BOARD ASSURANCE FRAMEWORK 2019/20 Q1 REPORT

Author: Risk and Assurance Manager Sponsor: Director of Corporate & Legal Affairs **Trust Board paper G**

Executive Summary

Context

This paper informs the UHL Trust Board of the current position with the principal risks on the Board Assurance Framework (BAF) 2019/20.

Questions

1. What progress has been made with identifying the principal risks for the BAF 19/20?

Conclusion

1. The refresh of the BAF has involved sessions with the Trust Board at its Thinking Day in March, to identify the new principal risk themes, and in April, to inform the principal risk ratings, as well as work performed with the Executive Team during monthly Planning meetings and Board meetings. A first draft of the BAF for 19/20 was reviewed at the Audit Committee meeting in July 2019. All feedback from the AC, including minor tweaks to some principal risk descriptions, has been considered by Executive Leads in the course of the review in July and a final version of the BAF for Q1 2019/20 has been endorsed by the Executive Team at its meeting on 30th July 2019. A copy of the BAF is included at appendix one.

Input Sought

The Board is invited to review and approve the content of the refreshed BAF 2019/20.

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:

a. Organisational Risk Register [Yes – links with BAF]

Datix Risk ID	Operational Risk Title(s) – add new line for each operational risk	Current Rating	Target Rating	CMG
	See appendix one			

b. Board Assurance Framework [Yes]

BAF entry	BAF Title	Current Rating
	See appendix one	

3. Related **Patient and Public Involvement** actions taken, or to be taken: [N/A]

4. Results of any **Equality Impact Assessment**, relating to this matter: [N/A]

5. Scheduled date for the **next paper** on this topic: [TB meeting]

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

7. Papers should not exceed **7 pages.** [My paper does comply, excluding appendices]

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST

REPORT TO: **UHL TRUST BOARD**

DATE: **1st AUGUST 2019**

REPORT BY: **STEPHEN WARD – DIRECTOR OF CORPORATE & LEGAL AFFAIRS**

SUBJECT: **BOARD ASSURANCE FRAMEWORK 2019/20 Q1 REPORT**

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1 INTRODUCTION

1.1 This paper informs the UHL Trust Board of the current position with the principal risks on the Board Assurance Framework (BAF) 2019/20.

2 BOARD ASSURANCE FRAMEWORK SUMMARY:

2.1 The Board has overall responsibility for ensuring controls are in place, sufficient to mitigate principal risks which may threaten the success of the Trust's strategic objective. The purpose of the BAF is to enable the Board to ensure that it receives assurance that principal risks are being effectively managed and to commission additional review where it identifies a gap in control and/or assurance.

2.2 Following the work with the Trust Board during their development days in March and April, along with work performed by the Executive Team, a draft version of the principal risks on the BAF were discussed at Audit Committee at its meeting in July 2019.

2.3 The Audit Committee largely approved the BAF, including the new reporting template. All feedback from the AC, including minor tweaks to some principal risk descriptions, has been considered by Executive Leads in the course of the review in July and a final version of the BAF for Q1 2019/20 has been endorsed by the Executive Team at its meeting on 30th July 2019. A copy of the BAF 19/20 is included at appendix one.

2.4 The Audit Committee will examine the principal risks on the BAF at each of its meetings during 2019/20. An established governance process will ensure the BAF is reported to the Executive Team on a monthly basis to test the effectiveness of control measures described and to manage progress with planned actions. The Trust Board will receive an updated version of the BAF on a quarterly basis, as well as progress reports in the overview paper it receives from the Audit Committee Chair.

3 RECOMMENDATIONS

3.1 The Board is invited to review and approve the content of the refreshed BAF 2019/20.

Report prepared by Risk & Assurance Manager, 30/07/2019.

Appendix 1 - 2019/20 Board Assurance Framework – June (FINAL)

Board Assurance Framework: Dashboard

Strategic Objective: Becoming the Best - Delivering caring at its best to every patient, every time	PR No.	Principal Risk Event *If we don't put in place effective systems and processes to deal with…(the threats described in each principal risk)… then it may result in…*	Executive Lead Owner	Monitoring Forums / Boards		Current Rating Q1 (L x I)	Q2 *Target* Rating (L x I)	Q3 *Target* Rating (L x I)	Q4 *Target* Rating (L x I)
	1	Failure to deliver key performance standards for emergency, planned and cancer care	COO	EQPB	QOC / PPPC	5 x 4 = 20	5 x 4 = 20	5 x 4 = 20	4 x 4 = 16
	2	Failure to reduce patient harm	MD / CN	EQPB	QOC	3 x 5 = 15	3 x 5 = 15	3 x 5 = 15	2 x 5 = 10
	3	Serious/catastrophic failure in a specific clinical service	MD / COO	EQPB	QOC	3 x 5 = 15	3 x 5 = 15	3 x 5 = 15	2 x 5 = 10
	4	Failure to deliver the Quality Strategy to plan	CEO	ESB	TB	3 x 4 = 12	3 x 4 = 12	2 x 4 = 8	2 x 4 = 8
	5	Failure to recruit, develop and retain a workforce of sufficient quantity and skills	DPOD	EPCB (EQPB)	PPPC	5 x 4 = 20	5 x 4 = 20	5 x 4 = 20	4 x 4 = 16
	6a	Serious disruption to the Trust's critical estates infrastructure	DEF	EQPB	QOC	4 x 5 = 20	4 x 5 = 20	4 x 5 = 20	4 x 5 = 20
	6b	Serious disruption to the Trust's critical IT infrastructure	CIO	EIM&T (EQPB)	QOC	4 x 5 = 20	4 x 5 = 20	4 x 5 = 20	4 x 4 = 16
	7	Failure to progress the Trust's site investment and reconfiguration plans	DEF / CFO	ESB	TB	4 x 4 = 16	4 x 4 = 16	4 x 4 = 16	3 x 4 = 12
	8	Failure to deliver the e-hospital strategy including the required process and cultural change	CIO	EIM&T (EQPB)	PPPC	4 x 3 = 12	4 x 3 = 12	4 x 3 = 12	3 x 3 = 9
	9	Failure to meet the financial control total including through improved productivity	CFO	EQPB	FIC	3 x 4 = 12	3 x 4 = 12	2 x 4 = 8	2 x 4 = 8
	10	Failure to work with the wider system	DSC	ESB	TB	4 x 4 = 16	4 x 4 = 16	3 x 4 = 12	3 x 4 = 12
	11	Failure to maintain and enhance research market competitiveness by failing to develop Leicestershire Academic Health Partners	MD / DSC	ESB	TB	3 x 3 = 9	3 x 3 = 9	3 x 3 = 9	2 x 3 = 6

BAF Rating System: rating on event occurring (L x I):

Likelihood	Impact: Rare	Minor	Moderate	Major	Extreme
Extremely unlikely	1	2	3	4	5
Unlikely	2	4	6	8	10
Possible	3	6	9	12	15
Likely	4	8	12	16	20
Almost certain	5	10	15	20	25

PR Score	PR Rating
1-6	Low
8-12	Moderate
15-20	High
25	Extreme

Appendix 1 - 2019/20 Board Assurance Framework – June (FINAL)

Review date:	June 2019	Executive lead(s):	COO	Lead Executive Board:	EQPB	Lead TB sub-committee & date reviewed:	QOC / PPPC
Strategic Objective	Becoming the Best - Delivering caring at its best to every patient, every time						
PR Event (PR 1)	**Failure to deliver key performance standards for emergency, planned and cancer care**						

BAF tracker - month	APR	MAY	JUN (Q1)	JUL	AUG	SEP (Q2)	OCT	NOV	DEC (Q3)	JAN	FEB	MAR (Q4)
BAF rating (L x I)	5 x 4 = 20	5 x 4 = 20	5 x 4 = 20									
Target rating (L x I)			5 x 4 = 20			5 x 4 = 20			5 x 4 = 20			4 x 4 = 16

Rationale for score: *Overall demand into the ED has continued (4 hour performance – was 73.7% for May, system performance including LLR UCCs was 81.5%) with capacity being the key constraint. At a system level, the A&E Delivery Board has approved a more focussed action plan for 2019/20 which responds to guidance issued nationally and regionally about which interventions are likely to have the most impact.*
For Cancer, UHL achieved the UHL trajectory for or national target for 6 out of the national targets, with 4 achieving the national standard outright. Performance has improved against our trajectory with only 2WW breast missing the trajectory by 3%. The 62 day standard remains the biggest challenge going forward.

Key threats / opportunities	Controls Assurance (to provide 'Confidence' / 'Evidence' / 'Certainty') that key systems and processes are working in practice	Gaps in control / assurance	Actions	Lead	Due Date
Emergency Care:					
Early patient flow.	• 4 times daily operational command meeting with senior representation when OPEL 4. Capacity Flow and escalation policy in place and followed and managed via Operational Command. • Focus on utilisation of community beds in operational command meetings and reviewed alongside with LPT • Reduction in Super Stranded Patients from a baseline of 202 down to 158 as of 15/07/2019 lead by weekly meetings with CMGs to unblock any delays to discharge and support from complex discharge team • Additional transport crews provided (at a cost to UHL).	1 Nursing workforce constraints continue to hamper flow and impacts on patient experience and performance (breached). 2 Ability to empty community beds when we are struggling with capacity and flow. 3 Delays in patients moving to community hospitals. 4 Insufficient transport adding unnecessary delay to patient discharge.	1 As per the actions within the People Strategy and Implementation Plan. 2 Continue to monitor and influence through operational command meetings. 3 Negotiate with LPT extension of criteria for admission. 4 Discussions with CCG in relation to requirements for extra support and UHL and CCG focus group to ensure the provider are contract compliant.	DM/ HoN/ HW	Review Aug 2019
Persistent unprecedented level of demand for services.	• Capacity and demand bed modelling reviewed quarterly. • Admission prevention & avoidance projects owned by LLR and reported through A&E Delivery Board. • A&E Delivery Board and sub groups – monitor progress of system wide actions, chaired by CCG MD.	1 Intermittent long ambulance handover delays continue to suggest processes internally and externally need strengthening. 2 Acuity of patients continues to increase, putting pressure on the Emergency Floor and at ward level. 2 Timing of ED arrivals (batching) both walk-in and ambulance still require in depth analysis and action to mitigate.	1 Ambulance handover task and finish group tasked with understanding the root cause to enable preventative actions to be put in place by Aug 2019. 2 The Trust will work with AEDB to understand what can be actioned to address the historical issue of batching. The Trust is	DM DM	Aug 2019 July 2019.

			working with commissioners to develop and embed a model for acute frailty and same day emergency care which may ease some pressure but will require earlier presentation of patients for the system to reap the full benefits.		
Planned Care:					
Increased RTT backlog	• Waiting list size managed through WAM. • Daily 40 week+ report sent to GM's and SM to manage long waiters. • Optimised booking using the OP tracker reducing vacant slots. • Tracking of numbers of referrals by tumour site and the impact it will have on the pathway. A daily report is provided in all areas to ensure that teams can be responsive to the fluctuating numbers of referrals.	1 Changes to pension taxation have led to services highlighting a reduced WLI take up. Capacity is inbuilt to the plan. 2 Clinical vacancies within services have resulted in reduced capacity and increased waiting list size and backlog.	1 Reporting to highlight changes in WLI activity. 2 Work with specialties on alternative options to deliver the activity.	WB WB	Sept 2019 Sept 2019
Cancer care:					
Increase in cancer referrals and conversion rates resulting in demand challenges.	• LLR STP Board reviewing position and opportunities system wide for improvement. • Pathway changes including: Straight to test, Breast and PMB utilising NUH model for Breast, PRISM (referral form) changes to ensure only appropriate referrals are sent. • Discussions with NHSE to review regional provision and wait times • Tracking number of referrals by tumour site and the impact it will have on the pathway. A daily report is provided in all areas to ensure that teams can be responsive to the fluctuating numbers of referrals	1 Theatre / Robotic capacity in Urology. 2 Head and Neck Consultant vacancies resulting in challenges to the 2WW performance and 62 day performance. 3 Late tertiary referrals.	1 UHL to use of Derby spare robotic sessions (staffing dependent). 2 Sessions being offered ad hoc from NGH and KGH. 3 Ensure that all tertiary referrals are only accepted at the point they are ready for treatment.	SL SL SL	Sept 2019 Sept 2019 Oct 2019

Appendix 1 - 2019/20 Board Assurance Framework – June (FINAL)

Review date:	June 2019	Executive lead(s):	MD / CN	Lead Executive Board:	EQPB	Lead TB sub-committee & date reviewed:	QOC
Strategic Objective	Becoming the Best - Delivering caring at its best to every patient, every time						
PR Event (PR 2)	**Failure to reduce patient harm**						

BAF tracker - month	APR	MAY	JUN (Q1)	JUL	AUG	SEP (Q2)	OCT	NOV	DEC (Q3)	JAN	FEB	MAR (Q4)
BAF rating (L x I)	4 x 5 = 20	4 x 5 = 20	3 x 5 = 15									
Target rating (L x I)			3 x 5 = 15			3 x 5 = 15			3 x 5 = 15			2 x 5 = 10
Rationale for score:												

Key threats / opportunities	Controls Assurance (to provide 'Confidence' / 'Evidence' / 'Certainty') that key systems and processes are working in practice	Gaps in control / assurance	Actions	Lead	Due Date
• Inadequate clinical practice and/or ineffective clinical governance. • Lack of resources to fully embed a proactive approach to managing safety.	• Set of quality priorities, along with key enabler priorities for 19/20 – included in the Quality Strategy (BtB), agreed by TB and performance monitored via the Executive Team (ESB). • Quality governance structures and teams at Executive and CMG levels – including EQPB (which receives monthly patient safety report including themes from incidents, risks and complaints), CMG Q&S Boards (or equivalent) (which receive monthly patient safety incident and risk reports) to identify, oversee and escalate / disseminate quality related matters. • Staff training programmes (induction, statutory & mandatory and non-mandatory) – recorded on HELM and monitored via Executive Team. • Maintenance of defined safe staffing levels on wards & departments – nursing and medical monitored on a daily basis. • Policies and procedures and guidelines including NatSSIPs/ LocSSIPs – process for policy approval and docs stored on INsite (Policy and Guideline Library) and accessible to all staff. • QI safety initiatives embedded in clinical settings – stop the line. • Patient Safety Portal – available on insite and accessible to all staff. • Ward assessment and accreditation programme. • Duty of candour processes. • Trust wide risk management and governance structure in place including: risk register, CAS broadcasts, Incident reporting, Complaints, Claims & Inquest management, clinical audit programme. • Regular liaison meetings with Leic Coroner re hospital deaths and inquests. • Senior leadership safety walkabout programme. • Medical Examiner and Learning from Deaths reviews triangulated with patient safety data. • CMG PRMs monitor Quality, Workforce, Finance and Operational performance and provide 2-way communication forum with opportunity to confirm and challenge CMGs and also for CMGs to flag issues / report noise in the system. • Corporate Safety & Governance forums - Adverse Events Committee meetings to scrutinise and analyse learning from incident investigations, Clinical Quality Review Group.	1 Lack of audit of improvement from actions taken to address incidents, risks, alerts, complaints. 2 Overdue RCA actions require urgent attention from relevant CMGs (CMG CDs). 3 Inconsistent implementation of LocSSIPs and checking processes for invasive procedures. 4 Full roll out and embedding of LocSSIPs and 5 steps to safer surgery procedures. 5 Some clinical policies and procedures have elapsed review dates.	1 Quality Improvement lead to launch quality improvement systems and processes to help measure improvement performance. 2 RCA actions escalated in safety report to EQPB. 3 QI priorities and supporting priorities progress reports to Exec Boards. 4 Partnership with AQuA to support QI journey including safely and timely discharge work. 5 Policy and Guideline process efficiency review.	MD / CN. MD. MD / CN. MD / CN. CN	Q3 19/20 Review monthly Review monthly Q2 19/20 Sept 2019

Appendix 1 - 2019/20 Board Assurance Framework – June (FINAL)

Review date:	June 2019	Executive lead(s):	MD / COO	Lead Executive Board:	EQPB	Lead TB sub-committee & date reviewed:	QOC
Strategic Objective	Becoming the Best - Delivering caring at its best to every patient, every time						
PR Event (PR 3)	**Serious/catastrophic failure in a specific clinical service**						

BAF tracker - month	APR	MAY	JUN (Q1)	JUL	AUG	SEP (Q2)	OCT	NOV	DEC (Q3)	JAN	FEB	MAR (Q4)
BAF rating (L x I)	3 x 5 = 15	3 x 5 = 15	3 x 5 = 15									
Target rating (L x I)			3 x 5 = 15			3 x 5 = 15			3 x 5 = 15			2 x 5 = 10
Rationale for score:												

Key threats / opportunities	Controls Assurance (to provide 'Confidence' / 'Evidence' / 'Certainty') that key systems and processes are working in practice	Gaps in control / assurance	Actions	Lead	Due Date
• Lack of business intelligence to analyse and triangulate system data collected. • Lack of forecasting based on knowledge gathered in the Trust. • Lack of resources to fully embed a proactive approach to managing safety. • Inadequate clinical practice and/or ineffective clinical governance.	• Q & P metrics report data required at national / local levels on a monthly basis and is reviewed by Executive Boards and Trust Board. • CMG PRMs monitor Quality, Workforce, Finance and Operational performance and provide 2-way communication forum with opportunity to confirm and challenge CMGs and also for CMGs to flag issues / report noise in the system. • Staff surveys including GMC / educational surveys provide staff opportunity to report issues. • Data gathered for business planning purposes to analyse trends - a multi-disciplinary team across UHL functions devised and populated a model which provides assessment against:- Quality & Safety (outcomes or effectiveness frameworks, Patient safety and incident reports, risk assessments flagged on risk register, CQC feedback); Finances (position against plan, margin assessments); Efficiency & effectiveness (weighted activity unit, benchmark efficiency position); Performance (Impact on RTT/cancer, waiting lists, demand and capacity); soft intelligence (transformation, reconfiguration). • Communication / listening events and forums - Whistle blowing, Freedom to Speak Up Guardian, 3636 line, senior leadership safety walkabout programme. • Regular dialogue with regulators and Commissioners. • External scrutiny - GIRFT validations, peer assurance reviews. • National audit data collection. • UHL Ward assessment and accreditation programme. • Supervision and education of clinical staff across all professions. • Clinical revalidation assessment process.	1 A framework to scan data collected by different groups to facilitate horizon scanning.	1 Develop an 'assured service framework' for all clinical services.	MD / COO	31/03/20

Appendix 1 - 2019/20 Board Assurance Framework – June (FINAL)

Review date:	June 2019	Executive lead(s):	CEO	Lead Executive Board:	ESB	Lead TB sub-committee & date reviewed:	TB
Strategic Objective	Becoming the Best - Delivering caring at its best to every patient, every time						
PR Event (PR4)	**Failure to deliver the Quality Strategy to plan**						

BAF tracker - month	**APR**	**MAY**	**JUN (Q1)**	**JUL**	**AUG**	**SEP (Q2)**	**OCT**	**NOV**	**DEC (Q3)**	**JAN**	**FEB**	**MAR (Q4)**
BAF rating (L x I)	3 x 4 = 12	3 x 4 = 12	3 x 4 = 12									
Target rating (L x I)			3 x 4 = 12			3 x 4 = 12			2 x 4 = 8			2 x 4 = 8

Rationale for score:	It is possible that the implementation of the Quality Strategy is delayed at this early stage due to the lack of infrastructure in place, with major impact on the Trust given the strategic importance of delivery for the Trust.

Key threats / opportunities	**Controls Assurance (to provide 'Confidence' / 'Evidence' / 'Certainty') that key systems and processes are working in practice**	**Gaps in control / assurance**	**Actions**	**Lead**	**Due Date**
• Lack of Trust-wide engagement; • Resources to lead: QI Leader and support teams; • Unrealistic expectations (time frames to deliver improvement); • Resources to back fill to front line roles; • Delivery infrastructure and engagement with the Culture and Leadership Programme.	1. Comms and engagement strategy in place and being enacted. 2. Quality Strategy infrastructure agreed at Exec level and at CMG level.	1. Comms & engagement: Ensuring that key messages are cascaded through organisation. 2. Quality Strategy infrastructure: a. Potential for delay in recruitment / agreed methodology. b. BTB hub: Resistance to change may hamper speedy progress. 3. Alignment to priorities: As QI resource is not yet in place, there may be a delay in the development of some priorities. 4. Culture and Leadership Programme: Staff do not engage of are not released from duties to take part.	1. Head of Comms to be appointed. Comms feedback loops in place and monitored monthly. 2. Infrastructure under development: a. Head of recruitment engaged to lead and monitor recruitment, with weekly report to CE. b. Director of Productivity engaged to lead process with exec support. 3. Gaps largely filled through existing QI trained staff until BTB team in place. 4. All leadership encouraged to release staff to attend sessions via CE briefing and followed up by email.	TJ CW BS RV BK	Aug 2019. Weekly Weekly July 2019 July 2019

Appendix 1 - 2019/20 Board Assurance Framework – June (FINAL)

Review date:	June 2019	Executive lead(s):	DPOD	Lead Executive Board:	EPCB (EQPB)	Lead TB sub-committee & date reviewed:	PPPC
Strategic Objective	Becoming the Best - Delivering caring at its best to every patient, every time						
PR Event (PR5)	**Failure to recruit, develop and retain a workforce of sufficient quantity and skills**						

BAF tracker - month	APR	MAY	JUN (Q1)	JUL	AUG	SEP (Q2)	OCT	NOV	DEC (Q3)	JAN	FEB	MAR (Q4)
BAF rating (L x I)	5 x 4 = 20	5 x 4 = 20	5 x 4 = 20									
Target rating (L x I)			5 x 4 = 20			5 x 4 = 20			5 x 4 = 20			4 x 4 = 16

Rationale for score: The People Strategy is a five year plan. The actions planned should help maintain the current score and avoid it rising to 25, and by the end of the financial year we hope to see the likelihood rating reduce.

Key threats / opportunities	Controls Assurance (to provide 'Confidence' / 'Evidence' / 'Certainty') that key systems and processes are working in practice	Gaps in control / assurance	Actions	Lead	Due Date
• Failure to recruit.	• People strategy in place covering talent identification, staff engagement and workforce planning - available on Insite, ratified by TB – Reporting to EPCB. • Nursing and Midwifery WF plan (appendix of People Strategy) – defined 12 month deliverables. • Medical WF plan (appendix of People Strategy) – defined 12 month deliverables. • People management policies, processes and professional support tools – available on Insite (including Recruitment and Selection Policy and Procedure) – process to review and update policies as appropriate. • Vacancy management and recruitment / retention process (TRAC system) – Time to Hire KPI in place, reported monthly as part of monthly WF data set. • Recruitment & overseas recruitment campaigns as part of corporate and CMG Workforce plans.	1. Development of delivery plan to align to NHS interim People Plan. 2. Significant vacancy areas remaining - e.g. Lack of skilled nursing workforce. 3. Developed WF plans for other staff groups e.g. AHP's, A&C staff.	1. Review and align deliverables of the People Strategy with NHS interim People Plan. a. Robust nursing & Midwifery WF plan in place – defined deliverables & timescales. b. Development of Medical WF plan including scoping of an international Recruitment HUB. 2. Validate the CMGs' risks on Datix risk register. 3. Development of WF plans in progress – staff group specific – to be clearly scoped by end July 2019.	HW/JTF CF/EM AF CMGs CDs. DB	July 2019 As per timescales As per timescales July 2019 July 2019
• Failure to develop.	• People strategy in place covering talent identification, staff engagement - available on Insite, ratified by TB – Reporting to EPCB. • Becoming the Best - Integrated Leadership Plan – phase 1 – Discovery - including QI Agents appointed and training delivered; leadership survey analysis and findings reported; Becoming the Best Focus Groups across all sites delivered. • Nursing and Midwifery WF plan (appendix of People Strategy) – defined 12 month deliverables. • Medical WF plan (Appendix of People Strategy) – defined 12 month deliverables.	1. Electronic Appraisal system incorporating people capability framework. 2. Analyse findings from discovery phrase of QS programme to identify and understanding the gap. 3. Fully utilising workforce, new ways of working and new roles. 4. Process for improving statutory and mandatory training bank performance.	1. Confirmation of funding for IT appraisal system and alignment with Medical revalidation. 2. A) Action synthesis event & TB Thinking Day. 2 B) Reviewing governance structures – to capture team around the patient. 2 C) Communicate Culture and Leadership themes from	SG BK HK/CF/ AF TJ/BK	Oct 2019 July 2019 Aug 2019 Aug 2019

	• People management policies, processes and professional support tools to support talent management and people capability development. • Core skills development including Statutory and Mandatory training – regular reporting as part of CMG PRMs and EPCB.		diagnostic. 3. Next intake of Improvement Agents and set out 'Mission Brief' in order to support 'Design' phase. 4. Establish process for improving statutory and mandatory training bank performance.	SG/BK BK/EM/ JJ	Aug 2019 Aug 2019
• Failure to retain.	• Employee Health & Wellbeing Steering Group and Action Plan. • People Strategy – Becoming the Best – defined measures reporting to EPCB. • Nursing and Midwifery WF plan (appendix of People Strategy) – defined 12 month deliverables. • Medical WF plan (Appendix of People Strategy) – defined 12 month deliverables • Equality and Diversity Board and integrated action plan.	1. Development of delivery plan for People Strategy and appendices to align to NHS interim People Plan. 2. Developed WF plans for other staff groups e.g. AHP's, A&C staff. 3. To add new indicators e.g. Learning Disability Employment programme and Sexual Orientation monitoring standard.	1. Review and align deliverables of the People Strategy with NHS interim People Plan. a. Robust nursing & Midwifery WF plan in place – defined deliverables & timescales. b. Development of Medical WF plan including scoping of an international Recruitment HUB. 2. Development of WF plans in progress – staff group specific. 3. Refresh Integrated E&D action plan to reflect requirements against performance indicators.	HW/JTF CF/EM AF/DB DB HW/BK	July 2019 As per plan As per timescales July 2019 Sept 2019

Appendix 1 - 2019/20 Board Assurance Framework – June (FINAL)

Review date:	June 2019	Executive lead(s):	DEF	Lead Executive Board:	EQPB	Lead TB sub-committee & date reviewed:	QOC
Strategic Objective	Becoming the Best - Delivering caring at its best to every patient, every time						
PR Event (PR6a)	**Serious disruption to the Trust's critical estate infrastructure**						

BAF tracker - month	APR	MAY	JUN (Q1)	JUL	AUG	SEP (Q2)	OCT	NOV	DEC (Q3)	JAN	FEB	MAR (Q4)
BAF rating (L x I)	4 x 5 = 20	4 x 5 = 20	4 x 5 = 20									
Target rating (L x I)			4 x 5 = 20			4 x 5 = 20			4 x 5 = 20			4 x 5 = 20

Rationale for score: Risk of sudden & unexpected failure of critical estate due to plant, building and infrastructure attrition through lack of backlog investment over many years manifesting as increasing incidence/risk of infrastructure failure interruptions. Dependency on Capital Investment including emergency bids.

Key threats / opportunities	Controls Assurance (to provide 'Confidence' / 'Evidence' / 'Certainty') that key systems and processes are working in practice	Gaps in control / assurance	Actions	Lead	Due Date
• Critical incident internally • Loss of ability to provide patient/patient support services, or to carry out normal work due to failure of infrastructure/ critical resource including: water, electrical supply, ventilation, piped medical gas, heating and drainage. • Critical infrastructure maintained in operational condition beyond design lifecycle and increasingly becoming liable to 'sudden and unexpected' failure. • Planned Preventative Maintenance systems in place, but there are skill and resource gaps	• Accountable Emergency Officer (AEO) – COO. • Emergency Preparedness, Resilience and Response (EPRR) Board – Chaired by AEO, meets quarterly, representatives from all CMG's and Corporate Services. • EPRR Policy in date and on insite. • EPRR risks loaded onto the Trust's Datix Risk Register. • EPRR three year work programme 2018 to 2021. • E&F Escalation and Emergency response arrangements in place. • 24/7 response from Estates & Facilities and specialist contractors, including 'out of hours' arrangements. • Annual assurance reports from independent specialists for services including: Electrical, Piped Medical Gas, Water and Specialist Ventilation. • Backlog maintenance reported in the ERIC return to the Department of Health and benchmarked against other NHS Trusts annually. • Annual Premises Assurance Model assessment. • Annual Patient-led Assessments of the Care Environment (PLACE) with scorecard reported nationally and benchmarked. • Some critical plant and equipment have back-up systems in the event of 'loss of' power/engineering services.	1. Corporate and Local resource to manage risk escalated from EPRR three year work programme – focus on CMGs / Corporate Service business continuity plans. 2. Engineering & Infrastructure backlog replacement programme funding. 3. Insufficient capital investment to adequately address the backlog maintenance liability. 4. Recruitment and retention of key operational and maintenance E&F staff. Potential shortfall in operational budget for recruitment of sufficient cleaning and Estates maintenance staff to deliver services and maintain estate with resilience and quality improvements.	1. Review resources in EP office to manage risks. 2. Risk based prioritised list developed by E&F Risk group to support the reduced 2019/20 Capital Programme across the following fields : • Condition; • Compliance; • Resilience; • Single point Failures. 3. A) 'State of the Nation' presentation to Trust Board in July to escalate lack of investment and extent of challenges and propose 10 year investment plans. 3 B) Paper to be presented to TB in September 2019 on risks and priorities and investment benefits. 3 C) Emergency capital bid to NHSi for c£10M. 4. E&F management restructure completed and plans are in place to implement operational changes.	COO/DSR DEF DEF & CFO DEF DEF DDEF DEF	July 2019 Aug 2019 July 2019 Sept 2019 July 2019 Jan 2020

Appendix 1 - 2019/20 Board Assurance Framework – June (FINAL)

Review date:	June 2019	Executive lead(s):	CIO	Lead Executive Board:	EIM&T / EQPB	Lead TB sub-committee & date reviewed:	QOC
Strategic Objective	Becoming the Best - Delivering caring at its best to every patient, every time						
PR Event (PR6b)	**Serious disruption to the Trust's critical IT infrastructure**						

BAF tracker - month	APR	MAY	JUN (Q1)	JUL	AUG	SEP (Q2)	OCT	NOV	DEC (Q3)	JAN	FEB	MAR (Q4)
BAF rating (L x I)	4 x 5 = 20	4 x 5 = 20	4 x 5 = 20									
Target rating (L x I)			4 x 5 = 20			4 x 5 = 20			4 x 5 = 20			4 x 4 = 16
Rationale for score:	Dependency on obsolete equipment/software, lack of fully redundant infrastructure, risk of cyber attack											

Key threats / opportunities	Controls Assurance (to provide 'Confidence' / 'Evidence' / 'Certainty') that key systems and processes are working in practice	Gaps in control / assurance	Actions	Lead	Due Date
• Critical incident impacting IM&T services – failure of software / hardware, cyber-attack. • Information security breach – loss of patient data. • Big Bang or Rising Tide event - fire, flood, terrorist attack. • Lack of capital investment in IT infrastructure. • Inability of IT vendors to provide fully resilient solutions.	• Emergency Preparedness, Resilience and Response (EPRR) Board - chaired by AEO, meets quarterly, representative from all CMGs and corporate services. • EPRR Policy & Incident response plans on Insite, in date. • EPRR and IM&T infrastructure risks uploaded onto the Datix risk register. • EPRR 3 year work programme includes IM&T resilience work. • PWC Audit of EPRR & IM&T Disaster Recovery (April/May 2019) – report confirms: o EPRR: the plan contains the activities necessary to make the Trust compliant. o Good practice around disaster recovery identified in PwC Audit (May 2019). • NHSE Core Standards self-assessment – partially compliant (2018/19). • Cyber security measures in place including monitoring of threats via NHS Digital CareCert, vulnerability scanning & anti-virus/anti malware tools, Monthly Cyber Security Board, IG toolkit, IG Steering Group and GDPR plan, regular penetration testing and close working relationship with IM&T managed business partner, recognised corporate risk around human factors/behaviours with actions to raise awareness via comms campaigns	1. Business Continuity Plans incomplete and not tested. 2. Critical applications not fully redundant by design. 3. Risks around server infrastructure dependent on execution of IM&T data centre strategy and move away from dependency on LRI Kensington data centre. 4. Responsibility for critical on site data centre environmental factors (power/cooling/fire suppression) requires clarification and investment. 5. Information Governance plan for implementation of GDPR analysis by Internal Auditors identified gaps with regard to the new regulation commenced in May 2018. 6. Cyber security risk from PC estate dependent on the completion of the eQuip hardware refresh programme. 7. Cyber security audits to be undertaken.	1. Business Continuity policy to be developed to include BIA process for CMGs / depts. to follow to develop Business Continuity Plans. 2. With IM&T vendors, develop redundant architecture for critical applications. 3. Undertaking Corporate Records Audit and developing info Asset Register (IAR). 4. Rollout of the eQuip hardware refresh programme. 5. Publish and progress data centre strategy including improved redundancy via cloud hosting options. 6. Agree responsibility for investment/maintenance of critical environmental factors and remediate. Identify alternative mechanisms to fund IT infrastructure investment given scarcity of capital funding. 7. Independent cyber security audits scheduled during Aug 2019 with action plan to be developed.	EPO. CIO HOP CIO CIO / DEF CFO / CIO CFO / CIO CIO	July 2019 Mar 2020 Mar 2020 Feb 2020 Dec 2019 Oct 2019 Dec 2019 Sep 2019

Appendix 1 - 2019/20 Board Assurance Framework – June (FINAL)

Review date:	June 2019	Executive lead(s):	DEF / CFO (/N Topham)	Lead Executive Board:	ESB	Lead TB sub-committee & date reviewed:	TB
Strategic Objective	Becoming the Best - Delivering caring at its best to every patient, every time						
PR Event (PR7)	**Failure to progress the Trust's site investment and reconfiguration plans**						

BAF tracker - month	APR	MAY	JUN (Q1)	JUL	AUG	SEP (Q2)	OCT	NOV	DEC (Q3)	JAN	FEB	MAR (Q4)
BAF rating (L x I)	4 x 4 = 16	4 x 4 = 16	4 x 4 = 16									
Target rating (L x I)			4 x 4 = 16			4 x 4 = 16			4 x 4 = 16			3 x 4 = 12

Rationale for score:	The score remains at 16 whilst there is uncertainty of when national capital will be available or process for accessing it. Possible indication in Spring 2020 which will hopefully reduce the score to 12 if there is an indication we are successful. Mitigations will help some services e.g. neonates and maternity, but not resolve the risk in other areas such as ICU at the LRI.

Key threats / opportunities	Controls Assurance (to provide 'Confidence' / 'Evidence' / 'Certainty') that key systems and processes are working in practice	Gaps in control / assurance	Actions	Lead	Due Date
• Lack of capital money to fund reconfiguration plans resulting in unsustainable clinical services, some with increasing clinical risk, split across 3 sites for an indefinite period	• Pre Consultation Business Case supported by the Regional Assurance panel (on 10th October 2018); concluded in March 2019. • NHSI are very supportive of our pre-consultation business case and have expressed willingness to support UHL to best position ourselves for when capital becomes available (meeting between CE and CFO and NHSI in May agreed actions to assess whether there is an opportunity to consult before capital is announced). CE is being chased up with Dale Bywater. • On July 17th, NHSI requested an update to the wave 4 bid by July '19 to inform the Comprehensive Spending Review. • CE and CFO are continuing discussions regarding potential alternative sources of funding. • Phasing and Clinical Impact of delay reported through ESB to Trust Board with an agreed action plan to mitigate risks. • Continue to present case as a single programme; but identify opportunity to deliver in phases, taking into account the clinical priorities.	1 Not all the clinical risks are adequately articulated and scored at CMG level. 2 Challenge on how to fund the mitigations with a revenue and capital impact: timescales for implementation needed. 3 Controls can only support those areas which have staffing mitigations; the lack of ICU capacity and need especially to improve LRI ICU. This cannot be resolved without capital. 4 Clinical scheme prioritisation impact of reducing availability of CRL to meet the existing building services.	1 Validate the CMGs' risks on Datix risk register. 2 Work has commenced to develop understanding of capital requirements over next 5 years. 3 Assessment of interim risk mitigations: paper on the risks for neonates, maternity and renal, identifying revenue and capital requirements to be presented to ESB in August and TB in September. 4 Emergency capital bid to NHSi to fund backlog and decontamination.	CMGs CDs PT NT/ JJ & CMGs CDs NB	July 2019 July 2019 Sept 2019 July 2019

Appendix 1 - 2019/20 Board Assurance Framework – June (FINAL)

Review date:	June 2019	Executive lead(s):	CIO	Lead Executive Board:	EIM&T (EQPB)	Lead TB sub-committee & date reviewed:	PPPC
Strategic Objective	Becoming the Best - Delivering caring at its best to every patient, every time						
PR Event (PR8)	**Failure to deliver the e-hospital strategy including the required process and cultural change**						

BAF tracker - month	APR	MAY	JUN (Q1)	JUL	AUG	SEP (Q2)	OCT	NOV	DEC (Q3)	JAN	FEB	MAR (Q4)
BAF rating (L x I)	4 x 3 = 12	4 x 3 = 12	4 x 3 = 12									
Target rating (L x I)			4 x 3 = 12			4 x 3 = 12			4 x 3 = 12			3 x 3 = 9
Rationale for score:	Assuming contract signature for the EPR project in July 2019, risk remains around capacity of the organisation to deliver process and cultural change.											

Key threats / opportunities	Controls Assurance (to provide 'Confidence' / 'Evidence' / 'Certainty') that key systems and processes are working in practice	Gaps in control / assurance	Actions	Lead	Due Date
• Lack of funding for IM&T programme. • Failure to progress UHL digital maturity by 2024. • IT capability to reduce dependency on paper and associated transformation is reduced or absent. • Significant cyber security risks will manifest if sufficient progress is not made to eliminate obsolete and legacy technology from the estate.	• IM&T capital programme monitored by CMIC group via risk based investment approach. • IM&T projects capacity and priorities monitored via IM&T Strategy board, Operational Management Group and Exec IM&T board. • Digital maturity progress reported at eHospital Programme and EIM&T boards. • Cyber security risks captured on trust risk register (Datix). • Ongoing progress monitored at STP level via the LLR IM&T Strategy Board. UHL CIO and CMIO in attendance and chaired by UHL CEO from July 2019.	1 Likelihood of access to external funding (HSLI/GDE) is unclear given national pressures on capital. 2 Ongoing impact on medical records service if reliance on paper records is not reduced. 3 Risk of data breach as a consequence of reliance on paper/faxes will not be reduced. 4 Failure to progress digital maturity index and improve HIMMS (EMRAM) scoring in line with national policy by 2024 may result in significant external (local and national) scrutiny. 5 IM&T capacity to deliver the eHospital programme to the required pace and quality constrained by size of the UHL team and ability of the IM&T Managed Business Partner (MBP) to support project work. 6 STP priorities may not align with UHL priorities.	1 Progress applications for available external IM&T capital funds. 2 IM&T and Medical records to record risk around reliance on paper records on CSI risk register. 3 Publish Cyber Security Strategy. 4 Risks and mitigation plans around legacy systems unable to be replaced or delayed (including faxes and paper records) recorded on Datix and reviewed/monitored at eHospital programme board. 5 Deliver 2019/20 eHospital programme milestones. 6 Review whether STP priorities require resources and whether UHL are able to commit in the timeframe required.	CIO CIO / CSI CD CIO. CMGs CIO CIO	Sept 2019 July 2019 Mar 2020. Review monthly. Oct 2019 Aug 2019
• Organisation not able to change process and/or culture at sufficient pace to realise the projected benefits of the eHospital programme by 2022.	• Change management support requirements identified on a project by project basis via the Local Organisational Readiness Assessment (LORA). • Organisational awareness campaign, updates cascaded to staff via CE briefings bimonthly. • Improvement agent network to be leveraged to identify "IT Champions" throughout the organisation at all levels.	1 Workflow changes and resistance to new ways of working may be encountered limiting benefits realisation and extending project timelines. 2 UHL staff not sufficiently aware of the eHospital programme, its objectives and how it will impact on their role. 3 Alignment of people strategy and eHospital strategy. 4 CMG engagement and ownership of digital transformation, including release of benefits and implementation of new ways of working is insufficient.	1 Full benefits plan defined. 2 Conflict around process change managed via eHospital board or Clinical Operational Design Authority (CODA) group by exception. 3 Publish comms strategy & engagement plan for eHospital programme including staff engagement sessions. 4 Development of eHospital / people & culture enabling plan.	HOPP MD HOPP CIO / DPOD	Sept 2019 Sept 2019 Oct 2019 Oct 2019

• Lack of implementation resource for eHospital projects due to ability to release clinical staff from front line duties	• eHospital clinical facilitators and project support officers in place & further recruitment in progress to support front line areas through change elements of eHospital projects.	1 No resources identified to allow backfill of clinical roles to support process change. 2 Detailed benefits plan for each project is required to ensure resources targeted appropriately.	1 Implement standard approach to benefits capture and monitoring to aid resource deployment. 2 Ensure programme level approach is coherent and maximises use of available implementation teams across projects.	HOPP HOPP	Sept 2019 Sept 2019

Appendix 1 - 2019/20 Board Assurance Framework – June (FINAL)

Review date:	June 2019	Executive lead(s):	CFO	Lead Executive Board:	EQPB	Lead TB sub-committee & date reviewed:	FIC
Strategic Objective	Becoming the Best - Delivering caring at its best to every patient, every time						
PR Event (PR9)	**Failure to meet the financial control total including through improved productivity**						

BAF tracker - month	APR	MAY	JUN (Q1)	JUL	AUG	SEP (Q2)	OCT	NOV	DEC (Q3)	JAN	FEB	MAR (Q4)
BAF rating (L x I)	3 x 4 = 12	3 x 4 = 12	3 x 4 = 12									
Target rating (L x I)			3 x 4 = 12			3 x 4 = 12			2 x 4 = 8			2 x 4 = 8
Rationale for score:												

Key threats / opportunities	Controls Assurance (to provide 'Confidence' / 'Evidence' / 'Certainty') that key systems and processes are working in practice	Gaps in control / assurance	Actions	Lead	Due Date
• Non-delivery of CMG and Corporate Directorate Control Totals including £26m Efficiencies and impact on Long Term Financial Plan for financial sustainability	• Annual and long-term financial model describing a statement of income and expenditure, a statement of long and short term assets and liabilities (including capital expenditure) and a statement of cash flow. • Signed-off Control Totals for CMGs and Corporate Departments that are being monitored and managed within the Financial Accountability Framework and Performance Management Framework. • CIP Plans that are targeted by theme for CMGs and Corporate Departments with cross-cutting schemes being supported by corporate based resource in addition to local CMG transformation leads. • Appropriate level of investment supporting the resolution of the demand/capacity challenges with additional capacity over the winter period. • Financial governance and performance monitoring arrangements at Trust Board (FIC), Audit Committee, Executive Meetings (EQPB), CMG PRMs, directorate and CMG service line levels. • Cost pressures and service developments minimised and managed through the Revenue and Investment Committee. • NHS I performance review meetings including I&E submissions and additional monthly review meetings with NHSI Finance team to review financial position including CIP and assessment of financial risks. • Commercial Strategy - to help exploit commercial opportunities available to the Trust and working with NHSI to ensure a consistent and jointly agreed position statement is made with regards the Trust's subsidiary company. • Corporate Services review (in line with the requirements of the Carter report). • Quality safeguards - to reduce expenditure are subject to Quality Impact Assessment – overseen by the COO, Medical Director, Chief Nurse & CFO. • Financial Recovery Board chaired by CEO. • Enhanced pay and non-pay controls as approved through the Financial Recovery Board.	1. The initial plan had a residual planning gap of £7.8m, including assumed delivery of QIPP schemes of £5.4m and unidentified CIP of £1.8m with some schemes red rated. 2. Emerging financial risks in four CMGs and Estates which are reporting YTD deficits to plan at Month 3. 3. Unfunded and emerging cost pressures driven by lack of access and availability of capital funding (i.e. decontamination, medical equipment and IM&T projects).	1. A) Central Finance team reviewing options to close the gap through recurrent means to be presented to CFO and FRB for review and approval. 1. B) QIPP working group in place to monitor effectiveness and delivery of QIPP schemes. 1. C) Efficiency Programme is continuing to work with all areas of the organisation to identify additional efficiency opportunities. 2. Financial Recovery plans being devised for those areas at risk to mitigate the financial pressures and operate within the Control Total. Dedicated financially focused Performance Review Meetings with all CMGs for July. 3. Re-instated Financial Recovery Board chaired by CEO.	CFO CFO CFO CFO / COO CEO	July 2019 Sept 2019 July 2019 July 2019 July 2019

Appendix 1 - 2019/20 Board Assurance Framework – June (FINAL)

• System imbalance and Commissioner affordability	• Governance structure in place around Contract Management Performance with CCGs and Specialised Commissioning.	1 As at Month 3 there is significant over-performance of Commissioner Contracts. 2 Following the recent settlement of 18/19 contract challenges a full assessment of this for 19/20 requires completion.	1 Over-performance and contract challenges co-ordinated through central finance and contracting teams. 2 Central finance and contracting team to model the impact of 18/19 challenges with 19/20.	CFO CFO	Ongoing July 2019
• Capital constraints impacting on reconfiguration and capital enabling schemes.	• Capital pressures and service developments minimised and managed through Capital Management Investment Committee (CMIC). • Capital Budgets in place which are monitored and managed through CMIC. • NHS I performance review meetings including capital requirements and additional monthly review meetings with NHSI Finance team incorporating Capital. • Reduced capital programme in place on the assumption that no external funding is available.	1 Emergency Capital Loan process is defined but likelihood and timeframes for decision making is unknown. 2 Lack of availability of capital within 2019/20 at a national level placing additional pressure within I&E for temporary or alternative solutions that will be unfunded cost pressures.	1 Emergency capital loan funding request outcomes. 2 Alternative funding options being explored with external/private sector partners to review 'off-balance sheet' options.	CFO CFO	July 2019 July 2019
• Availability of cash to support working capital requirements	• Working capital, capital loan, and internal capital funding arrangements. • Financial governance and cash monitoring arrangements at Trust Board through FIC.	1 Increased level of stoppages pending payment of outstanding supplier invoices. Significant cash inflows required following the 18/19 contract settlement process with CCGs.	1 Month 3 Cash Paper presented to FIC outlines the strategic position in relation to cash including an application for increased loans to support working capital requirements.	CFO	July 2019

Appendix 1 - 2019/20 Board Assurance Framework – June (FINAL)

Review date:	June 2019	Executive lead(s):	DSC	Lead Executive Board:	ESB	Lead TB sub-committee & date reviewed:	TB
Strategic Objective	Becoming the Best - Delivering caring at its best to every patient, every time						
PR Event (PR10)	**Failure to work with the wider system**						

BAF tracker - month	APR	MAY	JUN (Q1)	JUL	AUG	SEP (Q2)	OCT	NOV	DEC (Q3)	JAN	FEB	MAR (Q4)
BAF rating (L x I)	4 x 4 = 16	4 x 4 = 16	4 x 4 = 16									
Target rating (L x I)			4 x 4 = 16			4 x 4 = 16			3 x 4 = 16			3 x 4 = 12
Rationale for score:												

Key threats / opportunities	Controls Assurance (to provide 'Confidence' / 'Evidence' / 'Certainty') that key systems and processes are working in practice	Gaps in control / assurance	Actions	Lead	Due Date
• Governance structures across the Trust and the System are not fit to deliver the scale of opportunity.	• UHL CE is now joint STP lead, with DSC taking a lead role in development of governance in partnership with CCG STP lead. • Internal self-assessment reviews about the efficacy of the controls for this risk have been reported to ESB; Stakeholder meetings; Trust Board sub-committees and have identified gaps in active participation in several related STP work streams – this has been rectified with operations and strategy attendance at key STP meetings.	1 Review of the LLR STP has shown that this risk is not fully mitigated as assurance of efficacy of the partnership working is limited at this point. This tells us that the current governance processes are not yet fit for purpose and will not fully mitigate the risk as presented.	1 Revised STP governance to be designed agreed and enacted.	MW	Aug 2019
• Multiple CMGs and services now involved in delivery of models of care internally and with external partners.	• Positive engagement noted in delivery of models of care at CMG level. • CMG owned models of care agreed at part of PCBC process. • Regular updates about changes reported at OMG/ESB.	1 Specific allocated resource is required across the Trust and system to enact the transformation required – this is not in place for all CMGs.	1 Assess the need once STP workshops have been completed.	MW	Aug 2019
• Active Clinical input and leadership required across key STP work streams such as planned care, urgent care, Integrated Locality teams, and Home First to enable the models of care to put into place.	• Senior Clinical Cabinet briefed in June 2019 on both the requirements of an ICS model and consulted on how best to engage with clinical colleagues across UHL. • System wide workshops agreed with a focus on: – Ensuring all clinical staff are aware of the changes and implications of moving to an ICS contract. – Assessing what is required across local and regional networks to enable our models of care to be delivered across the LLR system.	1 Risk that clinical staff will not be released across the system – particularly staff groups such as GP's, therapists, pharmacists etc.	1 Clinical chairs will be writing out to invite staff groups to participate.	RV	July 2019
• System wide PMO including: Project and programme management; Specialist Support e.g. business intelligence, strategic planning; Change Management and Transformation Function not in place.	• Newly formed System Sustainability Group in place, with the LLR Planning Operational Group supporting actions from SSG.	1 There is a gap in agreed LLR paperwork with multiple business case and project paperwork.	1 Agree use of BtB QI methodology across the system.	RV	July 2019

Appendix 1 - 2019/20 Board Assurance Framework – June (FINAL)

Review date:	June 2019	Executive lead(s):	MD / DSC	Lead Executive Board:	ESB	Lead TB sub-committee & date reviewed:	TB
Strategic Objective	Becoming the Best - Delivering caring at its best to every patient, every time						
PR Event (PR11)	**Failure to maintain and enhance research market competitiveness by failing to develop Leicestershire Academic Health Partners**						

BAF tracker - month	**APR**	**MAY**	**JUN**	**JUL**	**AUG**	**SEP**	**OCT**	**NOV**	**DEC**	**JAN**	**FEB**	**MAR**
BAF rating (L x I)	3 x 3 = 9	3 x 3 = 9	3 x 3 = 9									
Target rating (L x I)			3 x 3 = 9			3 x 3 = 9			3 x 3 = 9			2 x 3 = 6
Rationale for score:	Current ratings based on position with MoU.											

Key threats / opportunities	**Controls Assurance (to provide 'Confidence' / 'Evidence' / 'Certainty') that key systems and processes are working in practice**	**Gaps in control / assurance**	**Actions**	**Lead**	**Due Date**
• Need to maintain senior engagement from partners. • Need to ensure LAHP Board Meetings are held on schedule. • Academic Health Teams now need to be established to deliver partner priority projects. • Branding and communications plans are needed. • Partners need to deliver the promised financial support for LAHP. • NHS clinical teams are busy and service focused, thus academic concerns are often not well integrated into clinical service development plans. • UoL academics are often not able to use their expertise to influence health policy and service developments. • Time will be needed to support colleagues' LAHP participation.	• The governance arrangements for LAHP are built on the existing bilateral joint UoL/UHL and UoL/LPT Strategy Board meetings, together with the existing close professional relationships and bilateral/trilateral working agreements already in place between the members. • Partners have signed a Memorandum of Understanding (MoU) to launch LAHP. • LAHP is based on an MoU now signed by all partners. • The MoU includes agreed deliverables and other commitments to which the LAHP have now signed up. • LAHP Director appointed. • LAHP Board constituted of senior leaders from each partner. • LAHP Board minutes reported to the 3 partner organisation boards.	1. A more detailed LAHP business plan for next 5 years is needed.	1 Short Term Deliverables (1-2 years): ➢ Establish an Operations Group. ➢ Establish Academic Health Teams. ➢ Appoint a Chief Operating Officer and establish a secretariat for LAHP. ➢ Create a business plan for the partnership with key deliverables, timescales and owners. ➢ Implement a communications strategy for LAHP. ➢ Begin discussions with other stakeholders and potential additional members. ➢ Establish relationship with EM Academic Health Services Network to develop commercial/philanthropic opportunities.	MD. LAHP Director (N Brunskill)	March 2020.

BAF Scoring process:

❖ Likelihood of Risk Event - score & example descriptors

1	2	3	4	5
Extremely unlikely	**Unlikely**	**Possible**	**Likely**	**Almost certain**
Extremely unlikely to happen except in very rare circumstances. Less than 1 chance in 1,000 (< 0.1% probability). No gaps in control. Well managed.	Unlikely to happen except in specific circumstances. Between 1 chance in 1,000 & 1 in 100 (0.1 - 1% probability). Some gaps in control; no substantial threats identified.	Likely to happen in a relatively small number of circumstances. Between 1 chance in 100 & 1 in 10 (1-10% probability). Evidence of potential threats with some gaps in control	Likely to happen in many but not the majority of circumstances. Between 1 chance in 10 & 1 in 2 (10 - 50% probability). Evidence of substantial threats with some gaps in control.	More likely to happen than not. Greater than 1 chance in 2 (>50% probability). Evidence of substantial threats with significant gaps in control.

How to assess the likelihood score: The likelihood is a reflection of how likely it is the risk event will occur (with the '**current** controls' / '**target** actions' in place).

❖ Impact / Consequence score & example descriptors

Risk Sub-type	1	2	3	4	5
	Rare	**Minor**	**Moderate**	**Major**	**Extreme**
REPUTATION - **loss of public confidence / breach of statutory duty / enforcement action** - **Harm (patient / non-patient - physical/ psychological)** - **Service disruption**	No harm. Minimal reduction in public, commissioner and regulator confidence Minor non-compliance with CQC Negligible disruption – service continues without impact	Minor harm – first aid treatment. Minor, short term reduction in public, commissioner and regulator confidence. Single breech of regulatory duty Temporary service restriction (delays) of <1 day	Moderate harm – semi permanent /medical treatment required. Significant, medium term reduction in public, commissioner and regulator confidence. Single breach of regulatory duty with Improvement Notice Temporary disruption to one or more Services (delays) of >1 day	Severe permanent/long-term harm. Widespread reduction in public, commissioner and regulator confidence. Multiple breeches in regulatory duty with subsequent Improvement notices and enforcement action Prolonged disruption to one or more critical services (delays) of >1 week	Fatalities/ permanent harm or irreversible health effects caused by an event. Widespread loss of public, commissioner and regulator confidence. Multiple breeches in regulatory duty with subsequent Special Administration or Suspension of CQC Registration / prosecution Closure of services / hospital

How to assess the consequence score: The impact / consequence is the effect of the risk event if it was to occur.