INTEGRATED RISK REPORT INCORPORATING THE 2016/17 BOARD ASSURANCE FRAMEWORK – REPORTING PERIOD AS AT 31/05/16

Author: Risk and Assurance Manager Sponsor: Medical Director Date: Thursday 7th July 2016

Executive Summary Paper F

Context

The 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. The 2016/17 BAF has been developed with reference to the revised annual priorities and this report provides the TB with the 2016/17 BAF position to 31st May 2016. The report also provides a summary of new organisational risks scoring 15 or above, opened during the reporting period.

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 on the BAF?
4. Does the TB have knowledge of new significant operational risks reported within the reporting period?

Conclusion

1. Executive leads of each strategic objective have provided an accurate picture of our principal risks affecting the achievement of our objectives. The Board should note that there may be risks associated with 'BREXIT' that will require inclusion within the BAF sometime in the future.
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. Some entries have not yet identified an assurance rating and this will be resolved during the next round of executive boards in July.
3. All actions are currently on track. There are a small number of actions where the deadline for completion has been extended in recognition of delays being encountered. Narrative within the BAF 'action tracker' provides further detail.
4. The TB are sighted to all new risks scoring 15 or above opened on the operational risk register during May 2016.

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 this version of the 2016/17 BAF noting:

- 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;
- the actions identified to address any gaps in either controls or assurances (or both);
- any areas which it feels that the Trust's controls are inadequate.

For Reference

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:

a. Organisational Risk Register [Yes]

If YES please give details of risk ID, risk title and current / target risk ratings.

Risk ID	Operational Risk Title(s)	Current rating	Target rating	CMG
2804	Outlying Medical Patients into other CMG beds due to insufficient ESM inpatient bed capacity	20	12	ESM
2836	There is a risk of single sex breaches on the Brain Injury Unit due to environmental design and inflow of patients.	15	2	ESM
2837	There is a risk of delay in acting upon monitoring investigation results in patients with multiple sclerosis.	15	2	ESM
2505	There is a risk of medical patients being outlied into the Ambulatory Surgical Unit due to lack of beds within the trust.	16	6	MSS

b. Board Assurance Framework [Yes]

If YES please give details of risk No.

Principal risks 1 – 19 – see BAF dashboard for details

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: [04/08/16]

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: **UHL TRUST BOARD**

DATE: **7th JULY 2016**

REPORT BY: **ANDREW FURLONG – MEDICAL DIRECTOR**

SUBJECT: **INTEGRATED RISK REPORT (INCORPORATING UHL BOARD ASSURANCE FRAMEWORK AS OF 31ST MAY 2016)**

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1 INTRODUCTION

1.1 This integrated risk report will assist the Trust Board (TB) to discharge its responsibilities by providing:-

a. A 2016/17 BAF based on the revised annual priorities.
b. A summary of risks that are new and have increased in risk rating on the operational risk register with a score of 15 and above.
c. An updated framework for managing the BAF and risk register following agreement at the Trust Board Thinking Day on 17th March 2016.

2. BAF AS OF 31ST MAY 2016

2.1 Executive risk owners have updated their BAF entries to reflect the progress to achieve the annual priorities for 2016/17. A copy of the 2016/17 BAF is attached at appendix one with all changes highlighted in red text for ease of reference

2.2 The TB is asked to note the following:

a. Title of principal risk two amended to reflect the fact that the transfer of the estates and facilities functions from IFM has now taken place. The new title more accurately reflects the remaining risk of failure to develop a high quality estates and facilities service. This risk will be further discussed at the EQB scheduled for 5th July 2016.

- Updates to principal risks 10 and 11 will be endorsed at the EWB on 19th July 2016.
- A number of principal risks do not yet indicate the level of assurance and this will be resolved during the next round of executive boards during July 2016.
- 'Bedding in' of the new BAF reporting framework is still in progress meaning that not all entries have been subject to the appropriate level of scrutiny by executive boards and again this will be addressed during the next two months.

2.3 Discussions with the Director of Workforce and Organisational Development have highlighted there may be workforce risks associated with 'BREXIT' and that this will be discussed at the EWB on 19th July. This may mean further amendments to principal risk 10 following these discussions.

3. UHL RISK REGISTER SUMMARY AS OF 31ST MAY 2016

3.1 At the end of the reporting period, there are 52 risks open on the operational risk register scoring 15 and above. Three new 'high' risks have been entered during the reporting period and are described below with full details included in appendix two:

Datix ID	Risk Title	Risk Rating	CMG
2804	Outlying Medical Patients into other CMG beds due to insufficient ESM inpatient bed capacity	20	ESM
2836	There is a risk of single sex breaches on the Brain Injury Unit due to environmental design and inflow of patients.	15	ESM
2837	There is a risk of delay in acting upon monitoring investigation results in patients with multiple sclerosis.	15	ESM

One risk has increased in rating during the reporting period and is described below with full details included in appendix two:

Datix ID	Risk Title	Risk Rating	CMG
2505	There is a risk of medical patients being outlied into the Ambulatory Surgical Unit due to lack of beds within the trust.	16	MSS

4 RECOMMENDATIONS

4.1 The TB is invited to:-

(a) receive and note this report;

(b) review this version of the 2016/17 BAF noting:

- any gaps in assurance 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;
- the actions identified to address any gaps in either controls or assurances (or both);
- any areas which it feels that the Trust's controls are inadequate.

UHL Corporate Risk Management Team
30th June 2016.

UHL Board Assurance Dashboard:		MAY 2016						
Strategic Objective	**Risk No.**	**Principal Risk Description**	**Owner**	**Current Risk Rating**	**Target Risk Rating**	**Risk Movement**	**Audit Committee Assurance Rating**	**Executive Board Committee for Endorsement**
Safe, high quality, patient centred healthcare	1	Lack of progress in implementing UHL Quality Commitment.	CN	16	8	⇔		EQB
	2	Failure to provide an appropriate environment for staff/ patients	DEF	12	8	⇩		EQB
An excellent integrated emergency care system	3	Emergency attendance/ admissions increase without a corresponding improvement in process and / or capacity	COO	25	6	⇔		EPB
Services which consistently meet national access standards	4	Failure to deliver the national access standards impacted by operational process and an imbalance in demand and capacity.	COO	16	6	⇔		EPB
Integrated care in partnership with others	5	There is a risk that UHL will lose existing, or fail to secure new, tertiary referrals flows from partner organisations which will risk our future status as a teaching hospital. Failure to support partner organisations to continue to provide sustainable local services, secondary referral flows will divert to UHL in an unplanned way which will compromise our ability to meet key performance measures.	DoMC	12	8	⇔		ESB
	6	Failure to progress the Better Care Together programme at sufficient pace and scale impacting on the development of the LLR vision	DoMC	16	10	⇔		ESB
Enhanced delivery in research, innovation and clinical education	7	Failure to achieve BRC status.	MD	9	6	⇔		ESB
	8	Too few trainers meeting GMC criteria means we fail to provide consistently high standards of medical education	MD	12	6	⇔		EWB / EQB
	9	Insufficient engagement of clinical services, investment and governance may cause failure to deliver the Genomic Medicine Centre project at UHL	MD	12	6	⇩		ESB
A caring, professional and engaged workforce	10	Lack of system wide consistency and sustainability in the way we manage change and improvement in order to deliver the capacity and capability shifts required for new models of care	DWOD	16	8	⇔		EWB
	11	Ineffective structure to deliver the recommendations of the national 'freedom to speak up review	DWOD	16	8	⇔		EWB
A clinically sustainable configuration of services, operating from excellent facilities	12	Insufficient estates infrastructure capacity may adversely affect major estate transformation programme	CFO	16	12	⇔		ESB
	13	Limited capital envelope to deliver the reconfigured estate which is required to meet the Trust's revenue obligations	CFO	16	8	⇩		ESB
	14	Failure to deliver clinically sustainable configuration of services	CFO	20	8	⇔		ESB
A financially sustainable NHS Trust	15	Failure to deliver the 2016/17 programme of services reviews, a key component of service-line management	CFO	9	6	⇔		ESB
	16	The Demand/Capacity gap if unresolved may cause a failure to achieve UHL deficit control total in 2016/17	CFO	15	10	⇔		EPB
	17	Failure to achieve a revised and approved 5 year financial strategy	CFO	15	10	⇔		EPB
Enabled by excellent IM&T	18	Delay to the approvals for the EPR programme	CIO	16	6	⇔		EIM&T
	19	Lack of alignment of IM&T priorities to UHL priorities	CIO	12	6	⇔		EIM&T

Board Assurance Framework:	Updated version as at:	May-16										
Principal risk 1:	Lack of progress in implementing 2016/17 UHL Quality Commitment								**Risk owner:**	CN / MD		
Strategic objective:	Safe, high quality, patient centred healthcare								**Objective owner:**	CN		
Annual Priorities	To reduce avoidable deaths and avoidable re-admissions . To reduce harm caused by unwarranted clinical variation through introduction of 4 key 7 DS clinical standards in core services; implement UHL EWS and eObs processes; and safe use of insulin. To use patient feedback to drive Improvements to services and care by ensuring patients are informed and involved in their care; better end of life planning and improve the experience of outpatients.								**Risk Assurance Rating**		Exec Board RAG Rating = EQB 7/6/16	
Current risk rating (I x L):	**April**	**May**	**June**	**July**	**August**	**Sept**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**March**
	4x4=16	4x4=16										
Principal risk 1:	4x2=8											

Controls: (preventive, corrective, directive, detective)	**Assurance on effectiveness of controls**		**Gaps in Control / Assurance**
	Internal	**External**	
Clinical Effectiveness **Directive controls** Screen all hospital deaths Sepsis screening tool and care pathway Implement daily PARR 30 report to direct specialised discharge planning and communication of risk with stakeholders **Detective controls** Hospital deaths screening tool findings % of deaths screened Case record review individual and thematic findings Dr Foster's Intelligence and HED data Audit of sepsis 6 interventions No of SIs in relation to deteriorating patient/ sepsis Readmission rates and findings of PARR30 tool **Patient Safety:**	**Clinical Effectiveness** SHMI scores reported to Mortality and Morbidity Committee and TB, QAC via Q&P report. Quarterly mortality report to ESB/QAC/TB 6 monthly TB report in relation to mortality parameters monthly review of mortality alerts reported to TB. UHL target SHMI <= 99 Current SHMI (Oct 14 - Sept 15) 96 Readmission rate to be < 8.5% Readmissions action plan progress reported monthly to Ward Programme Board Quarterly report to EQB Exception reports to EPB when rate over8.6% **Sepsis** % of patients where screening is used	Internal Audit mortality and morbidity review due Q3 2015/16. Internal audit review in relation to outpatient patient experience due Q4 2015/16.	(a) Currently not all deaths are screened. (1.1, 1.2 and 1.3) (c) Circa £4M funding gap to implement 7 day service standards. (1.4) (c) Workforce shortage may inhibit implementation of 7 day service standards (1.4) (a) No single measure to monitor performance of 7 day services (1.4) (c)Resource to support the implementation of the Insulin strategy not yet approved (1.5)

Patient Safety **Directive controls** 7 Day service standards (including implementation of 14 hour consultant review, diagnostics, professional standards and daily consultant review) Implement UHL EWS and e-obs Implement insulin safety strategy **Detective control** Quarterly patient safety report highlighting number of severe/ moderate harms % of deaths screened 7 DS NHSE audit returns Insulin related incidents reported via Datix **Patient Experience** **Directive Control** End of life care plans Use of the 5 questions **Detective Controls** EoLC audits of use of care plan % uptake of EoLc training Outpatient group monitoring data	% of patients where screening is used (threshold 100% of in patients) % of patients receiving antibiotics within 1 hour (threshold 90% of antibiotics within 60mins of recognition for admission units and 90 mins for base wards) **Patient experience** 6% improvement on patient involvement scores 10% improvement on care plan use and outpatient experience scores. Achieve 14 day correspondence standard.		strategy not yet approved (1.5) (c) EWS score to trigger sepsis care pathway in Nerve Centre not yet in place (1.6) (c)Many avoidable readmissions caused due to factors in the community beyond influence of UHL

Action tracker:	Due date	Owner	Progress update:	Status
Mortality database to be developed (1.1)	Jun 2016	MD	Database developed and currently in testing phase. Roll out anticipated June 2016.	3
UHL Medical Examiners as Mortality Screeners (1.2)	Jul 2016	MD	Roll out at LRI planned to go live 4th July 2016.	4
Participate in National retrospective case record review (1.3)	TBA	MD	No date for completion has been set nationally yet	1
Work with Nerve Centre to implement EWS score to trigger sepsis care pathway (1.6)	Sep-16	MD	On track	4
7-Day services gap analysis (1.4)	Jun-16	MD	On track	4
Scope resources require to deliver the Strategy for Insulin Safety (1.5)	Jul-16	MD	being considered by EQB 05/07/16	4
Incorporate PARR30 scores into ICE and Nerve Centre	TBA	MD	meeting with DOI 28.06.16	
Release wte discharge sister to prioritise high risk discharge planning	TBA	MD	funding secured HoOE May 2016	

Board Assurance Framework:	Updated version as at:	May-16										
Principal risk 2:	Failure to provide an appropriate environment for staff/ patients								**Risk owner:**	DEF		
Strategic objective:	Safe, high quality, patient centred healthcare								**Objective owner:**	CN		
Annual priorities	Develop a high quality in-house Estates and Facilities service								**Risk Assurance Rating**	Exec Board RAG Rating = (Date: xx/xx/xx)		
Current risk rating (I x L):	**April**	**May**	**June**	**July**	**August**	**Sept**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**March**
	4X3=12	4x2=8										
Target risk rating (I x L):	4x2=8											

Controls: (preventive, corrective, directive, detective)	**Assurance on effectiveness of controls**		**Gaps in Control / Assurance**
	Internal	**External**	
Preventative Control Estates management infrastructure in place Including committee structure (e.g. Fire Safety Committee, Water Management Committee, Waste Committee, IP Committee, etc) **Detective Control** IT systems to control processes and performance manage. Review of Estates and facilities related incident reports Service user feedback (Staff) **Directive Control** Outline plan in place for developing Estates and Facilities Service: 0 - 3 months - Maintain safe services 0-9 months - Ensure compliance 0-18 months - Review, develop and optimise quality of services **Corrective Control** Escalation processes for deteriorating standards/ performance	Cleanliness audits PLANET SYSTEM providing data for Estates and 'soft' services SAFFRON system providing data for Patient feeding/ catering services. Annual ERIC return to benchmark efficiency against other organisations (due July 2016) Monthly performance reporting to EQB/ QAC and TB in relation to KPIs (beginning July 2016)	Annual 'PLACE' review (next due March 2017). Annual peer audit/ review (next due November 2016)	(c) Lack of detailed plans to deliver outline plan (2.1) (a) Some data not robust in relation to detailed KPIs (2.2)

Action tracker:	**Due date**	**Owner**	**Progress update:**	**Status**
Develop detailed plans to deliver the outline plan	Sep-16	DEF		4
KPIs to be reviewed	Sep-16	DEF		4

Board Assurance Framework:	Updated version as at:	May-16										
Principal risk 3:	Emergency attendance/ admissions increase without a corresponding improvement in process and / or capacity								**Risk owner:**		Sam Leak, Director of Emergency Care and ESM	
Strategic objective:	An effective and integrated emergency care system								**Objective owner:**		COO	
Annual Priorities	Reduce ambulance handover delays in order to improve patient experience, care and safety. Fully utilise ambulatory care to reduce emergency admissions and reduce length of stay (including ICS). Develop a clear understanding of demand and capacity to support sustainable service delivery and to inform plans for addressing any gaps. Diagnose and reduce delays in the in-patient process to increase effective capacity								**Risk Assurance Rating**		Exec Board RAG Rating = (EPB: 28/06/16)	
Current risk rating (I x L):	**April**	**May**	**June**	**July**	**August**	**Sept**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**March**
	5x5=25	5x5=25										
Target risk rating (I x L):	3x2=6											

Controls: (preventive, corrective, directive, detective)	**Assurance on effectiveness of controls**		**Gaps in Control / Assurance**
	Internal	**External**	
Directive / Preventative Controls NHS '111' helpline GP referrals Local/ National communication campaigns Winter surge plan Triage by Lakeside Health (from 3/11/15) for all walk-in patients to ED. (reduced resource by 50% May 2016 and ceases November 16) Urgent Care Centre (UCC) now managed by UHL from 31/10/15 Admissions avoidance directory Reworking of LLR urgent care RAP- as detailed in COO report **Detective Controls** Q&P report monitoring ED 4-hour waits, ambulance handover >30 mins and >60 mins, total attendances / admissions. UCB RAP progressed by Healtheconomy monthly Comparative ED performance summaries showing total attendances and admissions	ED 4 hour wait performance (threshold 95%) YTD 80.22% Poor performance continues to be primarily driven by record ED attendances and emergency admissions but has also been contributed to by staffing issues. Total attendances and admissions (compared to previous year) 2% increase in emergency admissions 5.7% increase in total A&E attendances. Ambulance handover (threshold 0 delays over 30 mins) 11% >30<60mins, >60mins 6% Difficulties continue in accessing beds from ED leading to congestion in the assessment area and delayed ambulance handover. Handover delays have decreased (December 37% over 30 mins to 18% in June) however further improvements are essential especailly in the long waits (over 2 hours in Dec 3% June 1%)	National benchmarking of emergency care data ORG fortnightly board dashboard.	(c) Lack of effectiveness of admissions avoidance plan (3.1) (c)Lack of effectiveness of attendance avoidance plan Lack of winter surge capacity (3.1)

Action tracker:	**Due date**	**Owner**	**Progress update:**	**Status**
LLR plan to reduce admissions (including access to Primary Care) (3.1)	Review Jun - 16	COO	Admissions and attendance continue to increase.	2
Expansion of Majors by moving minors to DVT and TIA (3.2)	Jul-16	SL	Updated at EQSG - on track	4
ORG action plan to decrease attendances (3.2)		ORG	**Complete.** Acton plan in place and progress against milestones managed via ORG	5
Increased medical base ward capacity (possibility of ward 7) (3.1)	Sep-16	SL / COO	Options paper for ward 7 being produced for decision	4
Ensure patients are conveyed to the most appropriate to access e.g. UCC, Assessment bay, AAU (amb and non amb) (3.2)		SL	**Complete.** SOP developed and audited on a regular basis	5
Move to new build (3.2)	Mar-17	SL / CF	Ensure pathway reconfiguration and workforce matches requirement to address this risk	4

Board Assurance Framework:	Updated version as at:	May-16										
Principal risk 4	Failure to deliver the national access standards impacted by operational process and an imbalance in demand and capacity.								**Risk owner:**		Will Monaghan, Director Of Performance And Information	
Strategic objective:	Services which consistently meet national access standards								**Objective owner:**		COO	
Annual Priorities	Maintain 18-week RTT and diagnostic access standard compliance Deliver all cancer access standards sustainably								**Risk Assurance Rating**		Exec Board RAG Rating = (Date: xx/xx/xx)	
Current risk rating (I x L):	**April**	**May**	**June**	**July**	**August**	**Sept**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**March**
	4x4=16	4x4=16										
Target risk rating (I x L):	3 x 2 = 6											

Controls: (preventive, corrective, directive, detective)	**Assurance on effectiveness of controls**		**Gaps in Control / Assurance**
	Internal	**External**	
Detective Controls RTT incomplete waiting times, cancer access and diagnostic standards reported via Q&P report to TB **Corrective controls** Insourcing of external consultant staff to deliver additional sessions. Outsourcing of elective work to independent sector providers. Productivity improvements in-house. Additional premium expenditure work in house.	RTT Incomplete waiting times (threshold 92%). Currently 92.7%. Diagnostics: 0.6% (threshold 1%) Fail: Cancer Access Standards (reported quarterly). 2 ww for urgent GP referral (Threshold 93%). 89% 2 ww for symptomatic breast patients (threshold 93%). 96.1% 31 day wait for 1st treatment (threshold 96%). 94% 31 day wait for 2nd or subsequent treatments (Drugs - threshold 98%). 100% (Surgery - threshold 94%). 90.4% (Radiotherapy - threshold 94%). 98.8% 62 day wait for 1st treatment (threshold 85%). 75.9% 62 day wait for 1st treatment (CSS referral-threshold 90%). 92.6% Cancer wait 104 days (threshold TBC). 7	Cancer recovery action plan managed across the Trust, NHS Improvement and the CCG. Monthly performance call with NTDA. Internal audit review in relation to waiting times for elective care due in quarter 4 2015/16; initiated end January 2016. Elective IST have assured the action plans in Diagnostics and the Cancer plan.	(c) Lack of progress on 62 day backlog reduction due to ITU/HDU capacity and gaps in clinical capacity in key specialties (4.1). (c) Inability to manage the pressure through the ENT service (4.2).

Action tracker:	Due date	Owner	Progress update:	Status
Sustained achievement of 85% 62 day standard (4.1)	Sep-16	DPI	62 day backlog reduction currently off trajectory. Implementation of 'Next Steps' for cancer patients in key tumour sites to start end February 2016. The extension to deadline comes as part of our submission to the TDA for our sustainable transformation plans.	4
Development of ITU additional capacity plan including increased frequency of step downs. (4.1)	Sep-16	HoO ITAPS		4
Further insourcing of external consultant staff to deliver additional sessions (4.2)	Jul-16	DPI		4

Board Assurance Framework:	Updated version as at:	May-16										
Principal risk 5:	There is a risk that UHL will lose existing, or fail to secure new, tertiary referrals flows from partner organisations which will risk our future status as a teaching hospital. Failure to support partner organisations to continue to provide sustainable local services, secondary referral flows will divert to UHL in an unplanned way which will compromise our ability to meet key performance measures.								**Risk owner:**		Director of Marketing and Comms (DoMC)	
Strategic objective:	Integrated care in partnership with others								**Objective owner:**		DoMC	
Annual priorities	Develop new and existing partnerships with a range of partners, including tertiary and local service providers to deliver a sustainable network of providers across the region. Progress the implementation of the EMPATH strategic outline case								**Risk Assurance Rating**		Exec Board RAG Rating = (Date: xx/xx/xx)	
Current risk rating (I x L):	**April**	**May**	**June**	**July**	**August**	**Sept**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**March**
	4x3=12	4x3=12										
Target risk rating (I x L):	4x2=8											

Controls: (preventive, corrective, directive, detective)	**Assurance on effectiveness of controls**		**Gaps in Control / Assurance**
	Internal	**External**	
Directive Controls NHS England Five Year Forward View sets out the national strategic direction. UHL Business Decision Process. UHL/NUH Children's Services Collaborative Group. Partnership Board for Specialised Services established in Northamptonshire. Membership includes Northants CCGs; NHS England; KGH; NGH and UHL. Tripartite Working Group UHL/NUH/ULHT. ULHT/UHL Urology Steering Group. SEMOC Steering Group. Memorandum of Understanding (MoU) for key work programmes.	ULHT/UHL Urology Steering Group and SEMOC Steering Group work programmes and risk registers reporting to UHL Tertiary Partnership Board. UHL Tertiary Partnerships Board reporting to ESB Monthly. Statistical Process Control (SPC) Reporting of performance developed (vascular only).	Inclusion in acute services contract. Compliance with national service specifications and standards, External service reviews (e.g. peer reviews).	(c) Lack of prioritised service level strategies and engagement plans. (5.1) (a) SPC Reporting required for other priority services. (5.3)

SLAs in place for all partnerships. Tertiary Partnership Strategy. Individual service strategies. **Detective/Corrective Controls** UHL Tertiary Partnerships Board. Tertiary partnership work-programme. Horizon scanning: NHS England (local and national); NICE; SCN; AHSN; NHS Networks			

Action tracker:	Due date	Owner	Progress update:	Status
(5.1) Apply criteria in Tertiary Partnership Strategy to prioritise service lines.	Jun-16	JC	To report to the Tertiary Partnership Board in July. Deadline extended due to the already established meeting schedule.	3
(5.2) Present vascular reporting to Tertiary Partnership Board.	May-16	JC	**Complete.** Will continue and use as a template for other priority services.	5
SPC Reporting to be developed for other priority services.	Sep-16	JC	To follow on from (5.1)	4

Board Assurance Framework:	Updated version as at:	May-16									
Principal risk 6:	Failure to progress the Better Care Together programme at sufficient pace and scale impacting on the development of the LLR vision								**Risk owner:**	Director of Marketing and Comms (DoMC)	
Strategic objective:	Integrated care in partnership with others								**Objective owner:**	DoMC	
Annual priorities	Work with partners to deliver year 3 of the Better Care Together programme to ensure we continue to make progress towards the LLR vision (including formal consultation).								**Risk Assurance Rating**	Exec Board RAG Rating = (Date: xx/xx/xx)	
Current risk rating (I x L):	**April**	**May**	**June**	**July**	**August**	**Sept**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**March**
	4x4=16	4x4=16										
Target risk rating (I x L):	2x5=10											

Controls: (preventive, corrective, directive, detective)	Assurance on effectiveness of controls		Gaps in Control / Assurance
	Internal	**External**	
Directive Controls BCT 5 Year Plan. BCT Strategic Outline Case. BCT Project Initiation Document. BCT governance arrangements, including a programme management office, multi-agency boards (BCT Partnership Board, BCT Delivery Board, BCT Service Reconfiguration Board, LLR Chief Officers, and CCG Commissioning Collaborative Board) all of which inform an overall BCT Board Assurance Framework. BCT project delivery structure and organisational specific delivery mechanisms,	Monthly updates (including high level risks and mitigating actions) received and reviewed by a number of internal boards and committees, namely Trust Board, Executive Strategy Board, Reconfiguration Programme Board. UHL bed base aligned to BCT requirements	Healthwatch organisations across LLR and the PPI Group. Clinical Senate (external to the LLR Partnership). Externally commissioned Health checks (also known as Gateway Reviews). Pre-consultation business case (PCBC) considered and signed off by partner boards, including CCG Boards, provider boards, local authorities etc. Ultimate decision to go to consultation sits with NHS England - NHS	(a) Some early schemes may not be delivering the anticipated impact e.g. LRI UEC, ICS. BCT programme dashboard (used to track progress) lacks sufficient detail making it difficult to hold work stream leads to account (6.1) (c) Capital availability uncertain and financial assumptions could be improved / updated (6.2 and 6.3)

including 8 integrated clinical work streams. UHL governance arrangements, including UHL Reconfiguration Programme Board and associated sub-committees / boards and work streams i.e. major capital business cases, estates, IM&T, Future Operating Model etc. **Detective Controls** Progress updates against pre-defined plans presented to both multi-agency boards and individual partner boards, including BCT Partnership Board, BCT Delivery Board, UHL Reconfiguration Board, UHL Executive Strategy Board and UHL Trust Board.		England lead the national (external) assurance process. NHS Improvement (formerly the Trust Development Authority) when reviewing and approving Trust plans.	

Action tracker:	Due date	Owner	Progress update:	Status
(6.1) A BCT Programme Dashboard to be established and agreed with the BCT PMO. BCT Delivery Board to review work stream plans to ensure there is sufficient stretch.	Sep-16	MW	On-going - high level milestones identified for all BCT Clinical Work streams with quarterly deliverables to promote transparency and to bolster accountability arrangements. This will be used to develop a dashboard - timescales being considered by the BCT PMO and Delivery Board - to be confirmed following the work being undertaken to challenge existing plans to ensure they contain sufficient / maximum stretch.	3
(6.2) Identifying how BCT (and associated cost improvement plans) will address the deficit requirements across LLR.	Jun-16	PT	High level CIP assumptions worked up and shared with LLR stakeholders to inform emerging LLR wide financial plans that will form part of the STP. BCT work streams challenged via a series of deep dive exercises and financial stretch targets assigned to each. BCT SROs have responded with potential solutions / plans to address the financial gap - these are being sense checked throughout June as part of the STP development process. Outputs are also being considered in terms of the potential impact on acute bed capacity.	4

(6.3) Implement proposed changes (subject to public consultation) over a longer time frame while still delivering financial balance by 20/21 and the priority order in respect to capital plans for UHL, plus options for exploring alternative sources of capital.	Jun-16	PT	Timescales for potential service changes (including those subject to consultation) are being considered as part of the exercise noted at 6.1 and 6.2 above.	4

Board Assurance Framework:	Updated version as at:	May-16										
Principal risk 7:	Failure to achieve BRC status								**Risk owner:**		Nigel Brunskill, DoR&D	
Strategic objective:	Enhanced delivery in research, innovation and clinical education								**Objective owner:**		MD	
Annual Priorities	Deliver a successful bid for a Biomedical Research Centre								**Risk Assurance Rating**		Exec Board RAG Rating = (Date: xx/xx/xx)	
Current risk rating (I x L):	**April**	**May**	**June**	**July**	**August**	**Sept**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**March**
	3x3=9											
Target risk rating (I x L):	3x2=6											

Controls: (preventive, corrective, directive, detective)	**Assurance on effectiveness of controls**		**Gaps in Control / Assurance**
	Internal	**External**	
Directive Controls Each BRU has a strategy document **Preventive Controls** UHL R&I supportive role to BRUs by meeting with Universities (Joint Strategic Meeting) Good working relationships between UHL and University partners Good track record of attracting subjects into studies Contracting and innovation team. Work with Medipex to commercialise our projects/ ideas. **Detective Controls** Financial monitoring of BRUs via Annual Report **Corrective controls** UHL to provide funding from external sources for targeted posts if necessary	Financial performance and academic output reported to UHL Joint Strategic meetings for assurance. In addition financial performance reported to each BRU Executive Board. Financial performance currently on plan. Highest recruiting Trust in the East Midlands and 7th nationally	NIHR monitor BRU performance University analysis of data	(c) NIHR national strategy not under UHL control (no local action can be taken) (c) Weak support from academic partners (7.1 and 7.2)

Action tracker:	**Due date**	**Owner**	**Progress update:**	**Status**
(7.1) Develop new 4-way strategy meeting with UHL, UoL, LU and DMU (7.1)	Jun-16	MD	On-going	4
(7.2) Closer joint working with Universities to develop application (7.2)	Jun-16	MD	Full application now in progress	4

Board Assurance Framework:	Updated version as at:	May-16										
Principal risk 8:	Too few trainers meeting GMC criteria means we fail to provide consistently high standards of medical education								**Risk owner:**		Sue Carr, Clinical Education	
Strategic objective:	Enhanced delivery in research, innovation and clinical education								**Objective owner:**		MD	
Annual priorities	Improve the experience of our medical students to enhance their training and improve retention, and help to introduce the new University of Leicester Medical Curriculum. Develop and implement our Commercial Strategy to deliver innovation and growth across both clinical and non-clinical opportunities. Launch the Leicester Academy for the Study of Ageing (LASA)								**Risk Assurance Rating**		Exec Board RAG Rating = (Date: 07/06/16)	
Current risk rating (I x L):	**April**	**May**	**June**	**July**	**August**	**Sept**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**March**
	3x4=12	3x4=12										
Target risk rating (I x L):	3x2=6											

Controls: (preventive, corrective, directive, detective)	**Assurance on effectiveness of controls**		**Gaps in Control / Assurance**
	Internal	**External**	
Directive Controls Medical Education Strategy Operational guidance EWB and CMG scrutiny / challenge of Medical Education issues **Detective Controls** Medical education database to show number of accredited trainers which feeds into Medical Education Quality dashboard. Reported to EWB via Medical Education Committee minutes. University Dean's report.	Medical Education Quality Dashboard shows the percentage of medical staff complying with GMC requirements (per CMG). Target 100%. Current position (per CMG) = • CHUGGS 76% • CSI: o Imaging 89% o Pathology 67% • ESM 68% • ITAPS 79% • MSS 88% • RRCV 73% • W&C: o Women's 96.5% o Children's 80% University Deans report to show % of fully recognised medical trainers in UHL (threshold 100%) by July 2016. Current position = 74% (down from 75% previous period). UHL trainee survey	HEEM accreditation visits. GMC trainee survey results.	(c & a) Accuracy of database uncertain (8.1)

Action tracker:	Due date	Owner	Progress update:	Status
Ensure engagement with CMGs to embed Medical Education Dashboard to ensure more robust data (8.1)	Jun-16	S Carr	On-going engagement with CMG Med ED leads. Extra provision of online supervisor training in place to improve accreditation rates among supervisors. Triangulation of internal and external data sources to improve database accuracy.	4

Board Assurance Framework:	Updated version as at:		May-16									
Principal risk 9:	Insufficient engagement of clinical services, investment and governance may cause failure to deliver the Genomic Medicine Centre project at UHL								**Risk owner:**		Nigel Brunskill, DoR&D	
Strategic objective:	Enhanced delivery in research, innovation and clinical education								**Objective owner:**		MD	
Annual priorities	Support the development of the Genomic Medical Centre and Precision Medicine Institute								**Risk Assurance Rating**		Exec Board RAG Rating = (Date: xx/xx/xx)	
Current risk rating (I x L):	**April**	**May**	**June**	**July**	**August**	**Sept**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**March**
	4x4=16	4x3=12										
Target risk rating (I x L):	3x2=6											

Controls: (preventive, corrective, directive, detective)	**Assurance on effectiveness of controls**		**Gaps in Control / Assurance**
	Internal	**External**	
Directive Controls Director of R&I meets with key CMG managers to ensure engagement. Genomic Medicine Centre (GMC) CMG leads for Cancer and rare diseases New pathway for samples initiated with Genomic Medicine Centre at Cambridge (previously Nottingham). **Preventive Controls** **E**ngagement with CMGs via comms strategy including weekly national and local (i.e. UHL) news letters Contracting and innovation team Work with Medplex to help commercialise our projects ideas **Detective Controls** Research study subject recruitment trajectory (sufficient income depends upon meeting recruitment thresholds). Monitored by GMC Steering Committee and UHL Exec Team	Monthly and annual trajectory for recruitment into this project. Currently we are slightly below trajectory for rare diseases but this is improving. New pathway for samples initiated with Genomic Medicine Centre at Cambridge to resolve issues	Eastern England Genomic Centre monitoring against recruitment trajectory.	(c) Ineffective recruitment into studies attributable to lack of research staff (9.1)

Action tracker:	**Due date**	**Owner**	**Progress update:**	**Status**

(9.1) Engagement of CMGs with process	Jun-16	MD DRI	DRI and MD leading on engagement programme. Meeting with Clinical Genetics and W&C CMG Management to discuss Clinical Genetics workforce plan.	4
(9.1) Appoint nurse to cover maternity leave in May	Jun-16	MD CRI	Out to advert	4
(9.1) Recruitment against trajectories	Jun-16	DRI	Recruitment for rare diseases on trajectory; recruitment for cancer to start July. Likelihood of recruitment failure reduced therefore risk score downgraded.	4
Finalise IT plans	Jun-16	DRI	Ensure UoL team deliver CiVi CRM to timelines	4

Board Assurance Framework:	Updated version as at:	May-16										
Principal risk 10:	Lack of system wide consistency and sustainability in the way we manage change and improvement impacting on the way we deliver the capacity and capability shifts required for new models of care								**Risk owner:**	DoWD		
Strategic objective:	A caring, professional and engaged workforce								**Objective owner:**	DoWD		
Annual priorities	Develop an integrated workforce strategy to deliver a diverse and flexible multi-skilled workforce that operates across traditional organisational boundaries and enhances internal sustainability . Deliver the Year 1 Implementation Plan for the UHL Way, ensuring an improved level of staff engagement and a consistent approach to change and development. Develop training for new and enhanced roles, i.e. Physician's Associates, Advanced Nurse Practitioners, Clinical Coders Develop a more inclusive and diverse workforce to better represent the community we serve and to provide services that meet the needs of all patients								**Risk Assurance Rating**	Exec Board RAG Rating To be endorsed at EWB 19/7/16		
Current risk rating (I x L):	**April**	**May**	**June**	**July**	**August**	**Sept**	**Oct**	**Nov**	**Dec**	**Jan**		**March**
	4x4=16	4x4=16										
Target risk rating (I x L):	4x2=8											

Controls: (preventive, corrective, directive, detective)	**Assurance on effectiveness of controls**		**Gaps in Control / Assurance**
	Internal	**External**	
Develop Integrated Workforce Strategy **Directive Controls** LETC/BCT Programme Board BCT Workforce Implementation Group Workforce enabling group (strategic) New roles group **Detective Controls** Not yet agreed	No assurance sources available for development of integrated workforce strategy as key measures/ metrics have yet to be agreed.		(a) No measures/ metrics to track progress of workforce enabling plan. 10.1 (c) Ineffective training for new and enhanced roles 10.2
Deliver year 1 implementation of 'The UHL Way' **Directive controls** Executive Workforce Board UHL Way Steering Group UHL 'LiA' Sponsor group **Detective Controls** Schedule of activities for each component of	Measures against schedule of activities for the 4 components: 1. Better engagement 2. Better teams 3. Better change 4. Academy	East Midlands Leadership Academy Leicestershire Improvement Innovation Patient Safety Forum	(c) Internal reporting / Goverance structures yet to be finalised. 10.3

'The UHL Way'	UHL Pulse Check National Staff Survey data		

Action tracker:	Due date	Owner	Progress update:	Status
Strategic Workforce Planning - Develop a view of capacity and capability changes across the system. 10.1	Mar-17	DoWD		4
Agree a delivery plan and measures/ metrics for strategic Workforce Planning group. 10.1	Jun-16	DoWD	**Complete**	5
Identify internal governance structure to implement 'The UHL Way'. 10.3	Jun-16	DoWD		4
Improve effectiveness of training via new roles group 10.2	Mar-17	DoWD		4

Board Assurance Framework:	Updated version as at:	May-16									
Principal risk 11:	Ineffective structure to deliver the recommendations of the national 'freedom to speak up review							**Risk owner:**	DoWD		
Strategic objective:	A caring, professional and engaged workforce							**Objective owner:**	DoWD		
Annual priorities	Deliver the recommendations of "Freedom to Speak Up" Review to further promote a more open and honest reporting culture							**Risk Assurance Rating**	Exec Board RAG Rating To be endorsed at EWB on 19/7/16		
Current risk rating (I x L):	**April**	**May**	**June**	**July**	**August**	**Sept**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**March**
	4x4=16	4x4=16										
Target risk rating (I x L):	4x2=8											

Controls: (preventive, corrective, directive, detective)	Assurance on effectiveness of controls		Gaps in Control / Assurance
	Internal	**External**	
Freedom to speak up **Directive controls** UHL Whistle blowing policy Freedom to speak up internal policy Executive Quality Board Executive Workforce Board Quality Assurance Committee **Detective controls** No. of whistleblowing reported issues (via 3636 / gripe tool etc) Project plan with milestones for freedom to speak up Casework monitoring (investigations)	No. UHL Whistleblowing reported cases for reporting period: X		(c) No internal governance structure to comply with national recommendations. 11.1 (c) No local Guardian (Freedom to speak up). 11.2 (c) Lack of resources for project (funding for Guardian). 11.3

Action tracker:	Due date	Owner	Progress update:	Status
Governance structure to be developed for Freedom to speak up. 11.1	Sep-16	DoWD		4
Local Guardian to be appointed (Freedom to speak up). 11.2	Mar-17	DoWD		4
Consideration of resources and potential business case to deliver the plan. 11.3	Sep-16	DoWD		4

Board Assurance Framework:	Updated version as at:		May-16									
Principal risk 12:	Insufficient estates infrastructure capacity may adversely affect major estate transformation programme								**Risk owner:**		DEF	
Strategic objective:	A clinically sustainable configuration of services, operating from excellent facilities								**Objective owner:**		CFO	
Annual priorities	Complete and open Phase 1 of the new Emergency Floor Deliver our reconfiguration business cases for vascular and level 3 ICU (and dependent services)								**Risk Assurance Rating**		Exec Board RAG Rating = (Date: xx/xx/xx)	
Current risk rating (I x L):	**April**	**May**	**June**	**July**	**August**	**Sept**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**March**
	4x4=16	4x4=16										
Target risk rating (I x L):	4X3=12											

Controls: (preventive, corrective, directive, detective)	**Assurance on effectiveness of controls**		**Gaps in Control / Assurance**
	Internal	**External**	
Directive Controls UHL reconfiguration programme governance structure aligned to BCT Reconfiguration investment programme demands linked to current infrastructure. Estates work stream to support reconfiguration established Five year capital plan and individual capital business cases identified to support reconfiguration Property / Space Management - clinical and non clinical schedules in place **Detective Controls** Survey to identify high risk elements of engineering and building infrastructure. Monthly report to Capital Investment Monitoring committee to track progress against capital backlog and capital projects Regular reports to Executive Performance Board (EPB). Highlight reports developed monthly and reported to the UHL Reconfiguration Programme Board.	Major Capital - On track against revised schedule Annual programme - On track against revised schedule	Eric data Lord Carter review and recommendations Capita report	(c) A programme of infrastructure improvements is currently being identified (12.1) (c) Overall programme of works not yet identified and quantified in relation to risk (12.2)

Action tracker:	Due date	Owner	Progress update:	Status
Assessment of current capacity being established through a set of comprehensive technical/engineering site surveys for GGH and LRI (12.1)	Jun-16	DEF	Surveys are nearing completion with report due by end of May 2016; ESB update July 2016. The draft report for GH has been received and is being reviewed by the estates capital team. The LRI report is due this month but it is now known that there is insufficient electrical data to fully inform the electrical review. This will impact upon the second stage report covering where do we want to be and how do we get there. See remedial action below.	3
Identification of investment required and allocation of capital funding to develop a programme of works (12.2)	TBA	DEF	Prioritisation of backlog capital once 2016/17 annual capital resources confirmed by IFPIC. Phasing options to be included with further programme to be developed once capital availability is confirmed. This date is now at risk. A revised timeline will be presented after the gap analysis	3
Remedial action. The estates capital team are currently carrying out a gap analysis. This will review each service, identifying gaps in information available, the impact of the lack of data on the validity of the second stage report and the cost benefit of acquiring the relevant data. Information relating to this will be included in the July update to ESB (12.2)	Jul-16	DEF		3
Capital plan C includes an allocation of £1.5m which will support the immediate	Jul-16	DEF	Capital availability will be clear end of Q1	4

Board Assurance Framework:	Updated version as at:		May-16									
Principal risk 13:	Limited capital envelope to deliver the reconfigured estate which is required to meet the Trust's revenue obligations								**Risk owner:**		CFO	
Strategic objective:	A clinically sustainable configuration of services, operating from excellent facilities								**Objective owner:**		CFO	
Annual priorities	Develop outline business cases for our integrated Children's Hospital, Women's Services and planned ambulatory care hub								**Risk Assurance Rating**		Exec Board RAG Rating = (Date: xx/xx/xx)	
Current risk rating (I x L):	**April**	**May**	**June**	**July**	**August**	**Sept**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**March**
	4x5=20	4x4=16										
Target risk rating (I x L):	4x2=8											

Controls: (preventive, corrective, directive, detective)	**Assurance on effectiveness of controls**		**Gaps in Control / Assurance**
	Internal	**External**	
Directive Controls/Preventive Controls Five year capital plan and individual capital business cases identified to support reconfiguration Business case development is overseen by the strategy directorate and business case project boards manage and monitor individual schemes. Capital plan and overarching programme for reconfiguration is regularly reviewed by the executive team. **Detective Controls** Capital Investment Monitoring Committee to monitor the programme of capital expenditure and early warning to issues. Monthly reports to ESB and IFPIC on progress of reconfiguration capital programme. Highlight reports produced for each project board. **Corrective Control** Revised programme timescale approved by IFPIC	Capital expenditure and progress against reconfiguration programme monitored via Capital Investment committee ESB/ IFPIC/ TB. On track against revised schedule. Resource expenditure for development of business cases - on track/ monitored on a monthly basis Affordability of business cases (i.e. schemes within allocated budget envelope) - on track against revised programme. Individual projects capital expenditure monitored via highlight report which are reviewed by the Major Business Case meeting and Reconfiguration Board.	UHL's Annual Operating Plan, as submitted to NHS Improvement, includes capital requirements for 2016/17 strategic programme (awaiting feedback). Monthly meetings with NHSI ensures Trust's capital priorities are clearly identified and known. Formal communication with Regional Director at NHSE and NHSI regarding the strategic capital requirements linked to BCT. LLR BCT (and now STP) include the external capital values as part of the system wide case for change.	c) Limited capital funding within 2016/17 programme and future years (13.1 and 13.2) (c) ITU interim configuration has been delayed due to capital availability, this will not be confirmed until Q1 2016/17. Capital plan C has been developed which allows for the development of additional ward capacity at GH for HPB which is now necessary before the ICU interim move. Development of ICU construction will commence at the back end of 2016/17. In addition to capital there are risks to Trust capacity that may delay move further. Interim measures have been put in place to manage risks in short-term, these arrangements need to be reviewed if any further delays (13.3)

Action tracker:	Due date	Owner	Progress update:	Status
Consideration to be given to alternative sources of funding. (13.1)	~~01/06/2016~~ August 16	CFO	Exploratory discussions with expert PF2 advisors (Deloitte) regarding which capital schemes could potentially be suitable. Meeting with PFU in May 2016, options still being	3
Maintain dialogue with NHSI and NHSE regarding the pressing need for external capital to facilitate strategic change (13.2)	~~01/06/2016~~ August 16	CEO/CFO	Alongside recent correspondence and discussion regarding BCT and its capital requirements, the LLR STP represents a further opportunity to formalise and emphasise the requirement.	3
Capital plan C has identified best way to prioritise / progress all reconfiguration projects within a reduced funding allocation (13.3)	Jul-16	CFO	Capital availability will hopefully be clearer at the end of Q1	4

Board Assurance Framework:	Updated version as at:	May-16									
Principal risk 14:	Failure to deliver clinically sustainable configuration of services								Risk owner:	CFO	
Strategic objective:	A clinically sustainable configuration of services, operating from excellent facilities								Objective owner:	CFO	
Annual priorities	Develop new models of care that will support the development of our services and our reconfiguration plan								Risk Assurance Rating	Exec Board RAG Rating = (Date: xx/xx/xx)	
Current risk rating (I x L):	April	May	June	July	August	Sept	Oct	Nov	Dec	Jan	Feb	March
	4x5=20	4x5=20										
Target risk rating (I x L):	4x2=8											

Controls: (preventive, corrective, directive, detective)	Assurance on effectiveness of controls		Gaps in Control / Assurance
	Internal	External	
Directive Controls UHL reconfiguration programme governance structure aligned to BCT Strategic capital business case work streams aligned to BCT Monthly meetings with the NHSI to identify new business cases coming up for approval Detailed programme plan identifying key milestones for delivery of the capital plan. Project plans and resources identified against each project. A future operating model at speciality level which supports a two acute site footprint: Out of hospital contract approved and project established to shift appropriate activity into	Progress of all reconfiguration programme work streams is monitored via aggregated reporting to ESB/ IFPIC/ TB. Monthly updates via aggregated reporting (highlight reports) to ESB/ IFPIC/ TB. Overall reconfiguration programme is RAG rated. Currently reported as 'amber 'due to complexity of programme and risks associated with delivery.	Regular meetings with NHSI NHS England BCT Programme Board Gateway / Assurance review carried out Feb - 16	(c) Agreed that current capacity and demand management / left shift assumptions of a reduction in 462 beds which determines future size and configuration of services is not achievable. (14.1) (a) Bed capacity model/assumptions being reviewed as part of the BCT programme (14.2). (c)Development of plan for all services at the LGH to determine the gap in the current capital plan

established to shift appropriate activity into the community. **Detective Controls** Gateway / Assurance review A monthly highlight report to indicate RAG rating of reconfiguration programme submitted to the UHL Reconfiguration Programme Delivery Board. Monthly aggregate reporting to ESB, IFPIC and Trust Board. Monthly meetings with the NTDA to discuss the programme of delivery Monitoring of progress towards UHL two acute site model Monitoring of business case timescales for delivery. Requirements identified to deliver key projects overseen by PMO			the gap in the current capital plan (14.3) (Roadmap exercise) (c) Delay in BCT public consultation - being managed by response to NHS Assurance panel (14.4)

Action tracker:	Due date	Owner	Progress update:	Status
Demand and capacity issue being fully modelled and then considered by BCT Delivery Board on June 13th. Conclusions need to feed into NHSE led assurance process in advance of public consultation and reconfiguration. Internal work with estates, clinical, finance and workforce teams continues throughout June and July to support implementation when plans are agreed. (14.1, 14.2, 14.3, 14.4)	~~01/06/2016~~ July 16	COO / CFO	Modelling and options appraisal work underway. Workshop on the estates impact and possible mitigations to be held 9th June, followed by an organisational workshop to review the impact by end of June. Estates strategy and Development Control Plans to be updated thereafter (report to August ESB).	3

Board Assurance Framework:	Updated version as at:		May-16									
Principal risk 15:	Failure to deliver the 2016/17 programme of services reviews, a key component of service-line management (SLM)								**Risk owner:**		CFO	
Strategic objective:	A financially sustainable NHS Organisation								**Objective owner:**		CFO	
Annual priorities	Implement service line reporting through the programme of service reviews to ensure the on-going viability of our clinical services Deliver operational productivity and efficiency improvements in line with the Carter Report								**Risk Assurance Rating**		Exec Board RAG Rating = (Date: xx/xx/xx)	
Current risk rating (I x L):	**April**	**May**	**June**	**July**	**August**	**Sept**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**March**
	3x3=9	3x3=9										
Target risk rating (I x L):	3x2=6											

Controls: (preventive, corrective, directive, detective)	**Assurance on effectiveness of controls**		**Gaps in Control / Assurance**
	Internal	**External**	
Directive Controls Governance arrangements established Overarching project plan for service reviews developed New structure / methodology agreed for capturing outputs in a consistent way, aligned to the IHI Triple Aim and UHL way New virtual team structure to support the intensive service reviews. Steering Group in place to monitor and provide assurance regarding the service review programme (all levels i.e. standard, enhance and intensive). **Detective Controls** SLM / Service Review Data Packs now to include a range of metrics, beyond finance Monthly updates required from services against pre-determined work programme. Measureable outcomes now embedded into the process via improved methodology - Where relevant, schemes with a financial benefit are added to the CIP Tracker	Regular update reports to ESB, EPB and IFPIC. Previous programme suspended. New programme being developed as agreed through ESB. Individual service reviews will report through to the Steering Group and the Steering Group will provide quarterly updates to ESB.	Internal Audit (PWC) October 2015 - Service Line Reporting	(c) BI capacity is (at times) limited which impacts on Data Pack production (15.1) (c) Clinical engagement can be variable (as is clinical capacity to get involved) (15.2) (c) Improvement tools / change management techniques are under development with the UHL Way better change Team (15.3) (a) Assurance that resources are placed with the services who need them the most (15.4)

Action tracker:	Due date	Owner	Progress update:	Status
Revised Data Pack being scoped for discussion with BI leads. (15.1)	Jun-16	CFO	A sample data pack was circulated to the steering group on 11.5.16. Expert members to consider data for appropriateness	4
Clinical engagement can be variable (as is clinical capacity to get involved) (15.2)	Jun-16	CFO	**Complete.** Time resources needed with clinicians has been reduced by amalgamating work streams together.	5
Improvement tools (for use by clinical services) to be finalised (15.3)	Jun-16	CFO		3
Assurance that resources are placed with the services who need them the most (15.4)	Jun-16	CFO	The plan involves: Stratification of services to determine the level of input required (Intensive, Standard and Enhanced). The priority order of services to be completed are dependant on their positioning in the Stratification matrix. This information will then be developed into a programme plan. The stratification matrix has been simplified by the Steering Group. Revised measures have been agreed and the data is being collected for the next steering group 22.6.16	4

Board Assurance Framework:	Updated version as at:		May-16									
Principal risk 16:	The Demand/Capacity gap if unresolved may cause a failure to achieve UHL deficit control total in 2016/17								**Risk owner:**		CFO	
Strategic objective:	A financially sustainable NHS organisation								**Objective owner:**		CFO	
Annual priorities	Reduce our deficit in line with our 5-Year Plan Reduce our agency spend to the national cash target								**Risk Assurance Rating**		Exec Board RAG Rating = (Date: xx/xx/xx)	
Current risk rating (I x L):	**April**	**May**	**June**	**July**	**August**	**Sept**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**March**
	5x3=15	5x3=15										
Target risk rating (I x L):	5x2=10											

Controls: (preventive, corrective, directive, detective)	**Assurance on effectiveness of controls**		**Gaps in Control / Assurance**
	Internal	**External**	
Directive Controls Agreed Financial Plan for 2016/17 (AOP) Standing Financial Instructions UHL Service and Financial strategy as per SOC and LTFM. **Preventative Controls** Sign-off and agreement of contracts with CCGs and NHS England CIP delivery plan for 2016/17 **Detective Controls** Monthly finance reporting in relation to income and expenditure and CIP **Corrective Controls** Identification and mitigation of excess cost pressures Planned reduction in agency spend	Contracts signed with both main commissioners. Robust internal process to set the financial plan for 2016/17 as agreed by IFPIC and TB. Favourable variance to plan of £172k at M2 with a year end forecast in-line with the revised I&E plan of a deficit of £31.7m (excluding STF). CIP within the year to date position has delivered to plan of £4.4m.. The detailed position will be reviewed by the Executive Performance Board monthly Integrated Finance, Performance & Investment Committee and Trust Board monthly Run rates to achieve £31.7m in each area (pay, non-pay, CIP and income) updated for month 2 and reported to Committees/Trust Board.	Regular review of financial plan by NHS Improvement.	At the start of the 2016/17 year, there is unidentified/ invalidated CIP. (16.1)

Reasonable assurance rating that risk is being managed:	Due date	Owner	Progress update:	Status
CIP gap needs to be resolved. (16.1)	Jun-16	COO	Actions being taken to correct the start of year gap. Monthly report to IFPIC contains the detail	3
Outstanding cost pressure list (i.e. any remaining items from budget/contract setting exercise) requires final decisions to be made by CEO and Executive Team.	~~01/05/2016~~ Jun-16	CFO	Initial review held with Executive Team with further work required that will be concluded by 30th June 2016	3

Board Assurance Framework:	Updated version as at:	May-16										
Principal risk 17:	Failure to achieve a revised and approved 5 year financial strategy								**Risk owner:**	CFO		
Strategic objective:	A financially sustainable NHS organisation								**Objective owner:**	CFO		
Annual priorities	Reduce our deficit in line with our 5-Year Plan Reduce our agency spend to the national cash target								**Risk Assurance Rating**	Exec Board RAG Rating = (Date: xx/xx/xx)		
Current risk rating (I x L):	**April**	**May**	**June**	**July**	**August**	**Sept**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**March**
	5x3=15	5x3=15										
Target risk rating (I x L):	5x2=10											

Controls: (preventive, corrective, directive, detective)	**Assurance on effectiveness of controls**		**Gaps in Control / Assurance**
	Internal	**External**	
Directive Controls Overall strategic direction of travel defined through Better Care Together. Financial Strategy fully modelled and understood by all parties locally and nationally. UHL's working capital strategy in place. 2016/17 financial plan in place and monitored appropriately **Detective Controls** Monthly monitoring of performance against financial plan. IFPIC and TB receive half yearly updates in relation to financial strategy and LTFM **Corrective controls** Explore options for other (non-NHS) sources of capital funding	Monthly reporting against 2016/17 plan. - As at M2 the Trust is £172k favourable to plan. Half yearly review of LTFM to ensure fitness for purpose i.e. checking consistency with UHL's strategy and ensuring we have a deliverable recovery plan over the medium term. Strong links to overall BCT 5 year strategy and the financial consequences (revenue and capital) of the transformational business cases	NHS England and NTDA review of: BCT SOC BCT PCBC Financial strategy LTFM System-wide five-year 'place-based' sustainability and transformation plan (STP) Individual business cases above a certain level	(c)LTFM not yet formally approved (17.1) (c)SOC not yet formally approved (17.2) (c)STP still in production (17.3) (c) Currently seeking authority to proceed with public consultation

Action tracker:	**Due date**	**Owner**	**Progress update:**	**Status**
As per the annual work plan for IFPIC, UHL's LTFM and therefore its financial strategy is being refreshed. (17.1, 17.2)	Jun-16	CFO	On track	4
UHL's financial strategy including the finalisation of the 2016/17 plan needs to be incorporated into the LLR STP financial model. (17.3)	Jun-16	CFO	On track	4

Board Assurance Framework:	Updated version as at:	May-16										
Principal risk 18:	Delay to the approvals for the EPR programme								**Risk owner:**		CIO	
Strategic objective:	Enabled by excellent IM&T								**Objective owner:**		CIO	
Annual priorities	Conclude the EPR business case and start implementation								**Risk Assurance Rating**		Exec Board RAG Rating = (Date: xx/xx/xx)	
Current risk rating (I x L):	**April**	**May**	**June**	**July**	**August**	**Sept**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**March**
	4 x 4 = 16	4x4=16										
Target risk rating (I x L):	3 x 2 = 6											

Controls: (preventive, corrective, directive, detective)	**Assurance on effectiveness of controls**		**Gaps in Control / Assurance**
	Internal	**External**	
Directive Controls Weekly communications with key contacts throughout the external approvals chain. EPR project plan. IM&T transformation Board. EPR programme Board and the joint Governance Board. **Detective Controls** Weekly meeting to discuss progress and issues - Milestones that relate to the EPR early works are monitored to ensure that all work, that can be, is progressing to time. **Corrective Controls** We have a contingency plan in place for the provision of services to the new ED if the plan has no realistic chance of meeting their timelines. Works that support the EPR project but could be used for an alternative, if approval was not forthcoming, have continued.	Internal and external meetings about the FBC are being undertaken. Until National TDA approval is given we can't engage with our key partners to implement the system, however we continue to work to mitigate the impact of the delay. Upgrades are now taking place on our major IT systems including Clinicom, ORMIS and planning for EDIS to ensure they can be supported for a longer period prior to replacement by EPR or alternative.	Internal audit review of implementation of gateway actions following review of EPR implementation in Q3 2015/16. HSCIC are undertaking a health check review on the EPR Project during March 2016	(c)The NTDA have been unable to meet their timetable. This is due to the nationally deteriorating position around capital and is outside of the control of UHL (18.1).

Action tracker:	**Due date**	**Owner**	**Progress update:**	**Status**

Progress work with NTDA/DoH to progress a firm timetable (18.1)	Review Jun-16	CIO	The business case was not added to the NTDA National Investment Committee for approval on the 10/03/16 due to issues with the capital resource limit (CRL). Further work is required on the financial model. The NTDA are supportive of the business case for EPR however due to financial constraints and capital limits the case currently exceeds the acceptable CRL and has not been forwarded onto the National Investment Committee for approval. Deadline extended to reflect this. Plans to upgrade our core systems to ensure services can be maintained are underway. This is likely to cost around £1m in the short term for software & hardware plus IT and organisational time and effort to implement over 6 month period.	2

Board Assurance Framework:	Updated version as at:		May-16									
Principal risk 19:	Lack of alignment of IM&T priorities to UHL priorities								**Risk owner:**		CIO	
Strategic objective:	Enabled by excellent IM&T								**Objective owner:**		CIO	
Annual priorities	Improve access to and integration of our IT systems								**Risk Assurance Rating**		Exec Board RAG Rating = (Date: xx/xx/xx)	
Current risk rating (I x L):	**April**	**May**	**June**	**July**	**August**	**Sept**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**March**
	3 x 4 = 12	3x4=12										
Target risk rating (I x L):	3 x 2 = 6											

Controls: (preventive, corrective, directive, detective)	**Assurance on effectiveness of controls**		**Gaps in Control / Assurance**
	Internal	**External**	
Directive Controls Prioritisation Group meets monthly. Standard operating procedure for bringing and authorising new work tasks. Progress updates reported to Executive IM&T board quarterly. UHL IM&T Governance Structure. **Detective Controls** Prioritisation matrix to define projects. Service Level Agreements. Weekly and monthly meetings to discuss issues and monitor progress.	Weekly reporting within IM&T Monthly Prioritisation meetings Reports to Executive IM&T board	Internal audit review (15/16) of UHL IM&T service delivery reporting methods and quality	(c) No link to UHL Operations directorate within the Prioritisation Group (19.1)

Action tracker:	**Due date**	**Owner**	**Progress update:**	**Status**
UHL COO to chair the Prioritisation Group on a quarterly basis (19.1)	Jun-16	CIO	Richard M, came to the June Meeting. More work is required to make best use of the COOs time to maximise the throughput of prioritised work	4

Reasonable assurance rating:

Green	G	Effective controls in place and appropriate assurances are available
Amber	A	Effective controls thought to be in place but assurances are uncertain / insufficient
Red	R	Effective controls may not be in place and assurances are not available to the Board

Risk rating criteria:

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%)

Action tracker status:

5	Complete
4	On-track
3	Some delay. Expected to be completed as planned
2	Significant delay. Unlikely to be completed as planned.
1	Not yet commenced.
0	Objective revised.

BAF Risk Rating Matrix:

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
2804	Emergency and Specialist Medicine		Outlying Medical Patients into other CMG beds due to insuffient ESM inpatient bed capacity	31/08/2016 05/06/2106		There is a risk that ongoing pressures in medical admissions that the Emergency and Specialist Medicine CMG medicine bed base will be insufficient resulting in the need to out lie into other speciality/CMG beds jeopardizing delivery of the RTT targets and affecting quality and safety of patient care. There is a requirement to outlie medical patients because of: o 8% increase in medical admissions and current insufficient medical bed capacity o Discharge processes not as efficient as they should be internally impacting patient flow and patients waiting in ED for admission o Continued delayed transfers of care o On-going risks and potential harm to patients as a consequence of overcrowding in ED o OOH teams have to make decisions to use all available capacity to cope with pressures in ED The ability to open extra beds within the CMG is compounded by: o >100 Nursing vacancies o 3 Geriatrician vacancies o High patient acuity o High inflow of patients being admitted o No available bed capacity on the LRI site	Patient safety	Review of capacity requirements throughout the day 4 X daily. Issues escalated at Gold command meetings and outlying plans executed as necessary taking into account impact on elective activity. Opportunities to use community capacity (beds and community services) promoted at site meetings. Daily board rounds and conference calls to confirm and challenge requirements for patients who have met criteria for discharge and where there are delays ICS/ICRS in reach in place. PCC roles fully embedded. Discharges before 11am and 1pm monitored weekly supported by review of weekly ward based metrics. Ward based discharge group working to implement new ways of delivering safe and early discharge. Explicit criteria for outlying in place supported by recent clarification from Assistant HON. Review of complaints and incidents data. Safety rota developed to ensure there is an identified consultant to review outliers on non-medical wards. Access to community resources to enable patients to be discharged in a timely manner. CMG to access and act on additional corporate support to focus on discharge processes. Matron for discharge appointed to provide consistent care for patients needing to be outlied. Continue to review outlying daily at conference call and flow team dedicated matron. Undertake a review of the required bed base for 2016/2017.	Major	Almost certain	20	Commence UHL way 3 "W" project on elderly care wards 01/06/2016 review 31/08/2016	12	GST

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
2505	Musculoskeletal and Specialist Surgery		There is a risk of medical patients being outlied into the Ambulatory Surgical Unit due to lack of beds within the trust.	13/03/2015	31/05/2016	Allocating Medical, Oncology or Haematology inpatients to the Ambulatory Surgical Unit at the LRI when there is a shortage of inpatient beds for patients will result in additional risk for patients: 1.□The Ambulatory Surgical Unit is a purpose built area for patients undergoing a variety of day case surgical procedures. It currently has a mixture of adults, and community dentals patients on a daily basis. 2.□The Ambulatory Surgical Unit is currently open and staffed as follows: 07:30 am Monday (24hrs) until Saturday 8pm 3.□It is not suitable for inpatient care with dependant patients staying overnight due to the lack of basic facilities as listed below: -□bed pan washer/macerator -□meal provisions -□BEDS - lack of beds- as trolleys are used in the day ward. -□Drip stands -□Commodes / Toilets -□Hoist -□Storage facilities/lack of stores -□EMPA/lack of WiFi -□Isolated from other clinical wards -□Ward not staffed at weekends -□Staff do not have the correct skill set to manage these patients - are not IV assessed. -□Lack of domestic cover. -□Lack of storage - so outlied patients stores are held in crates in the ward corridor - restricting access and flow. -□Essential drugs -□Essential fluids	Patient safety	The Ambulatory Surgical Unit to be used only when the trust has exhausted all other options available within UHL to accommodate the additional emergency patients. Senior decision makers within medicine are able to assess which patients are most suitable to be outlied to the day surgery unit based on the following nursing and medical criteria: Patients who are the most medically stable and meet the following criteria: "□Ambulant patients "□Do not score on EWS "□Low falls risk "□No Dementia or confusion "□Patients near to discharge awaiting results "□No high risk mental health patients - no infected patients - review of elective TCI's - Review of staffing needs dependent on patient cohort - Undertake exit interviews	Major	Almost certain	20	Matron/NIC to ensure that all patients meet the agreed criteria to be outlied. Medical matron to visit the area whilst inpatients remain on the day surgical unit to offer support and advice - 31/5/16 Safe staffing levels to be monitored and escalated by the NIC/Matron to ensure there is adequate staff to care for the extra patients on the Ambulatory Surgical Unit - 31/5/16 Levels of privacy and dignity should be monitored at all times by the allocated staff - 31/5/16 NIC/Matron should ensure that patients and relatives are kept fully informed - 31/5/16 General Manager /CMG manager to explore the possibility of patient having their day case procedures on inpatient wards within the CMG prior to being cancelled□- On-going□ Daily review of elective patients to proactively manage flow or cancel, discussed at daily Gold meeting - 31/5/16	6	MAT

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
2836	Emergency and Specialist Medicine		There is a risk of single sex breaches on the Brain Injury Unit due to environmental design and inflow of patients.	31/07/2016	05/09/2016	Causes "□Current environmental design of the unit does not afford single sex segregation at all times. "□Unit provides specialist Brain Injury Unit treatment - breaches are classified as "clinically justified" as patient admissions are not controllable. Consequences "□Breach in single sex guidance occurs at times which is unavoidable as the facility provides mixed sex specialist care. "□Under the single sex guidance these breaches are deemed clinically justifiable. "□Potential complaints regarding privacy and dignity. "□Reduced quality of care through dignity. "□Reduced patient experience.	Patient safety	* Increased number of side rooms provisions developed mid 2015 * Red pegs * Privacy Signs * Daily review of side rooms availability v admissions of patients * Patient information * Staff training * Patient satisfaction surveys * Complaints monitoring * Matron ward rounds * Same sex monitoring compliance * Department of Health elimination of mix sex accommodation guidance * Nursing metrics/clinical quality measures dashboard monthly reviews	Moderate	Almost certain	15	Develop BIU admissions policy which ensures (where possible males are kept in the bay and females the side room) 31/07/2016. Work with infection control to develop a policy to ensure infected/at risk patients are provided high quality care whilst waiting for admittance to the BIU 31/07/2016. Develop a BIU relocation plan to be agreed by the CMG board with clear timeframe's for delivery 31/03/2017	2	SPIZZE

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
2837	Emergency and Specialist Medicine		There is a risk of delay in acting upon monitoring investigation results in patients with multiple sclerosis.	30/06/2016	05/09/2016	Causes "□All results are sent as a paper copy to the named consultant's in-tray. "□There is duplication of workload as results are sent to the same consultant more than once in the space of 2 months even if a result has been noted, acted upon, a letter dictated and filed. "□The number of patients with multiple sclerosis on disease modifying therapies (DMT) requiring monitoring has significantly increased year on year to now around 500 patients. "□The number of disease modifying therapies available has increased by 4 in the past year to 12 different options. Consequences "□Abnormal results could be missed resulting in serious harm to patients from consequences of drug toxicity or life-threatening complications. "□Breaching recommended monitoring standards risks patient safety and increases the likelihood of adversely impacting on the reputation of the Trust. "□Duplication of work, less efficient use of time. "□Unsustainable increased workload for MS specialist nurses and consultants - adverse impact on staff health. "□Penalties to Trust from NPSA/CQC due to adverse events and lack of compliance with due diligence for DMT monitoring	Patient safety	"□Paper results for blood, urine tests and MRI scans are sent to consultant. "□Face-to-face outpatient clinic reviews by doctors or MS nurses.	Extreme	Possible	15	To set up DAWN monitoring software Andrew Carruthers (IM&T Head of Design) and 4S. 30/04/2017	2	IL