July 2015		4
5.9	Project plan to be developed Integrated Frail Older Person Service Project plan to be developed	DS		~~May 2015~~ July 2015	The second workshop is to be held in June with the final report expected at the end of July. The report is to then go to the August ESB meeting for approval. Deadline extended to reflect this sequence.	3
6	**Failure to retain BRU status.**					
6.1	BRUs to re-consider theme structures for renewal, identifying potential new theme leads.	MD		June 2015		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

6.2	BRUs to identify potential recruits and work with UoL/ LU to structure recruitment packages.	MD		June 2015		4
6.3	UHL to use Research Capability Funding to pump prime appointments if possible and LU planning new academic appointments to support lifestyle BRU.	MD		June 2015		4
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.**					
7.1	Discuss NED lead for medical education with Chairman	MD		May 2015	**Complete**	5
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		September 2015	Meetings planned to discuss with facilities with Darryn Kerr, Gareth Faulkner and Stuart Turner and a draft strategy for medical education facilities developed. However, it is necessary to develop an inter-professional strategy and work with other academic partners to develop facilities for the longer term	4
7.3	Engagement with CMGs in ensuring education expenditure matches income	MD		August 2015	Meetings held with all CMGs, updates given about education and training issues and funding and supporting documentation to advice re calculation for expenditure. Follow up meetings will be held over next few months	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

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	Quality dashboard is now being completed quarterly by education quality manager and education leads. Will be demonstrated as example of best practice on UK NACT website Local faculty group to be piloted with CMG education lead in O&G, DCE involved in College Tutor appointments but roles need to be funded and visible in job plans	4
8	**Insufficient engagement of clinical services, investment and governance may cause failure to deliver the Genomic Medicine Centre project at UHL**					
8.2	'The 100,000 Genomes Project' paper with detailed costing to go to Revenue and Investment Committee	MD		May 2015	**Complete**	5
8.3	Targeted use of Research Capability Funding	MD		April/ May 2015	**Complete.** Allocation of funding to Research Stakeholders has taken place	5
9	**Changes in senior management/ leaders in partner organisations may adversely affect relationships / partnerships with universities.**					
9.2	Develop regular meeting with DMU	MD		Jun 2015		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**					
10.1	Scrutinise at CMG level the organisational health dashboard at quarterly EWB.	DHR	J Tyler-Fantom	September 2015	Work is being undertaken in ensuring all fields/data are up to date in the Organisational Health Dashboard.	4
10.2	Continue with the spread of LiA to enable staff to make contributions to changes and improvements at work	DHR	B Kotecha	March 2016	Progress on track against LiA Year 3 Plan	4
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.	DHR	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	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

10.4	Improvements in local leadership and the management of well led teams including holding to account for the basics	DHR	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 - to be discussed at the June NED meeting.	4
10.6	Targeted interventions for BME band 5 and 6 to be developed and implemented	DMC	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
10.9	CMGs to nominate appropriate managers to receive staff concerns	MD	DSR	September 2015		4
10.10	Appoint dedicated resource to manage international recruitment MTI scheme	MD	AMD	June 2015	**Complete.** Appointment made, commences in post on 01.07.15	5
10.11	Training for clinicians on role redesign and functional mapping	MD	AMD	December 2015	Resource identified through Better Care Together Team	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		4
11	**Insufficient estates infrastructure capacity and the lack of capacity of the Estates team may adversely affect major estate transformation programme**					
11.1	PMO support to be engaged in order to develop effective governance arrangements	DEF	Mike Webster	May 2015	**Complete.** Capita appointed as 'PMO light' in supporting by the governance and reporting process	5

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

11.2	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	Mike Webster	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	Darryn Kerr	September 2015	Work in progress	4
12	**Limited capital envelope to deliver the reconfigured estate which is required to meet the Trust's revenue obligations**					
12.1	Additional resource support to be identified and implemented	DEF	Nigel Bond/ Richard Kinnersley	May 2015	**Complete.** Two additional substantive Project Managers recruited within the EFMC team and external PM's will be appointed where required to provide additional project support. The Strategic Projects team has been transferred to the EFMC	5
12.2	Discussions between D. Kerr and P. Traynor to identify contingency funding	DEF	Darryn Kerr	September 2015	Work in progress	1
13	**Lack of robust assurance in relation to statutory compliance of the estate**					
13.1	Additional assurance to be identified through spot checks and deep dive analysis	DEF		July 2015		4
13.2	Develop improved software dashboard reporting (CASS)	DEF		September 2015		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		September 2015	Initial meeting was held on the 12.05.15 with the NTDA where they recognised the need for NTDA resource	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

14.2	Work stream to be established to identify gaps in the current capital plan	DS		September 2015	Work has started- the LTFM has been updated and a revised project programme has been put in place	4
15	**Failure to deliver the 2015/16 programme of services reviews, a key component of service-line management (SLM)**					
15.1	Discuss with the Director of CIP the Future Operating Model and that through this we will cement delivery	DS		July 2015	Discussions are on-going. A paper is to go to the EPB on the 28 June for approval	4
15.2	High level updates to be included in the Director of Strategy's monthly report for ESB.	DS		~~May 2015~~ July 2015	An update went to April ESB; the next update is to come to the July ESB (previously scheduled for June) as part of the Strategy update following discussion at EPB on the 28 June. Deadline extended to reflect this	3
15.3	Approach and scheduling of service reviews to be reviewed to ensure process remains viable and/or to identify resource requirement.	DS		July 2015	Discussions have started	4
16	**Failure to deliver UHL's deficit control total in 2015/16**					
16.1	DoF and contract team working to complete and sign final detailed version of CCG contract	DoF		May 2015	**Complete**	4
16.2	Full population of 2015/16 CIP plans to achieve £43million	DoF/COO	DCIPFOM	~~May 2015~~ June 2015	As of 8/6/15 – we have £41m on the tracker. Deadline to achieve full amount extended by one month.	4
17	**Failure to achieve a revised and approved 5 year financial strategy**					
17.1	Approval to be sought for SOC	CEO		TBA (Awaiting information from BCT programme Board for approx. date)		
17.2	Production of revised LTFM and submission for approval to Trust Board and TDA	DoF		June 2015	Approval of LTFM by TB awaiting submission and approval by TDA	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

17.3	Liaise with TDA to agree process for LTFM submission and sign-off	DoF		July 2015		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	Further reviews have happened with the NTDA. The current timetable has the recommendation going to their Capital investment Group in June 2015	3
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	Plan is currently being finalised for this action	4
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	Aug 2015	Gartner have been approached to facilitate this work on behalf of the Trust and IBM	4
19.2	Production of a 2014/15 annual review	CIO	T. Hind	May 2015	**Complete.** Document now finalised.	5
19.3	Production of a quarterly newsletter available to all staff	CIO	T. Webb	August 2015	Plans are in place	4
19.4	LiA event to surface any issues with the service delivery and the delivery model	CIO	M. Cloney/ J. Spiers	June 2015	22nd of June has been booked for the event. There is also a timetable of post event activities to enable us to respond to the items raised.	4

Key

CEO	Chief Executive
DF	Director of Finance
MD	Medical Director
DoF	Director of Finance
DEF	Director of Estates and Facilities
DP&I	Director of Performance and Improvement
COO	Chief Operating Officer
DHR	Director of Human Resources
DS	Director of Strategy
DMC	Director of Marketing and Communications
CIO	Chief Information Officer

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

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

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