Trust Board Paper Z

To:	**Trust Board**
From:	**Director of Corporate and Legal Affairs**
Date:	**20 December 2013**
CQC regulation:	N/A

Title:	**ASSURANCE AND ESCALATION FRAMEWORK**

Author/Responsible Director: Director of Corporate and Legal Affairs

Purpose of the Report: To consider a draft Assurance and Escalation Framework and to invite the Board to adopt the Framework.

The Report is provided to the Committee for:

Decision	√	Discussion	√
Assurance		Endorsement	√

Summary / Key Points: The Trust Board considered at its development session on 17 October 2013 the components of an Assurance and Escalation Framework. A draft framework has now been prepared and is submitted for consideration.

Recommendations: The Trust Board is invited to consider and approve the Assurance and Escalation Framework, subject to any modifications which the Board wishes to make.

Previously considered at another corporate UHL Committee? Trust Board development session 17 October 2013; Executive Performance Board 17 December 2013.

Strategic Risk Register: N/A	**Performance KPIs year to date:** N/A

Resource Implications (e.g. Financial, HR): N/A

Assurance Implications:

Patient and Public Involvement (PPI) Implications: N/A

Stakeholder Engagement Implications: N/A

Equality Impact: N/A

Information exempt from Disclosure: N/A

Requirement for further review? The Assurance and Escalation Framework will be subject to further development as the new Clinical Management Group arrangements become embedded; as the Trust develops its approach to service line management; and will be subject also to annual review and consideration by the Trust Board.

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST

Assurance and Escalation Framework

DRAFT

December 2013

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Assurance and Escalation Framework

C O N T E N T S

APPENDICES

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST

Assurance and Escalation Framework

1. INTRODUCTION

1.1 University Hospitals of Leicester NHS Trust (the Trust) is committed to providing safe high quality care and has developed a range of policies, systems and processes which together comprise a robust and integrated Assurance and Escalation Framework (the framework) to clarify how issues or concerns which may detrimentally impact upon the quality of care that the Trust provides are escalated throughout the organisation.

1.2 The framework describes how the organisation is able to identify, monitor, escalate and manage concerns in a timely fashion and at an appropriate level.

1.3 A diagram illustrating the Trust's management arrangements is appended at 'A'.

2. PURPOSE

2.1 This Framework describes the Trust's structures and systems through which the Trust Board receives assurance. It also describes the processes for the escalation of concerns or risks which could threaten the delivery of the Trust's strategic objectives, service delivery or patient safety. A number of key areas have been described within this document for clarity.

2.2 This framework will be reviewed on an annual basis in order to reflect any changes in governance, assurance and escalation processes.

3. IDENTIFICATION OF ISSUES AND CONCERNS

3.1 The Trust has an open and learning culture encouraging monitoring and comments and concerns to be communicated relating to issues which may impact on quality. The Trust acknowledges that issues which may impact on quality may be identified both internally and externally, examples of which are indicated in table 1 below.

Table 1

Internal sources	External sources
Staff and management	Patients, relatives, carers and the public
Patient surveys and other forms of patient feedback	External audit
Clinical audit	Specialty audit or review
Specialty audit or review	Regulatory bodies, i.e. Care Quality Commission (CQC), Health and Safety Executive (HSE)
Risk register	Commissioners or Trust Development Authority
Trends identified through complaints, litigation,	Self-assessment against national reporting standards

Internal sources	External sources
incidents and PILS reporting	/ reports, e.g. NICE
Board walkabouts	National clinical benchmarking data
Compliance monitoring, e.g. Infection, Prevention and Control Audits	
Public interest disclosures – whistleblowing	
Exit questionnaires	

4. REPORTING MECHANISMS

4.1 The Trust has a number of policies and systems which encourage staff and management at all levels to be involved in performance monitoring and to raise concerns about any issues which may result in possible threats to the quality of delivery of patient care.

4.2 Patients, carers and the public are encouraged to make comments and / or raise concerns both formally and informally via a variety of methods if issues arise.

4.3 The NHS Trust Development Authority (TDA), commissioners, other healthcare providers and healthcare professionals have a range of means by which they can raise concerns about the Trust. The various methods by which the reporting of issues or concerns is possible are outlined in table 2 below.

Table 2

Internal mechanisms for reporting issues	External mechanisms for reporting issues
Line management processes	Patient Information and Liaison Service (PILS)
Serious incidents	Serious incidents
On-line incident reporting	Patient safety incidents reported via the NRLS
Whistleblowing Policy	Complaints – both formal and informal
3636 Staff Concerns Reporting Line	Complaints and Parliamentary Health Service Ombudsmen
HR policies such as Grievance and Disciplinary	Litigation
Safeguarding policies (Children and Vulnerable Adults)	Healthwatch
Board Walkabouts	NHS Choices
Staff Surveys	Patient surveys
Corporate governance policies	Local Authority – Health Overview and Scrutiny Committees
Risk Management Policy and supporting risk management procedures	Clinical Quality Review meetings (commissioner-led)
Trade Union / Staff Side	CQUIN (Commissioning for Quality and Innovation)
Information Governance policies and processes	GP / other health professional concerns
Appraisals and Performance Development process	Trust Development Authority Integrated Delivery Meetings
Clinical Management Group/Corporate Directorate performance review processes	

4.4 In the event that a concern cannot be raised through the above routes and is deemed to be so urgent that the issue requires immediate escalation, then the matter can be brought to the attention of the Director responsible and if applicable recorded on the relevant risk register.

4.5 Of particular importance to note is the NHS TDA Accountability Framework for NHS Trust Boards (April 2013). This Framework sets out a clear set of rules under which the Trust is required to operate.

5. REGULATORY BODIES

5.1 The Trust is subject to regulation through self-assessment, review, spot checks and triangulation. Much of the Trust's regulatory activity is risk based. This is also subject to risk-based intervention from a number of regulatory bodies including e.g. the Care Quality Commission and Monitor (via the NHS Provider Licence and, post- FT authorisation, through the Risk Assessment Framework).

5.2 Reports about the Trust and its services by regulatory bodies, together with an action plan, are considered by the relevant Committee and the Trust Board. The process for managing external visits, accreditations and reviews is set out in the Trust's 'Policy for responding to external recommendations and requirements from external agency visits'.

6. TRUST'S RISK MONITORING, ESCALATION AND ASSURANCE PROCESS

6.1 The Trust operates within a clear risk management framework which sets out how risk is identified, assimilated into the risk register, reported, monitored and escalated throughout the Trust's governance structures. The framework is set out in the Risk Management Policy and is supported by relevant policies, including the Risk Assessment Policy and Policy for reporting and management of incidents including the investigation of Serious Untoward Incidents.

6.2 Key strategic risks are documented in the Trust's Board Assurance Framework (BAF). Each strategic risk is assigned to an Executive Director as the risk owner and the Executive Team and Trust Board review the Framework on a monthly basis to identify and review key risks to the achievement of the Trust's principal objectives. Controls in place and assurance sources, along with any gaps assurance, are identified and reviewed.

6.3 A more detailed operational risk register is in use within the organisation. Risks at a local level are identified and assessed prior to submission to Clinical Management Group (CMG) Boards for approval. Following approval, risks and their mitigating actions are recorded on the UHL organisational risk register.

6.4 Risks are reviewed by the risk owners and local CMG and Corporate Directorate Boards at a frequency determined by the severity of the risk and in line with the Risk Management Policy. Local Boards are responsible for ensuring effective management of risks within their areas and identifying issues that need to be escalated for resolution.

6.5 All risks that are rated as 'extreme' or 'high' are reported to the Executive Team on a monthly basis by the Corporate Risk Team and the Executive Team is responsible for ensuring that risks are being managed effectively at a CMG/Corporate Directorate level. In addition, the Executive Team exercise responsibility to identify any extreme or high risks from the organisational risk register or risks from the strategic operating environment and/or the UHL Annual Operating Plan that may be of strategic significance for potential entry onto the Board Assurance Framework – which are then highlighted to the Trust Board.

6.6 The BAF is reviewed and updated monthly by the Executive Team and an 'action tracker' is used to monitor whether actions to close any gaps in controls and/or assurance are being taken within agreed timescales.

6.7 The BAF is presented to the Trust Board for review on a monthly basis and the Board is also provided with a monthly report showing all new extreme and high risks opened during the reporting period. On a quarterly basis, a report is submitted to the Trust Board showing all current extreme and high risks sitting on the organisational risk register.

6.8 For ease of reference, the process outlined above is reflected in a flow chart within the Risk Management Policy and this is attached at Appendix B.

7. INTERNAL AND EXTERNAL SOURCES OF ASSESSMENT / ASSURANCE

7.1 Internal and external sources of assessment / assurance cover the range of the Trust's activities and include:

Table 3

Internal Sources of Assurance	External Sources of Assurance
Internal Audit (review of internal systems and processes)	External Audit Reports
Quality and Performance Report	Audit Commission (review of Quality Account)
Reports from committees	Commissioner Appreciative Enquiries
Serious incident monitoring	National Audits (e.g. Diabetes, Falls)
Performance review meetings	Independent Reviews (e.g. Parliamentary Health Service Ombudsman)
Board reports	Local Counter Fraud Service reports
Quality Account	Network reviews (e.g. QIPP)
Quality Impact Assessments and Equality Impact Assessments	NHS Litigation Authority compliance
Staff survey results	NHS TDA Accountability Framework
Patient survey results	Monitor Provider Licence and Risk Assessment Frameworks
Ward Performance System (criteria for wards on 'special support')	NHS Outcomes Framework
	CQC assessments
	National staff surveys and benchmarking
	Patient Choices

7.2 The Trust also commissions external reviews of its activities / services where the need for additional independent assessment / assurance is identified.

8. COMMISSIONERS AND NHS TRUST DEVELOPMENT AUTHORITY

8.1 In addition to the internal routes for raising concerns and risk, there are formal mechanisms by which the Trust's Commissioners and Trust Development Authority (TDA) can raise concerns. These include:

- Board to Board meetings
- CPM – Contract Performance Meeting (Commissioners)
- CQRG – Clinical Quality Review Group (Commissioners)
- Oversight self-certification for aspirant Foundation Trusts (TDA)
- GP concerns
- Serious Untoward Incident (SUI) process
- Patient Safety Incidents (PSI) reported via the NRLS (National Patient Safety Reporting and Learning System)
- Integrated Delivery Meetings (TDA)

9. ESCALATION AND ASSURANCE

Background and Introduction

9.1 The Trust's approach to performance management aims to provide an integrated and robust monitoring and management process from specialty level through to the Trust Board. It is designed to capture, report, monitor, communicate and predict Trust performance for a range of national, local, strategic quality and operational targets and indicators, which assist the Trust, Clinical Management Groups (CMG) and Corporate Directorates in their understanding and management of their performance.

9.2 Data presentation is designed to be fit for purpose, informative, and clear and simple to understand / interpret, with its use of performance assessment colours and symbols which draw attention to areas of potential risk. A Data Quality Review Group has been established, reporting quarterly to the Executive Team, to ensure the validity and robustness of data.

9.3 The structure of the various performance reports used to evaluate performance is consistent, irrespective of whether the reported data relates to corporate, CMG or specialty areas.

9.4 The content of the reports is continually reviewed and enhanced and is readily adaptable so that, as other targets or indicators develop or emerge, they can be readily incorporated.

9.5 The current approach has evolved over a number of years. During this time, it has incorporated many quality management and governance measures, as well as retaining its more established measures aligned to areas such as activity, patient access and workforce management. Additional modifications have occurred as the Trust prepares to achieve Foundation Trust Status.

The approach in place within the Trust comprises the following components:

- Quality and Performance report
- CMG Performance Management and Development Process
- Role of Boards and Committees
- Escalation Process

Quality and Performance report

9.6 The monthly Quality and Performance Report provides a fully integrated quality and performance dashboard.

The monthly report:-

- is structured in line with the NHS Trust Development Authority accountability framework for NHS Trust Boards and includes information on outcome measures; quality governance measures; and access measures;

- includes performance indicators rated red, amber or green and an overview of both in-month and year to date performance, and trends;

- is complemented by commentaries from the accountable Executive Directors identifying key issues to the Board and, where necessary, corrective actions to bring performance back on track.

9.7 The performance indicators and measures included in the report reflect the priorities and commitments agreed by the Department of Health, National Trust Development Authority, the Trust's Commissioners as well as those of the Trust itself. The report enables the Trust to identify remedial action which may be required to address an area of adverse performance.

The report is reviewed and discussed each month at:

- Executive Performance Board (accountable to the Chief Executive)
- Finance and Performance Committee (accountable to Trust Board)
- Quality and Assurance Committee (accountable to Trust Board)
- Trust Board

9.8 The report contains data on performance shown by month, quarter and year to date. An executive summary is provided to highlight performance successes and exceptions pertinent to the reporting period.

9.9 At each of the meetings referred to in paragraph 9.7 above, the reasons for any sub-optimal performance are explored, with actions undertaken or required recorded appropriately. If necessary, the Executive Performance Board will escalate issues to the Finance and Performance Committee, Quality Assurance Committee or Trust Board.

9.10 Such meetings also provide the means for an on-going assessment of the appropriateness of the indicators and their targets / trajectories, as well as the opportunity to discuss the inclusion of additional indicators.

Clinical Management Group Performance Management and Development

9.11 During November 2013, the Executive Team has replaced its former monthly cycle of Clinical Division 'Confirm and Challenge' meetings with the following new arrangements-:

- **monthly performance meeting** - held between the senior CMG team (ie Director, General Manager, Head of Nursing and relevant leads) and the Chief Operating Officer (Chair), Director of Finance and Business Services, Chief Nurse, Medical Director and Director of Human Resources. This meeting is to develop a standard agenda covering quality, performance, finance and workforce;

- **quarterly development meeting** – held between the senior CMG team (as above), plus their Heads of Service and the Chief Executive (Chair), Chief Operating Officer, Director of Finance and Business Services, Chief Nurse, Medical Director, Director of Human Resources, Director of Strategy and Director of Marketing and Communications. This meeting will focus on service planning, strategic development, horizon scanning, etc.

9.12 These arrangements ensure that the Trust maintains a strong grip on quality and performance issues whilst at the same time making sure that time is dedicated to discussing development and strategy with a wider group of CMG leaders.

9.13 At the time of writing, discussions are taking place on the potential establishment of a further senior group, namely, the Executive Workforce Board. It is anticipated that this group will focus on the Trust's workforce model, values, behaviours and attitudes, HR health indicators and workforce equality.

Role of Boards and Committees

9.14 The Quality and Performance report is received at a number of meetings, committees and boards, as identified previously. The first such meetings – CMG Performance Management meetings - are chaired by the Trust's Chief Operating Officer. This meeting considers performance data for the preceding month. By exception, any areas of sub-optimal performance are examined and CMGs are expected to identify causes for this and to put in place the required remedial action.

9.15 The next stage in the cycle is a review of the Trust's performance at the monthly meeting of the Executive Performance Board, chaired by the Chief Executive. Discussions at this meeting identify key issues needing to be discussed, addressed and, if necessary, escalated.

9.16 Following this, two formal committees of the Trust Board, the Finance and Performance Committee (F&P) and Quality Assurance Committee (QAC), each chaired by a Non-Executive Director of the Trust, meet and receive, as a standard agenda item, a copy of the Quality and Performance report. Consideration of the report and Executive Directors' by the committees is informed by the outcome of earlier discussions held at the commentary CMG Performance Management meetings and Executive Performance Board meeting. The purpose of the Committees is:

- To provide the Board with a means of independent and objective assurance following review of the Trust's financial management and management of performance against the range of national and locally agreed targets.
- To monitor the financial performance of individual CMGs and Directorates, by considering regular management performance reports from individual CMGs and Directorates.
- To consider performance against external performance targets set from time to time by the DOH and Trust Development Authority, and
- To consider performance against a range of internally developed clinical, financial and operational indicators
- To monitor performance against the key operational targets, with the QAC considering specifically the quality and safety implications of the position
- To escalate quality and safety concerns arising from under performance to the Trust Board
- To provide assurance to the Trust Board on finance and performance quality and safety within the Trust

9.17 The Finance and Performance Committee reviews the performance of each CMG at least annually and more frequently where performance matters are escalated to it. The CMG management team is required to attend these meetings. The Quality Assurance Committee requests representatives of CMGs to attend its meetings based on matters highlighted as potentially or actually having adverse implications for quality and safety within the Trust.

Escalation Process

9.18 Although professional judgement will always be employed when determining the types of issues to be brought to the attention of the Finance and Performance Committee, Quality Assurance Committee and Trust Board, the Trust recognises that this must be supported by a more systematic process of escalation. This assists with bringing the necessary focus to resolving operational and financial challenges and provides and emphasizes objective performance measurement.

9.19 Consequently, the Trust plans during 2014 to formalise a range of trigger points or thresholds, linked to the finance, service and contractual performance measures which will be used as the principal means against which the Trust's Clinical Management Groups are

held to account by the Trust's Executive Directors. This work has commenced via the Service Line Management Board where initial discussions have focused on the construction of a 'balanced scorecard' allowing performance to be measured with regard to key performance indicators for quality, workforce, operational performance and financial delivery.

9.20 Ward performance is assessed having regard to the Trust's Ward performance System approved by the Trust Board on 31 October 2013. This system provides a basis for examining the performance of wards by tracking performance monthly against a series of clinical measures set out in a 'clinical measures dashboard'.

9.21 The data derived from the clinical measures dashboard is used to inform the compilation of the Ward Performance Tool.

9.22 Data on performance set out in the clinical measures dashboard and Ward Performance Tool is subject to monitoring by Heads of Nursing on a 'peer review' basis; and also subject to monitoring by the Nursing Executive Team (chaired by the Chief Nurse).

9.23 Data set out in the clinical measures dashboard and Ward Performance Tool is also reported formally monthly by the Chief Nurse via the Quality and Performance Report to the Executive Performance Board, Quality Assurance Committee and Trust Board.

Performance Management

9.24 Where performance is within the identified thresholds, management of any adverse performance remains within the remit of the CMG Management Team. Where performance is adverse , the CMG is expected to prepare a time defined rectification plan to be reviewed at the CMG Performance Management meetings, Executive Performance Board and, if appropriate, Finance and Performance Committee and/or Quality Assurance Committee and/or Trust Board. In these circumstances, the CMG can expect to receive targeted support from outside of the CMG. In the event that performance remains adverse, then the CMG may be designated as in need of 'special measures', in which case the CMG shall lose autonomy to act without Executive Director agreement.

9.25 Any CMG asked to produce a rectification plan may be requested to attend the Trust's Finance and Performance Committee or Quality Assurance Committee, where a review of the plan will be undertaken. If any group or body is tasked with addressing any adverse performance, a summary update on progress will be expected.

9.26 If a material or protracted variance from an agreed trajectory within a rectification plan manifests itself, it may also be escalated to the Chief Executive for further formal action. Escalation to the next level occurs in the month that thresholds are breached.

9.27 To foster a culture of 'earned autonomy', consideration is being given to modifying the existing arrangements so that CMGs which are performing successfully are 'released' from the requirement to attend monthly Performance Management meetings. Again, this work is being taken forward via the Service Line Management Board.

9.28 The principles within this document are equally applicable to the system of performance services review undertaken by CMGs when reviewing the performance of their portfolio of clinical services. In this respect the CMG is acting as a 'span of control' as defined in Monitor's guidance governing the implementation of Service Line Management. The system of performance management at this level shall include routines and reports including, but not limited to:

- CMG Boards to meet at least monthly with a standard agenda, minuted and action tracking where required
- The agenda will include a minimum range of review areas such as Quality, Workforce, Activity, Finance and Risk.
- Escalation triggers are expected to be as robust as those applicable to CMGs.

Response to concerns and incidents

9.29 In addition to the formalised and periodic processes which are described in this framework document, it is important that the Trust has the capability to respond to concerns or incidents in a timely fashion, particularly where they may represent a threat to patient safety or statutory compliance.

9.30 In this area the Trust operates according to two basic principles:

- all staff have a duty to raise concerns and report incidents
- those in receipt for such concerns or reports have a duty to respond to them effectively so as to mitigate risk.

9.31 In practice, the response required varies considerably according to the nature of the concern. In some cases, immediate action may be required e.g. critical staffing shortages in a ward area. In other cases, and particularly with more complex or longstanding issues, the commissioning of a full report may be the appropriate response. However, the response must always be:

- timely
- proportionate
- comprehensive
- inclusive
- effective

9.32 The level of the organisation at which an issue should be addressed also varies considerably. The principle of subsidiarity is generally followed i.e. the lowest level consistent with providing an effective response. If one level finds that it cannot provide an effective response, it is has a duty to escalate to the next level. However, escalation should not be used simply to pass on a problem.

9.33 In some situations, it will be appropriate to bring in external or independent support. This may be particularly necessary in situations of internal conflict or where the necessary expertise does not exist within the Trust. Decisions to commission external support will generally be taken at CMG Director or Executive level.

10. TRUST BOARD COMMITTEE STRUCTURE

10.1 The Board has adopted a committee structure to strengthen its focus on quality and safety and finance and performance. The structure is designed to provide effective governance over, and challenge to, the Trust's various business activities. The committees therefore carry out detailed work of assurance on behalf of the Board.

10.2 All of the Board committees are chaired by a Non-Executive Director and comprise a mixture of both Non-Executive and Executive Directors within their memberships. The exceptions to this are the Audit Committee and the Remuneration Committee, respectively, which comprise Non-Executive Directors exclusively.

10.3 A diagram setting out the Trust's Board Committee structure is attached at Appendix 'C'.

Audit Committee

10.4 This Committee's focus is to seek assurance that financial reporting and internal control principles are applied, and to maintain an appropriate relationship with the organisation's auditors, both internal and external. The Audit Committee meets five times a year and provides assurance to the Board about the reliability and robustness of the processes of internal control. This includes the power to review the work of other committees', including that in relation to quality, and to provide assurance to the Board with regard to internal controls. The Audit Committee also has responsibility for oversight of risk management.

Finance and Performance Committee

10.5 This Committee meets monthly and oversees the effective management of the financial resources of the Trust and operational performance across a range of measures.

Quality Assurance Committee

10.6 This Committee seeks assurance that there are effective arrangements for monitoring and continually improving the quality of healthcare provided to patients. The Committee ensures that appropriate scrutiny is given to the three key facets of quality – effectiveness, patient safety and patient experience. Quality performance is discussed in detail regularly at the Committee which meets monthly and this group complements the role of the board as a driving force for continuous quality improvement across the full range of services.

10.7 In November 2013, the Executive Team took the decision to replace the 'Quality and Performance Management Group' with a new body, the Executive Quality Board. This new Board is seen as a key component of the arrangements in place at Executive level to provide assurance on internal control and compliance, including the provision of assurance to the Quality Assurance Committee.

10.8 This Board, which meets monthly, is chaired by the Chief Nurse. The Medical Director is Vice-Chair and the other representatives are as follows:

- Chief Operating Officer
- Director of Clinical Quality
- Director of Nursing
- Director of Safety and Risk
- Deputy Medical Directors (2)
- Deputy Director of Infection Prevention and Control
- Associate Medical Director (Safety and Effectiveness)
- Head of Outcomes and Effectiveness
- CMG representatives (either Clinical Director of Lead Nurse).

10.9 The principal purpose of the Executive Quality Board is to enable the Executive Team to obtain assurance that high standards of care are provided by the Trust and, in particular, that adequate and appropriate governance structures, processes and controls are in place throughout the Trust to:

(a) promote safety and excellence in patient care;

(b) identify, prioritise and manage risk arising from clinical care;

(c) ensure the effective and efficient use of resources through evidence-based clinical practice;

(d) protect the health and safety of Trust employees;

(e) ensure that all statutory elements of clinical governance are adhered to within the Trust.

10.10 The Executive Quality Board oversees the work of a number of sub-committees, listed below:

Clinical Ethics Committee
Clinical Audit Committee
Complaints Review Group (TBE)
End of Life Committee (TBE)
Frail Elderly Committee (TBE)
Health and Safety Committee
Hospital Transfusion Committee
Infection Prevention Assurance Committee
Learning from Experience Group
Medicines Management Board
Mortality Review Committee
New and Innovative Procedures Authorisation Group
Organ Donation Committee
Patient Experience Committee (TBE)
Resuscitation Committee
Safeguarding Committee
Thrombosis Committee
NB: (TBE) = to be established

10.11 A work programme is currently being prepared for the Executive Quality Board. Amongst other matters, the Board will oversee compliance with the Trust's Clinical Audit Policy and Mortality and Morbidity Policy, respectively, and seek to provide assurance onward on those and other matters to the Quality Assurance Committee.

Remuneration Committee

10.12 Acting on behalf of the Board, the duties of this Committee are to take decisions on the remuneration and terms of service for the Chief Executive and other Executive Directors. It also monitors and evaluates the performance of the Executive Directors and oversees contractual arrangements, including proper calculation and scrutiny of termination payments. The Committee additionally has a role in succession planning for Executive Director roles. It meets at least four times per year.

11. MONITORING OF ACTION PLANS AND TRACKERS

11.1 The Trust has developed a common action plan template. All action plans are developed in accordance with this model.

11.2 The Trust has processes in place to monitor action arising from external reviews, internal audit reports and Serious Untoward Incidents.

12. REVIEW

12.1 The Assurance and Escalation Framework will be subject to further development as the new Clinical Management Group arrangements (introduced between September and November 2013) become embedded, and as the Trust develops its approach to service line management.

12.2 The Assurance and Escalation Framework will be reviewed on an annual basis by the Trust Board.

Stephen Ward
Director of Corporate and Legal Affairs

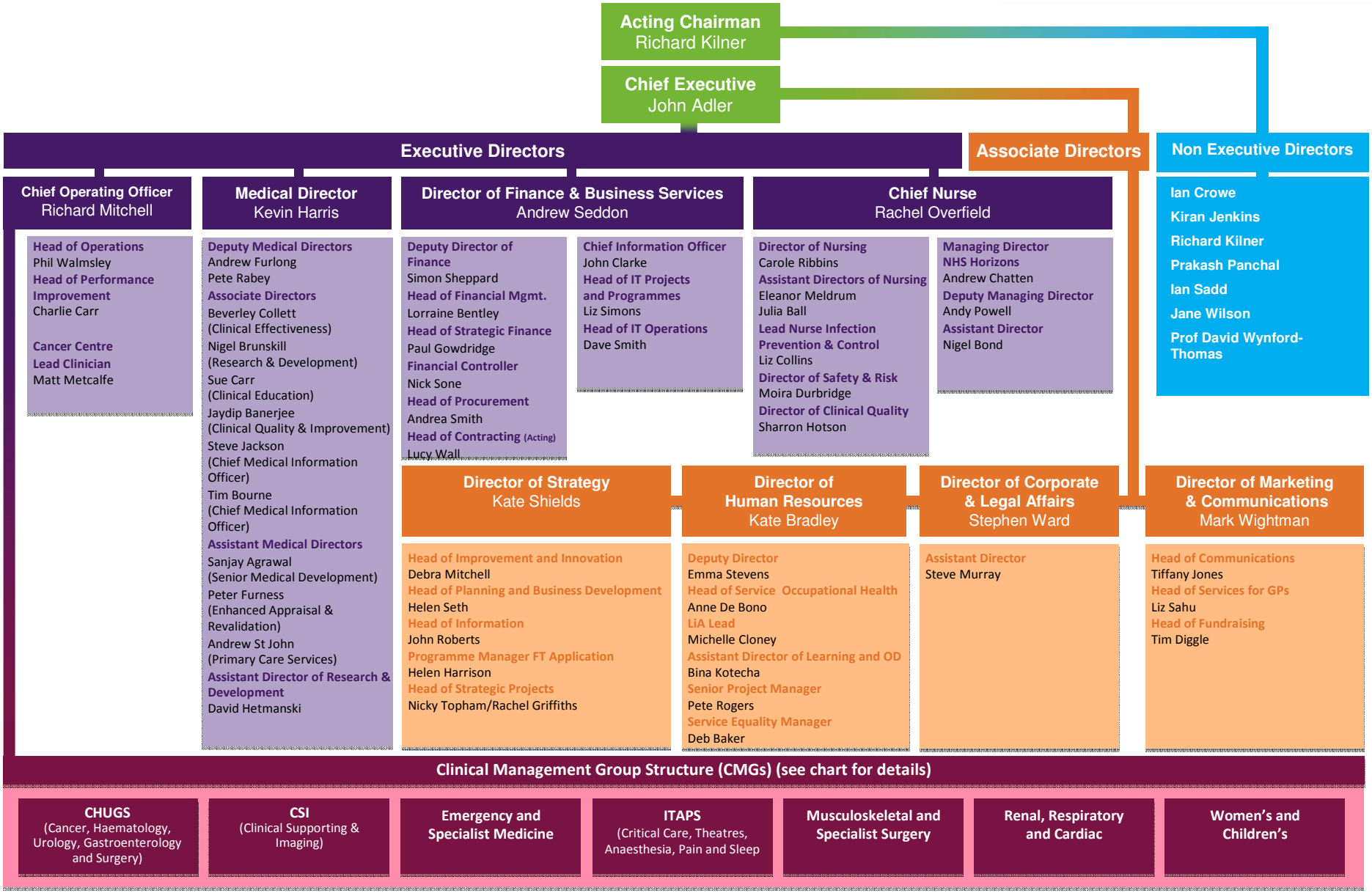
18 December 2013

Trust Board Bulletin 20 December 2013 Paper 1

Management Structure University Hospitals of Leicester NHS Trust

University Hospitals of Leicester NHS
NHS Trust

Caring at its best



University Hospitals of Leicester NHS
NHS Trust

Caring at its best

Management Structure University Hospitals of Leicester NHS Trust

Chief Operating Officer
Richard Mitchell

Clinical Management Group Structure (CMGs)

CHUGS
(Cancer, Haematology, Urology, Gastroenterology and Surgery)

Clinical Director
John Jameson

Deputy Clinical Director
Nicky Rudd

General Manager
Jo Fawcus

Deputy General Manager
Michael Nattrass

Head of Nursing
Georgina Kenney

Deputy Head of Nursing
Kerry Johnston

Human Resources Lead
Clare Blakemore

Finance Lead
Sab Esat

Quality & Safety Lead
TBC

Education Lead
TBC

PPI Leads
George Kenney
Kerry Johnson

Research Lead
Anne Thomas

CSI
(Clinical Supporting & Imaging)

Clinical Director/Associate Director for Clinical Improvement
Suzanne Khalid

Deputy Clinical Director
Andy Rickett

General Manager
Nigel Kee

Deputy General Manager
Chris Shatford

Head of Nursing
Jeanette Halborg

Human Resources Lead
Joanne Tyler Fantom

Finance Lead
Tony Maton

Quality & Safety Lead
TBC

Education Lead
TBC

PPI Lead
Jeanette Halborg

Research Lead

Emergency and Specialist Medicine

Clinical Director
Catherine Free

Deputy Clinical Director
Mark Ardron

General Manager
Jane Edyvean

Deputy General Manager
TBC

Head of Nursing
Gill Staton

Deputy Heads of Nursing
Lisa Lane/Kerry Morgan (Emergency)
Sue Burton (Specialist Medicine)

Human Resources Lead
Kalwant Khaira

Finance Lead
Raj Rughani

Quality & Safety Lead
TBC

Education Lead
Rose Webster

PPI Lead
Gill Staton

Research Lead

ITAPS
(Critical Care, Theatres, Anaesthesia, Pain and Sleep

Clinical Director
Paul Spiers

Deputy Clinical Director
Helen Brooks

General Manager
Monica Harris

Deputy General Manager
Dale Travis

Head of Nursing
Jo Hollidge

Human Resources Lead
Kalwant Khaira

Finance Lead
Paul Gowdridge

Quality & Safety Lead
TBC

Education Lead
Justine Cadwallader

PPI Lead
Jo Hollidge

Research Lead
Jonathan Thompson

Musculoskeletal and Specialist Surgery

Clinical Director
Richard Power

Deputy Clinical Director
Kevin Boyd

General Manager
Sarah Taylor

Deputy General Manager
Chris Lyon

Head of Nursing
Nicola Grant

Deputy Head of Nursing
Kerry Pape

Human Resources Lead
Joanne Tyler Fantom

Finance Lead
Ryggs Gill

Quality & Safety Lead
(BC

Education Lead
Diane Champion

PPI Lead
Nicola Grant

Research Lead

Renal, Respiratory and Cardiac

Clinical Director
Nick Moore

Deputy Clinical Director
Leon Hadjinkolaou

General Manager
Sam Leak

Deputy General Manager
Faye Gordon

Head of Nursing
Sue Mason

Deputy Head of Nursing
Jo Bayes

Human Resources Lead
Clare Blakemore

Finance Lead
Lorraine Bentley

Quality & Safety Lead
TBC

Education Lead
TBC

PPI Lead
Jo Bayes

Research Lead

Women's and Children's

Clinical Director
Ian Scudamore

Deputy Clinical Director
Andy Currie

General Manager
David Yeomanson

Deputy General Manager
TBC

Head of Nursing
Kate Wilkins
Hiliary Killer

Deputy Head of Nursing
Elizabeth Aryeetey

Acting Head of Midwifery
Elaine Broughton

Human Resources Lead
Tina Larder

Finance Lead
Stuart Shearing

Quality & Safety Lead
TBC

Education Lead
Lynn Stokoe

PPI Lead
Hiliary Killer

Research Lead
David Field

University Hospitals of Leicester NHS
NHS Trust

Caring at its best

Management Structure University Hospitals of Leicester NHS Trust

Clinical Management Group Structure (CMGs) – Services

CHUGS
(Cancer, Haematology, Urology, Gastroenterology and Surgery)

CANCER AND HAEMATOLOGY
Head of Service
Mamta Garg (Haem)
Will Steward (Oncology)
David Peel (Oncology)
Service Manager
Angharad Rastrick

UROLOGY
Head of Service
Masood Khan
Service Manager
Lisa Gowan

GASTROENTEROLOGY (ENDOSCOPY)
Head of Service
Allister Grant
Service Manager
Gaynor Webb

GENERAL SURGERY
Head of Service
Andrew Miller (LRI)
Mathew Metcalfe (LGH)
Service Manager
Lisa Gowan

CSI
(Clinical Supporting & Imaging)

PHARMACY & THERAPIES
Chief Pharmacists
Bhav Pattani/Claire Ellwood
Head of Therapies
Lynn Cooke
Dietetics
Cathy Steele
Service Managers
Paul Couchman
Claire Meakin

MEDICAL RECORDS, OUTPATIENTS, BOOKING CENTRE, PHLEBOTOMY
Service Manager
Debbie Waters

IMAGING AND MEDICAL PHYSICS
Medical Lead
Andy Rickett
Manager
Carl Ratcliff
Service Managers
Mark Norton (Med Physic)
Judy Gilmour (Imaging)
Cathy Lea (Imaging)
Vacant (Breast Screening)

EMPATH
Managing Director
Paul Shaw
Medical Lead
Angus McGregor
Chief Operating Officer
Tony Scriven

Emergency and Specialist Medicine

EMERGENCY MEDICINE/ED
Service Manager
Rachel Williams
Head of Service
Ben Teasdale (ED)
Lee Walker (Acute)

GERIATRIC MEDICINE AND NEUROSCIENCES
Service Manager
Andy Palmer
Head of Service
Simon Conroy (Geriatrics)
Martin Fotherby and Rachel March (Stroke)
Peter Critchley (Neuro)

SPECIALIST MEDICINE
Service Manager
Linda Dales (Rheumatology, Dermatology, Diabetes and Endocrinology and IDU)
Heads of Service
James Francis (Rheum)
Rob Burd (Dermatology)
Ian Lawrence (Diabetes & Endocrinology)
Iain Stephenson (IDU)

ITAPS
(Critical Care, Theatres, Anaesthesia, Pain and Sleep

CMG Heads of Service
Chris Allsager (ITU)
David Kirkbride (LRI)
Vacancy (Gfd/LGH)
CMG General Manager
Paula Vaughan

INTENSIVE CARE
Lead Clinician
John Parker and Rakesh Vaja

THEATRES
Lead Clinician
Justin Williams
General Manager
Dale Travis
Service Manager
Max Tipler
Operational Manager
Vacancy

ANAESTHETICS
Lead Clinician
Justin Williams
Service Manager
Mark Tipler

PAIN
Lead Clinician
Margaret Bone

SLEEP
Lead Clinician
Andrew Hall

Musculoskeletal and Specialist Surgery

MUSCULOSKELETAL
Heads of Service
Aamer Ullah (Elective)
Patrick Wheeler (Sports & Exercise)
Jason Braybrook (Trauma)
Service Manager
Sue Nattrass
Operational Manager
Sally Legoode

SPECIALIST SURGERY
Heads of Service
James Deane (Ophthalmology)
Ade Mosaku (ORD)
Sanjay Varma (Plastics)
Akhtar Nasim (Vascular)
Sheila Shokuhi (Breast Care)
Anil Banerjee (ENT)
Ian Ormiston (Maxfax and Oral Surgery)
Service Managers
Chris Lyon (Ophthalmology)
Gaby Harris (ORD, ENT , MaxFax & Oral Surgery)
Steve Peck (Plastics)
Carolyn Stokes (Vascular)
Operational Managers
Debbie Harvey/Pat Bingley (Ophthalmology)
Catherine Seaby (ORD, ENT , Maxfax & Oral Surgery)
Maggie Gaskell (Plastics & Breast Care)
Vacancy (Vascular)

Renal, Respiratory and Cardiac

CARDIOLOGY, CARDIAC SURGERY AND THORACICS
Head of Service
Jan Kovac
Service Manager
Lorraine Bertram-Dickens
Operational Manager
Glen Sibbick

RENAL AND TRANSPLANT
Head of Service
James Medcalfe
Service Manager
Jon Gulliver
Technical Services Manager
Danny Withers

RESPIRATORY SERVICES
Heads of Service
Simon Range/Mick Steiner
Service Manager
Amanda Gough
Operational Manager
Lisa Jeffs

Women's and Children's

WOMENS
Heads of Service
Quenton Davies (Gynae)
Christina Oppenheimer (Maternity)
Jonathan Cusack (Neonates)
Pradeep Vasudevan (Clinical Genetics)
Service Managers
Cathy Morgan (interim)
Donata Marshall (Gynae, Neonates, Clinical Genetics)

CHILDREN'S
Heads of Service
Paediatric Medical Sub-Specialites & Education (Vacancy)
Children's Assessment Unit and Acute General Paediatrics (Vacancy)
Mark Duthie (General Paediatrics Surgery, ICU and HDU and Clinical Governance)
Giles Peek (EMCHC and ECMO)
Service Managers
Nancy Reed (EMCHC
Tina Clegg (Medicine)
Nick Kirk (Surgery)

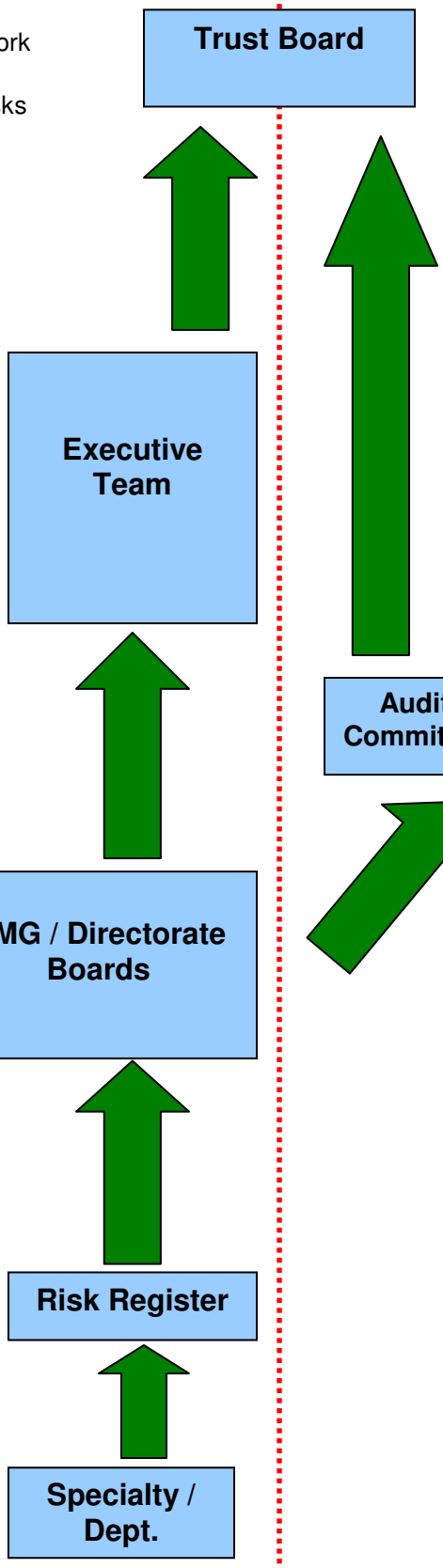
Appendix: B

UHL RISK REPORTING FRAMEWORK

Executive Function

Assurance Function

- Will review the Board Assurance Framework (BAF) no less then 4 times per year.
- Will receive a bi-annual report showing risks scoring 15 or above.



- Will receive notification from CMGs / Directorates of risks scoring 25.
- Will confirm & challenge risks scoring 25 for potential inclusion in BAF.
- Will receive monthly update of the BAF.
- Will receive a monthly report from the UHL corporate risk management team showing all risks scoring 15 or above and associated mitigating actions not completed within agreed timescales.
- Will receive a bi-annual report showing risks scoring between 8 and 12 (moderate risks).

Will hold CMGs / directorates to account for the effective management of local risks.

- Will receive an update of the Trust's BAF and a report showing risks scoring 15 or above (high and extreme) at each meeting

- Will receive a monthly report from corporate risk management team showing CMG or directorate risks scoring 15 or above (high and extreme).
- Will receive a quarterly report from corporate risk management team showing risks scoring between 8 and 12 (moderate).

- Approved risks entered on to risk register. See process at appendix six.

- Identify risks of all types/scores.
- Will provide monthly notification to CMG or directorate boards of new risk assessments for approval prior to entry on to the CMG/ directorate risk register.

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST **APPENDIX C**

COMMITTEE STRUCTURE

CHARITABLE FUNDS COMMITTEE
Chair : Prakash Panchal
Bi-monthly

TRUST BOARD
Acting Chair : Richard Kilner
Monthly (last Thursday)

AUDIT COMMITTEE
Chair : Kiran Jenkins
X 5 meetings per annum

FINANCE AND PERFORMANCE COMMITTEE
Chair : Richard Kilner
Monthly (last Wednesday)

QUALITY ASSURANCE COMMITTEE
Chair : Jane Wilson
Monthly (last week)

REMUNERATION AND TERMS OF SERVICE COMMITTEE
Chair : Richard Kilner
Quarterly

CHIEF EXECUTIVE
John Adler

EXECUTIVE TEAM
Chair : Chief Executive
Weekly – except when meetings of EPB and ESB are held

EXECUTIVE PERFORMANCE BOARD
Chair : Chief Executive
Monthly : last Tuesday

EXECUTIVE QUALITY BOARD
Chair : Chief Nurse
Monthly

EXECUTIVE STRATEGY BOARD
Chair : Chief Executive
Monthly : first Tuesday

EXECUTIVE WORKFORCE BOARD (TBE)

Commercial Executive
Cross CMG Forum
Data Quality Forum
Policy and Guideline Committee

CMG Performance Management Meetings

Clinical Ethics Committee
Clinical Audit Committee
Complaints Review Group (TBE)
End of Life Committee (TBE)
Frail Elderly Committee (TBE)
Health and Safety Committee
Hospital Transfusion Committee
Infection Prevention Assurance Committee
Learning from Experience Group
Medicines Management Board
Mortality Review Committee
New and Innovative Procedures Authorisation Group
Organ Donation Committee
Patient Experience Committee (TBE)
Resuscitation Committee
Safeguarding Committee
Thrombosis Committee

CMG Quarterly Development meetings
Foundation Trust Programme Board
Innovation and Improvement Framework Board
LLR Better Care Together Programme Board
Research and Development Executive
Site Reconfiguration Programme Board

UHL Doctors in Training Committee
UHL Medical Education and Training Committee
UHL Training, Education and Development Group
Listening into Action Sponsor Group
Local Education and Training Committee
Local Education and Training Group

SUB - COMMITTEES

SW/DB 5.12.13

TBE = To be established