# RISK REPORT INCORPORATING THE BOARD ASSURANCE FRAMEWORK (BAF)

Author: Risk and Assurance Manager Sponsor: Medical Director
Date: 3 September 2015 Trust Board paper L

## Executive Summary

### Context

The Board Assurance Framework (BAF) is the key source of evidence that links strategic objectives to risks, controls and assurances, and the main tool that the Trust Board (TB) should use in seeking assurance that those internal control mechanisms are effective. This report provides the TB with:-

a) The UHL 2015/16 BAF and action tracker as of 31 July 2015 and notification of any new extreme or high risks opened during July 2015.

### Questions

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

### Conclusion

1. Input from Executive owners of each strategic objective should have provided an accurate picture of our principal risks affecting the achievement of our objectives.
2. Many of our assurance sources are based on internal monitoring and some may benefit from external scrutiny (e.g. via internal audit) to provide additional assurance that controls are effective.
3. No actions have breached their due dates however six actions have had their deadlines extended.
4. The board is provided with a summary of all new extreme and high risk that have been entered on the UHL risk register

### Input Sought

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

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

# For Reference

Edit as appropriate:

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

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

2. This matter relates to the following governance initiatives:

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

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

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

5. Scheduled date for the next paper on this topic: [01/10/15]

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

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

**UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST**

**REPORT TO:** **TRUST BOARD**

**DATE:** **3RD SEPTEMBER 2015**

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

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

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## 1. INTRODUCTION

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

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

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

## 2. 2015/16 BAF POSITION AS OF 31ST JULY 2015

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

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

a. Two actions (2.1 and 2.2 – Chief Operating Officer), have moved to a red RAG rating due to inflow trends not improving and a failure of demand management plans. Consideration should be given as to whether there is therefore an increased risk to the achievement of the associated objective.

b. Six actions have moved to an amber rating reflecting delays in implementation (1.3 – Medical Director, 3.3 – Chief Operating Officer, 4.1 and 4.2 – Director of Strategy, 5.8 – Director of Marketing and Communications, and 17.3 – Director of Finance). The delay in completing these actions is not felt to materially alter the level of risk.

c. Eleven actions have been completed during this reporting period, relating to principal risks one (1.1 and 1.4), four (4.3) seven (7.3), ten (10.1), thirteen (13.1), fifteen (15.1, 15.2 and 15.3) sixteen (16.2) and seventeen (17.1) Consideration should be given as to whether the associated risk scores can be reduced in light of this.

d. Significant revisions of principal risks 12, 13 and 14 have identified three new actions (12.4, 12.5 and 14.3).

e. There are two changes of role titles i.e. Chief Financial Officer (previously Director of Finance) and Director of Workforce and Organisational Development (previously Director of HR)

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

effectively controlled. In light of the pressure to reduce our planned deficit from £36m to £34m the following objective is submitted for scrutiny:

- **'A Financially Sustainable NHS Foundation Trust'** (incorporating principal risk numbers 15, 16, and 17).

## 3. EXTREME AND HIGH RISK REPORT.

One new high risk has opened during July 2015 as described below. The detail of this risk is included at appendix three for information.

| Risk ID | Risk Title | Risk Score | CMG/ Directorate |
|---|---|---|---|
| 2561 | Non specialist Provision of Vascular Access Services on the LGH/GGH site in comparison to the services offered at the LRI | CSI | 2561 |

## 4. RECOMMENDATIONS

4.1 The TB is invited to:

(a) Receive and note this report;

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

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

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

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

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

Peter Cleaver
Risk and Assurance Manager
26th August 2015.

# UHL BOARD ASSURANCE FRAMEWORK 2015/16

**STRATEGIC OBJECTIVES**

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

**UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST – BOARD ASSURANCE FRAMEWORK**

**PERIOD: JULY 2015**

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

**BAF Consequence and Likelihood Descriptors:**

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

**UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST – BOARD ASSURANCE FRAMEWORK**

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

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

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

**UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST – BOARD ASSURANCE FRAMEWORK**

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

| **Key Controls**(What control measures or systems are in place to assist secure delivery of the objective) | **Assurance Source** (Provide examples of recent reports considered by Board or committee where delivery of the objectives is discussed and where the board can gain evidence that controls are effective). | **Gaps in Assurance (a)/ Control (c)** (i.e. What are we not doing - What gaps in systems, controls and assurance have been identified) | **Actions to Address Gaps** | **Timescale/ Action Owner** |
|---|---|---|---|---|
| Agreed set of metrics that measure internal and external emergency care performance | Reported to UHL TB monthly<br>Reported to EPB monthly<br>Reported to UHL Emergency Quality Steering Group monthly<br>Performance reported at UHL Gold Command meeting daily<br>Reported to UCB and CCGs<br>National benchmarking of emergency care data | Attendance and admissions continue to increase (+5% and (+7%). | UHL is working with LLR colleagues to identify a more effective work of reducing attendances and admissions. Plan to achieve this to be presented to UCB (2.2) | Sep 2015<br>COO |
| LLR Action plan to improve patient flow (i.e. admissions, reduction in discharge delays, making best use of existing ED capacity | | (c) LLR action plan not fully implemented | Continue to implement and monitor progress of LLR action plan (2.1) | Review Sep 2015<br>COO |

**UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST – BOARD ASSURANCE FRAMEWORK**

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

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

**UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST – BOARD ASSURANCE FRAMEWORK**

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|---|---|---|---|---|
| **Principal risk 4** | Existing and new tertiary flows of patients not secured compromising UHL's future more specialised status. | **Overall level of risk to the achievement of the objective** | **Current score 5x3=15** | **Target score 5x2=10** |
| **Executive Risk Lead(s)** | Director of Strategy | | | |
| **Link to strategic objectives** | Integrated care in partnership with others. | | | |

| **Key Controls**(What control measures or systems are in place to assist secure delivery of the objective) | **Assurance Source** (Provide examples of recent reports considered by Board or committee where delivery of the objectives is discussed and where the board can gain evidence that controls are effective). | **Gaps in Assurance (a)/ Control (c)** (i.e. What are we not doing - What gaps in systems, controls and assurance have been identified) | **Actions to Address Gaps** | **Timescale/ Action Owner** |
|---|---|---|---|---|
| Appointment to Head of Tertiary Partnerships role to lead on formalising and securing existing pathways and developing new ones. | Monthly reporting to ESB as part of Director of Strategy report. | (c) Significant amount of partnership work being taken through ESB. | Considering options/benefits/risks of establishing UHL Partnership Board. (4.1) | Oct 2015 DS |
| Children's and Cancer Collaborative Groups established with NUH. | Monthly reporting to ESB as part of Director of Strategy report. | (c) Significant amount of partnership being taken through ESB. | As action 4.1 | As action 4.1 |
| Memorandum of Understanding (MoU) between NUH and UHL signed in 2011. | Monthly reporting to ESB as part of Director of Strategy report. | (c) MoU was intended to support establishment of EMPATH and should include wider partnership opportunities. | MoU to be reviewed by both organisations. (4.2) | Oct 2015 DS |
| Partnership Board for Specialised Services established in Northamptonshire. Membership includes Northants CCGs; NHS England; KGH; NGH and UHL. | | | | |
| Meetings in place and planned at Director level with other provider organisations (regional and national) to explore partnership opportunities. | Monthly reporting to ESB as part of Director of Strategy report. | None | None | |

**UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST – BOARD ASSURANCE FRAMEWORK**

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

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

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

**UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST – BOARD ASSURANCE FRAMEWORK**

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

| **Key Controls**(What control measures or systems are in place to assist secure delivery of the objective) | **Assurance Source** (Provide examples of recent reports considered by Board or committee where delivery of the objectives is discussed and where the board can gain evidence that controls are effective). | **Gaps in Assurance (a)/ Control (c)** (i.e. What are we not doing - What gaps in systems, controls and assurance have been identified) | **Actions to Address Gaps** | **Timescale/ Action Owner** |
|---|---|---|---|---|
| Maintaining relationships with key partners to support joint NIHR/ BRU infrastructure | Joint BRU Board (bimonthly)<br><br>Annual Report Feedback from NIHR for each BRU (annual)<br><br>UHL R&D Executive (monthly)<br><br>R&D Report to Trust Board (quarterly) | (c) Requirement to replace senior staff and increase critical mass of senior academic staff in each of the three BRUs. | BRUs to re-consider theme structures for renewal, identifying potential new theme leads. (6.1)<br><br>BRUs to identify potential recruits and work with UoL/LU to structure recruitment packages. (6.2) | Dec 2015 MD<br><br>Dec 2015 MD |
| | Athena Swan Silver Status by University of Leicester and Loughborough University.<br>(The Athena Swan charter applies to higher education institutions) | (c) Athena Swan Silver not yet achieved by UoL and Loughborough University. This will be required for eligibility for NIHR awards | UoL and LU to ensure successful applications for Silver swan status. Individual medical school depts will need to separately apply for Athena Swan Silver status. (6.4) | Mar2016 MD |

**UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST – BOARD ASSURANCE FRAMEWORK**

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

| **Key Controls**(What control measures or systems are in place to assist secure delivery of the objective) | **Assurance Source** (Provide examples of recent reports considered by Board or committee where delivery of the objectives is discussed and where the board can gain evidence that controls are effective). | **Gaps in Assurance (a)/ Control (c)** (i.e. What are we not doing - What gaps in systems, controls and assurance have been identified) | **Actions to Address Gaps** | |
|---|---|---|---|---|
| Medical Education Strategy | Department of Clinical Education (DCE) Business Plan and risk register are discussed at regular DCE Team Meetings and information given to the Trust Board quarterly<br><br>Oversight by Executive Workforce Board<br><br>Bi-monthly UHL Medical Education Committee meetings (including CMG representation)<br><br>Database of recognised Trainers required by GMC 2016<br><br>Appointment processes for Level 3 educational roles established<br><br>Appraisal of Level 2 educational roles in UHL appraisal<br><br>KPI are measured using the:<br>• UHL Education Quality Dashboard<br>• CMG Education Leads and stakeholder meetings<br>• GMC Trainee Survey results<br>• UHL trainee survey<br>• HEEM accreditation visits | (c) Education facilities Identified as poor in external reports from HEEM and Leicester University<br><br>c) Ineffective control of clinical service pressures, vacancies and loss of posts on rotas that adversely affect quality of training and added impact of | Continue to improve facilities i.e. to re-provide LRI Jarvis education centre in 1771 building, provide UHL Simulation facility and consider feasibility of Glenfield as an expanding training site (7.2)<br><br>Medical education quality dashboard, SPA time in job plans for training, support for CMG Medical Education leads and local faculty groups (College Tutors etc) (7.4) | Nov 2015 MD<br><br>Aug 2015 MD |

**UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST – BOARD ASSURANCE FRAMEWORK**

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

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

**UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST – BOARD ASSURANCE FRAMEWORK**

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

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

**UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST – BOARD ASSURANCE FRAMEWORK**

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| **Principal risk 10** | Gaps in inclusive and effective leadership capacity and capability , lack of support for workforce well-being, and lack of effective team working across local teams may lead to deteriorating staff engagement and difficulties in recruiting and retaining medical and non-medical staff | **Overall level of risk to the achievement of the objective** | **Current score 4x4 = 16** | **Target score 4x2 = 8** |
| **Executive Risk Lead(s)** | Director of Workforce and Organisational Development | | | |
| **Link to strategic objectives** | A caring, professional and engaged workforce | | | |

| **Key Controls**(What control measures or systems are in place to assist secure delivery of the objective) | **Assurance Source** (Provide examples of recent reports considered by Board or committee where delivery of the objectives is discussed and where the board can gain evidence that controls are effective). | **Gaps in Assurance (a)/ Control (c)** (i.e. What are we not doing - What gaps in systems, controls and assurance have been identified) | **Actions to Address Gaps** | **Timescale/ Action Owner** |
|---|---|---|---|---|
| Organisational Development Plan | Reported to EWB quarterly<br>Reported to Trust Board quarterly<br>Internal Audit assurance via 2014/15 Programme<br>Key Performance Indicators included within OD plan<br>Progress against plan monitored monthly in CMGs | ( | | |
| LIA Programme | LIA Sponsor Group meet monthly<br>Reported to EWB quarterly<br>Reported to Trust Board quarterly (as part of the OD report). | (c) Analysis of LIA dataset has identified some key areas for improvement – coded as: Frustrations; Focus on Quality; Structures and leadership | Continue with the spread of LiA to enable staff to make contributions to changes and improvements at work (10.2) | Mar 2016<br>DWOD |
| Workforce Planning | Reported to EWB quarterly<br>Reported to Trust Board quarterly (as part of OD plan)<br>Key Performance Indicators included in organisational health dashboard and NTDA submission and include:<br>Pay spend against plan<br>Staff number (wte) against plan<br>Safe staffing levels within clinical areas | (c) Affordability against workforce plan is an issue related to lack of substantive staff leading to increase in premium spend | CMGs to produce a trajectory of premium spend linked to recruitment with which will be monitored through the weekly CMG performance meetings and Cross Cutting Workforce Meeting. (10.3) | Mar 2016<br>DWOD |

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

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

**UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST – BOARD ASSURANCE FRAMEWORK**

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

| **Key Controls**(What control measures or systems are in place to assist secure delivery of the objective) | **Assurance Source** (Provide examples of recent reports considered by Board or committee where delivery of the objectives is discussed and where the board can gain evidence that controls are effective). | **Gaps in Assurance (a)/ Control (c)** (i.e. What are we not doing - What gaps in systems, controls and assurance have been identified) | **Actions to Address Gaps** | **Timescale/ Action Owner** |
|---|---|---|---|---|
| Link the reconfiguration investment programme demands with current infrastructure, identifying future capacity requirements<br><br>Current infrastructure details being gathered for all three acute sites identifying high risk elements of engineering and building infrastructure | Highlight reports developed monthly and reported to the UHL Reconfiguration Programme Board | (a) Effective governance arrangements for oversight and scrutiny of this work are yet to be agreed. PMO developing reporting format<br><br>(c) A programme of infrastructure improvements is yet to be identified<br><br>(c) Timescale issues for infrastructure works which could impact on the overall programme have not yet been identified and quantified in relation to risk | Plans being developed and liaison between Estates and Strategy team programmed (11.6)<br><br>Assessment of current capacity being established (11.7)<br><br>Develop a programme of works (11.2)<br><br>Develop an operational risk register for the projects (11.3) | August 2015 DEF/DS<br><br>Sep 2015 DEF<br><br>Aug 2015 DEF<br><br>Sep 2015 DEF |
| Capital programme with ring fenced capital funding to support future infrastructure capacity demands | Capital Investments Monitoring Committee | (c) Currently no identified capital funding within 2015/16 | Identification of investment required and | Sep 2015 DEF/CFO |

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| | | programme and future years | allocation of capital funding (11.4) | |
| An established Estates and Facilities team with detailed knowledge of the estates and reconfiguration programme<br><br>Estates work stream to support reconfiguration established which reports in UHL reconfiguration programme board to ensure alignment with all other reconfiguration projects. | Regular reports to Executive Performance Board (EPB)<br><br>Monthly highlight reports completed and reported to EPB | (c) Conflicting responsibilities/roles of the estates and facilities team between UHL and the LLR estate and Facilities Management Collaborative | Define resource and skills gaps and agree an enhanced team structure to support the significant reconfiguration programme (11.5) | Sep 2015 DEF |

**UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST – BOARD ASSURANCE FRAMEWORK**

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

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

**UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST – BOARD ASSURANCE FRAMEWORK**

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

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

**UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST – BOARD ASSURANCE FRAMEWORK**

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

| **Key Controls**(What control measures or systems are in place to assist secure delivery of the objective) | **Assurance Source** (Provide examples of recent reports considered by Board or committee where delivery of the objectives is discussed and where the board can gain evidence that controls are effective). | **Gaps in Assurance (a)/ Control (c)** (i.e. What are we not doing - What gaps in systems, controls and assurance have been identified) | **Actions to Address Gaps** | **Timescale/ Action Owner** |
|---|---|---|---|---|
| **Business case approvals:**<br>• Strategic capital business case work stream established within UHL reconfiguration programme governance.<br>• Detailed programme plan which identifies key milestones for delivery of the capital plan over the coming years; business cases are differentiated between external funding/approval and internal approval.<br>• Monitoring of business case timescales for delivery via established governance structure | A monthly highlight report is submitted to the UHL Reconfiguration Programme Delivery Board. Monthly aggregate reporting to ESB, IFPIC and Trust Board. (Last reporting, July 15).<br><br>Monthly meetings with the NTDA to discuss the programme of delivery and identify new cases coming up for approval | (c) Lack of capacity within the NTDA to resource each of the business cases | NTDA to look at providing a management and financial lead for each business case (14.1) | Sep 2015<br>DS |
| Availability of transitional support:<br>Requirements identified to deliver key projects and this is overseen by programme management office (PMO) to ensure delivery and ensure progress as outlined in project plan.<br><br>Projects focus on reconfiguration/service transformation to support achievement of the UHL two acute site model, via:<br>• Models of care<br>• Future Operating Model<br>• Strategic business cases<br>• Enablers<br><br>Project resources identified against each project, particularly for business cases. A resource management process has been approved through the reconfiguration board to monitor spend against agreed budgets and available resources. | PMO in place to track and monitor overall UHL reconfiguration delivery.<br><br>Business case team oversee, manage and deliver cases for approval, including report on spend.<br><br>A report is submitted to the UHL Reconfiguration Programme Delivery Board on a monthly basis that tracks progress to date, including financial assurance, risks with mitigations. Summary report provided to ESB each month. | No gaps currently identified | Work stream to be established to identify gaps (14.2) | Sep 2015<br>DS |

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| **Consultation-**<br>• BCT Consultation programme established<br>• Each of the appropriate BC have a consultation and engagement plans in place and work closely through the UHL communication and engagement lead to ensure continuity with the BCT Plan | The reconfiguration communication lead sits on key project boards and the BCT communications and engagement group.<br>A monthly report is submitted to the UHL Reconfiguration Programme Delivery Board from the communication and engagement work stream. Last report 17.07 | | | |
| A future operating model at speciality level which supports a two acute site footprint:<br>Work stream exists to develop plans (bottom up) across beds, theatres, outpatients, diagnostics, and workforce with a series of workshops to map future capacity to inform reconfiguration. | Monthly reports submitted to UHL reconfiguration programme board. | (a) Further work required, as part of future operating model, to look at the remaining acute services at the LGH to determine the gap in the current capital plan | Complete site survey at LGH and then to overlay future operating model outputs. (14.3) | Sept 15<br>DS |
| Ability to shift activity into out of hospital settings in order to support two site acute model:<br>An out of hospital project has been established to develop and deliver plans to shift appropriate activity into the community. | Monthly reports submitted to UHL reconfiguration programme board. | | | |

**UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST – BOARD ASSURANCE FRAMEWORK**

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

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

**UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST – BOARD ASSURANCE FRAMEWORK**

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

| **Key Controls**(What control measures or systems are in place to assist secure delivery of the objective) | **Assurance Source** (Provide examples of recent reports considered by Board or committee where delivery of the objectives is discussed and where the board can gain evidence that controls are effective). | **Gaps in Assurance (a)/ Control (c)** (i.e. What are we not doing - What gaps in systems, controls and assurance have been identified) | **Actions to Address Gaps** | **Timescale/ Action Owner** |
|---|---|---|---|---|
| Completion and delegation of final, detailed income and expenditure control totals each CMG and Department within UHL | Final agreed financial plan including detailed budget book to IFPIC (draft in April 2015) in early May 2015<br><br>Full devolution of budgets to CMGs and Departments, clarity achieved by robust integrated planning process in advance of April 2015<br><br>Monthly reporting via Exec Performance Board, IFPIC and Trust Board | (c) Following excess spend particularly on premium pay in Q1 and the NTDA revision of the Trust's control total to £34.1m, a recovery/improvement plan is required | CFO to lead production of recovery plan internally and revised plan submission to NTDA (16.3) | CFO August 2015 |
| Sign off and agreement of contracts with CCGs and NHSE including activity plans for all areas and the terms and conditions attached to the contracts in 2015/16 | Detail of the agreed contracts to IFPIC (draft in April 2015) in early May 2015<br><br>Full devolution of activity and performance plans to CMGs and Departments, clarity achieved by robust integrated planning process in advance of April 2015<br><br>Monthly reporting via Exec Performance Board, IFPIC and Trust Board | | | |
| Finance and CIP delivery by CMGs at UHL | Weekly reviews between CFO/COO and all CMGs, covering key areas of performance including finance and CIPs<br><br>Monthly reporting via Exec Performance Board, IFPIC and Trust Board | | | |
| UHL service and financial strategy (as per SOC and LTFM) | Updates and reporting to the BCT UHL Monthly | | | |

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

**UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST – BOARD ASSURANCE FRAMEWORK**

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

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

**UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST – BOARD ASSURANCE FRAMEWORK**

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| **Principal risk 18** | Delay to the approvals for the EPR programme | **Overall level of risk to the achievement of the objective** | **Current score 4x4 =16** | **Target score 2x3=6** |
| **Executive Risk Lead(s)** | Chief Information Officer | | | |
| **Link to strategic objectives** | Enabled by excellent IM&T | | | |

| **Key Controls**(What control measures or systems are in place to assist secure delivery of the objective) | **Assurance Source** (Provide examples of recent reports considered by Board or committee where delivery of the objectives is discussed and where the board can gain evidence that controls are effective). | **Gaps in Assurance (a)/ Control (c)** (i.e. What are we not doing - What gaps in systems, controls and assurance have been identified) | **Actions to Address Gaps** | **Timescale/ Action Owner** |
|---|---|---|---|---|
| Communications with key contacts throughout the external approvals chain | Weekly meeting to discuss progress and issues.<br><br>Updates on the IM&T transformation Board, EPR programme Board and the joint Governance Board. | (c) Local TDA approval has been given and the project now sits with the Department of Health who are unable to give us a clear timetable | Further work with NTDA/DoH to progress a firm timetable to the ATP (18.1) | Aug 2015<br>CIO |
| Communications with key contacts throughout the Internal approvals chain | Weekly meeting to discuss progress and issues.<br><br>Updates on the IM&T transformation Board, EPR programme Board and the joint Governance Board. | (c) Lack of confirmed planning, hindered by the external ATP steps, could lead to delays in the internal processing of the final FBC | Further work to expose the executive and the Trust board to the likely shape of the FBC and the required internal steps. (18.2) | Aug 2015<br>CIO |

**UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST – BOARD ASSURANCE FRAMEWORK**

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

| **Key Controls**(What control measures or systems are in place to assist secure delivery of the objective) | **Assurance Source** (Provide examples of recent reports considered by Board or committee where delivery of the objectives is discussed and where the board can gain evidence that controls are effective). | **Gaps in Assurance (a)/ Control (c)** (i.e. What are we not doing - What gaps in systems, controls and assurance have been identified) | **Actions to Address Gaps** | **Timescale/ Action Owner** |
|---|---|---|---|---|
| Review of contractual deliverable and quality of service | External reviews, PWC and ISO 27001 Audit in 2014<br><br>Monthly service delivery board, covering all aspects of service delivery | (a) VfM review | Engage third party, as per contract, to asses and review VfM (19.1) | Aug 2015 CIO |
| Communication to end users of the performance of IBM and IM&T in service delivery | Monthly service delivery board, covering all aspects of service delivery<br><br>Performance reports are available on InSite<br><br>Project performance is reported quarterly through the trust executive | (c) Communication about successes is not sufficiently robust | Production of a quarterly newsletter available to all staff (19.3) | Aug 2015 CIO |
| End user's service meets their requirements | Liaison with the CMGs to ensure we are meeting their requirements<br><br>Monitoring of complaints around the service and it's delivery | (c) No formal process, post the contract award, to test the delivery principles | Following LiA Event in June, plans are being created to address the gaps found in the user expectations of the service (19.5) | Aug 2015 CIO |

**Appendix two**

# UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST
## ACTION TRACKER FOR THE 2015/16 BOARD ASSURANCE FRAMEWORK (BAF)

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

| REF | ACTION | BOARD LEVEL LEAD | OPS LEAD | COMPLETION DATE | PROGRESS UPDATE | STATUS |
|---|---|---|---|---|---|---|
| **1** | **Lack of progress in implementing UHL Quality Commitment (QC).** | | | | | |
| 1.1 | Nurse and medical workforce recruitment strategies | MD/CN | | Review July 2015 | **Complete.** Nursing recruitment strategy in place and monitored via NET. Medical workforce group are progressing with recruitment and new | 5 |
| 1.2 | Roll-out plan to be developed to move to 100% screening of deaths | MD | HOE | September 2015 | Process drafted and incorporated into policy. Being launched at M&M Lead's forum on 18th May. | 4 |
| 1.3 | Audit support to be provided. | MD | HOE | ~~July 2015~~ October 2015 | Funding approved. M&M Clerks and analyst recruitment process commenced. Job descriptions currently undergoing job panel evaluation. Deadline extended to reflect expected dates for roles to be filled | 3 |
| 1.4 | Monitor uptake of screening. | MD/CN | HOE | Review July 2015 | **Complete.** Screening uptake monitored via Mortality Review Committee | 5 |
| 1.5 | Mortality database to be developed. | MD/CN | HOE | ~~Review July 2015~~ October 2015 | Database scoping exercise being undertaken. Awaiting feedback from potential providers. Excel spread sheet database being used in the meantime. | 3 |
| **2** | **Demographic growth plus ineffective admission avoidance schemes may counteract any internal improvements in emergency pathway** | | | | | |
| 2.1 | Continue to implement and monitor progress of LLR action plan | COO | | Review September 2015 | Plan is reviewed through weekly EQSG and fortnightly UCB. The key problem remains inflow trend. | 2 |

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| 2.2 | UHL is working with LLR colleagues to identify a more effective work of reducing attendances and admissions. Plan to achieve this to be presented to UCB in July | COO | | ~~June 2015~~ ~~July 2015~~ September 2015 | Demand management is not proving to be as effective as had been hoped. Updated plan going to TB in September. Timescale extended to reflect this | 2 |
| **3** | **Failure to transfer elective activity to the community , develop referral pathways, and key changes to the cancer providers in the local health economy may adversely affect our ability to consistently meet national access standards** | | | | | |
| 3.3 | Theatre productivity improvements driven through the cross-cutting work stream. | COO | | ~~July 2015~~ September 2015 | Theatre CCT is concentrating on reducing out of hours sessions at present. Waiting list initiatives have reduced from 180 per month to 30 in July. The next stage of the action is to improve theatres in hours utilisation. End point not yet defined therefore review of progress in September | 3 |
| 3.4 | Recovery of cancer standards | COO | W Monaghan / C Carr | September 2015 | Revised tumour site plans and trajectory. Appointment of 3 band 7's to support key tumour sites underway. | 4 |
| 3.5 | Recovery of diagnostic 6 week standard | COO | W Monaghan / C Carr | September 2015 | Main issue within endoscopy, Medinet IS provider starting additional capacity 1st week in July | 4 |
| **4** | **Existing and new tertiary flows of patients not secured compromising UHL's future more specialised status.** | | | | | |
| 4.1 | Consider options/benefits/risks of establishing UHL Partnership Board. | DS | | ~~July 2015~~ October 2015 | Discussions are on-going to ensure members are aware on progress to date, the range of partnerships currently being explored and actions planned going forward a tertiary. It is anticipated that the feasibility of a UHL Partnership Board will be decided at meetings taking place in October. Deadline extended to reflect this | 3 |



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| 4.2 | Memorandum of Understanding (MoU) to be reviewed by both organisations. | DS | | ~~July 2015~~<br>October 2015 | Positive discussions have started at Chief Executive level between UHL and NUH looking at ways of working and taking a more strategic leadership position across the East Midlands. Priorities include cancer services, children's services, spinal services and engagement with United Lincolnshire Hospitals Trust<br>Discussions are on-going with meetings taking place in October. Deadline extended to reflect this | 3 |
| 4.3 | Future minutes of Partnership Board for Specialised Services to be included DS report to ESB. | DS | | July 2015 | **Complete.** A process has been put in place to ensure the minutes come to ESB under the strategy update. | 5 |
| **5** | **Failure to deliver RTT improvement plan. Failure to deliver integrated care in partnership with others including failure to: Deliver the Better Care Together year 2 programme of work; Participate in BCT formal public consultation with risk of challenge and judicial review; Develop and formalise partnerships with a range of providers; Explore and pioneer new models of care. Failure to deliver integrated care.** | | | | | |
| 5.3 | LLR wide business intelligence group established.<br>UHL dashboard in draft to be used to inform LLR wide dashboard. | DS | | ~~May 2015~~<br>~~July 2015~~<br>August 2015 | UHL dashboard has been agreed and shared with the LLR BCT PMO team. Following June TB, a BCT Programme Dashboard is to be established and agreed with the BCT PMO. The dashboard is to be aligned and consolidated to the UHL Reconfiguration Dashboard highlighting progress/risks against the eight BCT work streams. The BCT dashboard to be presented to the August TB meeting. | 3 |



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



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| 7.2 | Continue to improve facilities i.e. to re-provide LRI Jarvis education centre in 1771 building, provide UHL Simulation facility and consider feasibility of Glenfield as an expanding training site | MD | | ~~Sept 2015~~ November 2015 | Meetings held with facilities with Darryn Kerr, Nicky Topham July 2015 and outline education facilities strategy drafted. However, it is necessary to develop an inter-professional strategy and work with other academic partners to develop facilities for the longer term. Facilities strategy to be presented to Executive Workforce Board August. | 3 |
| 7.3 | Engagement with CMGs in ensuring education expenditure matches income | MD | | August 2015 | **Complete.** Meetings held with all CMGs, updates given about education and training issues and funding and supporting documentation to advice re calculation for expenditure. | 5 |
| 7.4 | Medical education quality dashboard, SPA time in job plans for training, support for CMG Medical Education leads and local faculty groups (College Tutors etc) to be developed | MD | | August 2015 | Quality dashboard is now being completed quarterly by education quality manager and education leads. Will be demonstrated as example of best practice on UK NACT website Local faculty group to be piloted with CMG education lead in O&G, DCE involved in College Tutor appointments but roles need to be funded and visible in job plans. Time for education roles remains to be reliably demonstrated in job plans | 4 |
| **8** | **Insufficient engagement of clinical services, investment and governance may cause failure to deliver the Genomic Medicine Centre project at UHL** | | | | | |
| 8.1 | Develop appropriate training for clinical and non-clinical staff | | Nigel Brunskill | March 2016 | | 4 |
| 8.2 | Support CMGs with transformation of GMC project into clinical services | | Nigel Brunskill | March 2016 | | 4 |



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| 8.3 | Coordinate public engagement activity aimed at (i) raising expectation of participating in the GMC project and (ii) benefits to patients of genomic medicine | | Nigel Brunskill | June 2016 | | 4 |
| **9** | **Changes in senior management/ leaders in partner organisations may adversely affect relationships / partnerships with universities.** | | | | | |
| 9.2 | Develop regular meeting with Universities | MD | Nigel Brunskill | March 2016 | Develop new 4 way strategy meeting with UHL, UoL, LU and DMU | 4 |
| **10** | **Gaps in inclusive and effective leadership capacity and capability , lack of support for workforce well-being, and lack of effective team working across local teams may lead to deteriorating staff engagement and difficulties in recruiting and retaining medical and non-medical staff** | | | | | |
| 10.1 | Scrutinise at CMG level the organisational health dashboard at quarterly EWB. | DWOD | J Tyler-Fantom | September 2015 | **Complete.** Work has been completed to develop the dashboard and to include all current monthly data when available. Regular item on all CMG monthly board agendas | 5 |
| 10.2 | Continue with the spread of LiA to enable staff to make contributions to changes and improvements at work | DWOD | B Kotecha | March 2016 | Progress on track against LiA Year 3 Plan | 4 |
| 10.3 | CMGs to produce a trajectory of premium spend linked to recruitment to be monitored through the CMG performance and Cross Cutting Workforce Meeting. | DWOD | B Kotecha | March 2016 | Plans in place to reduce Premium Spend – implementation monitored by existing performance meetings (CIP/Workforce). Work is underway in populating the Workforce Modelling Tool with recruitment and workforce plans. Workforce tool is now being populated on a monthly basis and now plans are in place to monitor actions to reduce premium expenditure based on the DH toolkit | 4 |
| 10.4 | Improvements in local leadership and the management of well led teams including holding to account for the basics | DWOD | B Kotecha | March 2016 | Progress on track against Trust Wide Action Plan | 4 |



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| 10.5 | NED apprenticeship scheme to be implemented | DMC | D Baker | March 2016 | Proposal drafted and discussed at the June NED meeting. Intention to report back on proposals at the September 2015 Board. | 4 |
| 10.6 | Targeted interventions for BME band 5 and 6 to be developed and implemented | DWOD | D Baker | March 2016 | Graduate traineeship scheme under development focussed around recruitment at operational manager level. Communication Plan being developed in promoting leadership development opportunities to band 5 and 6 BME staff | 4 |
| 10.7 | Await national guidance in relation to the post of 'Freedom to Speak' Guardian | MD | DSR | September 2015 | | 4 |
| 10.8 | Undertake actions from 'Freedom to Speak' gap analysis | MD | DSR | September 2015 | | 4 |
| 10.9 | CMGs to nominate appropriate managers to receive staff concerns | MD | DSR | September 2015 | | 4 |
| 10.11 | Training for clinicians on role redesign and functional mapping | MD | AMD | December 2015 | Resource identified through Better Care Together Team. Pilot work being undertaken in RRC re 'How to Staff a Ward Differently'. | 4 |
| 10.12 | Work with HEEM to influence posts to be redistributed | MD | AMD | March 2016 | Good clinical and education team engagement in discussions relating to redistribution. | 4 |
| 10.13 | Need to identify the resources required to implement the national nursing revalidation guidance and submit business cases for funding | CN | | March 2016 | Still awaiting confirmation from the NMC of launch date – update should have been circulated in July and will now be August | 4 |
| **11** | **Insufficient estates infrastructure capacity and the lack of capacity of the Estates team may adversely affect major estate transformation programme** | | | | | |
| 11.2 | Develop a programme of works for infrastructure improvements | DEF | Nigel Bond | September 2015 | Work in progress | 4 |
| 11.3 | Develop an operational risk register for the projects | DEF | DEF | ~~August 2015~~ September 2015 | Work in progress | 4 |



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| 11.4 | Identification of investment required and allocation of capital funding | DEF | Nigel Bond/ Richard Kinnersley | September 2015 | Work in progress | 4 |
| 11.5 | Define resource and skills gaps and agree an enhanced team structure to support the significant reconfiguration programme | DEF | | September 2015 | Work in progress | 4 |
| 11.6 | Plans being developed and liaison between Estates and Strategy team programmed to ensure effective governance and oversight and scrutiny of investment programme demands | DEF/DS | | August 2015 | | 4 |
| 11.7 | Assessment of current capacity of Estates infrastructure being established | DEF | | September 2015 | | 4 |
| **12** | **Limited capital envelope to deliver the reconfigured estate which is required to meet the Trust's revenue obligations** | | | | | |
| 12.3 | PMO holding estates workshop and followed by a joint estates and strategy workshop to develop a 'road map' of deliverability and programme of change | DEF/DS | | August 2015 | | 4 |
| 12.4 | On-going discussions between executive team and NTDA regarding availability of contingency funding (this action now replaces previous 12.2) | DEF/ DOS/ CFO | | September 2015 | | 4 |
| 12.5 | Consideration to be given to other avenues for sources of funding. (12.5) | DEF/ DOS/ CFO | | September 2015 | | 4 |
| **13** | **Lack of robust assurance in relation to statutory compliance of the estate** | | | | | |



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| 13.1 | Additional assurance to be identified through spot checks and deep dive analysis | DEF | Mike Webster | July 2015 | **Complete.** Currently underway and reported in compliance monthly report. The planned checks have taken place with a future inspection regime planned. In addition incident scenarios have been carried out to test IFM data, processes and systems the outcome of these are being reported to the Contract Management Panel with future scenarios planned bi-monthly | 5 |
| 13.2 | Develop improved software dashboard reporting (CASS) | DEF | Mike Webster | September 2015 | Supplier identified, quotation accepted and plans to commence work in July Population of software commenced in August. New Planet software system introduced by IFM in July now being evaluated | 4 |
| **14** | **Failure to deliver clinically sustainable configuration of services** | | | | | |
| 14.1 | NTDA to look at providing a management and financial lead for each of the business cases | DS | | September 2015 | Initial meeting was held on the 12.05.15 with the NTDA where they recognised the need for NTDA resource | 4 |
| 14.2 | Work stream to be established to identify gaps in the current capital plan | DS | | September 2015 | Work has started- the LTFM has been updated and a revised project programme has been put in place | 4 |
| 14.3 | Complete site survey at LGH and then to overlay future operating model outputs. | DS | | September 2015 | Work underway | 4 |
| **15** | **Failure to deliver the 2015/16 programme of services reviews, a key component of service-line management (SLM)** | | | | | |
| 15.1 | Discuss with the Director of CIP the Future Operating Model and that through this we will cement delivery | DS | | July 2015 | **Complete** Any CIP that is identified through the service review process is recorded by the CIP tracker | 5 |
| 15.2 | High level updates to be included in the Director of Strategy's monthly report for ESB. | DS | | ~~May 2015~~ July 2015 | **Complete** A process has been put in place to ensure ESB are sighted on the service review work programme. An update on service reviews was presented at the August ESB meeting. | 5 |



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| 15.3 | Approach and scheduling of service reviews to be reviewed to ensure process remains viable and/or to identify resource requirement. | DS | | July 2015 | **Complete** -An approach has been agreed, which is aligned to the "UHL Way" (Institute of Healthcare Improvement Triple Aim Measures) for benefit realisation. The role out plan is being sent to CMGs by the end of the month for confirmation and assurance of their commitment to support the process. | 5 |
| **16** | **Failure to deliver UHL's deficit control total in 2015/16** | | | | | |
| 16.2 | Full population of 2015/16 CIP plans to achieve £43million | CFO/COO | DCIPFOM | ~~May 2015~~ ~~June 2015~~ July 2015 | **Complete.** £43m on tracker | 5 |
| 16.3 | CFO to lead production of recovery plan internally and revised plan submission to NTDA | CFO | | August 2015 | | 4 |
| **17** | **Failure to achieve a revised and approved 5 year financial strategy** | | | | | |
| 17.1 | Approval to be sought for SOC | CEO | | TBA (Awaiting information from BCT programme Board for approx. date) | **Complete.** SOC approved by NHSTA/NHS England March 2015. | 5 |
| 17.3 | Liaise with TDA to agree process for LTFM submission and sign-off | CFO | | ~~July 2015~~ Review September 2015 | Revised financial strategy and LTFM submitted to NTDA in early August 2015 as part of ITFF funding application. Awaiting NTDA feedback. Review in September 2015 | 3 |
| **18** | **Delay to the approvals for the EPR programme** | | | | | |



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| 18.1 | Further work with NTDA to progress a firm timetable to the ATP | CIO | E. Simons | ~~May 2015~~ ~~June 2015~~ August 2015 | Further reviews have happened with the NTDA. The recommendation has gone to, and been approved by, the local NTDA Capital investment Group in June 2015<br><br>The plan is now sitting with the DoH for their approval. No formal timetable for this has been given. | 3 |
| 18.2 | Further work to expose the executive and the Trust board to the likely shape of the FBC and the required internal steps. | CIO | E. Simons | ~~July 2015~~ August 2015 | Plan is currently being finalised for this action above | 3 |
| **19** | **Perception of IM&T delivery by IBM leads to a lack of confidence in the service** | | | | | |
| 19.1 | Engage third party, as per contract, to asses and review VfM | CIO | T. Hind | August 2015 | Gartner have been approached to facilitate this work on behalf of the Trust and IBM | 4 |
| 19.3 | Production of a quarterly newsletter available to all staff | CIO | T. Webb | August 2015 | Plans are in place | 4 |
| 19.5 | The creation of a credible delivery plan to address the key concerns highlighted through the LIA process. | CIO | IM&T/J. Spiers | August 2015 | Work is underway with a Target of the August CEO briefings | 4 |

**Key**

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| CEO | Chief Executive |
| CFO | Chief Financial Officer |
| MD | Medical Director |
| DoF | Director of Finance |
| DEF | Director of Estates and Facilities |
| DP&I | Director of Performance and Improvement |
| COO | Chief Operating Officer |
| DWOD | Director of Workforce and Organisational Development |
| DS | Director of Strategy |
| DMC | Director of Marketing and Communications |
| CIO | Chief Information Officer |



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| CN | Chief Nurse |
| AMD (CE) | Associate Medical Director (Clinical Education) |
| HOE | Head of Outcomes and Effectiveness |
| DSR | Director of Safety and Risk |
| AMD | Associate Medical Director |



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| Risk ID | CMG | Specialty | Risk Title | Opened | Review Date | Description of Risk | Risk subtype | Controls in place | Impact | Likelihood | Current Risk Score | Action summary | Target Risk Score | Risk Owner |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 2561 | Clinical Support and Imaging | | Non specialist Provision of Vascular Access Services on the LGH/GGH site in comparison to the services offered at the LRI | 17/06/2015 | 31/12/2015 | Causes<br>No specialist provision of vascular access on LGH/ GGH Service currently provided by clinicians non-specialised , unplanned and non patient focused (high specialist role - not likely to recruit staff with appropriate skill level).<br>Staffing levels reduced due to retirement.<br><br>Consequences<br>Delays in provision of vascular access services cause harm to patients; delay in receiving appropriate treatment , failure of procedures , risk of infection and poor patient outcomes resulting in increased length of stay. Lack of cover to GGH/ LGH could possibly create discharge difficulties /failure to provide the most appropriate care delaying discharge. | Patient Safety | Nationally recognised Vascular Access Service provision at the LRI, delivered at exceptionally high standards.<br>Vascular access is provided in a planned , patient centred fashion by a very experienced team of nurse specialists. Service already offer out patient and direct access provision to prevent admission . | Moderate | Almost certain | 15 | Recruit to substantial posts following approval of the business case - 31/12/15 | 4 | JHA |