UNIVERSITY HOSPITALS BIRMINGHAM NHS FOUNDATION TRUST

BOARD OF DIRECTORS

THURSDAY 25 JANUARY 2018

Title:	**QUARTER 3 BOARD ASSURANCE FRAMEWORK**
Responsible Director:	David Burbridge, Director of Corporate Affairs
Contact:	Berit Reglar, Deputy Foundation Secretary

Purpose:	To provide the Board with the high level risks within the context of the Board Assurance Framework (BAF).
Confidentiality Level & Reason:	None
Medium Term Plan Ref:	Annual Plan
Key Issues Summary:	The BAF has been reviewed by the Executive team in conjunction with their Executive Risk Registers and any relevant divisional/corporate risk registers. Any historical data have been archived if superseded/no longer pertinent. Track changes have been used in the Appendix to assist the Board in the identification of any changes to the BAF. Key updates include: • Finance: o The Trust is on track to deliver agreed surplus dependant on a range of factors. • Operational Performance: o Norman Power step down facility is now open. Red - Green has been rolled out across all areas. KPI remains in place for discharges before 1pm. o The Newton Seamless surgery programme continues; the aim of the programme is to improve productivity within theatres. • Timely/effective transfer of care to other provides: o The findings of the Newton diagnostic were presented to the STP Board in January 2018. A new model for care in crisis will be presented to the STP Board in February 2018 for approval with an allocated rescue plant work programme identified. • Strategic Workforce: o A meeting was held with HEFT to look at the formulation of a combined workforce plan and identification of key workforce risks and current mitigation plans. A further meeting will be held to review work around workforce data and mitigation plans. • Adherence to regulatory requirements and national guidance: o By the end of Q3 2017/18 the clinical compliance

	framework has been implemented for all agreed specialities. An escalation process for non-compliance was agreed at the DCA Governance Group in November 2017. o Work continues to see how the Trust can collect data in the format required for the CQC's annual provider information request. • Failure to reduce the transmission of infection: o During Q3 5 outbreaks of C. difficile infection were reported. There has been a slight reduction in the use of piperacillin/tazobactam. • UK exit from EU may have an adverse impact on the Trust: o The Government has issued a technical note on citizen's rights which seeks to clarify aspects of its proposal for EU citizens' rights post Brexit. Affected staff holding Permanent Residence status will be able to exchange their status to Settled Status. For those not holding Permanent Resident status, the proposal is for application for Settles Status to be mandatory. Affected staff who are not yet able to evidence the five years' continuous residence necessary to obtain settled status, but who can evidence that they were resident before the specified date, will be given temporary status. This will enable them to remain in the UK until they have built up five years' continuous residence, allowing them to apply for settled status. • Risk to the Trust of the transaction involving HEFT not obtaining regulatory approval: o A meeting will be help between Department of Health, NHSI, NHSE to discuss transaction red lines on 23.01.2018.
Recommendations:	The Board is asked to: 1. Review the revised BAF and identify any gaps in controls or assurance; and 2. Consider the newly added risks and confirm appropriate risk owners.
Signed: David Burbridge	**Date:** January 2018

Appendix 1 Quarter 4 Board Assurance Framework Report

Key:

CORE PURPOSE 1: CLINICAL QUALITY Strategic Aim: To deliver and be recognised for the highest levels of quality evidenced by technology, information, and benchmarking	**1**
CORE PURPOSE 2: PATIENT EXPERIENCE Strategic Aim: To ensure shared decision making and enhanced engagement	**2**
CORE PURPOSE 3: WORKFORCE Strategic Aim: To create a fit for purpose workforce for today and tomorrow	**3**

Core Purpose/ Other association	Risk Description	Current Context	Owner	Current Risk	Residual Risk	Existing Controls	Assurances Internal/External	Progress/Action Required	Timescale
	Provides details of what the risk is	*What is causing the resulting risk*	*Owner of the risk overall*	*Current Risk rating*	*Expected risk once all the controls and actions have been*	*What is currently in place to mitigate the risk*	*Examples of evidence that the existing controls and new actions have been implemented*	*Additional actions that need to be implemented to reduce the risk and update on existing and new actions*	*Timescales to complete relevant actions*
1	Significant deterioration in the Trust's underlying financial position resulting in a deficit being reported in excess of planned levels Any material financial deterioration against the Trust's financial plan is likely to result in a reduced 'Use of Resources' score which forms part of the NHS regulators measurement of providers known as the 'Single Oversight Framework.'	The year on year impact of national tariff efficiency requirements, combined with changes to contract rules (marginal rates, fines, penalties) has increased the financial pressure on all NHS providers. The Trust's actual 2016/17 financial surplus was above plan, even after removing ad-hoc year end additional STF income. The Trust's 2017/18 financial plan has been approved by the Board and submitted to the NHSI. This plans for a £18.0m surplus which includes capital grants, donations and £16.9m of Sustainability & Transformation Funding (STF) income. The Trust's financial plans include delivery of £18.2m of CIP savings in 1718.	CFO	High (15)	Significant (12)	Trust Annual Financial Plan, NHS Improvement Annual Plan Return. monthly reporting to NHS Improvement and Board including CIP delivery expenditure and income. Scheme of Delegation. Internal policies and procedures. SFIs / Standing Orders. Trust financial system (SAGE) reflects the approved SFIs and Scheme of Delegation, therefore setting appropriate limits for procurement.	**Internal:** monthly financial reports to BoD, CEAG, CCQ meetings. Financial Improvement Group meetings with operational divisions. Internal Auditors' Progress Report updates to Audit Committee Scheme of Delegation **(review date 09/2017)** **External:** Monthly detailed financial performance reports to NHS Improvement. External Audit of Annual Accounts. Annual Operational Plan documents submitted to NHS Improvement. External Audit reviews and Counter Fraud Service Assessment. External assessment of effectiveness of Counter Fraud Service assessed as adequate.	The 2017/18 financial plan was submitted to the November 2016 Board of Directors. Final revisions and details were completed between December and March and reviewed by the CFO. The 2017/18 Operational Plan was submitted to NHS Improvement in December 2017, this was in line with the overall control total set by NHSI. Quarterly review by NHS Improvement of Trust performance to approve the release of STF income. Q2 201718: As at month 6 (April-Sept), the Trust remains on track to deliver the agreed surplus. However, this is dependant on a range of factors including delivery of planned activity, receipt of the full value of expected CQUIN and STF income, improvements in division adverse run rates (over spends), and delivery of CIPs. The Trust may be required to appeal to secure the STF funding linked to the delivery of the 4 hours A&E waiting time target. Should this appeal not be successful, the Trust's annual surplus will reduce but there will be no impact on the position reported to NHSI as they are now monitoring Trusts excluding STF income. The Internal Auditors' Progress Report updates to the Audit Committee on the Scheme of Delegation will not be presented until after the transaction outcome with HEFT. Q3 201718: As at month 9 (Apr - Dec), the Trust remains on track to deliver the agreed surplus.	Completed Completed Ongoing Ongoing Q3 ~~4~~ 1718
1	Risk of failure to deliver operational performance targets including Sustainability and Transformation Fund trajectory due to capacity issues.	The shortage of capacity is related to the volume of routine secondary care work, out of area referrals, delayed TOC, activity drift from other providers, inappropriate ED attendances due to perceived/actual lack of community provision, inability to repatriate patients to referring DGH. Winter pressures are also impacting on 4 hour waits, elective cancellations and knock on impact to RTT backlog with increased risk to 92% standard. The targets which are currently not being met are: - 62 day GP target - cancer waiting times ~~(as of August 66.8%) ;~~ - %patients waiting 4 hours or less in A&E ~~Quarter 2 performance is 85.4%.~~ - Last minute cancellations and the 28 day cancelled operations guarantee ~~(there have been 11 up until August);~~ ; and - 18 week RTT (3 specialities) below the 92% standard)	COO	Significant (12)	Significant (10)	Cancer Waiting List Assurance Group meets weekly and reviews the data to assess capacity and waiting time targets at the weekly Cancer Waiting Times Assurance Meeting which reports to the Cancer Steering Group and COOG Unscheduled Care Project has been reviewed and strengthened. Q2 17/18 Key priorities agreed as: 1] Improve flow; 2] Improve capacity in ED; 3] Improve behaviours and communication in ED; all overseen by the unscheduled care project. A joint remedial action plan between the Trust and the CCG to address the issues of increased attendances, pathways for mental health patients and flow continues to be implemented. 18 week RTT assurance group meets to assess whether targets are being achieved as well as reviewing and updating action plan to mitigate any issues ODG oversees improvement projects to improve productivity and efficiency to improve capacity availability.	**Internal:** Performance against national targets and waiting list size - performance reports to COOG, CEAG and BoD **(Jan 16, April 16, July 16, Oct 16, Jan 2017 April 2017, June 2017, Sept 17, Dec 2017)** Concept paper inpatient capacity strategy and business case development for an extended assessment unit presented at May CEAG 2017	Divisions working to implement the revised capacity requirements. The plans are reviewed ongoing and cross divisional actions are monitored at the fortnightly operational delivery group (ODG). Actions within the Integrated Performance Report to continue to be implemented to enable the Trust to meet the trajectory agreed with the commissioners: - % patients waiting 4 hours or less in A&E. - Cancer Waiting Times - 62 day GP target - a commissioner remedial action plan is in place. Improved Trust internal performance - remaining risk relates to Tertiary pathway. - Last minute Cancellations and the 28 day cancelled operations guarantee - 18 week RTT - Unfinished pathway performance was achieved at aggregate level in August but three areas perform below the 92% standard - recovery plans in are in place for these areas.	Ongoing
						Development of an operational plan to increase bed capacity through a combination of efficiency savings and increased funding to resolve capacity and demand mismatch between available medical and physical medical beds. Red - Green has been rolled out across all areas. KPI remains in place for discharges before 1pm. Norman Power step down facility is now open. ~~Red - Green is being rolled out and expected to be live in all areas by Christmas 2017. KPI in place for discharges before 1pm. Use of a step down facility at Norman Power is being implemented~~.	**Internal:** BoD ED paper **Oct 2016** and CEAG winter pressure report **Oct 2016** Concept paper inpatient capacity strategy and business case development for an extended assessment unit presented at May CEAG 2017	Concept paper inpatient capacity strategy and business case development for an extended assessment unit was presented to CEAG in May 2017. It included details of strategies for improving capacity through new staffing models and delivery of bed strategy.	Update on progress in Q3
						Strategic modelling to enable theatre capacity to meet anticipated demand. The Newton Seamless surgery programme continues; the aim of the programme is to improve productivity within theatres ~~has commenced and the aim of the programme is to improve productivity within theatres.~~	**Internal:** Performance against national targets and waiting list size - performance reports to COOG, CEAG and BoD **(Jan 16, April 16, July 16, Sep 16, Dec 2016, April 2017, June 2017, Sept 17)**	Continue to monitor achievement of target at weekly assurance meetings and provide monthly update at COOG. Continue to implement the seamless surgery project.	Ongoing
						Review demand from out of area referrals and put in place appropriate action(s).	**Internal:** CCQ papers and minutes **(Sept 15, Nov 15, Feb 16, May 16, June 16).** **External:** Agreement with CCCCG and SCCCG. Communications.	The NHS contract now requires all GP routine speciality referrals to be accepted. The Trust have for the specialities experiencing significant demand introduced a process that involves writing to the patient highlighting the subsequent pressure on waiting times and highlighting their right under the NHS to request via their CCG an alternative provider. Referral volumes from CCGs are monitored on a monthly basis via the Contracts team and any material movements are raised with respective CCGs. In addition, the Trust gave notice to Providers and Commissioners that it will no longer be accepting referrals from out of Birmingham into particular specialist areas. These include breast reconstruction and bone marrow transplants.	Ongoing
						Activity Reviews. Short, Medium and Long Term Plans.	**Internal:** Monitoring figures for capacity via bed meetings and dashboards. Short, medium and long term plans. COOG ODG fortnightly meetings	Divisional monitoring on a daily basis at the bed meeting. Quarterly reviews of activity and growth. Short, medium and long term plans presented to the Executive teams by Divisions. This continues to be monitored daily and is reviewed at fortnightly operational delivery group (ODG) The following four sub-groups have been set up (all report to COOG) to look at improvements in patient flow: - Scheduled Care - Unscheduled Care - Outpatients - Cancer	Ongoing

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Core Purpose/ Other association	Risk Description	Current Context	Owner	Current Risk	Residual Risk	Existing Controls	Assurances Internal/External	Progress/Action Required	Timescale
1	External factors impacting on the Trust's capacity and timely/effective transfer of care from UHB to other providers.	Social care/other provider delay. Drift from other providers, inappropriate ED attendances due to perceived/actual lack of community provision, inability to repatriate patients to referring DGH. Changing needs of patient population, commissioning intentions, strategic plans of other providers, inadequately funded quality initiatives from NHSE etc.	DOP	Significant (12)	Significant (10)	Alternative sources to prevent delays to discharge and systems in place to ensure this capacity is effectively managed.	Birmingham wide daily capacity reports. Minutes of (Birmingham & Solihull) BSOL A&E Delivery Board, and the STP Community Care First work stream. New capacity specifications.	The reduction in enhanced assessment/reablement beds by c25% since Q4 15/16 has had led to a significant increase in DTOCs. This followed the reductions in DTOCs delivered through the introduction of more streamlined internal discharge processes within UHB during 15/16. DTOC pressures are being compounded by Birmingham City Council financial pressures that are leading to reductions in social work capacity and community support. The recent announcement of additional social care funding in the budget will lead to a further £27m being made available for Birmingham. This will be given as a grant through the existing Better Care Fund and its use will need to be jointly agreed to: 1. meet adult social care needs, 2. reduce pressures on the NHS - including supporting more people to be discharged from hospital when they are ready - and 3. stabilising the social care provider market. This process completed during May 17. ~~Recent work in partnership with the Medical Director of NHSE has led to the development of a proposed inter-hospital transfer concordat. Its purpose, if supported, by providers across the West Midlands, is to ensure that all patients requiring transfer are transferred within a maximum of 48 hours. If implemented this would have a significant impact on patient flow by reducing repatriation delays that are incurred daily by our tertiary specialties. The concordat is to be discussed at the forthcoming regional Urgent & Emergency Care Network in May 17.~~ Q1 201718: The Trust will participate with the Local Authority and partner providers in the forthcoming CQC review of the Birmingham health and social care system for people aged over 65. The CQC have been asked to undertake system reviews in 12 areas in England where delayed transfer of care levels are high. ~~It is anticipated that these reviews will be completed by November 2017, although as yet the exact scope and outputs are unclear.~~ This will take place Jan 22-26 2018 Q2 201718: A plan to utilise the additional BCF funding for Birmingham & Solihull has been agreed and is now being implemented. The plan will be monitored at STP level via the BSOL A&E Delivery Board chaired by the Chief Executive for UHB. The Trust will also be working closely with BCC & SMBC with regards to the forthcoming CQC review of health & social care scheduled integrative and system diagnostic for 22/01/2018.	~~Q1 2017/18~~ Completed ~~Q2 2017/18~~ Q~~3~~ 4 2017/18 Q~~3~~ 4 201718
						Internal Monitoring and Management of patients referred for social care intervention and CHC nursing assessments	**Internal:** Discharge Hub meeting to review the progress on each patient referred and classified as a section 5. (DTOCs has reduced by 40%) CCQ papers and minutes **(May 16, June 16)** ALOS has to date reduced from 42 days to 35 days Executive & Operational Groups RRR Project agendas/minutes **External:** Agreement with CCCCG and SCCCG. A Steering group (STP Delivery Board) in place to develop a combined Trust and Local Authority Complex Discharge team. Chief Executive Letter to 3 LAs September 2015.	The strategy for out of hospital re-ablement is being developed as part of the STP out of hospital work stream. ~~Discharge hub is now set up . A therapy led trusted assessor model for patients for discharge who require a social care package it to start in May 17. It is envisaged that this will reduce DTOC delays for this patient group who currently have to wait for social service assessment.~~ ~~The STP Urgent Care in a Crisis work stream are in the process of reviewing the future model of re-ablement and intermediate care in Birmingham. This is likely to lead to current re-ablement capacity being provided out of a smaller number of homes. The outcome of this work should be available by Q1 2017/18 & result in a plan to streamline the re-ablement process & improve timelines. This will complement work underway within the STP to review community rapid response, step up and step down capacity in Birmingham which may lead to a new community based recovery team model of discharge from hospital.~~ ~~The Director of Partnerships is chairing on behalf of Birmingham & Solihull A&E Delivery Board (task & finish group) to review demand, capacity & operational processes with BCC re-ablement service. It is essential this service runs effectively to ensure patients are transferred promptly out of hospital into re-ablement capacity in nursing/residential homes. At present length of stay in these units is too long & referral and assessment processes are complex. LOS has now reduced from 42 days to 35 days with scope for further improvement.~~ ~~Q4 20617: The STP Urgent Care in a Crisis work stream are in the process of reviewing the future model of re-ablement and intermediate care in Birmingham. This is likely to lead to current re-ablement capacity being provided out of a smaller number of homes. The outcome of this work should be available by Q1 2017/18 & result in a plan to streamline the re-ablement process & improve timelines. This will complement work underway within the STP to review community rapid response, step up and step down capacity in Birmingham which may lead to a new community based recovery team models of discharge from hospital.~~ Q1 201718: An STP Urgent Care in a Crisis system diagnostic will commence July 2017. This will include Birmingham providers and the local authority, and will be undertaken with consultants (currently supporting with seamless surgery project). The initial diagnostic phase of the review will be completed Oct 2017, and will report to the STP Delivery Board which is chaired by the UHB Chief Executive. Diagnostics will lead to identifying opportunities to the system to redesign and improve the productivity of current services in order to reduce the delay in the transfer of care and ensure that patients receive the appropriate care in the appropriate location. Q3 201718: The findings of the Newton diagnostic were presented to the STP Board in January 2018. A new model for care in crisis will be presented to the STP Board in February 2018 for approval with an allocated rescue plant work programme identified.	~~Complete~~ ~~24/10/2017 Complete~~ ~~Complete~~ Q~~3~~ 4 2017/18 Q4 201718
						Chief Executive Officer corresponds frequently with NHS Improvement/Monitor/CQC. The Trust 5 Year Strategy has been approved by BoD. Full paper on the Annual Plan and Operational Plan being submitted to April BoD and to Monitor in May 2015	**Internal:** Quarterly NHS Improvement/Monitor reports to BoD. Feedback from Executive meetings with Government leads to establish influence over policy and strategy **External:** Quarterly reports to NHS Improvement/Monitor. Develop more links with influential departments and key staff.	Continue with existing controls	Ongoing
						Health and Social Care Bill. Commissioning support unit. Changes to NHS Improvement. NHS England and local CCGs.	**Internal:** BoD reports and minutes **(April 16, July 16).** **External:** Monitor validation of Trust financial and governance arrangements. NHS Improvement/Monitor Quarterly Governance Declaration (**April 16**) Annual Governance Compliance Declaration	Horizon scanning to identify consistency for Trust planning.	Ongoing
	Inability to recruit adequate numbers of sufficiently skilled, trained and competent staff including senior management (particularly academic consultants and doctors). This may be further compounded by the UK's exit from the EU affecting Trust EU Grants.	Junior Medical workforce of all grades (including Junior Doctor Contracts, ITU and theatre nursing staff, age profile of the healthcare scientist workforce and middle/senior management staff. Brexit - approx. 8% of the NHS workforce is made of up of EU and Commonwealth member countries. The Trust currently employs 50 consultants who are EU nationals.	EDOD/CN			The Strategic Workforce Group reviews all workforce issues. The Nursing Workforce Group and the Operational Workforce Group feed into the Strategic Workforce Group. The action plan for Health Care Scientists is also monitored by the Strategic Workforce Group. Assurance is provided by the papers from the Strategic Workforce Group, Nursing Workforce Group and Operational Workforce Group. The Strategic Workforce group meets bi-monthly. Recruitment plan and package to address nursing shortfalls which includes overseas recruitment, support package for out of practice and returning nurses and increasing recruitment/retention rates for newly qualified nurses. Establishment of executive led Strategic Workforce Group through which the Operational & Nursing Workforce Group will become formal sub groups. Establishment of Junior Doctor Review with governance through an Executive led Steering Group and CEAG to lead a review of the junior doctor workforce deployment	**Internal:** Workforce Group papers and minutes **(July 16)** Quarterly Papers from the Strategic Workforce Group, Nursing Workforce Group and Operational Workforce Group. Investment in Physician Associate Training programme in partnership with UoB. Bi-annual reports to BoD on both HR and Workforce/Education **(April and Oct each year)** and Annual Workforce Report **(July 16)** KPI evidence reports **(July 16).** Staff survey **(July 16).** Successful award and	The Trust ~~has~~ was presented ~~appointed~~ a new Guardian of Safe Working in November 2017. ~~see Board report March 17.~~ Work is being encompassed into the CEAG approved Junior Doctor Review which is due to commence in Q4 2015/16 & complete in Q3 (2016/17). Junior Doctor rota review completed. Revised offer for Junior Specialist Doctors (JSDs) out for advertisement which offers rotations that are commensurate with Trainee Doctor training rotations & therefore offer a parallel route towards CESR. Workshop around Advanced Clinical Practice (ACP) to commence in Q4 to increase understanding across different staff groups of the value of the roles & successful model of implementation. ACP forum established to support development of potential business case / implementation plan for role. ~~Workforce Plan for 2017/18 under construction following work with the Divisions as part of the annual planning process. Work will include a review of non-medical workforce solutions to mitigate current medical workforce shortages.~~ Strategic Workforce Group provides oversight across all workforce disciplines and receives reports from the established workforce subgroups across nursing, junior doctors, health care scientist and operational workforce group. The group continues to set the strategic direction for the initiation and implementation of workforce priorities to enable the Trust to meet its service priorities. The group is fully sighted on the current and potential future risk areas, current workforce performance against plan and oversight around the introduction of new roles and the annual workforce planning process. ~~The Junior Doctor Workforce Review has now been completed and has reported to CEAG in September with x 5 key recommendations. Discussions underway with the Medical Director and Chief Finance Officer regarding resourcing the required changes~~ A Physician Associate Implementation group has been established to support wider implementation of this staff group and a Clinical Tutor for PAs has now been appointed and who will work to establish an education and training programme which supports development of the role working with HEFT. Future workforce risks identified and will form part of the discussions with the Birmingham and Solihull Education Reform Group to ensure a BSoL mitigation plan. Diagnostic and Therapeutic radiography felt to be key risk areas and as such the Trust is leading on the national Trail Blazer to develop a degree apprenticeship in partnership with 15 other Trusts and BCU. Junior Doctor Workforce review entering its final phase and is due to report to CEAG in August with a set of recommendations around the future shape of the junior doctor workforce. Revised offer for Junior Specialist Doctors has been successful in terms of recruitment focus continues to be on retention. Physician Associate recruitment underway and supported by the establishment of a Clinical Tutor post to support development of education, training and support for this new area of the workforce. PA implementation group chaired by Division C established to support their smooth introduction and ensure their education and competency requirements. Group will monitor their role as part of the Junior Doctor Workforce Review work ~~Work to start to implement the key recommendations is underway . Establishment of a junior doctor facilitator post to support the work has been agreed as an interim measure prior to further implementation funding agreement.~~ ~~Physician Associate recruitment underway and supported by the establishment of a Clinical Tutor post to support development of education, training and support for this new area of the workforce. PA implementation group chaired by Division C established to support their smooth introduction and ensure their education and competency requirements. Group will monitor their role as part of the Junior Doctor Workforce Review work~~	Completed ~~Completed~~ Ongoing ~~Completed~~ Ongoing ~~Aug 2017~~ Ongoing ~~Ongoing~~ ~~Ongoing~~

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3				Significant (12)	Moderate (8)		project outcomes. Training records and ESR. Monthly Education Directorate Senior Team meetings with Divisions Education Directorate Business plans (when do these provide assurance until/how often are these updates?). CEAG minutes 09/2017 Monthly Junior Doctor Steering Group reporting	~~Flexible Workforce policies are also currently being developed by HR to retain our European workforce.~~ Q3 201718: Meeting with HEFT to look at formulation of a combined workforce plan and identification of key workforce risks and current mitigation plans held in December. Further meeting to be held with HEFT in Q4 201718 to review further work around workforce data and mitigation plans.	Q4 1718 Q4 1718
						Retention of key staff, clear and prioritised departmental objectives and appraisal system. Internal control systems which minimise demands on senior staff time. Leadership and management education programme established for middle and senior managers. Annual workforce planning process NHS Elect re-commissioned to work within the Trust to co-produce and deliver a second year programme of leadership and management training. Specific leadership programme for the triumvirate of Clinical Service Leads, Matrons, Group Managers planned. Talent Management champions trained and established with Talent Management embedded into revised appraisal documentation and policy. Mentorship and Coaching freely available through leadership portal on the website. Top Leaders programme available through NHS Academy with sponsorship for additional bespoke programmes identified.	**Internal:** Appraisal rates, senior management turnover rates; Weekly senior team meetings, including periodic review of departmental objectives and of senior managers' individual objectives; internal audit review to confirm the reliability of financial records and compliance with Trust policies and regulations. Vacancy rates currently 2.5% for nurse with 19 vacancies in ITU (lowest it has been) **External:** External audit reports (how often?) and action plans review to confirm the reliability of financial records and compliance with Trust policies and regulations	The Board of Directors receives a draft annual report outlining the Trust's proposed annual governance declaration in March every year. This declaration is then signed off in the following May and submitted to NHSI to ensure the Trust maintains compliance with its obligations. Continue with current process	Ongoing Ongoing
	Breach of regulatory requirements	Failure to provide specific information to NHSI or any other regulatory requirement	DCA			Governance Declaration	**Internal:** Board Meeting Minutes. Annual Governance Declaration	The Board of Directors receives a draft annual report outlining the Trust's proposed annual governance declaration in March every year. This declaration is then signed off in the following May and submitted to NHS Improvement to ensure the Trust maintains compliance with its obligations. The annual Board paper is included as part of the Annual Business Cycle to ensure that the declaration is submitted in line with NHS Improvement's deadlines.	~~Ongoing~~ Q4 2017/18
						Strategy & Performance Team	**Internal: Quarterly** Board Meeting Minutes.	Strategy team responds to regular (e.g. quarterly declaration follow-up questionnaire), ad-hoc and consultation requests from NHS Improvement/Monitor in line with agreed timescales. Responses are agreed by relevant directors. Team briefs executive directors of risks and key information ahead of quarterly phone calls with Monitor. Details of any material discussions are included in quarterly paper or monthly . NHSI website is also regularly checked to ensure nothing is missed. Continue with current process. ~~The Deputy Director of Finance will arrange a meeting with Director of Corporate Affairs to discuss creating a central repository to log all NHSI Requests.~~	Quarterly Ongoing ~~Q3 2017/18~~
		Failure to comply with regulatory requirements due to capacity/performance issues				Monthly Service Quality Performance report submitted to CCG detailing performance and a progress update on any indicators that are off target. Regular contact is maintained with commissioners via phone and email to ensure any concerns are addressed. Also monthly Strategic resilience Group meetings (including Clinical Subgroup) and Contract Review Meetings ensure that commissioners at all levels are fully appraised of an assured about any performance issues. Action plans and trajectories are reviewed internally by nominated leads to ensure the are robust and will deliver to trajectory and monitored through weekly assurance meetings and monthly Cancer Steering Group.	**Internal:** Integrated **Quarterly** Performance reports to BoD Weekly Cancer Steering group meetings to review capacity/performance issues and review action plans **External:** Letter from Monitor to Julie Moore on 15 May 2015 confirming return to 'green' governance rating. This provides assurance from NHSI until updated otherwise. The Trust has consistently maintained a rating in segment 2 in NHS Improvement's Single Oversight Framework since it was introduced in October 2016.	Actions within the Integrated Performance Report to continue to be implemented to enable the Trust to meet the trajectory agreed with the commissioners: - % patients waiting 4 hours or less in A&E - Cancer Waiting Times - 62 day GP target - a commissioner remedial action plan is in place. - Last minute Cancellations and the 28 day cancelled operations guarantee - 18 week RTT - recovery plans in place.	Ongoing

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1				Significant	Moderate	Constant capacity reviews and monitoring of service provision. Out of area transfers are being identified on a daily basis and will be reported to the WMAS and Commissioners. Additional capacity has been created - the Trust has opened over 170 beds in the last 18 months. Seasonal planning.	**Internal:** Board Report Patient Care Quality **Quarterly** Report to include Infection Control updates and Audit Committee DCA Group minutes and compliance framework paper (November 2017) Compliance Framework Cancer Waiting List Assurance Group meets weekly and reviews the data CQC report	Continue with existing controls and assurance as outlined in capacity risk above. A recent letter from Redditch & Bromsgrove CCG has noted that to support Worcester Acute Hospital NHS Foundation Trust (WAHT) they will be looking to divert GP referrals away from WAHT for a 3 month period. A significant proportion of additional patients could be referred to UHB as a result. The Director of Partnerships has met with the CCG and weekly referral numbers will be monitored to access the impact. Any variation over agreed contract levels will be charged at tariff + to reflect the additional costs incurred to manage this activity.	Ongoing
		Failure to adhere to regulatory requirements and national guidelines e.g. CQC - Cardiac Services, clinical audits, MHRA etc.				The Clinical Risk and Compliance Unit has processes in place to: - manage national and local audits to ensure evidence shows compliance with that process. - manage incidents and identify trends. - manage new and existing NICE guidance to ensure there is evidence to show compliance and where we are not able to adhere to the guidance e.g. we do not provide the service, the medical director's approval has been obtained. - manage NCEPOD studies and identify actions, in conjunction with the clinical teams in response to the outcome of the relevant study. - Manage oversight of any external visits - Manage the QSIS specialised services peer review programme A quarterly report on compliance with the above is provided to the divisional Clinical Quality Group meetings and the BoD (see clinical compliance report).	**Internal: Quarterly** compliance reports to BoD DCA Governance Group minutes National Audit presentation to CQMG **(November 2015 and November 2016)** DCQG quarterly compliance reports Procedure for Monitoring and Assuring Compliance against the Care Quality Commission (CQC) Essential Standards provides assurance until March 2015 **External:** QSIS 2015/16 self-declaration (how often?)	To update the Clinical Standards Procedure by end of November 2017. Complete 2016/17 QSIS self-declarations by 31 July 2017 Implement a robust process to monitor actions form local audits within the department (by November 2017). Q31718: The Clinical Standards Procedure is awaiting approved of Clinical Standards and Audit Policy which will be presented to PRG in Jan 2018 and then subsequently to CEAG for ratification. Once approval of policy received the associated procedure will be submitted d for approval	~~November 2017~~ Mar 2018 Complete d ~~November 2017~~ Mar 2018
		A Cardiac Surgery Quality Improvement Programme (CSQIP) was established in September 2015 and since November 2015 the Senior Manager Clinical Compliance has been the project lead for the CSQIP. The CQC carried out a focussed inspection in December 2015 and places 2 conditions of the Trust's registration following the visit. Following work undertaken by the Trust these CQC conditions were removed in Q2 2016. Through the work of the CSQIP improvements have been made to the service and in May 2016 the CQC removed the conditions on the Trust's registration. In September 2016 NHSE took over the monitoring of the service from the CQC and requires progress reports to be provided. The Trust is currently awaiting clarity on the frequency of these reports including what information is to be provided.					CSQIP project Plan, and Steering group papers and minutes (how often are meetings?) **Monthly** CQMG reports External: Letter from the CQC removing the conditions (May 2016) **Quarterly** reported data to the CQC Board and Audit Committee Compliance Report Weekly RCA cardiac meeting minutes Data on the Cardiac dashboard Cardiac Surgery Services Inspection Report - CQC and External review reports Board Assurance Framework Audit and assessment reports	A Cardiac Surgery Quality Improvement Programme (CSQIP) was established in September 2015 and since November 2015 the Senior Manager Clinical Compliance has been the project lead for the CSQIP. The CQC carried out a focussed inspection in December 2015 and places 2 conditions of the Trust's registration following the visit. Following work undertaken by the Trust these CQC conditions were removed in Q2 2016. Through the work of the CSQIP improvements have been made to the service and in May 2016 the CQC removed the conditions on the Trust's registration. In September 2016 NHSE took over the monitoring of the service from the CQC and require progress reports to be provided. Currently awaiting clarity on the frequency of these reports including what information is to be provided. Continue to monitor the implementation of the agreed actions ~~and provide external progress reports to NHSE (who have taken over the monitoring from CQC)~~	Ongoing
		The Trust is governed by several regulatory requirements and the Risk and Compliance Unit currently has specific oversight of the CQC requirements. In light of the CQC focused inspection of cardiac services the existing compliance framework has been reviewed. The key changes to the new compliance framework are: - focus will be on compliance at speciality level - additional measures have been identified to monitor compliance against.					**Internal:** Presentation at BOD seminar in **May 2016** **Quarterly** compliance reports to BoD	The new compliance framework is currently being fully implemented and the following actions remain: - Complete the scoring of all the returned compliance framework and feedback at the speciality meetings by 30 June 2017 - Complete template framework for Ambulatory Care and Theatres by 30 June 2017 Template framework for ITU is still outstanding. Meeting scheduled to finalise standards prior to self assessment. Q31718: The new compliance framework was discussed at a BoD seminar in May 2017. By the end of Q3 2017/18 the compliance framework has been implemented for all agreed specialities. An escalation process for non-compliance was agreed at the DCA Governance Group in November 2017. The Risk and Compliance Team continue to work with department leads to see how the organisation can collect data in the format required for the CQC's annual provider information request.	Complete Complete ~~Q3 201718~~ Complete Complete Ongoing

Appendix 1 Quarter 4 Board Assurance Framework Report

Key:									
CORE PURPOSE 1: CLINICAL QUALITY Strategic Aim: To deliver and be recognised for the highest levels of quality evidenced by technology, information, and benchmarking		1							
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Core Purpose/ Other association	Risk Description	Current Context	Owner	Current Risk	Residual Risk	Existing Controls	Assurances Internal/External	Progress/Action Required	Timescale
						As part of the Trust's ongoing initiative to both assure and improve the quality of care provided to patients, unannounced Board of Directors are arranged on a monthly basis and are led by either the Executive Medical Director or the Executive Chief Nurse. The locations for the visits are randomly identified by the Head of Clinical Risk and Compliance /Head of Quality Development / Director of Medical Directors Services who use various information sources such as: • Risk management reports, • Clinical Incidents, • Complaint information, • Executive Led Root Cause Analysis, • Operational information (implementation of new ways of working etc.), • Clinical dashboard performance, From the visits a report is drafted and provided to the relevant Divisional Management Team (DMT) who develop an action plan for completion. The action plan is then completed and reported back to the Trust Clinical Quality Monitoring Group (CQMG) which is chaired by the Executive Medical Director. The completed action plan is appended to the Executive Medical Director's Patient Safety Exception Report to the Clinical Quality Committee.	**Monthly** CQMG Reports on Board Governance Visits	Continue with existing controls	Ongoing
1	Failure to reduce the transmission of infection	Trust has had higher level of C Diff cases than the Trust's trajectories for 2016/17	CN	Moderate (8)	Low	An audit of current practice has been carried out which found the following had not been done adequately: Hand hygiene, screening of patients for MRSA, Device care (use of catheters), cleaning and decontamination and Isolating of patients. An action plan has been put in place which is monitored by the IPC Group. All actions have been completed in the MRSA action plan that is reported to the CCG. No MRSA bacteraemia cases apportioned to the Trust have been reported for Q1, ~~and~~ Q2 or Q3; During Q3 there have been 5 outbreaks of C. difficile infection reported. There has been a slight reduction in the use of piperacillin/tazobactam which is known to contribute to CDI. ~~Performance during quarter 1 for C. Diff has been very good with only two cases being identified to have had inappropriate antimicrobial therapy. During Q2 there have been 12 cases of C. difficile infection apportioned to the trust. This brings the trust back in to trajectory for CDI performance on case rate. There has been a slight reduction in the use of piperacillin/tazobactam which is known to contribute to CDI.~~	MRSA Action Plan and IPC Group Minutes Patient Care Quality Quarterly Report to include Infection Control updates **(May 16, Sept 16, Jan 2017 and April 2017, June 2017, Sept 2017)** Infection Prevention and Control Policy approved until **July 2018**	Continue to implement and monitor C Diff action plan at IPC group. This includes improving time to isolation, more timely specimen collection and improved antimicrobial prescribing	Ongoing
2	Reputational damage due to negative media coverage.	Adverse media coverage due to unforeseen circumstances or events.	DCOMMS	Moderate	Moderate	Delivery of the Communication Strategy and associated Policies and Procedures.	Whistle Blowing Policy (valid until **07/2017**), Contact with the Media Policy (valid until **05/2019**), Code of Conduct (valid until **03/2019**), IT Acceptable Use Policy (valid until **10/2019**). Social Media Policy (valid until **03/2020**) Social Media Procedure (valid until **04/2020**)	Relationships with local and national journalists developed. Staff are aware of procedural processes when approached by outside agencies. Communications team skills developed to manage adverse media. Stakeholder Engagement Strategy and Register. The use of social media is important to counter inaccurate or unbalanced views published on the internet. The IT Acceptable Use Policy sets the standard for expected staff behaviours when using social media sites. The Social Media Policy and associated Procedure set out the principles and framework for the creation and use of Social Media accounts by Trust staff in both a personal and professional capacity.	Ongoing Complete
						Proactive engagement as required.	Established relationships and direct lines with named media reps	Controlled media coverage around VIP visitors and patients from overseas. Limited negative press and balanced coverage in case of high-profile criminal/contamination cases covered by print and broadcast media Continuing engagement with documentary and news crews to showcase Trust expertise and support campaigns to benefit patients, e.g. organ donation	Ongoing Ongoing
						Use of Emergency Preparedness Plan/Major Incident Plan to respond to adverse publicity or misinformation e.g. following national coverage of high profile patients from abroad	PR templates/media packages/contact lists to ensure right messages get to right people asap Bi- annual Emergency Preparedness update Report to BOD **(04/2016 & 10/2016)** Celebrity VIP Policy (valid until **11/2020**)	Intense media attention in 2014/15 with high-profile patients from overseas proved effective media handling with positive coverage and no impact on Trust operations. Proven system for response with flexibility based on experience and in-house knowledge of media industry. Celebrity/VIP Policy to be drafted in the event of a major incident resulting in celebrities/VIP's attending, and to also cover celebrities/VIPs as patients. Celebrity/VIP Policy was approved at CEAG in November 2017.	Ongoing Ongoing Q3 201718 Completed
		Media coverage due to HEFT merger may result in a risk to the reputational damage of the Trust as a result of inconsistent messages.	DCOMMS	Moderate	Moderate	Delivery of the Communication Strategy and associated Policies and Procedures.	Contact with the Media Policy **(**valid until **05/2019)**, Staff Code of Conduct (valid until **03/2019)**	Inconsistent messages between the case for change to become one organisation with HEFT and the Sustainability and Transformation Plan may result in negative public perception. Communications streams are engaged to endure the right messages are delivered and that the Trust is engaged as possible and provide an oversight of this as far as possible.	Ongoing
1	Reputational/financial/organisational damage arising from commercial ventures or support provided to other Trusts	Relationship with HEFT could damage the Trust's reputation if expected outcomes with NHSI/NHS England and other stakeholders are not managed appropriately. This includes the impact of Trust intervention at HEFT on the capability of senior teams.	DSO & DCA	Moderate	Moderate	The Trust is currently assisting HEFT which has been classed as requiring support. The Director of Corporate Affairs and the Director for Delivery are joint SROs for the Case for Change project. Director of Strategic Operations is the lead director for the HEFT support work.	The intervention at HEFT is monitored directly by the Board through direct involvement of the Trust's Executive Team. Investment Committee papers. The group meets **every two months.**	Executive/Board Seminar held discuss developments re internal relationships. Identification of opportunities and clarification of areas to pursue continues. Review operational activity and provide recommendations to improve working practices to strengthen services provided. Strategic Operational Group in place to review. The Director of Strategic Operations and External Affairs provides updates to the Investment Committee every 6 months on the progress of existing projects as well as any identified future opportunities.	Completed Ongoing Ongoing
						Stakeholder Engagement Work stream led by DCOMMS.	BOD Minutes **(bi-monthly)** Stakeholder Engagement Work stream	Recharge funding to support backfill where appropriate.	Ongoing
						Oversight by BOD.	BOD Minutes (bi-monthly)	Impact of intervention at HEFT discussed at BOD.	Ongoing

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CORE PURPOSE 1: CLINICAL QUALITY Strategic Aim: To deliver and be recognised for the highest levels of quality evidenced by technology, information, and benchmarking	**1**
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Core Purpose/ Other association	Risk Description	Current Context	Owner	Current Risk	Residual Risk	Existing Controls	Assurances Internal/External	Progress/Action Required	Timescale
1	Failure in one or more components of business and IT systems, resulting in clinical service, department, equipment and/or staffing failure		MD	Low	Low	Full Business continuity plans in place. IT Services Disaster recovery plan is now actively underpinned by system recovery plans for critical systems. Q2 17/18 Although day to day resilience is in place providing robust management of the data through regular data backups, rigorous security controls and resilient systems, there may be gaps in our ability to provide resilience should we lose Data Centre. There are documented and approved service management processes, Security standards and policies, Architectural reviews of all system and infrastructure designs to ensure they meet compliance with industry standards. ISO 9001/ISO 27001 last LRQA Audit was March 2017, the certificate is maintained however we gained one new non-conformances, for security reporting within the department the departments audit schedule non-conformance was closed out as compliant. ISO 90001/ISO 27001. Regular data backups and checks that the back-ups have integrity. Documented and approved service management processes. Audit March 2017; certificate maintained	Emergency Planning Policy and procedures. Emergency preparedness training for senior managers undertaken. Emergency Preparedness Steering Group minutes. Reports from table top exercises. Emergency Preparedness Risk Register. Emergency Preparedness Steering Group. Testing and action plans. Contingency printing of PICS is carried out daily in clinical areas and recorded on the Clinical dashboard. Security standards and policies. Validation of table top exercises by an external auditor. ISO 9000	Testing of business plans has taken place. Major incident testing has taken place. Validation of systems through major incident testing with external stakeholders. The maturity of our systems and capabilities of our people is constantly improving but we need further development to create a truly robust environment. We do not have fully auditable systems permitting full review and management of access. RG to arrange meeting to go through the ISO 9001:2015 changes made with the management team in July/August 2017 (reviewed 23/0/8/2017) Documented and approved service management processes. EPSG reviews all the relevant risks and actions. All critical systems have been identified and internal testing through table top exercises has been carried out and reported back to EPSG. ASSIISO 9001/27001 Surveillance Audits continue as per ISO certification process. Audits are available on request (reviewed 19/04/2017)	Ongoing Ongoing
1	UK exit from EU may have an adverse impact on the Trust in areas including: 1. Recruitment 2. Research Funding 3. Contracts for equipment/consumables/services 4. Finance Performance	1. Recruitment: (as above). This may be further compounded by the UK's exit from the EU particularly academic consultants and doctors. 2. Research Funding: UK's exit from the EU may affect Trust EU Grants. 3. Contracts for equipment/consumables/services 4. Finance a. The Trust may see additional costs incurred as suppliers increase prices as a result of £ UK currency devaluations, changes in the EU/UK trading rules and regulations or general economic uncertainty linked to "Brexit". b. The Trust may lose EU funding for R&D projects and UK funding may be impacted.	EDOD/CFO	Moderate	Moderate	For Recruitment Monitoring trends nationally, locally and within the Trust. For Recruitment - as above. For Research Funding assessment of current EU funding needs to be completed, finding submissions for new EU grants need Exec. director approval. For Contracts and Finance - where major suppliers adjust prices due to these issues, this needs to be flagged, recorded and monitored. Where any material financial impact is identified this will be flagged and reported as required un the Trust Scheme of Delegation.	Assurances to be determined following guidance from UK Govt. Strategic Workforce Group meetings Watching brief on how the negotiations progress. Expect NHS wide system impact to be calculated. Check Trust assessed impact against national estimates when available.	~~Recruitment (as above): Flexible Workforce policies are also currently being developed by HR to retain our European workforce.~~ Article 50 of the Treaty of Lisbon was triggered on 29 March 2017. The precise implications of this are unknown at this stage. Contracts: a) Identify material contracts where the supply chain is located in the EU and not the UK. A contract's database is currently being populated. Initially the database will focus on procured contracts, with the intention to capsulate all contracts (including non-procured contracts) and agreements. b) Consider the potential financial and clinical impact for each contract. Research and Finance generally - The Trust is currently supporting one EU Grant which is costed at £504,548.02 as at end Q1 201718. This is being led by Hannover Medical School. At this stage the total project value is unknown. There are no further EU grants at however confirmation of this will be available once Research Connect goes 'live.' - There will also be future potential impacts on the MD-TECH and Innovation Engine projects as a result of Brexit as the Trust may not be part of these post-Brexit. - The AHSN is involved in the EU-wide EIT Health programme. Whilst this may not be a huge risk to the Trust as the EIT is cost-negative to the Trust (we pay a membership fee but do not directly receive the benefits). The AHSN members tend to get the funding. Again, the risk is that AHSN will not be members going forward and that is a risk to the reputation and attractiveness of the AHSN. A paper was presented to the Board of Directors regarding research issues. The Trust has identified all current EU staff. Seminars are being arranged to advise on applications for UK residency/citizenship for affected staff. The Strategic Workforce Group also monitor staff levels. Q3 1718: The Government has issued a technical Note on citizen's rights which seeks to clarify aspects of its proposal for EU citizens' rights post Brexit. Affected staff holding Permanent Residence status will be able to exchange their status to Settled Status. For those not holding Permanent Resident status, the proposal is for application for Settles Status to be mandatory. Holders of Permanent Residence are able to apply for UK citizenship from the date of "deemed acquisition" of Permanent Residence. Many Permanent Residence holders will become UK citizens prior to any new provisions for Settled Status coming into force. There is no guarantee that those obtaining Settled Status will be deemed to have acquired this status at an earlier date. Affected staff who are not yet able to evidence the five years' continuous residence necessary to obtain settled status, but who can evidence that they were resident before the specified date, will be given temporary status. This will enable them to remain in the UK until they have built up five years' continuous residence allowing them to apply for settled status.	~~Ongoing~~ ~~TBC~~ Ongoing ~~TBC~~ Ongoing TBC Ongoing Ongoing Ongoing Ongoing
1	There is a risk to the Trust of the transaction involving HEFT not obtaining regulatory approval. If the Trust fails to implement the proposed transaction then it will be more challenging to deliver/implement improved models of care with the consequent anticipated economies of scale leading to potential financial loss and deterioration of patient services.	Failure to obtain approval for the transaction may result in: 1. Impacting on the provision of services to the local population potentially causing an increase in demand for UHB existing services. 2. A disruption to the financial stability leading to an inability to continue providing sustainable and high quality services. 3. A potential impact on the Trust's working relationships with partners across the STP. 4. If the current arrangements are sustained, management would be stretched across both organisations.	~~CFO/DSO~~ EDOD	Significant	Possible	CMA approval on 30.08.2017.	Project Plan Workstream Groups Regular contact with CMA	To develop a strategy in the event the transaction is unsuccessful which may include a continuation of the existing arrangements/services. A Project Plan has been devised which will assess progress up to end 2018. Q2 201718: CMA approval was achieved on 30.08.2017. Q3 201718: A meeting will be help between DoH, NHSI, NHSE to discuss transaction red lines on 23.01.2018.	TBC Q4 201718
1	Risk to the Trust associated with the transaction involving HEFT.	If approval of the transaction is obtained there may be ongoing risks to the Trust which include: 1. Financial risks based on the assumption of HEFT's liabilities unless these are appropriately indemnified. 2. Failure to achieve financial stability resulting in inability to provide sustainable and high quality services due to financial constraints. 3. Without robust and timely implementation planning, clinical services delivery post transaction may be negatively impacted. 4. Stretched resources across the enlarged Trust to ensure delivery of both the transformation agenda and ongoing governance/care quality agenda. 5. The culture of both organisations are different as a consequence of historical reasons. There is a challenge of achieving a cohesive culture which recognises the	EDOD/DCA	Significant	Possible	Case for Change Team dedicated to ensuring a successful merger - 5 work stream groups Mobilisation plan		Agreement of target date for the transaction with NHSI. Approval of UHB Business Case by Trust Board. Post transaction integration risk management plan being developed. Workstream Groups have been created, with the support of the Trust, to look at mobilisation: - Workforce and Culture chaired by Director of Delivery meet fortnightly - Governance chaired by Director of Corporate Affairs meet fortnightly - Clinical Cases chaired by Deputy Medical Director meet fortnightly - Finance chaired by Chief Financial Officer meet weekly The sub-groups for the above Workstreams meet on a weekly basis Risk Register for both the target Trust (HEFT) and the acquiring Trust (UHB) and for the transaction. Long Term Financial Plans have been developed for the integrated future organisation. These have been reviewed and tested by external advisors (EY) and by NHSI. These have been presented to Board along with downside scenarios and potential mitigation actions. These plans are being updated to reflect the current trading performance at both UHB and HEFT. Current situation to be presented to Board in ~~October 2017~~ January 2018	TBC Ongoing ~~27/10/17~~ Q4 201718

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Core Purpose/ Other association	**Risk Description**	**Current Context**	**Owner**	**Current Risk**	**Residual Risk**	**Existing Controls**	**Assurances Internal/External**	**Progress/Action Required**	**Timescale**
		best of all predecessor organisations. 6. Threat to UHB sustainability and licence conditions. 7. Reduction in quality of services provided.							