Integrated risk management report

Author: Risk and Assurance Manager Sponsor: Medical Director Trust Board 2 June 2016 paper I

Executive Summary

Context

There have been a number of revisions to the risk management process in order to strengthen the arrangements and provide a more comprehensive process. These changes include the way that the Board Assurance Framework (BAF) is updated and reported and the process for reporting and managing organisational risks. The BAF is the key source of evidence that links strategic objectives to risks, controls and assurances, and the main tool that the Trust Board (TB) should use in seeking assurance that those internal control mechanisms are effective. The 2016/17 BAF has been developed with reference to the revised annual priorities. This report summarises the changes to the risk management processes highlighted above and provides the TB with the 2016/17 BAF for endorsement. In addition the report provides a summary of new organisational risks scoring 15 or above, opened during the reporting period.

Questions

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

Conclusion

1. Executive leads of each strategic objective have provided an accurate picture of our principal risks affecting the achievement of our objectives.
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. All actions are currently on track.
4. The TB are sighted to all new risks scoring 15 or above opened during April 2016.

Input Sought

We would welcome the board's input to:

(a) receive and note this report;
(b) review this version of the 2016/17 BAF noting:
- any gaps in assurances about the effectiveness of the controls to manage the principal risks and consider the nature of, and timescale for, any further assurances to be obtained;
- the actions identified to address any gaps in either controls or assurances (or both);

- any areas which it feels that the Trust's controls are inadequate;

(c) Agree an effective process for scrutinising BAF entries;
(d) Endorse the content of the 2016/17 BAF.

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]

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

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

If NO, why not? Eg. Current Risk Rating is LOW

b. Board Assurance Framework [Yes /]

If YES please give details of risk No., risk title and current / target risk ratings.

Principal Risk	Principal Risk Title	Current Rating	Target Rating
ALL			

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: [07/07/16]
6. Executive Summaries should not exceed **1 page**. [My paper does not comply]
7. Papers should not exceed **7 pages.** [My paper does not comply]

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST

REPORT TO: **UHL TRUST BOARD**

DATE: **2ND JUNE 2016**

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

SUBJECT: **INTEGRATED RISK REPORT (INCORPORATING UHL BOARD ASSURANCE FRAMEWORK AS OF 30TH APRIL 2016)**

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1 INTRODUCTION

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

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

2. BAF AS OF 30TH APRIL 2016

2.1 Executive risk owners have updated their BAF entries to reflect the annual priorities for 2016/17. Following this, a draft BAF was subject to a 'sense check' by the Chief Executive' and a number of further amendments were identified as being required. These have now been included in the final version that has previously been submitted to the UHL Executive Performance Board (EPB) and UHL Audit Committee (AC). A copy of the 2016/17 BAF is attached at appendix one with all changes highlighted in red text for ease of reference

2.2 A number of principal risks have been carried forward from the previous year however there have been significant updates associated with the whole document including 10 principal risks with changed titles and three new risks reflecting the changed emphasis of the annual priorities. The TB should note the 'extreme' risk in relation to increasing emergency attendances / admission and the remaining 12 high risks to the achievement of our strategic objectives.

2.3 A set of Key Lines of Enquiry (KLOE) have been developed to assist the TB and other trust committees when reviewing the BAF. As it will not be possible to review the full range of BAF entries at each TB meeting the TB is asked to agree the most effective way of scrutinising BAF entries.

3. UHL RISK REGISTER SUMMARY AS OF 30TH APRIL 2016

3.1 At the end of the reporting period, there are 52 operational risks open on the risk register scoring 15 and above with five new 'high' risks entered on the risk register during the reporting period. For ease of reference the new risks are summarised in the table below.

Risk ID	Risk Title	Rating	CMG
2816	There is an element of increased clinical risk by cohorting ED Patients in the new escalation area and the ED corridor	20	ESM
2819	Risk of lack of ITU and HDU capacity will have a detrimental effect on Vascular surgery at LRI	16	RRCV

2823	There is a risk of errors with patient medical review appointment and chemotherapy appointments due to gaps in admin workforce	16	CHUGS
2820	Risk of CDU patients developing a hospital acquired VTE if the VTE risk assessment form is not completed upon admission	16	RRCV
2791	Broadening Foundation - Loss of F1 doctors	16	RRCV

3.2 Thematic analysis of risks scoring 15 and above on the risk register shows that the majority of risks relate to workforce capacity and capability with potential for impact on quality of service and performance. Other themes, associated to strategic risks on the BAF, include estates services, emergency care provisions and IM&T services.

4 REVISED FRAMEWORK FOR MANAGING RISKS IN UHL

4.1 **BAF framework**: The proposal to disaggregate the BAF with principal risks to be reported to their relevant executive boards by the principal risk owner for endorsement prior to being reported to the Trust Board was approved. The updated framework for the BAF is attached at appendix two. Also attached at appendix three is a copy of the KLOEs to be used to support a consistent approach to managing the BAF.

4.2 **Risk Register framework**: There will be a greater emphasis on managing operational risks reported on the risk register at CMG level with only risks that need a decision to be taken reported to the Trust Board. The updated framework for the risk register is attached at appendix four, and includes greater scrutiny of CMGs risk registers at the weekly CMG Performance Management meetings. Attached at appendix five is a copy of the KLOEs to ensure accountability for management of operational risks at all levels.

5 RECOMMENDATIONS

5.1 The TB is invited to:-

(a) receive and note this report;

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

- any gaps in assurances about the effectiveness of the controls to manage the principal risks and consider the nature of, and timescale for, any further assurances to be obtained;
- the actions identified to address any gaps in either controls or assurances (or both);
- any areas which it feels that the Trust's controls are inadequate;

(c) Agree an effective process for scrutinising BAF entries;

(d) Endorse the content of the 2016/17 BAF.

UHL Corporate Risk Management Team
26th May 2016.

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

Board Assurance Framework:	Updated version as at:	Apr-16									
Principal risk 1:	Lack of progress in implementing 2016/17 UHL Quality Commitment								**Risk owner:**	CN / MD	
Strategic objective:	Safe, high quality, patient centred healthcare								**Objective owner:**	CN	
Annual Priorities	Reduce avoidable mortality and re-admissions through screening of deaths and the use of the re-admissions toolkit. Reduce harm through core 7 - day standards, new EWS and observation processes and safer use of insulin. Improve patient experience through involving them in their care, better end of life planning and improvements in outpatients. Prepare effectively for the 2016 CQC inspection.								**Risk Assurance Rating**	Exec Board RAG Rating = (Date: xx/xx/xx)	
Current risk rating (I x L):	**April**	**May**	**June**	**July**	**August**	**Sept**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**
	4x4=16										
Principal risk 1:	4x2=8										

Controls: (preventive, corrective, directive, detective)	**Assurance on effectiveness of controls**		**Gaps in Control / Assurance**
	Internal	**External**	
Clinical Effectiveness **Directive controls** Screen all hospital deaths Participate in case record review Sepsis 6 initiative **Detective controls** Hospital deaths screening tool Case record review Dr Foster's intelligence and HED data Sepsis screening tool No of SIs in relation to deteriorating patient/ sepsis **Patient Safety** **Directive controls** 7 Day service standards (including implementation of 14 hour consultant review, diagnostics, professional standards and daily consultant review)	**Clinical Effectiveness** SHMI scores reported to Mortality and Morbidity Committee and TB, QAC via Q&P report. Quarterly mortality report to ESB/QAC/TB 6 monthly TB report in relation to mortality parameters monthly review of mortality alerts reported to TB. UHL target SHMI <= 99 Current SHMI (Oct 14 - Sept 15) 96 Readmission rate to be < 8.5% **Sepsis** % of patients where screening is used (threshold 100% of in patients) % of patients receiving antibiotics within 1 hour (threshold **90% of antibioti**cs within 90mins of recognition)	Internal Audit mortality and morbidity review due Q3 2015/16. Internal audit review in relation to outpatient patient experience due Q4 2015/16.	(a) Currently not all deaths are screened and there is a requirement to move to 100%. (1.1, 1.2 and 1.3) (c) Currently a £5million funding gap to implement 7 day service standards. (1.4) (c) Workforce shortage may inhibit implementation of 7 day service standards (1.4) (a) No single measure to monitor performance of 7 day services (1.4) (a) no metrics in relation to insulin safety strategy (1.5)

Implement UHL EWS and e-obs Implement insulin safety strategy **Detective control** Quarterly patient safety report highlighting number of severe/ moderate harms % of deaths screened **Patient Experience** **Directive Control** End of life care plans What is guiding us in relation to keeping patients informed/ improving clinical correspondence times/ reducing in clinic	**Patient experience** 6% improvement on patient involvement scores 10% improvement on care plan use and outpatient experience scores. Achieve 14 day correspondence standard. **CQC:** TB TD x 4 ahead of June visit. CN / MD staff briefings and weekly newsletters. UHL CQC Programme Boards.		(c) No EWS score to trigger sepsis care pathway on Nerve Centre (1.6)

Action tracker:	Due date	Owner	Progress update:
Mortality database to be developed (1.1)	Jun 2016	MD	Database developed and currently in testing phase. Roll out anticipated June 2016.
Scoping of Medical Examiners as Mortality Screeners (1.2)	Jul 2016	MD	21 clinicians have expressed interest. Evening event planned for May and day long training session scheduled for May. Peter Furness appointed as UHL Lead Medical Examiner. Roll out at LRI anticipated July 2016.
Participate in National retrospective case record review (1.3)	TBA	MD	No date for completion has been set nationally yet
Work with Nerve Centre to implement EWS score to trigger sepsis care pathway (1.6)	Sep-16	MD	
7-Day services gap analysis (1.4)	TBA	MD	
Develop metrics for insulin safety strategy (1.5)	TBA	MD	

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

Controls: (preventive, corrective, directive, detective)	**Assurance on effectiveness of controls**		**Gaps in Control / Assurance**
	Internal	**External**	
Directive Controls The repatriation of estates and facilities services commenced on the announcement of the termination of the Interserve contract. The programme of change has been developed into three distinct phases: Phase 1 - The seamless transfer of all estates and facilities services from IFM back in-house by the agreed transfer date of the 1st May 2016 Phase 2 - Taking stock of the inherited levels of service quality, performance and resources and developing longer term plans to reform the Estates and Facilities service. Phase3 - Implementing the agreed plans to develop a high quality in-house Estates and Facilities service **Detective Controls** Baseline performance data measured at the end of the IFM Contract (30th April 2016) Monthly performance reports to measure performance improvements to Executive Performance Board (EPB). Annual Estates and Facilities Report to the Trust Board.	Estates and Facilities repatriation Programme Internal Audit/Assurance Programme performance:	External audit programmes including PLACE and CQC inspection	New estate and Facilities structure to be developed (interim structure in place until completion of Phase 2) and revised governance arrangements to be reviewed (2.1)

Action tracker:	**Due date**	**Owner**	**Progress update:**	**Status**
Phase 1 - Seamless transfer of all Estates and Facilities services on the agreed date (1st May 2016) (2.1)	Apr-16	DEF	All services transferred with no interruption of service	5
Phase 2 -Take stock of inherited services (including develop new structures) (2.1)	Oct-16	DEF	Commenced Phase 2 - May 2016	4

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

Controls: (preventive, corrective, directive, detective)	**Assurance on effectiveness of controls**		**Gaps in Control / Assurance**
	Internal	**External**	
Directive / Preventative Controls NHS '111' helpline GP referrals Local/ National communication campaigns Winter surge plan Triage by Lakeside Health (from 3/11/15) for all walk-in patients to ED. Urgent Care Centre (UCC) now managed by UHL from 31/10/15 Admissions avoidance directory Reworking of LLR urgent care RAP- as detailed in COO report **Detective Controls** Q&P report monitoring ED 4-hour waits, ambulance handover >30 mins and >60 mins, total attendances / admissions. Comparative ED performance summaries showing total attendances and admissions.	ED 4 hour wait performance (threshold 95%) 81.2% in April Poor performance continues to be primarily driven by record ED attendances and emergency admissions but has also been contributed to by staffing issues. Total attendances and admissions (compared to previous year) Attendance + 6.8% Admissions + 5.6% Ambulance handover (threshold 0 delays over 30 mins) 11% >30<60mins, >60mins 6% Difficulties continue in accessing beds from ED leading to congestion in the assessment area and delayed ambulance handover. Bed Occupancy. Monitored daily but not formally reported	National benchmarking of emergency care data Urgent Care Board fortnightly dashboard.	(c) Lack of effectiveness of admissions avoidance plan (3.1) (c)Lack of effectiveness of attendance avoidance plan Lack of winter surge capacity (3.1)

Action tracker:	**Due date**	**Owner**	**Progress update:**	**Status**
LLR plan to reduce admissions (including access to Primary Care) (3.1)	Review May - 16	COO	Admissions and attendance continue to increase.	1

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

Controls: (preventive, corrective, directive, detective)	**Assurance on effectiveness of controls**		**Gaps in Control / Assurance**
	Internal	**External**	
Detective Controls RTT incomplete waiting times, cancer access and diagnostic standards reported via Q&P report to TB **Corrective controls** Insourcing of external consultant staff to deliver additional sessions. Outsourcing of elective work to independent sector providers. Productivity improvements in-house. Additional premium expenditure work in house.	RTT Incomplete waiting times (threshold 92%). Currently 92.7%. Diagnostics: 0.7% (threshold 1%) Fail: Cancer Access Standards (reported quarterly). Current performance based on April data 2 ww for urgent GP referral (Threshold 93%). 90% forecasted 2 ww for symptomatic breast patients (threshold 93%). 96.2% 31 day wait for 1st treatment (threshold 96%). 89% 31 day wait for 2nd or subsequent treatments (Drugs - threshold 98%). 100% (Surgery - threshold 94%). 77.5% (Radiotherapy - threshold 94%). 96.4% 62 day wait for 1st treatment (threshold 85%).	Cancer recovery action plan managed across the Trust, NHS Improvement and the CCG. Monthly performance call with NTDA. Internal audit review in relation to waiting times for elective care due in quarter 4 2015/16; initiated end January 2016. Elective IST have assured the action plans in Diagnostics and the Cancer plan.	(c) Lack of progress on 62 day backlog reduction due to ITU/HDU capacity and gaps in clinical capacity in key specialties (4.1). (c) Inability to manage the pressure through the ENT service (4.2).

	70% 62 day wait for 1st treatment (CSS referral-threshold 90%). 77.3% Cancer wait 104 days (threshold TBC). 12			

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

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

Controls: (preventive, corrective, directive, detective)	**Assurance on effectiveness of controls**		**Gaps in Control / Assurance**
	Internal	**External**	
Directive Controls NHS England Five Year Forward View sets out the national strategic direction. UHL Business Decision Process. UHL/NUH Children's Services Collaborative Group. Partnership Board for Specialised Services established in Northamptonshire. Membership includes Northants CCGs; NHS England; KGH; NGH and UHL. Tripartite Working Group UHL/NUH/ULHT. ULHT/UHL Urology Steering Group. SEMOC Steering Group. Memorandum of Understanding (MoU) for key work programmes.	ULHT/UHL Urology Steering Group and SEMOC Steering Group work programmes and risk registers reporting to UHL Tertiary Partnership Board. UHL Tertiary Partnerships Board reporting to ESB Monthly.	Inclusion in acute services contract. Compliance with national service specifications and standards, External service reviews (e.g. peer reviews).	(C) Lack of prioritised service level strategies and engagement plans. (5.1) (A) Quantifiable reporting of return on investment e.g. income, activity, performance. (5.2)

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

Action tracker:	Due date	Owner	Progress update:	Status
(5.1) Apply criteria in Tertiary Partnership Strategy to prioritise service lines.	Jun-16	JC	To June SMT	4
(5.2) Present vascular reporting to Tertiary Partnership Board.	May-16	JC	To May Partnership Board.	4

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

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

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

Action tracker:	Due date	Owner	Progress update:	Status
(6.1) A BCT Programme Dashboard to be established and agreed with the BCT PMO. BCT Delivery Board to review wprkstream plans to ensure there is sufficient stretch.	tbc	MW	Ongoing - high level milestones identified for all BCT Clinical Workstreams with quarterly deliverables to promote transparency and to bolster accountability arrangements. This will be used to develop a dashboard - timescales being considered by the BCT PMO and Delivery Board - to be confirmed	4
(6.2) Identifying how BCT (and associated cost improvement plans) will address the deficit requirements across LLR.	Jun-16	PT		4
(6.3) Implement proposed changes (subject to public consultation) over a longer time frame while still delivering financial balance by 20/21 and the priority order in respect to capital plans for UHL, plus options for exploring alternative sources of capital.	Jun-16	PT		4

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

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

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

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

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

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

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

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

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

(9.1) Engagement of CMGs with process	Jun-16	MD DRI	DRI and MD leading on engagement programme. Meeting with Clinical Genetics and W&C CMG Management to discuss Clinical Genetics workforce plan.	4
(9.1) Appoint nurse to cover maternity leave in May	Jun-16	MD CRI	Out to advert	4
(9.1) Recruitment against trajectories	Jun-16	DRI	Rare Diseases: currently exceeding trajectory – catching up with ground lost previously Cancer: start recruitment - sample pathways through labs needs full engagement and buy in from pathology and theatres – this is underway	4
Finalise IT plans	Jun-16	DRI	Ensure UoL team deliver CiVi CRM to timelines	4

Board Assurance Framework:	Updated version as at:	Mar-16										
Principal risk 10:	Lack of system wide consistency and sustainability in the way we manage change and improvement impacting on the way we deliver the capacity and capability shifts required for new models of care								**Risk owner:**	DoWD		
Strategic objective:	A caring, professional and engaged workforce								**Objective owner:**	DoWD		
Annual priorities	Develop an integrated workforce strategy to deliver a flexible multi-skilled workforce that operates across traditional organisational boundaries and enhances internal sustainability . Deliver the Year 1 Implementation Plan for the UHL Way, ensuring an improved level of staff engagement and a consistent approach to change and development. Develop training for new and enhanced roles, i.e. Physician's Associates, Advanced Nurse Practitioners, Clinical Coders Deliver the recommendations of "Freedom to Speak Up" Review to further promote a more open and honest reporting culture								**Risk Assurance Rating**	Exec Board RAG Rating = (Date: xx/xx/xx)		
Current risk rating (I x L):	**April**	**May**	**June**	**July**	**August**	**Sept**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**March**
	4x4=16											
Target risk rating (I x L):	4x2=8											

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

Detective Controls Schedule of activities for each component of 'The UHL Way'	4. Academy UHL Pulse Check National Staff Survey data		

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

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

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

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

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

Controls: (preventive, corrective, directive, detective)	Assurance on effectiveness of controls		Gaps in Control / Assurance
	Internal	**External**	
Directive Controls UHL reconfiguration programme governance structure aligned to BCT Reconfiguration investment programme demands linked to current infrastructure. Estates work stream to support reconfiguration established Five year capital plan and individual capital business cases identified to support reconfiguration Property / Space Management - clinical and non clinical schedules in place **Detective Controls** Survey to identify high risk elements of engineering and building infrastructure.	Major Capital - On track against revised schedule Annual programme - On track against revised schedule		(c) A programme of infrastructure improvements is currently being identified (12.1) (c) Overall programme of works not yet identified and quantified in relation to risk (12.2)

Monthly report to Capital Investment Monitoring committee to track progress against capital backlog and capital projects Regular reports to Executive Performance Board (EPB). Highlight reports developed monthly and reported to the UHL Reconfiguration Programme Board.			

Action tracker:	Due date	Owner	Progress update:	Status
Assessment of current capacity being established through a set of comprehensive technical/engineering site surveys for GGH and LRI (12.1)	May-16	DEF	Surveys are nearing completion with report due by end of May 2016	4
Identification of investment required and allocation of capital funding to develop a programme of works (12.2)	Jun-16	DEF	Prioritisation of backlog capital once 2016/17 annual capital resouces confirmed by IFPIC. Phasing options to be included with further programme to be developed once capital availability is confirmed.	4

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

Controls: (preventive, corrective, directive, detective)	**Assurance on effectiveness of controls**		**Gaps in Control / Assurance**
	Internal	**External**	
Directive Controls/Preventive Controls Five year capital plan and individual capital business cases identified to support reconfiguration Business case development is overseen by the strategy directorate and business case project boards manage and monitor individual schemes. Capital plan and overarching programme for reconfiguration is regularly reviewed by the executive team. **Detective Controls** Capital Investment Monitoring Committee to monitor the programme of capital expenditure and early warning to issues. Monthly reports to ESB and IFPIC on progress of reconfiguration capital programme. Highlight reports produced for each project board. **Corrective Control** Revised programme timescale approved by IFPIC	Capital expenditure and progress against reconfiguration programme monitored via Capital Investment committee ESB/ IFPIC/ TB. On track against revised schedule. Resource expenditure for development of business cases - on track/ monitored on a monthly basis Affordability of business cases (i.e. schemes within allocated budget envelope) - on track against revised programme. Individual projects capital expenditure monitored via highlight report which are reviewed by the Major Business Case meeting and Reconfiguration Board.	UHL's Annual Operating Plan, as submitted to NHS Improvement, includes capital requirements for 2016/17 strategic programme (awaiting feedback). Monthly meetings with NHSI ensures Trust's capital priorities are clearly identified and known. Formal communication with Regional Director at NHSE and NHSI regarding the strategic capital requirements linked to BCT. LLR BCT (and now STP) include the external capital values as part of the system wide case for change.	c) Limited capital funding within 2016/17 programme and future years (13.1 and 13.2)

Action tracker:	Due date	Owner	Progress update:	Status
Consideration to be given to alternative sources of funding. (13.1)	Jun-16	CFO	Exploratory discussions with expert PF2 advisors (Deloitte) regarding which capital schemes could potentially be suitable.	3
Maintain dialogue with NHSI and NHSE regarding the pressing need for external capital to facilitate strategic change (13.2)	Jun-16	CEO/CFO	Alongside recent correspondence and discussion regarding BCT and its capital requirements, the LLR STP represents a further opportunity to formalise and emphasise the requirement.	3

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

Controls: (preventive, corrective, directive, detective)	Assurance on effectiveness of controls		Gaps in Control / Assurance
	Internal	**External**	
Directive Controls UHL reconfiguration programme governance structure aligned to BCT Strategic capital business case work streams aligned to BCT Monthly meetings with the NTDA to identify new business cases coming up for approval Detailed programme plan identifying key milestones for delivery of the capital plan. Project plans and resources identified against each project. A future operating model at speciality level which supports a two acute site footprint: Out of hospital contract approved and project established to shift appropriate activity into	Progress of all reconfiguration programme work streams is monitored via aggregated reporting to ESB/ IFPIC/ TB. Monthly updates via aggregated reporting (highlight reports) to ESB/ IFPIC/ TB. Overall reconfiguration programme is RAG rated. Currently reported as 'amber 'due to complexity of programme and risks associated with delivery.	Regular meetings with NTDA NHS England BCT Programme Board Gateway / Assurance review carried out Feb - 16	c) changes to capacity and demand management / left shift assumptions will determine future size and configuration of services. If this differs from current plan it may have significant cost/planning implications (14.1) (a) Further work required to look at the remaining services at the LGH to determine the gap in the current capital plan (14.2) (Roadmap exercise) (c) Delay in BCT public consultation (14.2)

established to shift appropriate activity into the community. **Detective Controls** Gateway / Assurance review A monthly highlight report to indicate RAG rating of reconfiguration programme submitted to the UHL Reconfiguration Programme Delivery Board. Monthly aggregate reporting to ESB, IFPIC and Trust Board. Monthly meetings with the NTDA to discuss the programme of delivery Monitoring of progress towards UHL two acute site model Monitoring of business case timescales for delivery. Requirements identified to deliver key projects overseen by PMO			consultation (14.3) (c) ITU interim configuration has been delayed due to capital availability, this will not be confirmed until Q1 2016/17. In addition to capital there are risks to Trust capacity that may delay move further. Interim measures have been put in place to manage risks in short-term, these arrangements need to be reviewed if any further delays (14.4)

Action tracker:	Due date	Owner	Progress update:	Status
Demand and capacity issue being fully modelled and then considered by BCT Delivery Board. Conclusions need to feed into NHSE led assurance process in advance of public consultation and reconfiguration (14.1, 14.2)	Jun-16	CEO	Modelling and options appraisal work underway	3
Actions and solutions to the capital availability problem are being tracked through principle risk 13 (14.4)				

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

Controls: (preventive, corrective, directive, detective)	**Assurance on effectiveness of controls**		**Gaps in Control / Assurance**
	Internal	**External**	
Directive Controls Governance arrangements established Overarching project plan for service reviews developed New structure / methodology agreed for capturing outputs in a consistent way, aligned to the IHI Triple Aim. New virtual team structure to support the intensive service reviews. New Project Steering Group to be set up using the 'virtual team' membership **Detective Controls** Monthly reporting to IFPIC and EPB as part of CIP report. SLM / Service Review Data Packs now to include a range of metrics, beyond finance Monthly updates required from services against pre-determined work programme. Measureable outcomes now embedded into the process via improved methodology - Where relevant, schemes with a financial benefit are added to the CIP Tracker	Regular update reports to ESB, EPB and IFPIC. Service Review Roll Out / Project Plan milestones monitored via the above governance structure - Currently slightly behind plan due to operational pressures impacting on clinical engagement.	Internal Audit (PWC) October 2015 - Service Line Reporting	(c) BI capacity is (at times) limited which impacts on Data Pack production (15.1) (c) Clinical engagement can be variable (as is clinical capacity to get involved) (15.2) (c) Improvement tools / change management techniques are under development (15.3)

Action tracker:	Due date	Owner	Progress update:	Status
Revised Data Pack being scoped for discussion with BI leads. (15.1)	Jun-16	CFO	The plan involves: 1) the development of a Stratification Dashboard to summarise how specialities are performing across a range of indicators. This is work in progress, due end of April 2) the allocation of specialties to standard, enhanced and intensive service reviews depending on what level of support is required to be complete once the matrix is	3
Improvement tools (for use by clinical services) to be finalised (15.2, 15.3)	Jun-16	CFO	Approach agreed. An Intensive Service Review will be piloted in 3 services have been identified and need to be agreed with operational teams , commencing in March 2016. Due date extended to reflect this. The roll out of the new approach	3

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

Controls: (preventive, corrective, directive, detective)	**Assurance on effectiveness of controls**		**Gaps in Control / Assurance**
	Internal	**External**	
Directive Controls Agreed Financial Plan for 2016/17 (AOP) Standing Financial Instructions UHL Service and Financial strategy as per SOC and LTFM. **Preventative Controls** Sign-off and agreement of contracts with CCGs and NHS England CIP delivery plan for 2016/17 **Detective Controls** Monthly finance reporting in relation to income and expenditure and CIP **Corrective Controls** Identification and mitigation of excess cost pressures Planned reduction in agency spend	Contracts signed with both main commissioners. Robust internal process to set the financial plan for 2016/17 as agreed by IFPIC and TB. Adverse variance to plan of £191k at M1 with a year end forecast in-line with the revised I&E plan of a deficit of £31.7m. CIP within the month by xxx has reduced the year to date under-performance to xxxx. The detailed position will be reviewed by the Executive Performance Board monthly Integrated Finance, Performance & Investment Committee and Trust Board monthly Run rates to achieve £31.7m in each area (pay, non-pay, CIP and income) updated for month 1 and reported to Committees/Trust Board.	Regular review of financial plan by NHS Improvement.	At the start of the 2016/17 year, there is unidentified/ invalidated CIP. (16.1)

Reasonable assurance rating that risk is being managed:	Due date	Owner	Progress update:	Status
CIP gap needs to be resolved. (16.1)	Jun-16	COO	Actions being taken to correct the start of year gap. Monthly report to IFPIC contains the detail	3
Outstanding cost pressure list (i.e. any remaining items from budget/contract setting exercise) requires final decisions to be made by CEO and Executive Team.	May-16	CFO	Exercise will be complete for May EPB/IFPIC meetings.	3

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

Controls: (preventive, corrective, directive, detective)	**Assurance on effectiveness of controls**		**Gaps in Control / Assurance**
	Internal	**External**	
Directive Controls Overall strategic direction of travel defined through Better Care Together. Financial Strategy fully modelled and understood by all parties locally and nationally. UHL's working capital strategy in place. 2016/17 financial plan in place and monitored appropriately **Detective Controls** Monthly monitoring of performance against financial plan. IFPIC and TB receive half yearly updates in relation to financial strategy and LTFM **Corrective controls** Explore options for other (non-NHS) sources of capital funding	Monthly reporting against 2016/17 plan. - As at M1 the Trust is £xxx adverse to plan. Half yearly review of LTFM to ensure fitness for purpose i.e. checking consistency with UHL's strategy and ensuring we have a deliverable recovery plan over the medium term. Strong links to overall BCT 5 year strategy and the financial consequences (revenue and capital) of the transformational business cases	NHS England and NTDA review of: BCT SOC BCT PCBC Financial strategy LTFM System-wide five-year 'place-based' sustainability and transformation plan (STP) Individual business cases above a certain level	(c)LTFM not yet formally approved (17.1) (c)SOC not yet formally approved (17.2) (c)STP still in production (17.3) (c) Currently seeking authority to proceed with public consultation

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

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

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

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

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

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

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

Action tracker:	**Due date**	**Owner**	**Progress update:**	**Status**
UHL COO to chair the Prioritisation Group on a quarterly basis (19.1)	Jun-16	CIO		4

Reasonable assurance rating:

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

Risk rating criteria:

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

Action tracker status:

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

BAF Risk Rating Matrix:

BAF flowchart to TB TD - 17/03/2016

Information & Communication – A flow of challenge operates throughout the organisation

TRUST BOARD

Monthly: BAF dashboard to be included in CEO TB paper. Full BAF to be included in a separate risk management item on TB agenda.

Purpose: To own the BAF and to assure itself that the BAF includes all principal risks to the achievement of its strategic objectives and that effective controls are in place and appropriate assurance sources are available.

3rd Line of Defence: Independent Assurance

AUDIT COMMITTEE

Every Meeting: BAF dashboard and full BAF report

Purpose: To assure itself that principal risks to the achievement of the strategic objectives are being adequately managed. To achieve this AC will scrutinise the assurance rating applied by the executive risk owner and provide a confirm or challenge against the assurance rating

2nd Line of Defence: Oversight

EXECUTIVE BOARDS

Monthly: To receive updated BAF entries directly from the relevant Executive risk owners and to hold them to account for the management of their entries using a set of key lines of enquiry provided by the corporate risk management team. Executive risk owners to return endorsed BAF amendments (and comments) to corporate risk management team within 24 hours of the Exec Board in order for the final version to be produced for the Trust Board.

Purpose: To increase exec ownership of the BAF and ensure a fully populated BAF is in place and endorsed by the appropriate executive board for escalation to the Trust Board.

1st Line of Defence: Implementation

EXECUTIVE PRINCIPAL RISK OWNERS

Monthly: To review and update their principal risks on the BAF up to the end of the previous month guided by a set of questions from the corporate risk management team. To complete the BAF Board paper template and forward to Trust Admin ahead of the relevant Exec Board.

Purpose: To ensure a fully populated BAF is in place for scrutiny by the relevant executive board prior to being reported to the Trust Board.

CORPORATE RISK MANAGEMENT TEAM

To design a risk management framework to identify, assess and control principal risks to the achievement of our strategic objectives and to support the delivery of the risk management policy.

BAF KEY LINES OF ENQUIRY

1ST LINE OF DEFENCE - KEY QUESTIONS FOR BAF EXECUTIVE DIRECTORS (PRINCIPAL RISK OWNERS)

1. Are you confident that the KPIs currently listed measure the effectiveness (performance) of the controls?
2. Has a deteriorating trend in the KPIs been noted and, if so, have you considered whether this is due to ineffective controls (i.e. indicating a gap in control)?
3. If the trend is deteriorating does this place us at greater risk of not achieving the appropriate strategic objective and if so have you adjusted the risk score accordingly (with reference to the BAF impact and likelihood scoring tables)?
4. If gaps in control or assurance have been identified what actions must be taken to resolve the gap.
5. Are all of your current actions 'on track' and, if not, what are the causes of the delays and the steps being taken to resolve any issues?
6. Are there any significant changes to your BAF entry that you need to make the Executive Team aware of?

2ND LINE OF DEFENCE - KEY QUESTIONS FOR EXECUTIVE BOARDS RECEIVING & SCRUTINISING THE BAF

1. Explain why risk score has moved/ not moved during the month? Does this take into account deterioration / improvement in KPIs?
2. Provide an explanation if no actions are described to close gaps?
3. Why have actions not been completed within the timescale described?
4. Are there any areas of concern that require escalation to the TB?
5. Is the Executive Board sufficiently assured that the content of the BAF provides an accurate picture of the current situation and can therefore endorse the content prior to submission to the TB?

3RD LINE OF DEFENCE – AUDIT COMMITTEE (INDEPENDENT ASSURANCE)

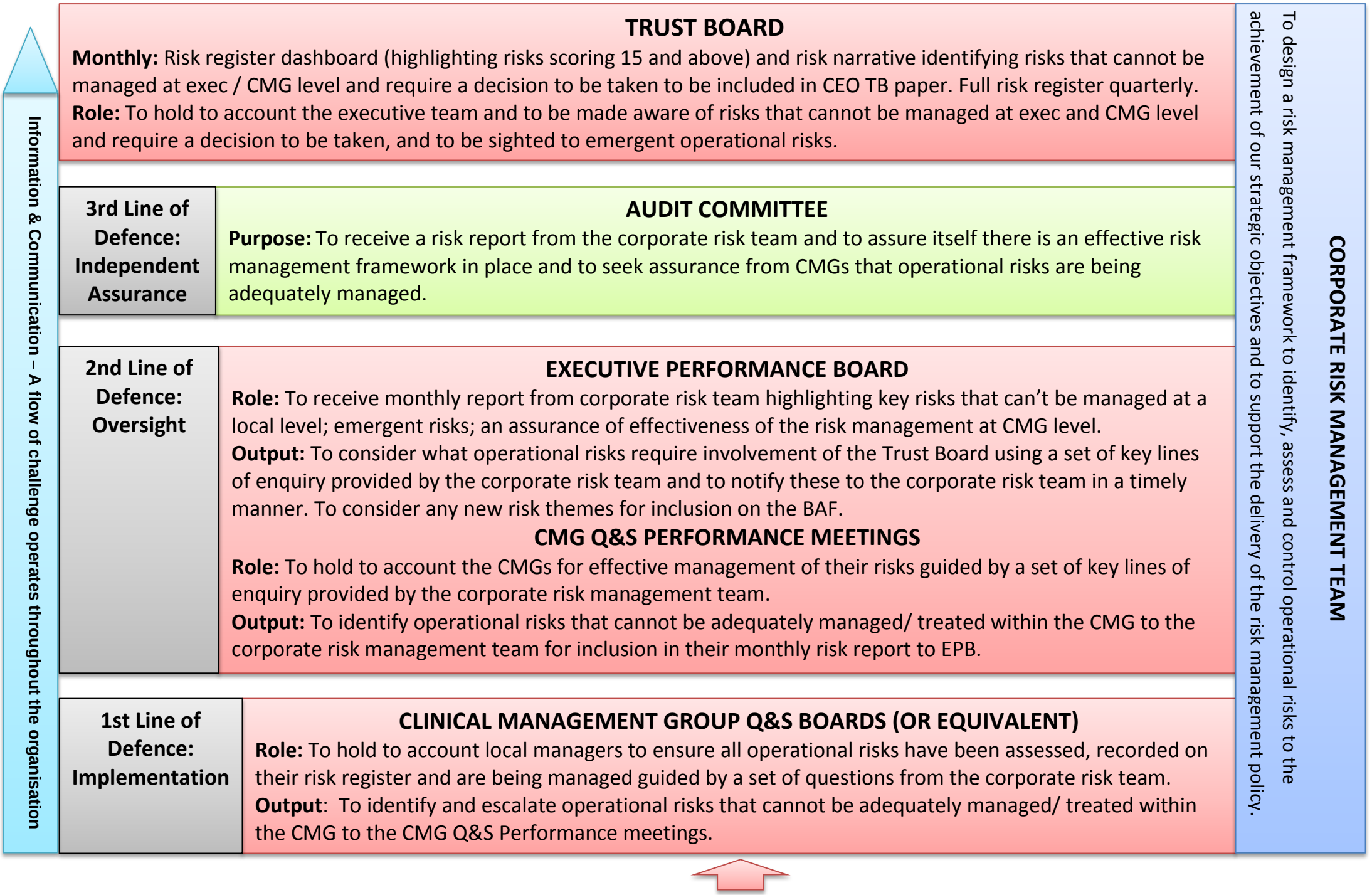
1. Is there evidence of appropriate intelligence sources being used to proactively identify new/emerging principal risks?
2. Are the timelines for risk reduction realistic and is there evidence of risk reduction over time?
3. Is there confidence that principal risks are being managed at all levels effectively to achieve strategic objectives?
4. Is there evidence that accountability for risk management is being effectively discharged?
5. Is the AC sufficiently assured that the principal risk to the achievement of the strategic objective / annual priorities has effective controls in place and appropriate assurances are available? AC to provide a confirm and challenge against the assurance rating provided by the principal risk owner.

TRUST BOARD

For each principal risk escalated by the Exec Board to the TB:

1. What are the specific areas of concern that the Exec Board requires support from the TB? (This information should be included in the risk management paper, providing the Exec owner has fed back the outcome from discussions at the exec board to the corporate risk team – see 2nd line of defence, above).
2. Is the Trust Board sufficiently assured that the content of the BAF provides an accurate picture of the current situation?
3. Is there confidence that principal risks are being managed at all levels effectively to achieve strategic objectives (and annual priorities)?

Risk Register flowchart to TB TD - 17/03/2016



ORGANISATIONAL RISK REGISTER KEY LINES OF ENQUIRY

1ST LINE OF DEFENCE

CMG QUALITY AND SAFETY BOARDS

1. Is the risk assessment form completed accurately? – check the risk titles clearly articulates the risks? Are appropriate causes/ consequences adequately described? Are controls listed current and effective? Do the current risk ratings accurately reflect the severity of the risks? Do the actions to treat the risks appropriately address the causes and/or consequences previously listed and are they achievable within timescales and affordable within CMG/ department budgets?
2. Is the CMG Q&S board sufficiently assurance that actions to manage existing risks are progressing within the agreed timeframe and is this reflected in the current risk ratings (i.e. if actions have been taken can the score be decreased)?
3. Are there any areas of concern in relation to the management of these risks which may impact on the trust and needs to be brought to the attention of the UHL Executive Team and Trust Board?
4. Taking into consideration external factors that may impact on your CMG are you assured that all operational risks are captured on your CMG risk register? If not, what emergent risks should be considered for full assessment?
5. Are there any risks that require notification to other trust committees/ groups for specialist guidance / management? (e.g. Medical Equipment Executive, Medicines Optimisation Committee, Health and Safety Committee, etc)

2ND LINE OF DEFENCE

CMG QUALITY AND SAFETY PERFORMANCE MEETINGS

1 Do your risk register entries accurately reflect all significant risks impacting on your CMG (i.e. consider deteriorating quality and performance indicators, external inspectorate recommendations, etc)?
2 What sources of intelligence does the CMG use to identify new 'emerging' risks?
3 Is there evidence of risk reduction over time and if not, why not?
4 Are there any risks that you feel cannot be adequately managed/ treated within the CMG (e.g. lack of funding, etc) and therefore require escalation to the UHL Executive team and possibly to the Trust Board (if so, what and why)?

EXECUTIVE PERFORMANCE BOARD

1. Other than those risks identified by the CMG Quality and Safety Performance meetings for escalation, are there any other risks that, in the opinion of the executive team, require escalation to the TB?
2. Are there any new risk register themes identified that require entry onto the BAF?
3. Is the Executive Team aware of any further 'emerging' risks not yet captured at CMG level and if so who will be the risk owner for these?
4. Is there evidence of adverse events impacting on the trust that have not previously been identified as a risk?

3rd LINE OF DEFENCE – AUDIT COMMITTEE (INDEPENDENT ASSURANCE)

1 Is there evidence of appropriate intelligence sources being used to proactively identify new/emerging risks?

2. Is there confidence that risks are being managed at all levels effectively to achieve organisational objectives and annual priorities?

3. Are significant risks that cannot be managed effectively at a local level being brought to the attention of the Trust Board with appropriate recommendations for action (tolerate, transfer, terminate, and treat)?

4. Are we being 'taken by surprise'?

TRUST BOARD

For each risk register entry escalated by the Exec Board / Performance review (CMG Board) to the TB:

1. What are the specific areas of concern that the Exec Board/ CMG requires support from the TB and are there appropriate recommendations included for action? (This information should be included in the risk management paper, providing the CMG has fed back the outcome from discussions at the exec board / performance review to the corporate risk team).
2. Is there evidence that accountability (at an executive level) for (operational) risk management is being effectively discharged?