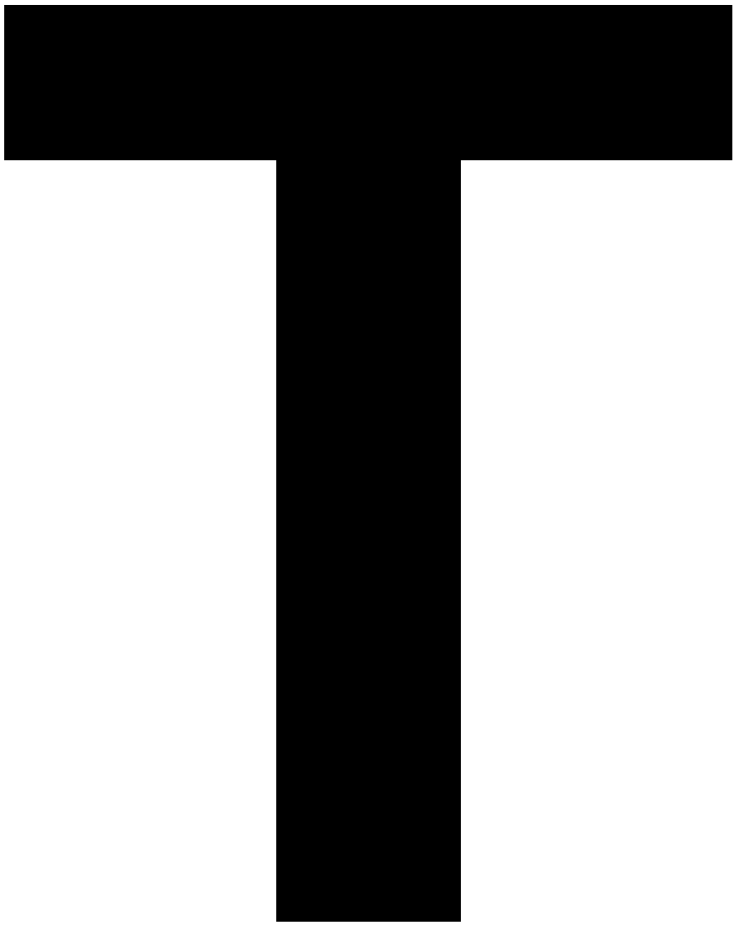


Trust Board Paper T

To:	Trust Board
From:	Stephen Ward, Director of Corporate & Legal Affairs
Date:	20th December 2013
CQC regulation:	N/A

Title:	NHS trust oversight self certification

Author/Responsible Director: Helen Harrison, FT Programme Manager / Stephen Ward, Director of Corporate & Legal Affairs

Purpose of the Report:

At the beginning of April 2013, the NHS Trust Development Authority (NTDA) published a single set of systems, policies and processes governing all aspects of its interactions with NHS trusts in the form of '*Delivering High Quality Care for Patients: The Accountability Framework for NHS Trust Boards'.*

In accordance with the Accountability Framework, the Trust is required to complete two self certifications in relation to the Foundation Trust application process. Copies of the November 2013 self certifications are attached as Appendix A and B.

The Report is provided to the Board for:

Decision	X	Discussion	X
Assurance		Endorsement	

Summary / Key Points:

- Subject to discussion at the December 2013 Trust Board meeting on matters relating to operational and financial performance, it is proposed that the December 2013 self certification against Monitor Licensing Requirements (Appendix A) and Trust Board Statements (Appendix B) be updated following the Trust Board meeting and submitted to the NHS Trust Development Authority accordingly

Recommendations:

The Trust Board is asked to provide the Director of Corporate and Legal Affairs with the delegated authority to agree a form of words with the Chief Executive in respect of the December 2013 self certifications (Appendix A and B), to be updated following the Trust Board meeting and submitted to the NHS Trust Development Authority accordingly

Previously considered at another corporate UHL Committee? No

Strategic Risk Register: No	**Performance KPIs year to date:** N/A

Resource Implications (eg Financial, HR): No

Assurance Implications: Yes

Patient and Public Involvement (PPI) Implications: No

Stakeholder Engagement Implications: No

Equality Impact: None

Information exempt from Disclosure: None

Requirement for further review? All future trust oversight self certifications will be presented to the Trust Board for approval

NHS TRUST DEVELOPMENT AUTHORITY

OVERSIGHT: Monthly self-certification requirements - Compliance Monitor

Monthly Data.

CONTACT INFORMATION:

Enter Your Name: John Adler

Enter Your Email Address john.adler@uhl-tr.nhs.uk

Full Telephone Number: 01162588940 Tel Extension: 8940

SELF-CERTIFICATION DETAILS:

Select Your Trust: University Hospitals Of Leicester NHS Trust

Submission Date: 29/11/2013 Reporting Year: 2013/14

Select the Month

○ April	○ May	○ June
○ July	○ August	○ September
◉ October	○ November	○ December
○ January	○ February	○ March

COMPLIANCE WITH MONITOR LICENCE REQUIREMENTS FOR NHS TRUSTS:

1. **Condition G4** – Fit and proper persons as Governors and Directors (also applicable to those performing equivalent or similar functions).
2. **Condition G5** – Having regard to monitor Guidance.
3. **Condition G7** – Registration with the Care Quality Commission.
4. **Condition G8** – Patient eligibility and selection criteria.

5. **Condition P1** – Recording of information.
6. **Condition P2** – Provision of information.
7. **Condition P3** – Assurance report on submissions to Monitor.
8. **Condition P4** – Compliance with the National Tariff.
9. **Condition P5** – Constructive engagement concerning local tariff modifications.

10. **Condition C1** – The right of patients to make choices.
11. **Condition C2** – Competition oversight.

12. **Condition IC1** – Provision of integrated care.

Further guidance can be found in Monitor's response to the statutory consultation on the new NHS provider licence: The new NHS Provider Licence

COMPLIANCE WITH MONITOR LICENCE REQUIREMENTS FOR NHS TRUSTS:

		Comment where non-compliant or at risk of non-compliance
1. Condition G4 Fit and proper persons as Governors and Directors.	Yes	
		Timescale for compliance:
2. Condition G5 Having regard to monitor Guidance.	Yes	
		Timescale for compliance:
3. Condition G7 Registration with the Care Quality Commission.	Yes	
		Timescale for compliance:

		Comment where non-compliant or at risk of non-compliance
4. Condition G8 Patient eligibility and selection criteria.	Yes	
		Timescale for compliance:

		Comment where non-compliant or at risk of non-compliance
5. Condition P1 Recording of information.	Yes	
		Timescale for compliance:
6. Condition P2 Provision of information.	Yes	
		Timescale for compliance:
7. Condition P3 Assurance report on submissions to Monitor.	Yes	
		Timescale for compliance:
8. Condition P4 Compliance with the National Tariff.	Yes	
		Timescale for compliance:

		Comment where non-compliant or at risk of non-compliance
9. Condition P5 Constructive engagement concerning local tariff modifications.	Yes	
		Timescale for compliance:

		Comment where non-compliant or at risk of non-compliance
10. Condition C1 The right of patients to make choices.	Yes	
		Timescale for compliance:
11. Condition C2 Competition oversight.	Yes	
		Timescale for compliance:
12. Condition IC1 Provision of integrated care.	Yes	
		Timescale for compliance:

NHS TRUST DEVELOPMENT AUTHORITY

OVERSIGHT: Monthly self-certification requirements - Board Statements

Monthly Data.

CONTACT INFORMATION:

Enter Your Name: John Adler

Enter Your Email Address: john.adler@uhl-tr.nhs.uk

Full Telephone Number: 01162588940 Tel Extension: 8940

SELF-CERTIFICATION DETAILS:

Select Your Trust: University Hospitals Of Leicester NHS Trust

Submission Date: 29/11/2013 Reporting Year: 2013/14

Select the Month

○ April	○ May	○ June
○ July	○ August	○ September
◉ October	○ November	○ December
○ January	○ February	○ March

BOARD STATEMENTS:

CLINICAL QUALITY
FINANCE
GOVERNANCE

The NHS TDA's role is to ensure, on behalf of the Secretary of State, that aspirant FTs are ready to proceed for assessment by Monitor. As such, the processes outlined here replace those previously undertaken by both SHAs and the Department of Health.

In line with the recommendations of the Mid Staffordshire Public Inquiry, the achievement of FT status will only be possible for NHS Trusts that are delivering the key fundamentals of clinical quality, good patient experience, and national and local standards and targets, within the available financial envelope.

BOARD STATEMENTS:

For CLINICAL QUALITY, that

1. The Board is satisfied that, to the best of its knowledge and using its own processes and having had regard to the TDA's oversight model (supported by Care Quality Commission information, its own information on serious incidents, patterns of complaints, and including any further metrics it chooses to adopt), the trust has, and will keep in place, effective arrangements for the purpose of monitoring and continually improving the quality of healthcare provided to its patients.

1. CLINICAL QUALITY Indicate compliance.	Yes
Timescale for compliance:	
RESPONSE: Comment where non-compliant or at risk of non-compliance	

BOARD STATEMENTS:

For CLINICAL QUALITY, that

2. The board is satisfied that plans in place are sufficient to ensure ongoing compliance with the Care Quality Commission's registration requirements.

2. CLINICAL QUALITY
Indicate compliance.

Yes

Timescale for compliance:

RESPONSE:

Comment where non-compliant or at risk of non-compliance

BOARD STATEMENTS:

For CLINICAL QUALITY, that

3. The board is satisfied that processes and procedures are in place to ensure all medical practitioners providing care on behalf of the trust have met the relevant registration and revalidation requirements.

3. CLINICAL QUALITY
Indicate compliance.

Yes

Timescale for compliance:

RESPONSE:

Comment where non-compliant or at risk of non-compliance

BOARD STATEMENTS:

For FINANCE, that

4. The board is satisfied that the trust shall at all times remain a going concern, as defined by the most up to date accounting standards in force from time to time.

4. FINANCE
Indicate compliance.

Yes

Timescale for compliance:

RESPONSE:

Comment where non-compliant or at risk of non-compliance

BOARD STATEMENTS:

For GOVERNANCE, that

5. The board will ensure that the trust remains at all times compliant with the NTDA accountability framework and shows regard to the NHS Constitution at all times.

5. GOVERNANCE
Indicate compliance.

Yes

Timescale for compliance:

RESPONSE:

Comment where non-compliant or at risk of non-compliance

BOARD STATEMENTS:

For GOVERNANCE, that

6. All current key risks to compliance with the NTDA's Accountability Framework have been identified (raised either internally or by external audit and assessment bodies) and addressed – or there are appropriate action plans in place to address the issues in a timely manner.

6. GOVERNANCE
Indicate compliance.

Risk

Timescale for compliance:

28/11/2013

RESPONSE:

Comment where non-compliant or at risk of non-compliance

The Trust has reported to the NTDA that it is £19.5m adverse to plan as at month 7. Urgent discussions continue with the NTDA and commissioners regarding the year end forecast. The Trust has commissioned independent advice to assist in verifying the financial position and forecast. A special Board meeting will be held on 13th December 2013 to agree the submission to the NTDA due on 16th December 2013. The financial forecast will be reported publicly to the Trust Board on 20th December 2013.

BOARD STATEMENTS:

For GOVERNANCE, that

7. The board has considered all likely future risks to compliance with the NTDA Accountability Framework and has reviewed appropriate evidence regarding the level of severity, likelihood of a breach occurring and the plans for mitigation of these risks to ensure continued compliance.

7. GOVERNANCE
Indicate compliance.

Yes

Timescale for compliance:

RESPONSE:

Comment where non-compliant or at risk of non-compliance

BOARD STATEMENTS:

For GOVERNANCE, that

8. The necessary planning, performance management and corporate and clinical risk management processes and mitigation plans are in place to deliver the annual operating plan, including that all audit committee recommendations accepted by the board are implemented satisfactorily.

8. GOVERNANCE
Indicate compliance.

Yes

Timescale for compliance:

RESPONSE:

Comment where non-compliant or at risk of non-compliance

BOARD STATEMENTS:

For GOVERNANCE, that

9. An Annual Governance Statement is in place, and the trust is compliant with the risk management and assurance framework requirements that support the Statement pursuant to the most up to date guidance from HM Treasury (www.hm-treasury.gov.uk).

9. GOVERNANCE
Indicate compliance.

Yes

Timescale for compliance:

RESPONSE:

Comment where non-compliant or at risk of non-compliance

BOARD STATEMENTS:

For GOVERNANCE, that

10. The Board is satisfied that plans in place are sufficient to ensure ongoing compliance with all existing targets as set out in the NTDA oversight model; and a commitment to comply with all known targets going forward.

10. GOVERNANCE
Indicate compliance.

No

Timescale for compliance:

01/04/2014

RESPONSE:

Comment where non-compliant or at risk of non-compliance

UHL is currently non compliant with the ED 4 hour wait target and the Referral to Treatment (RTT) - admitted and non-admitted targets.
The Trust is working towards sustainable compliance with the ED target. An Emergency Care Improvement Hub has been established, which brings together partners from across health and social care.
The formal agreement of a RTT plan by commissioners remains outstanding. An initial RTT action plan was submitted to commissioners on 14th August 2013 and a revised plan was subsequently submitted on 11th September 2013. As requested, we have submitted a further recovery plan to commissioners on 28th November 2013. Recovery of the RTT admitted and non-admitted targets is expected by 2014/15. Previous reported performance appears to have been enhanced by not taking patients in chronological order. This is being investigated

BOARD STATEMENTS:

For GOVERNANCE, that

11. The trust has achieved a minimum of Level 2 performance against the requirements of the Information Governance Toolkit.

11. GOVERNANCE
Indicate compliance.

Yes

Timescale for compliance:

RESPONSE:

Comment where non-compliant or at risk of non-compliance

BOARD STATEMENTS:

For GOVERNANCE, that

12. The board will ensure that the trust will at all times operate effectively. This includes maintaining its register of interests, ensuring that there are no material conflicts of interest in the board of directors; and that all board positions are filled, or plans are in place to fill any vacancies.

12. GOVERNANCE
Indicate compliance.

Yes

Timescale for compliance:

RESPONSE:

Comment where non-compliant or at risk of non-compliance

BOARD STATEMENTS:

For GOVERNANCE, that

13. The board is satisfied that all executive and non-executive directors have the appropriate qualifications, experience and skills to discharge their functions effectively, including setting strategy, monitoring and managing performance and risks, and ensuring management capacity and capability.

13. GOVERNANCE
Indicate compliance.

Yes

Timescale for compliance:

RESPONSE:

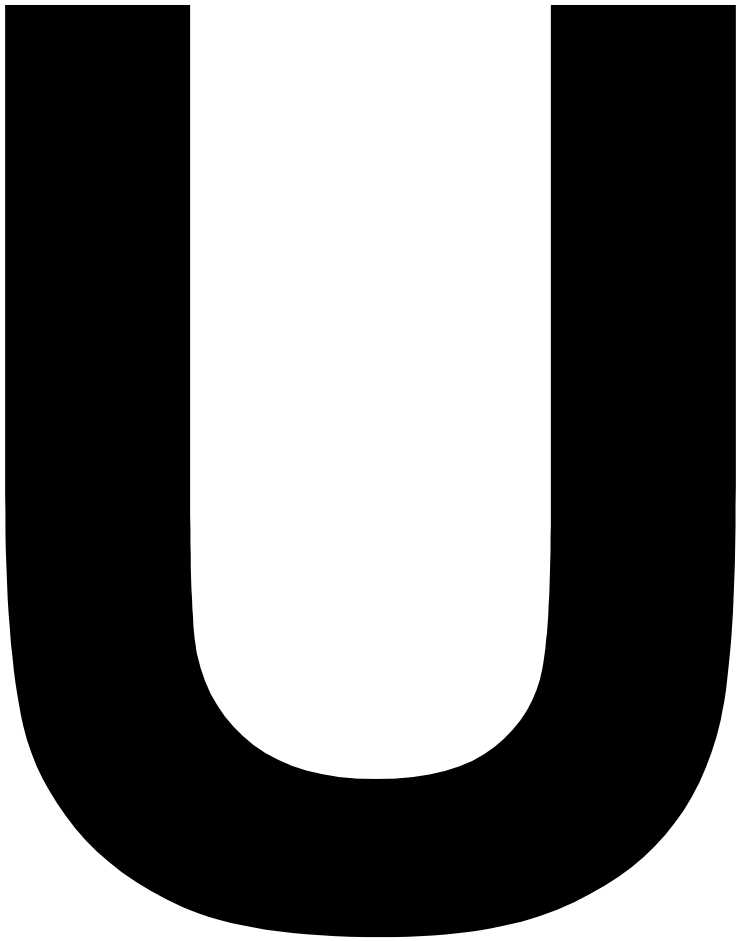
Comment where non-compliant or at risk of non-compliance

BOARD STATEMENTS:

For GOVERNANCE, that

14. The board is satisfied that: the management team has the capacity, capability and experience necessary to deliver the annual operating plan; and the management structure in place is adequate to deliver the annual operating plan.

14. GOVERNANCE Indicate compliance.	Yes
Timescale for compliance:	
RESPONSE:	
Comment where non-compliant or at risk of non-compliance	



Trust Board Paper U

To:	Trust Board
From:	Kate Shields, Director of Strategy
Date:	20th December 2013
CQC regulation:	N/A

Title:	Securing Sustainable Services

Author/Responsible Director: Kate Shields, Director of Strategy

Purpose of the Report:

To advise the Board of proposed changes to the process for assessing trusts on their journey to foundation trust (FT) status

The Report is provided to the Board for:

Decision		Discussion	X
Assurance		Endorsement	

Summary / Key Points:

- On 25th November 2013 the NHS Trust Development Authority (NTDA) issued a joint letter (on behalf of the NTDA, Monitor and the Care Quality Commission (CQC)) to all NHS trusts (attached as Appendix A)
- The letter, entitled 'Securing sustainable services for patients' sets out the revised process for assessing trusts on their journey to FT status

Key points of note are:

- The fundamental requirements for FT status set out in Monitor's *Guide for Applicants* remain, however, the sequencing of the future assessment process will now be as follows:
  - **1)** NHS trusts will continue to work with the NTDA to ensure that they are ready for the assessment process
  - **2)** The first part of the formal assessment process will be an inspection of the trust by the CQC. Achieving an overall rating of "Good" or "Outstanding" will be required to pass to the next stage
  - **3)** Trusts that meet the CQC requirements will move forward in the application process, culminating in consideration by the NTDA Board. The NTDA aim to reach a decision on applications **within two to three months of the CQC inspection**, which includes the time needed for the CQC to produce its report.
  - **4)** Monitor will undertake its assessment process (set out in the *Guide for Applicants)*, with the aim of reaching a decision on an application **within four to six months of receiving a referral from the NTDA.** The total time from the CQC inspection to Monitor's decision should **normally be six to nine months**

Further improvements and next steps

- Bringing forward Monitor's assessment of quality governance. Monitor will undertake this assessment while the trust is still working with the NTDA to develop its application
- Streamlining the different aspects of financial assessment and Historic Due Diligence so that they occur at the most appropriate point in the process and add as much value as possible
- Embedding public and patient involvement more thoroughly into the process by broadening the basis of the public consultation which trusts undertake and by ensuring this area is clearly reflected in assessments of the quality of care
- The CQC's new inspection process includes an assessment of how well-led an organisation

is. As the assessment of leadership and governance is also a central part of the FT assessment process (and the NTDA's broader oversight of NHS trusts), a single, shared framework describing effective culture, leadership and governance is being developed.	
Recommendations: The Trust Board is asked to **note** changes to the process for assessing the Trust's readiness for FT status set out in this paper	
Previously considered at another corporate UHL Committee? No	
Strategic Risk Register: No	**Performance KPIs year to date:** N/A
Resource Implications (eg Financial, HR): No	
Assurance Implications: Yes	
Patient and Public Involvement (PPI) Implications: No	
Stakeholder Engagement Implications: Yes	
Equality Impact: None	
Information exempt from Disclosure: None	
Requirement for further review? Yes, the revised process for assessing the Trust' readiness for FT status will be reflected in a review of the Trust's overall FT application timeline	

Dear colleague

Securing sustainable services for patients

The challenges facing NHS leaders have never been greater. The drive to continually improve the quality of services for patients, the growing financial pressures, and the focus on developing a healthier and more open culture mean that the agenda for you and your organisations is both demanding and highly complex. In this context, putting services on a sustainable footing and moving your organisations towards Foundation Trust (FT) status is a greater challenge than ever before, but a fundamentally important one nevertheless.

This letter provides a high level update on changes to the process for developing and assessing NHS trusts on their journey to FT status. It is the product of a detailed review of the process conducted jointly by the NHS TDA, Monitor and the CQC. The need for a review was driven by three main factors: first, the recommendations set out in the most recent report of the Mid Staffordshire Public Inquiry; second, the need to align the assessment process with the new Chief Inspector of Hospitals regime; and third, the need to reflect the role which the NHS TDA has taken on following the abolition of the Strategic Health Authorities and the opportunity it presented to streamline the end-to-end assessment process.

Overview of the revised process

The fundamental requirements for FT status as set out in Monitor's *Guide for Applicants* remain consistent: centred on high quality services; sound strategic and business planning; and strong governance and leadership. In line with the recommendations of the Mid Staffordshire Inquiry, the quality of services will be given priority at all times. The sequencing of the future assessment process will be as follows:

- **NHS trusts will work with the NHS TDA to ensure they are ready for the assessment process**, and are providing high quality services underpinned by a strong business plan. The NHS TDA will provide development and support for NHS trusts, alongside its routine oversight, to help them prepare for the assessment process.

- **The first part of the formal assessment process will be a thorough inspection of the trust by the Chief Inspector of Hospitals.** Aspirant trusts will be inspected alongside other organisations as part of the Chief Inspector's routine programme. Once the CQC's new ratings system is fully rolled out, an overall rating of "Good" or "Outstanding" will be required to pass to the next stage of the assessment process. In the meantime, the Chief Inspector will indicate in the inspection report whether a Trust's FT application should proceed. In advance of the roll out of the new inspection methodology for non-acute Trusts in October 2014, Monitor, NHS TDA and CQC are devising an interim arrangement that enables CQC to provide robust assurance of non-acute trusts.

- **Trusts that meet the CQC requirements will quickly move forward in the application process, culminating in consideration by the NHS TDA Board.** The Board will assess the organisation's overall readiness for FT status, including its business plan, FT application, and quality of services. If the NHS TDA Board is satisfied that the trust is ready to proceed then it will offer its support, on behalf of the Secretary of State, for the organisation to move to Monitor for assessment. The NHS TDA will aim to reach a decision on applications within two to three months of the CQC inspection, which includes the time needed for the CQC to produce its report. Organisations already with Monitor for assessment will receive their CQC inspection during the Monitor phase and will not be required to go back to the NHS TDA for approval.

- **Monitor will then undertake its assessment process as set out in the *Guide for Applicants* to determine whether the organisation should be authorised as a Foundation Trust.** Monitor will normally aim to reach a decision on an application within four to six months of receiving a referral from the NHS TDA. This means that the total time from the CQC inspection to Monitor's decision should normally be six to nine months, assuming the aspirant organisation passes all of the required assessments.

Placing the Chief Inspector's inspection at the front end of the process will ensure that the quality of services sits at the heart of the assessment, and will allow organisations to focus on getting the quality of their services to the right standard before advancing to the Monitor phase of the assessment process.

Inevitably, the need for a thorough inspection by the Chief Inspector has led to delays for a number of organisations in their journey to FT status. However, NHS TDA, Monitor and CQC are working closely together so that, as the Chief Inspector's regime is rolled out, those organisations providing high quality sustainable services will be able to move quickly through the process. The Chief Inspector is already organising his inspection schedule to minimise the delay to those Trusts that are well advanced in the FT pipeline. Three aspirant trusts have been included in the first wave of CQC inspections (Quarter 3 2013/14), with a further ten aspirants, including six non-acute providers, included in the second wave (Quarter 4 2013/14).

Further improvements and next steps

Our review has also considered some of the more detailed elements of the assessment in order to streamline and align them as effectively as possible. Changes we have agreed include:

- **Bringing forward Monitor's assessment of quality governance** so that it takes place at an earlier stage in the process**.** The existing Monitor team will undertake this assessment while the trust is still working with the NHS TDA to develop its application. This will provide Monitor with an earlier insight into aspirant trusts, and will help to reduce the number of organisations which struggle to pass Monitor's final assessment due to quality governance concerns.

- **Streamlining the different aspects of financial assessment and Historic Due Diligence** to ensure that they occur at the most appropriate point in the process and add as much value as possible. This area will be the subject of further work by Monitor and the NHS TDA.

- **Embedding public and patient involvement more thoroughly into the process** by broadening the basis of the public consultation which trusts undertake, and by ensuring this area is clearly reflected in assessments of the quality of care.

A key part of the CQC's new inspection process will include an assessment of how well-led an organisation is, which will include scrutiny of culture, leadership and governance. As the assessment of leadership and governance is also a central part of the FT assessment process, and of the NHS TDA's broader oversight of NHS trusts, we are developing a single, shared framework that describes effective culture, leadership and governance. Our ambition is for this framework to be used by organisations themselves to develop and understand their own position, by Monitor and the NHS TDA in their oversight of providers, and by the CQC in its inspection processes. We will be working together over the coming period to make this shared framework a reality.

In making these changes, our aim is to ensure that the Foundation Trust assessment process is aligned, coherent and efficient, while ensuring that the tests of quality and sustainability are rigorous and relevant. In the meantime, should you have any questions about how the new process will apply to your organisation, please contact the relevant Portfolio Director at the NHS TDA.

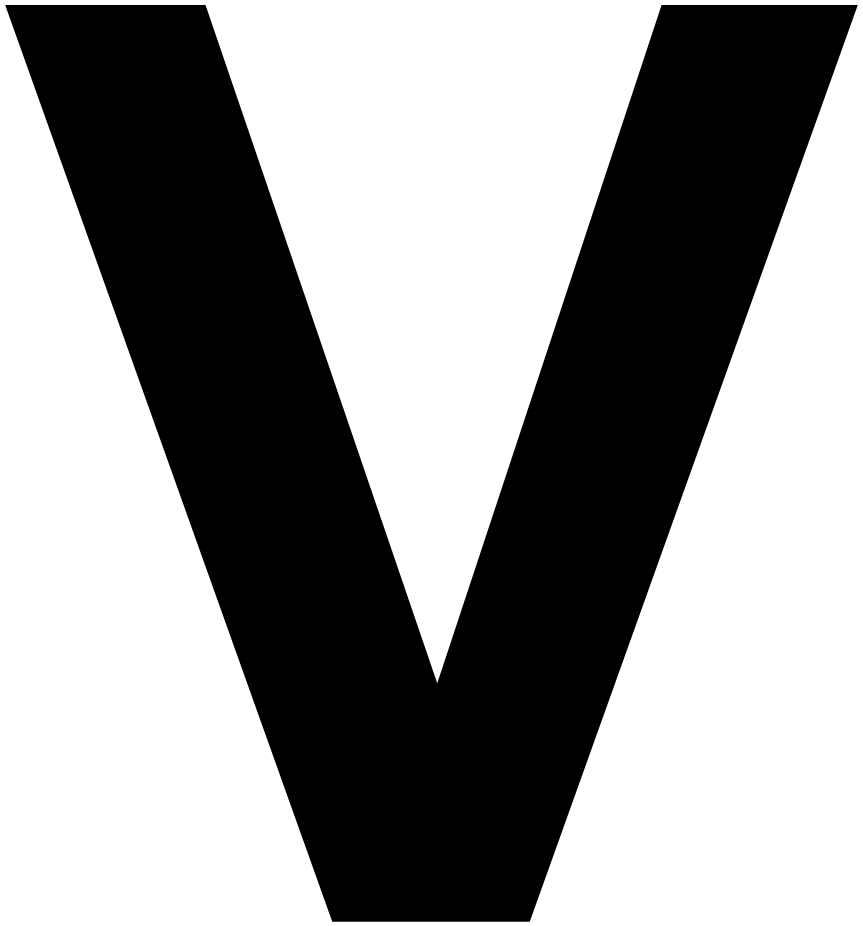
We hope to see many more providers meeting the standards required to become an FT over the coming months, as our progress towards creating a strong provider sector offering high quality services for patients continues.

Yours sincerely,

David Flory CBE
Chief Executive
NHS Trust Development Authority

David Bennett
Chair/Chief Executive
Monitor

Professor Sir Mike Richards
Chief Inspector of Hospitals
Care Quality Commission



Trust Board Paper V

To:	Trust Board
From:	Kate Shield
Date:	20 December 2013
CQC regulation:	All

Title:	**2014/16 OPERATIONAL PLAN – 1ST DRAFT**

Author/Responsible Director: Kate Shields/Helen Seth

Purpose of the Report:
The purpose of this paper is to:

i. Provide an overview of the national and local landscape within which we are developing our 2-year operational plans.
ii. Provide a high level overview of our 1st draft CMG plans.
iii. Outline next steps.

The Report is provided to the Board for:

Decision		Discussion	X
Assurance		Endorsement	

Summary / Key Points:
On the 4 November, NHS England, Monitor, National Trust Development Authority (NTDA) and the Local Government Authority (LGA) wrote to all CCG's, NHS and Foundation Trusts, Local Authorities and Social Care Services to outline draft strategic and operational planning guidance, focusing specifically on process and expectations. The guidance outlined 14 key objectives (Appendix 1) and emphasised the expectation that 5-year integrated transformation plans will be developed across the NHS and social care.

In the immediate term there is a clear expectation that 2-year operational plans will create headroom in 2014/15 for a stepped change in performance in 2015/16.

The report reflects the 1st cut of CMG initiatives. These are still under development and are presented to give a flavour of service plans to date. Please note they reflect work in progress.

Following discussion between executives and the CMG leads it is proposed that a one day workshop will be held in January to progress this work further with a view to a single framework for our business plan with clear trajectories for delivery.

Recommendations:
The Trust Board are asked to:
RECEIVE this report
NOTE the progress to date
PROVIDE comment as necessary

Previously considered at another corporate UHL Committee?

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

Resource Implications (eg Financial, HR): Set out in the AOP 2013/14**.**

Assurance Implications:N/A
Patient and Public Involvement (PPI) Implications: Yes
Stakeholder Engagement Implications:
Equality Impact:
Information exempt from Disclosure:
Requirement for further review?

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST

REPORT TO: Trust Board

REPORT FROM: Kate Shields, Director of Strategy

AUTHOR: Helen Seth

RE: 1st Draft CMG Operational Plans 2014-2016

DATE: 20 December 2013

1. PURPOSE

The purpose of this paper is to:

i. Provide an overview of the national and local landscape within which we are developing our 2-year operational plans.

ii. Provide a high level overview of our 1st draft CMG plans.

iii. Outline next steps.

2. CONTEXT

The NHS and social care system face unprecedented levels of financial and service pressure. The size of the challenge calls for fundamental change which will only be achieved through joint working, the commitment to implement an integrated service between NHS and local government, seven day working and the risk appetite to push forward long-term transformation, pump primed as necessary through non-recurrent financial resources.

On the 4 November, NHS England, Monitor, National Trust Development Authority (NTDA) and the Local Government Authority (LGA) wrote to all CCG's, NHS and Foundation Trusts, Local Authorities and Social Care Services to outline draft strategic and operational planning guidance, focusing specifically on process and expectations. The guidance outlined 14 key objectives (Appendix 1) and emphasised the expectation that 5-year integrated transformation plans will be developed across the NHS and social care. The latter will ultimately need to show how local partners will jointly rise to the challenge, be accountable for delivery and secure clinical and financial sustainability.

In the immediate term there is a clear expectation that 2-year operational plans will create headroom in 2014/15 for a stepped change in performance in 2015/16.

The establishment of the CMG's in September has provided a timely opportunity to engage clinical services in the development of their service plans on the basis of 2 year's detail, within an evolving 5-year strategy framework.

3. FINANCIAL CONTEXT

The Trust's financial performance in 2013/2014, the first cut Financial Plan for 2014/15 and the Terms of Reference for the Health Economy External Review are covered by separate papers to Trust Board in December. They are not therefore replicated in this paper. Future iterations of our Service and Financial Plans will be presented for Trust Board consideration in a single integrated document as the

necessary level of detail becomes available. Final approval will be required in March, 2014.

4. IMPROVEMENT AND DEVELOPMENT PRIORITIES

Our Annual Plan for 2013/14 was developed against a backdrop of numerous performance, economic and service challenges. Four material themes were identified. These reflect the "must do's" for our short, medium and long term plans. The themes are as follows:

i. The Emergency Department and emergency process

a. Discharge processes

b. Risk stratification – Care of the Elderly

c. Dementia Care

d. Seven day working

ii. Clinical and financial sustainability

a. Transformation in models of care

b. Medical model and productivity

c. Theatre productivity

d. Reducing premium spend

e. Commissioner Intentions

f. Seven day working

iii. Delivering quality

a. Delivering our quality commitment

b. Patient experience

c. Nursing establishment

d. Workforce planning

e. Seven day working

iv. Securing appropriate clinical configuration

a. Within the Trust

b. Across the local health community

c. Specialised services

d. Strategic Partnerships

Some progress has been made in 2013/14 however in other areas there has either been no change or indeed a worsening position. It is clear therefore that these themes remain key priorities for our forthcoming operational plans. These need to be

developed in line with our commitment to deliver cost control in 2014/15 and incremental deficit reduction. There will be limited opportunity to invest to save. 2014/16 will need to demonstrate the ability to save, in order to invest.

5. PROGRESS TO DATE

A workshop called "Delivering our Strategic Direction" was held with our newly established CMGs in November. It was hosted by the Director of Strategy and provided a timely opportunity to set the scene and define the context within which 2-year Operational Plans are to be developed.

Each CMG nominated a strategy lead to work in partnership with the Business and Strategy Support Team to define and develop the process by which our operational plans will be developed between now and consideration in detail by Trust Board at the end of March, 2014. A further workshop is planned for January 2014 with an extended invitation to heads of service and patient and public representatives.

6. HIGH LEVEL OVERVIEW – 1st DRAFT PLANS FOR 2014-2016

Key initiatives are still under development. They are summarised by CMG below and are presented to give a flavour of service plans the CMGs have developed to date. Please note they reflect work in progress.

Renal, Respiratory, Cardiac	Acute and Specialist Medicine	Cancer, Haematology, Urology and Gastroenterology and Surgery	Critical Care, Theatres, Anaesthesia, Pain and Sleep	Musculoskeletal and Specialist Surgery	Women's and Children's	Clinical Support and Imaging
Develop pathways with partners to decrease hospital admission and improve patient experience - For known patients develop direct access / crisis management / virtual ward so the patients can come straight to the service without needing to attend ED. Work with commissioners and contracting to set up telemedicine support to primary care to enable decision making in the community without sending patients onto UCC or ED Decrease 30 day emergency readmission rates (quality improvement and cost avoidance) Focus on top 3 HRGS per speciality to validate PLICS position and identify opportunities for cost improvement without detriment to quality	Transformation in Emergency Department model of care process and workforce design. Complete 43m capital investment programme - Emergency Floor Project Develop 7/7 services and the further development of care pathways with community partners supporting early and safe discharge Develop geriatric input to ensure that all areas caring for older people have access to a geriatrician. Implement focussed comprehensive geriatric assessment working in partnership with social care Implementation of the diabetes "super 7" Development of integrated acute and rehabilitation care pathways for stroke Ensure appropriate service requirement commissioned to achieve compliance with	Surgical Triage Emergency Pathways - Consultant led surgical triage ideally 7 days/wk. 11am – 7pm. Currently the project has agreement for Mon-Fri. This will require investment in Consultant posts but will ensure patients are triaged by a Consultant while the on-call Consultant is in theatre. Key benefits: Reduced LOS, efficient utilisation of beds which will impact positively on elective admissions Phase 2 of the surgical triage capital development project agreed for 2014/15. Business case to be submitted (SAU relocates to Ward 7 and has an access lift to ED replicating the AMU model) Review and reconfiguration of emergency admissions including the implementation of a Urology nursing outreach team; Chemotherapy - Aim to achieve more efficient throughput within the Chemotherapy Unit,	Deliver a planned maintenance programme - Expansion of emergency operating capacity Friday/ Monday. Short stay and ambulatory model of surgical care. Continue to provide theatre resources to meet the service and admitted pathway demands by removing suitable activity to a clean room setting and managing resources to greatest effect. Theatres - Workforce and retention planning. Roll out of LiA initiatives and programme of training Critical Care - LRI phase 1 build – 3 physical bed space expansion Critical Care - LRI/LGH change in consultant work plans to begin cross site on call rota Retain establishment of nursing staff to ensure critical care capacity is open – build increasing flexibility	Develop Trauma Services to include dedicated Spinal service and improved performance against BPT criteria for Fractured Neck of Femur Develop One Stop Screening Services for Breast Care patients thereby improving the patient experience and reducing multiple attendances Relocate Outpatient and Elective Services as part of the LLR Alliance Contract - moving care closer to home where it is safe and appropriate to do so Develop Full Business Case for Vascular Surgery (from LRI to GGH to facilitate co-location with cardio-vascular services Develop robust workforce models mapped to demand (specialties including Maxillofacial, Orthodontics and Restorative Dentistry)	Further strengthen Paediatric Acute Services working towards the delivery of single front door with Paediatric Emergency Department Develop East Midlands Congenital Heart Centre to ensure it meets the new Congenital Heart Review criteria Progress the development of Gynaecology services to include ambulatory Gynaecology, networking Gynae-Oncology, and working with community providers Create additional Maternity and Neonatal capacity through appropriate service modification, innovation and development Expand Children's and Neonatal surgery ensuring adequate intensive care and high dependency support	Consistently deliver ED turnaround time standards for imaging. **Further reduce imaging waiting times from request to report in all modalities.** **Consistently deliver cancer target turnaround time standards for imaging.** **Consolidation of imaging and therapy services with the community as part of the Alliance contract proposal.** **Support the Trust's BRUs from an imaging, pathology and medical physics perspective.** **Completed and implemented Management of Change in pharmacy and imaging giving us a flexible cross site 7 day /week workforce.**

Renal, Respiratory, Cardiac	Acute and Specialist Medicine	Cancer, Haematology, Urology and Gastroenterology and Surgery	Critical Care, Theatres, Anaesthesia, Pain and Sleep	Musculoskeletal and Specialist Surgery	Women's and Children's	Clinical Support and Imaging
Work in partnership with neighbouring acute Trusts to lead the market for example: Burton - Short term to support a shortfall in staff and expertise and quality Kettering and Northampton General Hospital - Medium to long term pathway reconfiguration for cancer, respiratory and procedures. Attendance at MDT's to increase surgical referrals to LRI. Ireland - Waiting list initiatives Renal dialysis - Ensure robust delivery of renal dialysis in the community, maintain market share of delivery and thereby enable cost efficiency through procurement at scale Renal access - Increase Vascular access conversions compliance	specifications eg:HIV Maximising opportunities from the Alliance contract as part of core OP deliverable – OP redesign	Bone marrow patients often have an extremely long length of stay. The service plans to utilise an offsite facility where patients can go to after treatment rather than stay in a hospital bed (subject to appropriate safeguards) Nottingham Alliance - The CMG needs to understand the implications and ideas around partnership proposals with Nottingham for BMT and Haemophilia. Northampton Alliance - Discussions are underway to form an alliance with NGH and KGH to deliver sustainable Oncology The intention is to form a strong joint Cancer Centre. Elective General surgery and Urology day case work will move to suitable community hospitals allowing capacity to be utilised on the main sites	into workforce requirements to meeting daily changing demand HDU repatriation – Work with colleagues to improve patient flow, patient outcomes, SHMI and income to the Trust Critical Care - Approval for phase 2 physical build to meet future demand and consolidate capacity and expertise. Consolidate new anaesthetic roles. Separation of paediatric operating. Roll out LiA initiatives - Reduce same day cancellation rate. Improve efficiency through theatres Pain - Left shift to community setting – outpatients, acupuncture, day case treatments and Pain Management Programme		**Promote and develop specialist services as Regional and National** Centres of Excellence e.g. Clinical Genetics and Primary Ciliary Dyskinesia	

Renal, Respiratory, Cardiac	Acute and Specialist Medicine	Cancer, Haematology, Urology and Gastroenterology and Surgery	Critical Care, Theatres, Anaesthesia, Pain and Sleep	Musculoskeletal and Specialist Surgery	Women's and Children's	Clinical Support and Imaging
		This will provide a sustainable solution for RTT and cancer delivery. By 2015/2016 100% of patients suitable for radical radiotherapy are to have IMRT (50% in 2014/2015). To support delivery there will be a requirement for the 4th linear accelerator bunker to be replaced. At the same time a business case will be developed and submitted to NHS England identifying the need for a 5th bunker (decant). This is CQUIN target. Gastroenterology Bowel Screening – UHL Bowel Screening Centre established (split from Kettering). Screeners appointed and screening running from March 2014. Gastroenterology - JAG Accreditation GGH. The endoscopy unit requires building works to achieve JAG accreditation.	Pain - Investment in inpatient pain consultant sessions, supporting earlier **discharge for surgical and medical patients thereby reducing occupied bed days** **Pain - Become centre of choice for East Midlands – Specialist Commissioning (partnership working opportunity)** **Pain - First full year of Paediatric Pain Management Programme – strengthen out of LLR referral patterns for all MPT services** **Sleep - Left shift to community setting – annual device checks and home sleep study set up in the 2014/16 period with a longer term view to left shift for the county OSA service**			

Renal, Respiratory, Cardiac	Acute and Specialist Medicine	Cancer, Haematology, Urology and Gastroenterology and Surgery	Critical Care, Theatres, Anaesthesia, Pain and Sleep	Musculoskeletal and Specialist Surgery	Women's and Children's	Clinical Support and Imaging
		Bowel Scope - An application has been submitted for the second wave of bowel scope (flexi-sigmoidoscopy screening programme). This is a national mandatory programme to be **implemented from December 2014. It will require extra capacity of 17 endoscopy lists per week. Opportunities to work in partnership and utilise capacity at Loughborough Hospital are being explored. This would require investment to get the JAG accreditation. This is an opportunity identified as part of the Elective Care Alliance Contract submission.** **Gastroenterology - Working with ethnic minority communities on health promotion in relation to all GI diseases.**	Sleep - Investment in Sleep Disorder services footprint to support left shift change in Service delivery model – conversion of outpatient space into complex sleep study areas matching OSA shift into community and increased demand for neurology complex sleep disorders Sleep - Development of system to capture OSA patient base as part of British Sleep Society accreditation criteria supporting bid to become centre of choice and facilitating accurate clinical outcome data and **performance measures**			

Renal, Respiratory, Cardiac	Acute and Specialist Medicine	Cancer, Haematology, Urology and Gastroenterology and Surgery	Critical Care, Theatres, Anaesthesia, Pain and Sleep	Musculoskeletal and Specialist Surgery	Women's and Children's	Clinical Support and Imaging
		Urology Transformation - A major part of 2014/15 will focus on the Urology service. Potential removal of the bladder reconstruction service circa 15 patients per year – insufficient critical mass, not clinically sustainable. Palliative Care - End of life planning is a major focus. The Amber advanced care planning process will be rolled out and a business case will be submitted to the CCGs for consideration				

7. NEXT STEPS

Following an initial review of the first cut strategic plans, the publication of the 7 day working standards and the imminent financial recovery plan it is clear that we need to understand and address our 'drivers of deficit' in more detail.

Following discussion between executives and the CMG leads it is proposed that a one day workshop will be held in January to consider the next steps including:

i. Service based visions

ii. 2 – 5 year strategic intentions

iii. Delivering site reconfiguration

iv. Single framework for our business plan with clear trajectories.

v. CMG contribution to 7 day working (medical modernisation and ED)

vi. Cost control

vii. Theatre productivity

viii. Service model modernisation (workforce initiatives)

ix. Growing business – opportunities and stretch.

8. RECOMMENDATIONS

The Trust Board are asked to:

RECEIVE this report

NOTE the progress to date

PROVIDE comment as necessary

APPENDIX 1 – NATIONAL PLANNING GUIDANCE (NOVEMBER 2013)

NHS England, Monitor, National Trust Development Authority (NTDA) and the Local Government Authority (LGA) confirmed 14 key objectives that need to be considered as part of the strategic and operational planning processes:

i. Improving outcomes (informed by detailed patient and public participation)

ii. Delivering quality, meeting expectations and securing sustainability

iii. Consistent assumptions (e.g. demographic growth rates)

iv. Strengthening tariff guidance (including confirmation that when a Trust is reimbursed at less than 100% of national tariff, both commissioner and provider will be jointly engaged in the reinvestment decision and that there will be transparency in the re-investment scheme. This will include non-payment for readmissions, marginal rate for emergency tariff

v. Confirmed allocations (to be published week commencing 16 December)

vi. Efficiency assumptions (4% 2014/15 subject to consultation)

vii. Weighted average cost inflation (2.1% 2014/15 subject to consultation)

viii. Tariff deflator (1.9% 2014/15 subject to consultation – excludes impact of CSNT on specific HRG groups)

ix. CQUIN (Scheme to be revised. Guidance will be published in December,2 013)

x. Integration Transformation Fund (Further guidance in December, 2013)

xi. Joint working

xii. Unit of planning (support to commissioners)

xiii. Support

xiv. Assurance/ Challenge process – the processes used in 2013/14 will be enhanced including an additional step to reconciled commissioners and provider plans

W

Trust Board Paper W

To:	**Trust Board**
From:	Kate Shields Director of Strategy
Date:	**20 December 2013**
CQC regulation:	All applicable

Title:	University Hospitals of Leicester Travel Plan

Author/Responsible Director:
Andrew Chatten Managing Director NHS Horizons / Kate Shields Director of Strategy

Purpose of the Report:
To seek Trust Board endorsement of the UHL Travel Plan

The Report is provided to the Board for:

Decision		Discussion	
Assurance		Endorsement	X

Summary / Key Points:

- The report attached is an Executive Summary of the UHL Travel Plan. A full copy is available for review by request.

Planning Regulations

- Local Authority planning regulations, inclusive of section 106 of the Town and Country Planning Act 1990, have implications for UHL in delivery of capital programmes and operational management of hospital sites. This is because Local Authorities can insist upon inclusions and / or amendments to planning applications in order for consent to be given. This can include section 106 provisions for issues relating to travel and environmental considerations.
- This is particularly impactful with regard to travel planning and as such UHL has previously prepared on a voluntary basis, Travel Plans. The last one being completed in 2001, with annual updates thereafter.
- As part of the significant capital programme and site reconfiguration proposals which will be phased from 2013 to 2018, UHL commissioned a new Travel Plan which is presented for endorsement in this report.
- The Travel Plan will be used to engage the City Council about prospective planning applications and will act as a touchstone for them at a strategic level, reducing the risk of surprises with specific projects and meeting our responsibilities under section 106 of the Town and Country Planning Act 1990.
- The 2013 UHL Travel Plan is focused on encouraging people to choose alternative transport modes, reducing the environmental impact of single occupancy car use. This will form a strand of our sustainability plan
- It should be noted that the Travel Plan is not a planning application as such as specific planning applications will be subject to individual traffic impact assessments. These are by nature more detailed than the Travel Plan
- The 2013 Travel Plan has assessed modes and volumes of travel across the three UHL acute sites and has made a series of recommended actions to best encourage the use of alternative modes of transport.

- Trust Board are not being asked to approve capital resources for the recommended actions as the Travel Pan is a high level strategic document which sets a general direction of travel according to core principles. Any business cases approved as part of the site reconfiguration will therefore have to consider travel implications. Any capital implications will be considered as part of the Business case process.
- Trust Board are asked to note that the Travel Plan is a reference point and a component part in determining UHL's strategy for car parking. A Task and Finish group is currently reviewing this fully considering all aspects of parking including staff permit allocations, alternative modes of transport (including the hospital hopper) and patient/visitor parking.

Recommendations:
The Trust Board endorse the UHL Travel Plan

Previously considered at another corporate UHL Committee?
The UHL Travel Plan was approved by the Executive Team on the 10th December 2013. Comments regarding the Plan from Executive Team regarding the resourcing of recommended actions within it, have been addressed in this Trust Board Paper.

Board Assurance Framework:	**Performance KPIs year to date:**
No	N/A

Resource Implications (eg Financial, HR):
Subject to feasibility reports and pre-tender estimates.

Assurance Implications:
To ensure compliance with planning requirements.

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

Stakeholder Engagement Implications:
Leicester City Council engagement via planning processes.

Equality Impact:
N/A

Information exempt from Disclosure:
N/A

Requirement for further review?
February 2014

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST

REPORT TO: Trust Board

DATE: 20th December 2013

REPORT BY: Kate Shields Director of Strategy / Andrew Chatten Managing Director of NHS Horizons

SUBJECT: Travel Plan

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1. INTRODUCTION

1.1 On the 10th December 2013 the Executive Team approved the request to present the Travel Plan to the UHL Trust Board subject to the following clarifications;

7.0	**UHL TRAVEL PLAN** *(paper F – sought ET's consideration of the Travel Plan in order that it could be presented to Trust Board on 20 December 2013 for approval. Mr A Chatten, Managing Director, LLR FMC attended to present this item.)*		
	It was noted that the Leicester City Council required the Trust to submit a travel plan approved by the Trust Board. The Executive Team noted that further work was required on the travel plan report and suggested that the following inclusions were made prior to its submission to the Trust Board:- (a) in respect of the requirement for funding - appropriate wording to be included (i.e whether the initiatives would be undertaken through new work schemes, existing budgets, backlog monies etc.); (b) an update on the content of the Travel plan (e.g. the development a multi storey car park). The Travel plan needed to show the wider trends of capacity and travel, and (c) the action plan to include indicative timescales.	**MD, LLR FMC**	**13.12.13**

The responses to the clarifications sought are as follows;

- Trust Board are not being asked to approve capital resources for the recommended actions as the Travel Plan is a high level strategic document which sets a general direction of travel according to core principles. Any business cases approved as part of the site reconfiguration will therefore have to consider travel implications. Any

capital implications will be considered as part of the Business case process.

- NHS Horizons will prepare costing and feasibility responses to the action plan in January 2014 and feed this into the site reconfiguration business planning process and the Executive Task and Finish Group for Car Parking.
- The Travel Plan addresses the wider trends of capacity and travel as a strategic document with which to engage the City Council contingent to the planning application processes and business cases.
- Timescales for delivery of aspects of the recommended actions from the Travel Plan will be determined from the progression of business cases and also from the direction of an Executive Task and Finish Group.
- Trust Board are asked to note that the Travel Plan is a reference point and a component part in determining UHL's strategy for car parking. A Task and Finish group is currently reviewing this fully considering all aspects of parking including staff permit allocations, alternative modes of transport (including the hospital hopper) and patient/visitor parking

1.2 The Travel Plan is a large document therefore an Executive Summary has been produced. The full Plan is available for review upon request.

2. AIM

The aim of this paper is to seek Trust Board endorsement of the UHL Travel Plan. This endorsement is important as the City Council requires this before it will formally consider the Travel Plan The Travel Plan is a high level strategic document that sets out the intentions of UHL to meet its responsibilities under Sector 106 of the Town and Country Planning Act 1990.

3. BACKGROUND

3.1 Local Authority planning regulations, inclusive of section 106 of the Town and Country Planning Act 1990, have implications for UHL in its delivery of capital programmes and on-going operational management of hospital sites. Under the National Planning Policy Framework, Travel Plans are required for any developments that generate significant amounts of movement. In addition, Travel Plans are required by NHS Policy: *All Trusts should have a Board approved active Travel Plan as part of their Sustainable Development Management Plan.*

This is particularly important with regard to travel planning and as UHL has over many years planned site re-configuration it has previously prepared (on a voluntary basis) Travel Plans. The last Travel Plan was completed in 2001, with annual updates thereafter.

Due to the significant capital programme and site reconfiguration process phased from 2013 to 2018, UHL commissioned a new Travel Plan which is presented for endorsement in this report**.** Cummins Consultancy was employed at the end of 2012 to work with the Travelwise Manager in the creation of a new Travel Plan.

3.2 This Travel Plan will be used to engage the City Council about prospective planning applications and will act as a touchstone for them at a strategic level, reducing the risk of surprises for specific projects and avoiding potential conflict under section 106 of the Town and Country Planning Act 1990.

The Travel Plan is not a planning request in itself. Individual business cases will need to have specific applications and these planning applications will be subject to individual traffic impact assessments, which are more detailed

3.3 The 2013 Travel Plan has assessed modes and volumes of travel across the three UHL acute sites and has made a series of recommended actions to best encourage the use of alternative modes of transport.

3.4 Trust Board are asked to note that the Travel Plan will be a reference point and a component part in determining UHL's strategy for car parking. A Task and Finish group is currently reviewing this focussing on staff permit allocations, alternative modes of transport (including the hospital hopper) and patient/visitor parking.

4. PROPOSALS

4.1 Appendix 1 contains an executive summary of the Travel Plan.

5. CONSIDERATIONS on the proposal

5.1 The details within the Travel Plan and the final recommendations have been made after extensive consultation and surveys. The following actions were taken:

- Travel questionnaire created for patients and staff;
- Approval for the content of the above was gained from the city council;
- The travel questionnaires were circulated both via electronic and paper based means. The survey was advertised and responders could complete the survey on line or in paper based form;
- Surveys were carried out with regards to current provision of car parking and travel facilities on all 3 sites;
- Car park surveys were conducted to establish usage rates and capacity.

5.2 The local council are keen to work with the Trust on all projects however they wish to see consideration travel and environmental impacts for all aspects of builds.

5.3 The local council need to be able to see that the Trust is committed to providing alternatives to car use.

5.4 Many of the actions within the plan overlap with the work that will be looked at by the new Executive Task and Finish group for Travel and Car Parking.

6. CONCLUSIONS

6.1 This Travel Plan has Executive support and now needs Trust Board endorsement before being presented to the City Council.

6.2 UHL has to have a Travel Plan in place to support gaining planning permission for individual schemes as part of the Trust reconfiguration programme

7.0 RECOMMENDATIONS

7.1 The Trust Board are requested to endorse the UHL Travel Plan.

Appendix 1

Travel Plan Executive Summary

Travel Plan Executive Summary

1.0 Introduction and Background

1.1 A Travel Plan (TP) is defined by the Department for Transport (DfT) and by the Department for Communities and Local Government (DCLG) as: *A long term management strategy for an occupier or site that seeks to deliver sustainable transport objectives through positive action and is articulated in a document that is regularly reviewed.*

1.2 In essence, a TP is intended to encourage people to choose alternative transport modes over single occupancy car use and where possible, reduce the need to travel at all. Such a plan should include a range of measures designed to achieve this goal.

1.3 Under the National Planning Policy Framework, Travel Plans are required at developments that generate significant amounts of movement. In addition, Travel Plans are required by NHS Policy: *All Trusts should have a Board approved active Travel Plan as part of their Sustainable Development Management Plan.*

1.4 There are unique issues surrounding the transportation needs of hospitals, which typically feature a significant number of shift patterns, staff working "on call", and the need to travel between sites. It is also necessary to consider the needs of patients with limited mobility and the need for patients with chronic conditions, and their visitors, to be able to access the site easily and reliably. These unique transportation needs have therefore underpinned the analysis within this TP.

1.5 This TP has been prepared to demonstrate UHL's commitment to sustainable travel, and to inform Highways Officers at Leicester City Council of how UHL will promote the use of alternative sustainable modes of travel and discourage single vehicle occupancy, including targets and methods for management and monitoring of measures.

1.6 This document supersedes an existing TP for UHL which was adopted in 2001. Since then there have been a number of measures implemented as part of the TP, which include:

- Improved cycle and pedestrian infrastructure;
- A car parking strategy;
- The introduction of a UHL bus service;
- Discount schemes for staff travelling sustainably; and
- Various events to encourage healthier transport modes.

2.0 Benefits of Travel Plans

2.1 There are multiple reasons as to why TPs are important to modern society. In order to summarise their importance, the benefits derived from TPs have been categorised under the following headings:

- Health benefits;
- Environmental benefits; and
- Financial benefits.

3.0 Objectives of the Travel Plan

3.1 Setting clear objectives is considered to be essential to ensuring a successful Travel Plan (TP).

3.2 Objectives provide a clear context for the measures proposed within the Travel Plan, and allow an opportunity for measurable target-setting.

3.3 Based upon a review of the measures in the 2001 Travel Plan and Travel Planning policy, a set of objectives have been established for this TP. The TP objectives are set out in Table below:

Objective A	Build on the successes of the initiatives since and including the 2001 Travel Plan.
Objective B	Reduce unnecessary travel.
Objective C	Make sustainable modes more affordable and attractive, increasing sustainable travel across the three sites.
Objective D	Reduce UHLs impact on climate change and the local environment.
Objective E	Reduce the number of single occupancy car trips by staff, patients and visitors.
Objective F	Encourage staff, patients and visitors to live a healthier and more active lifestyle
Objective G	Increase the accessibility of the three sites to those with mobility impairments.

3.4 The measures within the Travel Plan are designed to achieve the above objectives.

4.0 Audits and Surveys

4.1 In order to fully understand travel opportunities and constraints at UHL, site visits were undertaken at each of the UHL hospitals. These site visits form the basis of an audit of each site's accessibility by sustainable modes of travel.

4.2 In order to fully understand travel and transportation issues across the Trust, staff travel and patient/visitor surveys were undertaken. The results of these surveys have been used to establish mode share targets for this Travel Plan (TP), and to inform the measures to achieve these targets. The Trust has performed well against the original modal split targets set in 2001 (some of the significant findings are listed in appendix 1).

4.3 In order to provide an understanding of the level of existing parking supply at each UHL site, and the level of occupancy at each car park, manual count car park surveys were commissioned and undertaken by an independent survey company on the 19th and 21st of March 2013.

4.4 In addition to the above car park surveys 'in/out' vehicle surveys were undertaken at all site entrances, in order to ascertain the relative usage of each site access.

4.5 Car park management is considered to be fundamental to the effective implementation of the measures described in this Travel Plan (TP) to encourage people to travel by non-car modes by decreasing the attractiveness of car travel relative to other modes. Effective car park management can also offer financial and operational benefits which can contribute to the efficiency of an organisation as a whole. To this end, the consultancy firm employee to look at the TP plan have also analysed the UHL's current parking policies and suggested changes, these are detailed in appendix 2.

5.0 Measures to Encourage Sustainable Travel

5.1 A series of measures have been devised which encourage travel behaviours away from single occupancy car use ("stick" measures) and towards more sustainable modes ("carrot" measures).

5.2 Negative "stick" measures, designed to directly discourage the use of single-occupancy car travel, are detailed in appendix 2.

5.3 The positive "carrot" measures proposed have been considered separately by mode, and include the following:

- Encouraging Cycling;
- Encouraging Motorcycling;
- Encouraging Public Transport Use;
- Encouraging Car Sharing;
- Encouraging Walking; and
- Other Initiatives.

5.4 Appendix 3 contains more details with regards to the "carrot" measures.

6.0 Monitoring and Review

6.1 Monitoring and review is of central importance to the progression of the TP.

6.2 After reviewing the data from the travel survey results in, a series of targets can be established in order to encourage the overall modal shift to more sustainable forms of travel. These should consist of short, medium and long term modal shift goals. Details of these goals are contained in Appendix 4.

7.0 Action Plan and Budget

7.1 In order to maximise the value of the TP measures and to achieve the targets, it is important to establish a clear timetabled Action Plan. This is intended to ensure that the steps to implementing each measure are thought thorough in detail.

7.2 It is also important to ensure that appropriate funding is made available to ensure that the TP can continue to be implemented on the same basis in future, particularly as there may be a capital cost associated with some measures.

7.3 The proposed Action Plan is set out in Appendix 5, those categorised as “low” primarily involve only stationary costs and the cost of staff time. Those categorised as “medium” would be expected to cost under approximately £10,000. Costs categorised as “high” would be expected to cost £10,000 or more to implement.

Appendix 1

Headline figures from the Travel Surveys:

Overall information:

- 70% of staff work full time
- 53% work 9am to 5pm
- 52% drive to work as single driver, 60% travel by car in total
- 13% use the hopper to travel to work;
- 24% use public transport of some kind;
- 53% of staff would use sustainable transport if their normal mode was not available.
- 61% of staff would be willing to try sustainable modes some of the time.

How far do our staff live from their place of work?

- 4% within 1 mile;
- 21% between 1 and 3 miles;
- 26% between 3 and 5 miles;
- 25% between 5 and 10 miles;
- 16% between 10 and 20 miles;
- 9% over 20 miles.

Patient information with regards to travel:

- 75% of patients travel to site by car (23% single driver, 27% as passenger, 22% as driver with passenger, 3% taxi);
- 15% of patients use the bus to get to the hospital (4% use the hopper);
- 57% of patients would use sustainable transport if some changes were made.

Appendix 2

Following a detailed review of existing parking policy, supply, and usage at the 3 UHL sites, and in light of government guidance on hospital car parking, the following car park measures should be considered for future implementation:

- Increasing patient/visitor parking charges, with a focus on shorter-stay parking.
- Increasing staff car parking charges, potentially combined with a decremental charging system;
- Adjusting the assessment criteria for staff permits to account for actual distances;
- Providing barrier control at all car parks potentially combined with a “pay on exit” system at patient/visitor car parks;
- Reducing staff parking supply, particularly in locations where occupancy is already low;
- Offering incentives such as a preferential, guaranteed or reduced cost parking space to car sharers; and
- Promoting an up-to-date car sharing database.

Appendix 3

Proposed Initiatives to Encourage Cycling

Initiative	Description
Cycle to Work Scheme	Reintroduce salary sacrifice scheme. Allow staff to purchase cycles with a tax reduction.
Review of Existing Cycle Storage	A review into the provision and location of cycle stores across the site.
Cycle Lanes on Site	Providing cycle lanes throughout the main routes in the three sites to the main cycle storages.
Cycle Discounts	Continue to negotiate with local retailers to provide discounts for hospital employees.
Cycle Buddy Scheme	Buddy scheme where cyclists can meet up and arrange to cycle to and from work together.
Staff Showers	Provide showers and changing facilities for the use of staff travelling to work by cycle.

Proposed Initiatives to Encourage Public Transport Use

Initiative	Description
Review Hopper Service	Review the extent and running times of the Hopper Service route.
Fare Discounts	Implement a fare discount scheme for members of staff.
Electronic Bus Information	Information for buses across the network provided electronically.
Improved Waiting Facilities	Provision of additional bus shelters and seating within UHL sites

Proposed Initiatives to Encourage Car Sharing

Initiative	Description
Car Share Incentives	Provide guaranteed car share spaces in more of the most attractive (i.e. convenient) spaces within existing car parks.
Emergency Ride Home	Provide a guaranteed free emergency taxi ride home to car sharers who are let down by their sharing partner.
Car Sharing Database	Promote Leicester*share* scheme.

Proposed Initiatives to Encourage Walking

Initiative	Description
Review of Pedestrian Routes	Review of the existing pedestrian infrastructure across the three hospitals
Walking Buddy Scheme	Buddy scheme where walkers can meet up and arrange to walk to and from work together

Other proposed initiatives

Initiative	Description
Transport Awareness Week	A week aimed at promoting cycling, walking, and public transport across the Trust.
Transport Newsletter	Newsletter detailing all the relevant transport information to staff.
Promote Smarter Travel Leicester (STL) Scheme	Maximise benefits of existing STL scheme by promoting benefits.
Personalised Journey Planning (PJP)	Provision of a PJP service for all staff, patients and visitors.

Appendix 4

UHL Staff Modal Shift Targets

Travel Mode	Existing Modal Split Percentage	Short Term Target Modal Shift Change	Medium Term Target Modal Shift Change	Long Term Target Modal Shift Change	Total Target Modal Shift Change
Single-Occupancy Car	**51.7%**	**- 5%**	**- 5%**	**- 5%**	**- 15%**
Taxi	0.4%	+/-0%	+/-0%	+/-0%	+/-0%
Car Share	7.9%	+1%	+1%	+1%	+ 3%
Bus	21.8%	+1%	+1%	+1%	+ 3%
Train	2.1%	+/-0%	+/-0%	+/-0%	+/-0%
Walking	4.7%	+1%	+1%	+1%	+ 3%
Bicycle	4.9%	+1%	+1%	+1%	+ 3%
Motorcycle	0.9%	+1%	+1%	+1%	+ 3%
Other	6.0%	+/-0%	+/-0%	+/-0%	+/-0%

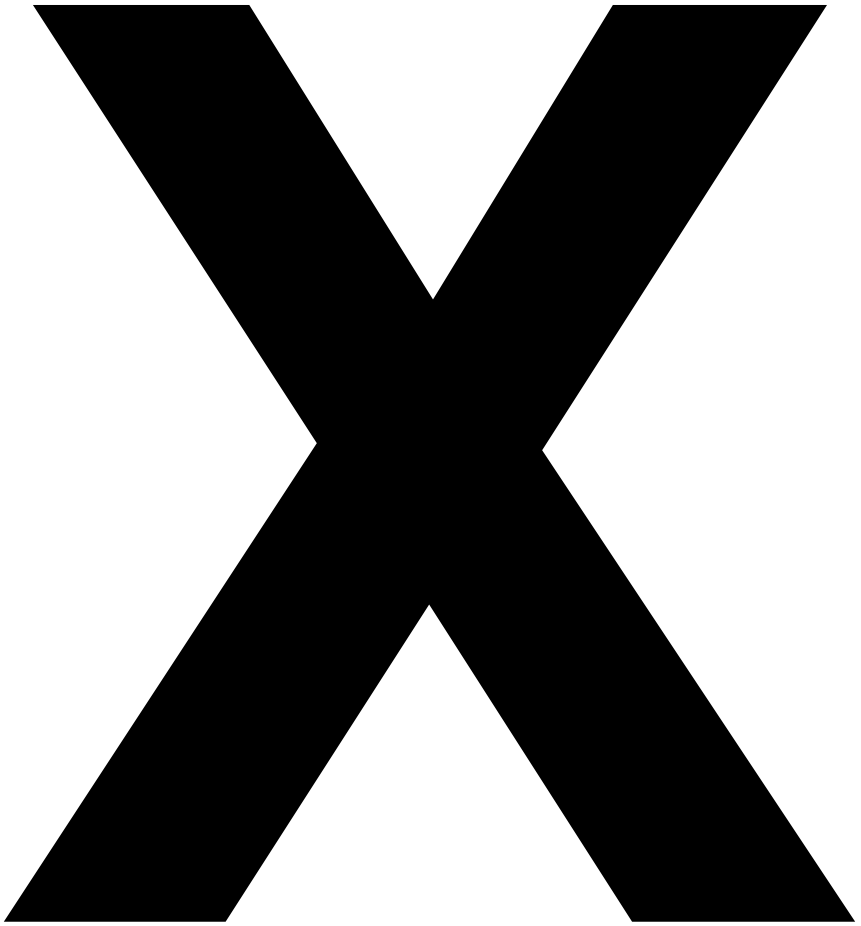
UHL Patient/Visitor Modal Shift Targets

Travel Mode	Existing Modal Split Percentage	Short Term Target Modal Shift Change	Medium Term Target Modal Shift Change	Long Term Target Modal Shift Change	Total Target Modal Shift Change
Single-Occupancy Car	**23.3%**	**- 2.5%**	**- 2.5%**	**- 2.5%**	**- 7.5%**
Car: As Passenger or With passenger	**48.8%**	**- 2.5%**	**- 2.5%**	**- 2.5%**	**- 7.5%**
Taxi	2.9%	+/-0%	+/-0%	+/-0%	+/-0%
Volunteer Car	2.7%	+/-0%	+/-0%	+/-0%	+/-0%
Ambulance	2.4%	+/-0%	+/-0%	+/-0%	+/-0%
Bus	15.0%	+2%	+2%	+2%	+ 5%
Walking	1.9%	+2%	+2%	+2%	+ 5%
Bicycle	0.3%	+1%	+1%	+1%	+ 5%
Train	0.3%	+/-0%	+/-0%	+/-0%	+/-0%
Motorcycle	0.0%	+/-0%	+/-0%	+/-0%	+/-0%
Other	2.4%	+/-0%	+/-0%	+/-0%	+/-0%

Appendix 5 (Action Plan)

Initiative	Measure	Cost	Timescale	Responsibility
Cycle to Work Scheme	Reintroduce salary sacrifice scheme. Allow staff to purchase cycles with a tax reduction.	Low	On-Going	TPC
Review of Existing Cycle Storage	Assess current cycle provision and identify areas to provide additional cycle parking.	Low	On-Going	TPC
	Provide new cycle parking at building entrances.	Medium	Medium Term	TPC
Cycle Lanes on Site	Identify cycle routes across each site.	Low	Short Term	TPC
	Mark out cycle lanes identified.	Medium	Medium Term	TPC
Liaise with the Local Authority over cycle lanes	Contact local authorities to organise consultation.	Low	Long Term	TPC
	Work with the local authority to provide cycle lanes to the hospitals.	Low	Long Term	TPC
Cycle Discounts	Continue to negotiate with local retailers to provide discounts for hospital employees.	Low	On-Going	TPC
Cycle Buddy Scheme	Implement and advertise a cycle buddy scheme where cyclists can meet up and arrange to cycle to and from work together.	Low	Short Term	TPC
Staff Showers	Provide showers and changing facilities for the use of staff travelling to work by cycle.	Medium	Medium Term	TPC
Review Hopper Service	Investigate the possibility of providing additional buses at peak times.	Low	Short Term	TPC
	Investigate the possibility of extending the hopper service.	High	Medium Term	TPC
	Promote Hospital Hopper to general users	Low	On-going	TPC
	Implement findings and recommendations.	Low-High	Long Term	TPC
Fare Discounts	Implement a fare discount scheme for members of staff.	Low	Medium Term	TPC
Electronic Bus Information	Investigate reintroducing real time bus information on electronic boards.	High	On-going	TPC
	Produce a smart-phone App providing sustainable transport information across the three sites.	Medium	Medium Term	TPC

Car sharing database	Promote 'Leicester*share*' car sharing scheme.	Low	Short Term	TPC
Car Share Spaces	Provide marked guaranteed car share spaces in the most attractive (i.e. convenient) spaces within existing car parks.	Low	Short Term	TPC
Emergency Ride Home	Provide a guaranteed free emergency taxi ride home to car sharers who are let down by their sharing partner registered to the car sharing database.	Low	Short Term	TPC
Review of Pedestrian Routes	Assess current pedestrian provision and identify areas to improve infrastructure.	Low	On-Going	TPC
	Provide improved infrastructure as described in the measures section.	High	Medium Term	TPC
	Assess current traffic calming measures and identify areas to improve infrastructure.	Low	Short Term	TPC
Walking Buddy Scheme	Implement and promote the buddy walking scheme.	Low	Short Term	TPC
Transport Awareness Week	Promote a week aimed at encouraging cycling, walking, and public transport across the Trust.	Low	Short-Term	TPC
	Hold 'Transport Awareness Week' in the spring/summer.	Low	Short-Term	TPC
Transport Newsletter	Establish and then produce a Trust-wide newsletter or e-newsletter every quarter.	Low	Short Term	TPC
Promote Smarter Travel Leicester (STL) Scheme	Promote the benefits of the STL scheme.	Low	Short Term	TPC
Personalised Journey Planning (PJP)	Provide a PJP service for all staff, patients and visitors. Promote the PJP service.	Low/medium	Medium Term	TPC
Car Park Management	Review existing car parking uses and requirements going forward.	Low	Short Term	TPC
	Install barrier control at all UHL car parks, with pay on exit facility.	High	Medium Term	TPC
	Phase out entirely the use of rented off-site car parking at all UHL sites.	Medium	Long Term	TPC



To:	**Trust Board**
From:	**Rachel Overfield - Chief Nurse**
Date:	**20 December 2013**
CQC regulation:	Outcome 16 – Assessing and Monitoring the Quality of Service Provision

Title:	**UHL RISK REPORT INCORPORATING THE BOARD ASSURANCE FRAMEWORK (BAF) 2013/14**

Author/Responsible Director: Chief Nurse

Purpose of the Report:
The report provides the Board with an updated BAF and oversight of any new extreme and high risks within the Trust. The report includes:-

a) A copy of the BAF as of 30 November 2013.
b) An action tracker to monitor progress of BAF actions
c) A summary diagram of risk movements from the previous month.
d) New extreme and/ or high risk opened during the reporting period.

The Report is provided to the Board for:

Decision		Discussion	**X**
Assurance	**X**	Endorsement	

Summary :

- There have been six BAF entries that have seen increased scores during the reporting period
- The Board is asked to consider the proposal to remove BAF entry number six (failure to achieve FT status) for future iterations of the BAF.
- Board members are invited to review the following BAF risks.
  Ineffective strategic planning and response to external influences (Director of Strategy).
  Failure to achieve FT status (risk owner – Director of Strategy).
  Failure to maintain productive and effective relationships (risk owner Director of Communications and Marketing).
- One new high risk has opened on the UHL risk register during November 2013.

Recommendations:
Taking into account the contents of this report and its appendices the Board are invited to:

(a) review and comment upon this iteration of the BAF, as it deems appropriate;

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

(c) identify any areas which it feels that the Trust's controls are inadequate and do not, therefore, effectively manage the principal risks to the organisation achieving its objectives;

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

(e) identify any other actions which it feels need to be taken to address any 'significant control issues' to provide assurance on the Trust meeting its principal objectives;

(f) consider and endorse the proposal by the Director of Strategy and the UHL Risk and Assurance Manager outlined in section 2.4 of the report (i.e. removal of BAF entry number six).

Strategic Risk Register Yes	**Performance KPIs year to date** N/A
Resource Implications (eg Financial, HR) N/A	
Assurance Implications: Yes	
Patient and Public Involvement (PPI) Implications: Yes	
Equality Impact N/A	
Information exempt from Disclosure: No	
Requirement for further review? Yes. Monthly review by the Board	

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST

REPORT TO: **TRUST BOARD**

DATE: **20 DECEMBER 2013**

REPORT BY: **RACHEL OVERFIELD - CHIEF NURSE**

SUBJECT: **UHL RISK REPORT INCORPORATING THE BOARD ASSURANCE FRAMEWORK (BAF) 2013/14**

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1. INTRODUCTION

1.1 This report provides the Board with:-

a) A copy of the BAF as of 30 November 2013.
b) An action tracker to monitor progress of BAF actions.
c) A summary diagram of BAF scores to show any changes from the previous month.
d) Notification of any new extreme or high risks opened during the reporting period.

2. BAF POSITION AS OF 30 NOVEMBER 2013

2.1 A copy of the BAF is attached at appendix one with changes to narrative since the previous version shown in red text.

2.2 The progress of actions associated with the BAF is monitored by reference to the action tracker attached at appendix two. The Board is asked to note the deletion of action numbers 3.6 and 10.2 as both of these are incorporated within other actions.

2.3 Appendix three provides a summary of changes to BAF scores and the Board is asked to note that during this reporting period six scores have increased as described in the table below.

Risk No.	Score (from/ to)	Rationale
3	16 - 20	Reflecting the difficulties being encountered in filling nurse staffing vacancies due to shortages of qualified nurses.
4	12 - 16	Reflecting the current lack of organisational change
5	12 -16	Reflecting the lack of robust strategic planning prior to appointment of Director of Strategy.
9	12 - 20	Reflecting the continuing failure to achieve compliance with RTT targets for admitted and non-admitted patients and ED targets.
10	12 - 15	Reflecting the slow pace of reconfiguration.
11	9 - 12	Reflecting that business continuity plans

		have not yet been received from Interserve.

2.4 Following discussions between the Director of Strategy and the UHL Risk and Assurance Manager the Board is asked to consider a proposal for BAF entry number six (failure to achieve FT status) to be removed from future iterations as the risk is reflecting a consequence of the failure to control other risks in the BAF (e.g. maintenance of quality standards, operational performance, ED, financial sustainability, etc).

2.5 To provide an opportunity for more detailed scrutiny three BAF entries are presented on a monthly basis for Board members to review against the parameters listed in appendix four.

- Ineffective strategic planning and response to external influences (Director of Strategy).
- Failure to achieve FT status (risk owner – Director of Strategy).
- Failure to maintain productive and effective relationships (risk owner Director of Communications and Marketing).

3 EXTREME AND HIGH RISK REPORT.

3.1 The Board is asked to note that one new high risk has opened during November 2013 as described below. The details of this risk are included at appendix five.

Risk ID	Risk Title	Risk Score	CMG/Corporate Directorate
2248	Lack of IR(ME)R training records held across the Trust	16	Clinical Support & Imaging

4. RECOMMENDATIONS

4.1 Taking into account the contents of this report and its appendices the Board is invited to:

(a) review and comment upon this iteration of the BAF, as it deems appropriate:

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

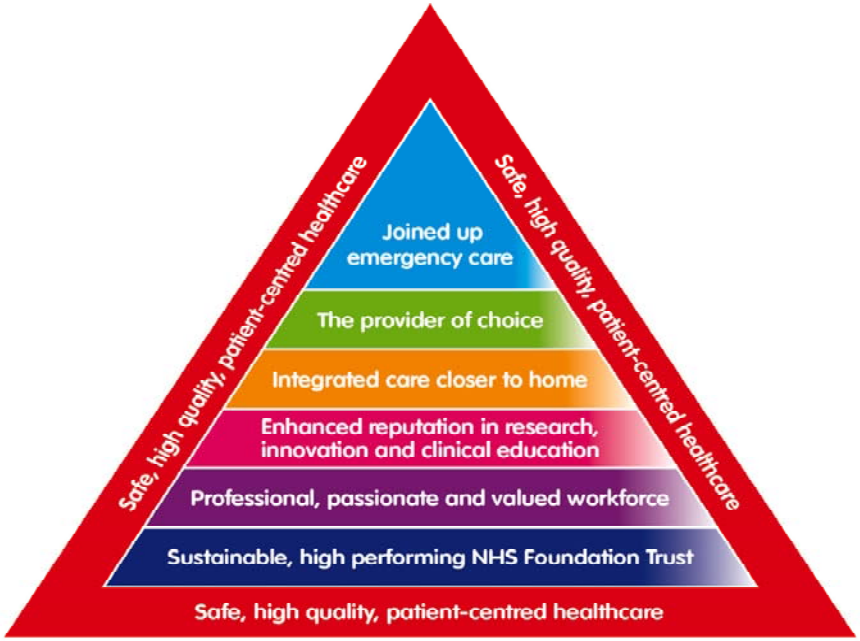
(c) identify any areas which it feels that the Trust's controls are inadequate and do not, therefore, effectively manage the principal risks to the organisation achieving its objectives;

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

(e) identify any other actions which it feels need to be taken to address any 'significant control issues' to provide assurance on the Trust meeting its principal objectives;

(f) consider and endorse the proposal by the Director of Strategy and the UHL Risk and Assurance Manager outlined in section 2.4 of this report.

Peter Cleaver,
Risk and Assurance Manager,
12 December 2013.


Safe, high quality, patient-centred healthcare
Safe, high quality, patient-centred healthcare
Joined up emergency care
The provider of choice
Integrated care closer to home
Enhanced reputation in research, innovation and clinical education
Professional, passionate and valued workforce
Sustainable, high performing NHS Foundation Trust
Safe, high quality, patient-centred healthcare

PERIOD: NOVEMBER 2013

RISK TITLE	STRATEGIC OBJECTIVE	CURRENT SCORE	TARGET SCORE
Risk 1 – Failure to achieve financial sustainability	g - To be a sustainable, high performing NHS Foundation Trust	25	12
Risk 2 – Failure to transform the emergency care system	b - To enable joined up emergency care	25	12
Risk 3 – Inability to recruit, retain, develop and motivate staff	f - To maintain a professional, passionate and valued workforce e - To enjoy an enhanced reputation in research, innovation and clinical education.	20	12
Risk 4 – Ineffective organisational transformation	a - To provide safe, high quality patient-centred health care c - To be the provider of choice d - To enable integrated care closer to home	16	12
Risk 5 – Ineffective strategic planning and response to external influences	a - To provide safe, high quality patient-centred health care c - To be the provider of choice g - To be a sustainable, high performing NHS Foundation Trust	16	12
Risk 6 – Failure to achieve FT status	g - To be a sustainable, high performing NHS Foundation Trust	16	12
Risk 7 – Failure to maintain productive and effective relationships	c - To be the provider of choice d - To enable integrated care closer to home f - To maintain a professional, passionate and valued workforce	15	10
Risk 8 – Failure to achieve and sustain quality standards	a - To provide safe, high quality patient-centred health care c - To be the provider of choice	16	12
Risk 9 – Failure to achieve and sustain high standards of operational performance	a - To provide safe, high quality patient-centred health care	20	12
Risk 10 – Inadequate reconfiguration of buildings and services	a - To provide safe, high quality patient-centred health care	15	9
Risk 11– Loss of business continuity	g - To be a sustainable, high performing NHS Foundation Trust	12	6
Risk 12 – Failure to exploit the potential of IM&T	a - To provide safe, high quality patient-centred health care d - To enable integrated care closer to home	9	6
Risk 13 - Failure to enhance education and training culture	e – To enjoy an enhanced reputation in research, innovation and clinical education	12	6

STRATEGIC OBJECTIVES:-	
a - To provide safe, high quality patient-centred health care.	**e - To enjoy an enhanced reputation in research, innovation and clinical education.**
b - To enable joined up emergency care.	**f - To maintain a professional, passionate and valued workforce.**
c - To be the provider of choice.	**g - To be a sustainable, high performing NHS Foundation Trust.**
d - To enable integrated care closer to home.	

N.B. Action dates are end of month unless otherwise stated

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST – BOARD ASSURANCE FRAMEWORK NOVEMBER 2013

RISK NUMBER/ TITLE:	**RISK 1 – FAILURE TO ACHIEVE FINANCIAL SUSTAINABILITY**
LINK TO STRATEGIC OBJECTIVE(S)	**g. - To be a sustainable, high performing NHS Foundation Trust.**
EXECUTIVE LEAD:	Director of Finance and Business Services

Principal Risk (What could prevent the objective(s) being achieved)	**What are we doing about it?** **(Key Controls)** What control measures or systems we have in place to assist secure delivery of the objective (describe process rather than management group)	**Current Score I x L**	**How do we know we are doing it?** **(Key Assurances of controls)** Provide examples of recent reports considered by Board or committee where delivery of the objectives is discussed and where the board can gain evidence that controls are effective.	**What are we not doing?** **(Gaps in Controls C) / Assurance (A)** What gaps in systems, controls and assurance have been identified?	**How can we fill the gaps or manage the risk better?** **(Actions to address gaps)**	**Target Score I x L**	**Timescale** When will the action be completed?
Failure to achieve financial sustainability including:	Overarching financial governance processes including PLICS process and expenditure controls. Revised variance analysis and reporting metrics especially for the ETPB Self-assessment and SLM baseline exercise completed and project manager identified Finalised SLM Action plan Full information has now been received on UHL allocations from all the no-recurrent funding streams including transformation monies. This information is being incorporated into the financial forecasts.	5X5=25	Monthly /weekly financial reporting to Exec Team Performance Board, F&P Committee and Board. Cost centre reporting and monthly PLICS reporting. Monthly confirm and challenge processes at specialty and CMG level. Annual internal and external audit programmes. Monthly meetings with the NTDA and the CCG Contract Performance Meeting	(c) SLM programme not fully implemented	ESB will continue to meet every 6 weeks to ensure implementation of SLM across the Trust (expected Mar 2014) (1.19)	4x3=12	Mar 2014 DFBS
Failure to achieve CIP.	Strengthened CIP governance structure including appt of Head of CIP programme		Progress in delivery of CIPs is monitored by CIP Programme Board (meeting fortnightly) and reported to ET and Board.	(c) Under-delivery of CIP programme (£0.8m adverse to plan M7)			

Locum expenditure.	Workforce plan to identify effective methods to recruit to 'difficult to fill' areas Reinstatement of weekly workforce panel to approve all new posts. STAFFflow for medical locums saving £130k of every £1m expenditure Financial Recovery plans developed Non Contractual Payments are discussed at monthly CMG meetings Confirm and Challenge Meetings All CMGs (by specialty) have produced premium spend trajectories and associated plans until March 2014 Weekly Staff Bank data reports are issued for medical and nursing (qualified and unqualified) staff Action plan to increase bank staff capacity and drive down agency nurse expenditure.		The use of locum staff in 'difficult to fill' areas reported monthly to the Board via the Q&P report. A reduction in the use of locums would be an assurance of success in recruiting substantive staff to 'difficult to fill' areas. Increase in contracted staff numbers of medical and nursing professions of 252wte since Mar 12. Saving in excess of £0.6m 5 weeks after 'go live' date Monthly Q&P report to TB Monthly confirm and challenge meetings Non contractual payments (premium spend) are reported monthly to the Finance and Performance Committee A weekly report is presented to ET. Weekly meetings with HoNs and DHR to monitor progress.	(c) Further investigation required as to the increase in Consultant numbers by 41wte (7.7%)			
Loss of income due to tariff/tariff changes (including referral rate for emergency admissions – MRET)	Contract meetings with Commissioners Negotiations with Commissioners concluded at a transactional level. Ongoing discussions with commissioners about planned re-investment of the MRET deductions.		Monthly /weekly financial reporting to Finance and Performance (F&P) Committee and Board.	(c) Failing to manage marginal activity efficiently and effectively. This is being addressed via ongoing discussions with Commissioners			

Ineffective processes for Counting and Coding.	Clinical coding project.		Ad-Hoc reports on annual counting and coding process. PbR clinical coding audit Jan 2013 (final report received 29 May 2013). IG toolkit audit (sample of 200 General Surgery episodes).	(c) Error rates in audit sample could be indicative of underlying process issues (c) Error rates identified as: Primary diagnoses incorrect 8.0% › Secondary diagnoses incorrect 3.6%. › Primary procedure incorrect 6.4% › Secondary procedure incorrect 4.5%.	Submit application for clinical coding to be included as a 2nd wave LIA pioneering team to involve clinicians. (1.20)		Review Jan 2014 DS
Loss of liquidity.	Liquidity Plan.		Monthly /weekly financial reporting to F&P Committee and Board. Detailed cash management plans presented at August 2013 F&P committee				
Lack of robust control over pay and non-pay expenditure.	Pay and Non-pay recovery action plan in place and monitored monthly Catalogue control project.		Monthly /weekly financial reporting to F&P Committee and Board. Non-pay management plan presented at July F&P committee Ongoing Monitoring via F&P Committee.				
Commissioner fines against performance targets.	Contract meetings with Commissioners and negotiations with Commissioners concluded at a transactional level. Plans and trajectories developed to reduce admission rates that are monitored at monthly C&C meetings.		Monthly /weekly monitoring of action plans, key performance target, and financial reporting to F&P Committee and Board.				
Use of readmission monies.	Contract meetings with Commissioners Negotiations with Commissioners concluded at a transactional level Ownership of readmissions work streams in divisions clarified		Monthly /weekly financial reporting to F&P Committee and Board.				
Ineffective organisational transformation.	See risk 4		See risk 4.	See risk 4.	See risk 4.		See risk 4

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST – BOARD ASSURANCE FRAMEWORK NOVEMBER 2013

RISK NUMBER/ TITLE:	**RISK 2 – FAILURE TO TRANSFORM THE EMERGENCY CARE SYSTEM**
LINK TO STRATEGIC OBJECTIVE(S)	**b. - To enable joined up emergency care.**
EXECUTIVE LEAD:	Chief Operating Officer

Principal Risk (What could prevent the objective(s) being achieved)	**What are we doing about it?** **(Key Controls)** What control measures or systems we have in place to assist secure delivery of the objective (describe process rather than management group)	**Current Score I x L**	**How do we know we are doing it?** **(Key Assurances of controls)** Provide examples of recent reports considered by Board or committee where delivery of the objectives is discussed and where the board can gain evidence that controls are effective.	**What are we not doing?** **(Gaps in Controls C) / Assurance (A)** What gaps in systems, controls and assurance have been identified?	**How can we fill the gaps or manage the risk better?** **(Actions to address gaps)**	**Target Score I x L**	**Timescale** When will the action be completed?
Failure to transform emergency care system leading to demands on ED and admissions units continuing to exceed capacity.	Health Economy has submitted response plan to NHSE requirements for an Emergency Care system under the A&E Performance Gateway Reference 00062.	5x5=25	Once plan agreed with NTDA, it will be circulated to the Board	No gaps	No actions	4x3=12	
	Emergency Care Action Team formed. Chaired by Chief executive to ensure Emergency Care Pathway Programme actions are being undertaken in line with NHSE action plan and any blockages to improvement removed. Development of action plan to address key issues		Action Plan circulated to the Board on a monthly basis as part of the Report on the Emergency Access Target within the Quality and Performance Report	Gaps described below	Actions described below		
	A new plan has been submitted detailing a clear trajectory for performance improvement and includes key themes from plan: Single front door		Project plan developed by CCG project manager Risks from 'single front door' to be escalated via ECAT and raised with CCG Managing Director as required	No gaps	No actions		
	ED assessment process is being operated.		Forms part of Quality Metrics for ED reported daily update and part of monthly board performance report	No gaps	No actions		
	Recruitment campaign for continued recruitment of ED medical and nursing staff including fortnightly meetings with HR to highlight delays and solutions in the recruitment process.		Vacancy rates and bank/agency usage reported to Trust Board on a monthly basis Recruitment plan being led by HR and monitored as part of ECAT	(c) Difficulties are being encountered in filling vacancies within the emergency care pathway. Agency and bank requests continue to increase in response to increasing sickness rates, additional capacity, and vacancies. (c) Staffing vacancies for medical and nursing staff remain high.	Continue with substantive appts until funded establishment is achieved (2.7)		Review Jan 2014 COO

	Formation of an EFU and AFU to meet increased demand of elderly patients		'Time to see consultant' metric included in National ED quarterly indicator.	No gaps	No actions		
	Maintenance of AMU discharge rate above 40%		Reported to Operational Board twice monthly and will be included in Emergency Care Update report in Q&P Report.	No gaps	No actions		
	New daily MDT Board Rounds on all medical wards and medical plans within 24hrs of admission		Reported to Operational Board twice monthly and will be included in Emergency Care Update report in Q&P Report.	No gaps	No actions		
	EDDs to be available on all patients within 24 hours of admission. Review built in to daily discharge meetings to check accuracy of EDDs (from 2/09/13).		Monitored and reported to Operational Board twice monthly and will be included in Emergency Care Update report in Q&P report	No gaps	No actions		
	Maintain winter capacity in place to allow new process to embed		All winter capacity beds are to be kept open until the target is consistently met	No gaps	No actions		
	DTOCs to be kept to a minimal level		Forms part of the Report on Emergency Access in the Q&P Report.	(c) Lack of availability of rehabilitation beds for increasing numbers of patients.	CCG/LPT to increase capacity by use of Intermediate Care Services (2.9)		Review Jan 2014 CO O

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST – BOARD ASSURANCE FRAMEWORK NOVEMBER 2013

RISK NUMBER/ TITLE:	**RISK 3 – INABILITY TO RECRUIT, RETAIN, DEVELOP AND MOTIVATE STAFF**
LINK TO STRATEGIC OBJECTIVE(S))	**e. - To enjoy an enhanced reputation in research, innovation and clinical education** **f. - To maintain a professional, passionate and valued workforce**
EXECUTIVE LEAD:	Director of Human Resources

Principal Risk (What could prevent the objective(s) being achieved)	**What are we doing about it?** **(Key Controls)** What control measures or systems we have in place to assist secure delivery of the objective (describe process rather than management group)	**Current Score I x L**	**How do we know we are doing it?** **(Key Assurances of controls)** Provide examples of recent reports considered by Board or committee where delivery of the objectives is discussed and where the board can gain evidence that controls are effective.	**What are we not doing?** **(Gaps in Controls C) / Assurance (A)** What gaps in systems, controls and assurance have been identified?	**How can we fill the gaps or manage the risk better?** **(Actions to address gaps)**	**Target Score I x L**	**Timescale** When will the action be completed?
Inability to recruit, retain, develop and motivate suitably qualified staff leading to inadequate organisational capacity and development.	Leadership and talent management programmes to identify and develop 'leaders' within UHL.	4x5=20	Development of UHL talent profiles.	No gaps identified.	No actions required.	4x3=12	
			Talent profile update reports to Remuneration Committee.	No gaps identified.	No actions required.		
	Substantial work program to strengthen leadership contained within OD Plan.			No gaps identified.	No actions required.		
	Organisational Development (OD) plan.		A central enabler of delivering against the OD Plan work streams will be adopting, 'Listening into Action' (LiA) and progress reports on the LiA will be presented to the Trust Board on a quarterly basis.	No gaps identified.	No actions required.		
	A central enabler of delivering against the OD Plan work streams will be adopting, 'Listening into Action (LiA). A Sponsor Group personally led by our Chief Executive and including, Executive Leads and other key clinical influencers has been established.		Progress reports on the LiA will be presented to the Trust Board on a quarterly basis.	No gaps identified. No gaps identified.	No actions required. No actions required.		
	Staff engagement action plan encompassing six integrated elements that shape and enable successful and measurable staff engagement		Results of National staff survey and local patient polling reported to Board on a six monthly basis. Improving staff satisfaction position.	No gaps identified.	No actions required.		
			Staff sickness levels may also provide an indicator of staff satisfaction and performance. Staff sickness rate is 3.85% for M7	No gaps identified	No actions required.		

	Appraisal and objective setting in line with UHL strategic direction. Local actions and appraisal performance trajectories agreed with CMGs and Directorates Boards		Appraisal rates reported monthly to Board via Quality and Performance report. Month 6 appraisal rate = 91%	(C) Appraisal rate consistently below target (target =95%)	Implement targeted recovery plans and trajectories for each cost centre		Dec 2013 DHR
	Summary of quality findings communicated across the Trust; to identify how to improve the quality of the appraisal experience for the individual and the quality of appraisal meeting recording.		Results of quality audits to ensure adequacy of appraisals reported to the Board via the quarterly workforce and OD report.	No gaps identified.	No actions required.		
			Appraisal Quality Assurance Findings reported to Trust Board via OD Update Report June 2013 Quality Assurance Framework to monitor appraisals on an annual cycle (next due March 2014).	No gaps identified.	No actions required.		
	Workforce plans to identify effective methods to recruit to 'difficult to fill areas). CMG and Directorates 2013/14 Workforce Plans.		Nursing Workforce Plan reported to the Board in September 2013 highlighting demand and initiatives to reduce gap between supply and demand. The use of locum staff in 'difficult to fill' areas is reported to the Board on a monthly basis via the Q&P report. Reduction in the use of such staff would be an assurance of our success in recruiting substantive staff.	(c) Approximately 500 nursing staff vacancies identified across UHL following nursing staff review. Difficulties in recruitment due to many hospitals within UK looking to recruit in response to Francis report. (c) Risks with employing high number from an International Pool in terms of ensuring competence	Active recruitment strategy including implementation of a dedicated nursing recruitment team. (3.8) Develop an employer brand and maximise use of social media (3.9) Programme of induction and adaptation in development with Nursing education leads, timetabled to ensure capacity to support programme. (3.10)		Dec 2013 CN/ DHR April 2014 DHR April 2014 DHR
	Reward /recognition strategy and programmes (e.g. salary sacrifice, staff awards, etc). Recruitment and Retention Premia for ED medical and nursing staff			(a) Reward and recognition strategy requires revision to include how we will provide assurance that reward and recognition programmes are making a difference to staffing recruitment/ retention/ motivation.	Revise and launch reward and recognition strategy. (3.1) Development of Pay Progression Policy for Agenda for Change staff (3.3)		Jan 2014 DHR Dec 2013 DHR

	UHL Branding – to attract a wider and more capable workforce. Includes development of recruitment literature and website, recruitment events, international recruitment. Reporting and monitoring of posts with 5 or less applicants.		Evaluate recruitment events and numbers of applicants. Reports issued to Nursing Workforce Group (last report 4 Feb). Reporting will be to the Board via the quarterly workforce an OD report. Quarterly report to senior HR team and to Board via quarterly workforce and OD report	(a) Better baselining of information to be able to measure improvement. (c) Lack of engagement in production of website material.	Take baseline from January and measure progress now that there is a structured plan for bulk recruitment. Identify a lead from each professional group to develop and encourage the production of fresh and up to date material. (3.2)		Dec 2013 DHR
	Statutory and mandatory training programme for 9 key subject areas in line with National Core Skills Framework		Monthly monitoring of statutory and mandatory training uptake via reports to TB and ESB against 9 key subject areas (currently showing month on month improvements (58% at M7)	(c) Compliance against the 9 key subject areas is 55% (a) Potentially there may be inaccuracies of training data within the e-UHL system	Ensure Statutory and Mandatory training is easy to access and complete with 75% compliance by reviewing delivery mode, access and increasing capacity to deliver against specific subject areas (3.5) Update e-UHL records to ensure accuracy of reporting on a real time basis (3.7)		Mar 2014 DHR Mar 2014 DHR

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST – BOARD ASSURANCE FRAMEWORK NOVEMBER 2013

RISK NUMBER/ TITLE:	**RISK 4 – INEFFECTIVE ORGANISATIONAL TRANSFORMATION**
LINK TO STRATEGIC OBJECTIVE(S)	**a. - To provide safe, high quality patient-centred health care.** **c. - To be the provider of choice.** **d. - To enable integrated care closer to home**
EXECUTIVE LEAD:	Director of Strategy

Principal Risk (What could prevent the objective(s) being achieved)	**What are we doing about it?** **(Key Controls)** What control measures or systems we have in place to assist secure delivery of the objective (describe process rather than management group)	**Current Score I x L**	**How do we know we are doing it?** **(Key Assurances of controls)** Provide examples of recent reports considered by Board or committee where delivery of the objectives is discussed and where the board can gain evidence that controls are effective.	**What are we not doing?** **(Gaps in Controls C) / Assurance (A)** What gaps in systems, controls and assurance have been identified?	**How can we fill the gaps or manage the risk better?** **(Actions to address gaps)**	**Target Score I x L**	**Timescale** When will the action be completed?
Failure to put in place a robust approach to organisational transformation, adequately linked to related initiatives and financial planning/outputs	Development of Improvement and Innovation Framework (IIF) Outputs from this transformation programme will drive the implementation of the clinical strategy.	4x4=16	Monthly progress reports to Exec Strategy Board and F&P Committee. Approval of framework and operational arrangements due at Trust Board June 2013. Monitoring of overall Framework will be via IIF Board and F&P Ctte and monitoring of financial outputs (CIPs) will be via CIP Delivery Board, Exec Performance Board and F&P Committee. Delivery of whole hospital change programmes requires alignment with the whole local Health Economy change programme – currently described through the Better Care Together programme	(c) Gaps are evident in the alignment of transformational process between UHL and principle partners – this is being raised through the Better Care Together Programme structures	Review outputs from Chief Officers Group and strategic Planning Group to ensure gaps in current processes are being addressed (4.1)	4x3=12	Review Feb 2014 DS

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST – BOARD ASSURANCE FRAMEWORK NOVEMBER 2013

RISK NUMBER / TITLE	**RISK 5 - INEFFECTIVE STRATEGIC PLANNING AND RESPONSE TO EXTERNAL INFLUENCES**
LINK TO STRATEGIC OBJECTIVE(S)	**a. - To provide safe, high quality patient-centred health care.** **c. - To be the provider of choice.** **e. - To enjoy an enhanced reputation in research innovation and clinical education.** **g. - To be a sustainable, high performing NHS Foundation Trust**
EXECUTIVE LEAD:	Director of Strategy

Principal Risk (What could prevent the objective(s) being achieved)	**What are we doing about it?** **(Key Controls)** What control measures or systems we have in place to assist secure delivery of the objective (describe process rather than management group)	**Current Score I x L**	**How do we know we are doing it?** **(Key assurances of controls)** Provide examples of recent reports considered by Board or committee where delivery of the objectives is discussed and where the board can gain evidence that controls are effective.	**What are we not doing?** **(Gaps in Controls C) / Assurance (A)** What gaps in systems, controls and assurance have been identified?	**How can we fill the gaps or manage the risk better?** **(Actions to address gaps)**	**Target Score I x L**	**Timescale** When will the action be completed?
Failure to put in place appropriate systems to horizon scan and respond appropriately to external drivers. Failure to proactively develop whole organisation and service line clinical strategies	Appointment of Strategy Director	4x4=16	Plan agreed by Remuneration Committee	None identified	Not applicable	4x3=12	N/A
	Allocation of market intelligence responsibility to Director of Marketing and Communications		Agreed by Remuneration Committee	None identified	Not applicable		N/A
	Co-ordinated approach to business intelligence gathering and response via Clinical Management Groups Workshop 'hosted by the Director of Strategy 'delivering our strategic direction' held in November with all CMGs to set the external context within which we will need to develop a LLR Integrated 5-yaer plan, within which our 2-yaer operational plans will sit. CMG Strategy Leads now engaged in the BSST meetings to improve engagement, alignment and teamwork. ESB forward plan reflecting a 12 month programme aligned with: • the development of the IBP/LTFM • the reconfiguration programme • the development of the next AOP • The TB Development Programme The TB formal agenda		Weekly strategic planning meetings in place – cross CMG and corporate team attendance with delivery led through the Strategy Directorate Development of a clear, clinically based 5 year strategic will provide assurance that strategic planning is taking place Reports to ESB Regular reports to TB reflecting progress of 12 month programme	None identified None identified	Not applicable Not applicable		

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST – BOARD ASSURANCE FRAMEWORK NOVEMBER 2013

RISK NUMBER/ TITLE:	**RISK 6 – FAILURE TO ACHIEVE FT STATUS**
LINK TO STRATEGIC OBJECTIVE(S)	**g. - To be a sustainable, high performing NHS Foundation Trust.**
EXECUTIVE LEAD:	Director of Strategy

Principal Risk (What could prevent the objective(s) being achieved)	**What are we doing about it?** **(Key Controls)** What control measures or systems we have in place to assist secure delivery of the objective (describe process rather than management group)	Current Score I x L	**How do we know we are doing it?** **(Key Assurances of controls)** Provide examples of recent reports considered by Board or committee where delivery of the objectives is discussed and where the board can gain evidence that controls are effective.	**What are we not doing?** **(Gaps in Controls C) / Assurance (A)** What gaps in systems, controls and assurance have been identified?	**How can we fill the gaps or manage the risk better?** **(Actions to address gaps)**	Target Score I x L	**Timescale** When will the action be completed?
Failure to meet the requirements of the FT application process in terms of service quality, strategy, financial resilience and governance	FT Programme Board provides strategic direction and monitors the FT application programme.	4x4=16	Monthly progress against the FT programme is reported to the Board to provide oversight.	No gaps identified.	No actions required.	4x3=12	
	FT Workstream group of Executive and operational Leads to ensure delivery of IBP and evidence to support HDD1 and 2 processes.		Feedback from external assessment of application progress by SHA	No gaps identified.	No actions required.		
	FT application project plan / project team in place FT Integrated Development Plan		Reports to FTPB and Trust Board	No gaps identified	Not applicable		N/A
	Progression of Better Care Together Programme which underpins the UHL service strategy and LTFM. Appointment of Director of Strategy as BCT lead Chief Officers have sponsored the establishment of the LLR Strategy Leads Group to support the development of a 5 year Integrated Health and Care Plan. UHL's lead representative on this working group is the Head of Planning and Business Development.		Economic modelling incorporated into the Trust Reconfiguration Strategic Outline Case (SOC) structure and process. Regular reports to Exec Strategy Board and Trust Board Various inputs from Exec Team to BCT work.	No gaps identified No gaps identified	Not applicable Not applicable		
			Feedback and recommendations from the independent reviews against the Quality Governance Framework and the Board Governance Framework.	(c) Independent reports identify a number of recommendations.	Action plans to be developed to address recommendations from independent reviews. (6.11)		Dec 2013 CEO
	Monitoring of KPIs in particular in relation to financial position and key operational performance indicators.		Monthly reports to Executive Performance Board, F&P Committee and Trust Board	None identified.	Not applicable		N/A
			Achievement against the new TDA Accountability Framework is reported to the Trust board and the TDA on a monthly basis.	None identified	Not applicable		N/A

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST – BOARD ASSURANCE FRAMEWORK NOVEMBER 2013

RISK NUMBER/ TITLE:	**RISK 7– FAILURE TO MAINTAIN PRODUCTIVE AND EFFECTIVE RELATIONSHIPS**
LINK TO STRATEGIC OBJECTIVE(S)	**c. - To be the provider of choice.** **d. - To enable integrated care closer to home.** **f. – To maintain a professional, passionate and valued workforce.**
EXECUTIVE LEAD:	Director of Marketing and Communications

Principal Risk (What could prevent the objective(s) being achieved)	**What are we doing about it?** **(Key Controls)** What control measures or systems we have in place to assist secure delivery of the objective (describe process rather than management group)	**Current Score I x L**	**How do we know we are doing it?** **(Key Assurances of controls)** Provide examples of recent reports considered by Board or committee where delivery of the objectives is discussed and where the board can gain evidence that controls are effective.	**What are we not doing?** **(Gaps in Controls C) / Assurance (A)** What gaps in systems, controls and assurance have been identified?	**How can we fill the gaps or manage the risk better?** **(Actions to address gaps)**	**Target Score I x L**	**Timescale** When will the action be completed?
Failure to maintain productive relationships with external partners/ stakeholders leading to potential loss of activity and income, poor reputation and failure to retain/ reconfigure clinical services.	Stakeholder Engagement Strategy. Regular meetings with external stakeholders and Director of Communications and member of Executive Team to identify and resolve concerns. Regular stakeholder briefing provided by an e-newsletter to inform stakeholders of UHL news. Leicester, Leicestershire and Rutland (LLR) health and social care partners have committed to a collaborative programme of change ('Better Care Together')	5X3=15	Twice yearly GP surveys with results reported to UHL Executive Team. Latest survey results discussed at the April 2013 Board and showed increasing levels of satisfaction… a trend which has now continued for 18 months. Annual Reputation / Relationship survey to key professional and public stakeholders Nov 13. Anecdotal feedback from partners and soft intelligence indicates that relations with key organisations and individuals are improving under new UHL leadership. However, progress on Better Care Together and discussions re: health economy finances in Nov / Dec 2013 could be contra indicators.	(c) No external and 'dispassionate' professional view of stakeholder / relationship management activity	Invite PWC (Trust's Auditors) to offer opinion on the plan / talk to a selection of stakeholders. (7.3)	5X2=10	Jan 2014 DCM

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST – BOARD ASSURANCE FRAMEWORK NOVEMBER 2013

RISK NUMBER/ TITLE:	**RISK 8 – FAILURE TO ACHIEVE AND SUSTAIN QUALITY STANDARDS**
LINK TO STRATEGIC OBJECTIVE(S)	**a. – To provide safe, high quality patient-centred health-care**
EXECUTIVE LEAD:	Chief Nurse (with Medical Director)

Principal Risk (What could prevent the objective(s) being achieved)	**What are we doing about it?** **(Key Controls)** What control measures or systems we have in place to assist secure delivery of the objective (describe process rather than management group)	**Current Score I x L**	**How do we know we are doing it?** **(Key Assurances of controls)** Provide examples of recent reports considered by Board or committee where delivery of the objectives is discussed and where the board can gain evidence that controls are effective.	**What are we not doing?** **(Gaps in Controls C) / Assurance (A)** What gaps in systems, controls and assurance have been identified?	**How can we fill the gaps or manage the risk better?** **(Actions to address gaps)**	**Target Score I x L**	**Timescale** When will the action be completed?
Failure to achieve and sustain quality standards leading to failure to reduce patient harm with subsequent deterioration in patient experience/ satisfaction/ outcomes, loss of reputation and deterioration of 'friends and family test' score.	Standardised M&M meetings in each speciality.	4x4=16	Routine analysis and monitoring of out of hours/weekend mortality at CMG Boards.	No gaps.	No action needed.	4x3=12	
	Systematic speciality review of "alerts" of deterioration to address cause and agree remedial action by Mortality Review Committee. Reports to Executive Quality Board, QAC, and by exception to ET and TB.		Quality and Performance Report and National Quality dashboard presented to ET and TB. Currently SMHI "within expected" (i.e. 106).	(a) UHL risk adjusted perinatal mortality rate above regional and national average. (c) High HSMR for low risk procedures	Women's CMG to work with Dr Foster and other trusts to better understand risk adjustment model (8.2). Review of all deaths identified in low risk groups. Working with DFI to ensure data has been recorded accurately (8.12)		Jan 2014 MD Dec 2013 MD
	Robust implementation of actions to achieve Quality Commitment (save 1000 extra lives in 3 years).		SHMI remains "within expected" (i.e. 106). Independent analysis of mortality review performed by Public Health. Results reported at November 2013 TB meeting.	No gaps identified.	No action needed.		
	Agreed patient centred care priorities for 2013-14: - Older people's care - Dementia care - Discharge Planning		Quality Action Group meets monthly. Achievement against key objectives and milestones report to Trust board on a monthly basis. A moderate improvement in the older people survey scores has been recorded.	No gaps identified.	No action needed.		
	Multi-professional training in older peoples care and dementia care in line with LLR dementia strategy.		Quality Action Group monitoring of training numbers and location.	No gaps identified.	No action needed.		

	Protected time for matrons and ward sisters to lead on key outcomes.		CMG/ specialty reporting on matron activity and implementation or supervisory practice.	(c) Present vacancy levels prevent adoption of supervisory practice.	Active recruitment to ward nursing establishment so releasing ward sister –for supervisory practice (8.5).		Sep 2014 CN
	To promote and support older peoples champions network and new dementia champions network.		Monthly monitoring of numbers and activity.	No gaps identified.	No action needed.		
	Targeted development activities for key performance indicators - answering call bells - assistance to toilet - involved in care - discharge information		Monthly monitoring and tracking of patient feedback results. Monthly monitoring of Friends and Family Test reported to the TB (66.2% at M7).				
	Quality Commitment 2013 – 2016: • Save 1000 extra lives • Avoid 5000 harm events • Provide patient centred care so that we consistently achieve a 75 point patient recommendation score		Quality Action Groups monitoring action plans and progress against annual priority improvements. A Quality Commitment dashboard has been developed to present updates to the TB on the 3 core metrics for tracking performance against our 3 goals. These metrics will be tracked up to 2015. Impressive drops in fall numbers have been observed in Datix reports and in the Safety Thermometer audit.				
	Relentless attention to 5 Critical Safety Actions (CSA) initiatives to lower mortality.		Q&P report to TB showing outcomes for 5 CSAs. 4CSAs form part of local CQUIN monitoring. RAG rated green at end of quarter 2. M&M CSA removed from CQUIN monitoring due to full implementation For Quarter 1 the CSA programme saw a 50% reduction in SUIs against the same period last year.	(c) Lack of a unified IT system in relation to ordering and receiving results means that many differing processes are being used to acknowledge/respond to results. Potential risk of results not being acted upon in a timely fashion.	Implementation of Electronic Patient Record (EPR). (8.10)		2015 CIO
	NHS Safety thermometer utilised to measure the prevalence of harm and how many patients remain 'harm free' (Monthly point prevalence for '4 Harms'). Monthly meetings with operational/clinical and managerial leads for each harm in place.		Monthly outcome report of '4 Harms' is reported to Trust board via Q&P report. The percentage of Harm Free Care for M7 was 94.74% reflecting a reduction in the number of patients with newly acquired harms.	(a) Some data may not be accurate due to complex DoH definitions of each harm in relation to whether it is community or hospital acquired.	UHL to be part of the DH review in to the use of the Safety Thermometer tool (8.11)		Review Dec 2013 CN

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST – BOARD ASSURANCE FRAMEWORK NOVEMBER 2013

RISK NUMBER/ TITLE:	**RISK 9 – FAILURE TO ACHIEVE AND MAINTAIN HIGH STANDARDS OF OPERATIONAL PERFORMANCE**
LINK TO STRATEGIC OBJECTIVE(S)	**a. - To provide safe, high quality patient-centred health-care** **c. - To be the provider of choice.** **g. - To be a sustainable, high performing NHS Foundation Trust.**
EXECUTIVE LEAD:	Chief Operating Officer

Principal Risk (What could prevent the objective(s) being achieved)	**What are we doing about it?** **(Key Controls)** What control measures or systems we have in place to assist secure delivery of the objective (describe process rather than management group)	**Current Score I x L**	**How do we know we are doing it?** **(Key Assurances of controls)** Provide examples of recent reports considered by Board or committee where delivery of the objectives is discussed and where the board can gain evidence that controls are effective.	**What are we not doing?** **(Gaps in Controls C) / Assurance (A)** What gaps in systems, controls and assurance have been identified?	**How can we fill the gaps or manage the risk better?** **(Actions to address gaps)**	**Target Score I x L**	**Timescale** When will the action be completed?
Failure to achieve and sustain operational targets leading to contractual penalties, patient dissatisfaction and poor reputation.	Referral to treatment (RTT) backlog plans (patients over 18 weeks) and operational performance of 90% (for admitted) and 95 % (for non-admitted). Further recovery plans submitted to Commissioners for external assurance	4x5=20	Key specialities will go onto weekly performance meetings with COO Weekly patient level reporting meeting for all key specialties Monthly Q&P report to Trust Board showing 18 week RTT performance Daily RTT performance and prospective reports to inform decision making	(c) 83.5% admitted RTT performance (M7). Backlog plans require further development in line with review of demand and capacity in key specialties. Recovery of the admitted and non admitted standards at Trust and speciality level is not anticipated until the new financial year. (c) Capacity issues created by emergency demand causes cancellations of operations.	Re-configuration of surgical beds to create a 'protected area' for surgical patients or by use of independent sector. (9.2)	4x3=12	Review Jan 2014 COO
	Transformational theatre project to improve theatre efficiency to 80 -90%.		Monthly theatre utilisation rates. Theatre Transformation monthly meeting. Transformation update to Board.	No gaps identified.	No actions required.		
	Emergency Care process redesign (phase 1) implemented 18 February 2013 to improve and sustain ED performance.		Monthly report to Trust Board in relation to Emergency Dept (ED) flow (including 4 hour breaches).	See risk number 2.	See risk number 2.		

	Cancer 62 day performance - Tumour site improvement trajectory agreed and each tumour site has developed action plans to achieve targets. Senior Cancer Manager appointed Lead Cancer Clinician appointed Action plan to resolve Imaging issues implemented.		Cancer action board established and weekly meetings with all tumour sites represented Monthly trajectory agreed and Cancer action plan agreed with CCGs in June 2013 and reported and monitored at Executive Performance board. Chief Operating Officer receives reports from Cancer Manager and 62 day performance included within Monthly Q&P report to Trust Board.				

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST – BOARD ASSURANCE FRAMEWORK NOVEMBER 2013

RISK NUMBER/ TITLE:	**RISK 10 – INADEQUATE RECONFIGURATION OF BUILDINGS AND SERVICES**
LINK TO STRATEGIC OBJECTIVE(S)	**a. - To provide safe, high quality patient-centred health care**
EXECUTIVE LEAD:	Director of Strategy

Principal Risk (What could prevent the objective(s) being achieved)	**What are we doing about it?** **(Key Controls)** What control measures or systems we have in place to assist secure delivery of the objective (describe process rather than management group)	**Current Score I x L**	**How do we know we are doing it?** **(Key Assurances of controls)** Provide examples of recent reports considered by Board or committee where delivery of the objectives is discussed and where the board can gain evidence that controls are effective.	**What are we not doing?** **(Gaps in Controls C) / Assurance (A)** What gaps in systems, controls and assurance have been identified?	**How can we fill the gaps or manage the risk better?** **(Actions to address gaps)**	**Target Score I x L**	**Timescale** When will the action be completed?
Inadequate reconfiguration of buildings and services leading to less effective use of estate and services.	Clinical Strategy.	3x5=15	Trust Board development session on development of approach to strategic planning and development of SOC. This outlined the methodology being used to ensure any changes in configuration is specifically designed to deliver optimum quality of care Ongoing monitoring of service outcomes by MRC to ensure outcomes improve. Improvement in health outcomes and effective Infection Prevention and Control practices monitored by Executive Quality Board (Q+P report) with escalation to ET, QAC and TB as required.	(a) Service specific KPIs not yet identified for all services	Prioritisation of key areas within the clinical strategy for delivery (10.1) Iterative development of strategic plans with specialities. Monitored by CMG and Executive Boards (10.5)	3X3=9	Dec 2013 MD March 2014 MD
	Estates Strategy including award of FM contract to private sector partner to deliver an Estates solution that will be a key enabler for our clinical strategy in relation to clinical adjacencies. Reconfiguration Programme working with clinicians to develop a 'preferred' way forwards' with regards to the alignment of the future estate with clinical strategy		Facilities Management Collaborative (FMC) will monitor against agreed KPIs to provide assurance of successful outsourced service.	(c) Estates plans not fully developed to achieve the strategy. (c) The success of the plans will be dependent upon capital funding and successful approval by the NTDA.	Reconfiguration programme to develop a strategic outline case which will inform the future estate strategy (10.6) Secure capital funding. (10.3)		Jan 2014 DS Dec 2013 DFBS
	CMG service development strategies and plans to deliver key developments.		Progress of divisional development plans reported to Service Reconfiguration Board.	No gaps identified.	No actions required.		
	Service Reconfiguration Board.		Monthly ET Strategy session to provide oversight of reconfiguration.	No gaps identified.	No actions required.		

	Capital expenditure programme to fund developments.		Capital expenditure reports reported to the Board via F&P Committee.	No gaps identified.	No actions required.		
	Managed Business Partner for IM&T services to deliver IT that will be a key enabler for our clinical strategy. IM&T incorporated into Improvement and Innovation Framework.		IM&T Board in place.	No gaps identified.	No actions required.		

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST – BOARD ASSURANCE FRAMEWORK NOVEMBER 2013

RISK NUMBER/ TITLE:	**RISK 11 – LOSS OF BUSINESS CONTINUITY**
LINK TO STRATEGIC OBJECTIVE(S))	**g. - To be a sustainable, high performing NHS Foundation Trust.**
EXECUTIVE LEAD:	Chief Operating Officer

Principal Risk (What could prevent the objective(s) being achieved)	**What are we doing about it?** **(Key Controls)** What control measures or systems we have in place to assist secure delivery of the objective (describe process rather than management group)	Current Score I x L	**How do we know we are doing it?** **(Key Assurances of controls)** Provide examples of recent reports considered by Board or committee where delivery of the objectives is discussed and where the board can gain evidence that controls are effective.	**What are we not doing?** **(Gaps in Controls C) / Assurance (A)** What gaps in systems, controls and assurance have been identified?	**How can we fill the gaps or manage the risk better?** **(Actions to address gaps)**	Target Score I x L	**Timescale** When will the action be completed?
Inability to react /recover from events that threaten business continuity leading to sustained downtime and inability to provide full range of services.	Major incident/business continuity/ disaster recovery and Pandemic plans developed and tested for UHL/ wider health community. This includes UHL staff training in major incident planning/ coordination and multi agency involvement across Leicestershire to effectively manage and recover from any event threatening business continuity. Tailored training packages for service area based staff.	3x4=12	Annual Emergency planning Report identifying good practice presented to the GRMC July 2012. Training Needs Analysis developed to identify training requirements for staff supported by appropriate training packages for Senior Managers on Call External auditing and assurances to SHA, Business Continuity Self-Assessment, June 2010, completed by Richard Jarvis Completion of the National Capabilities Survey, November 2013 completed by Aaron Vogel. Results included in the annual report on Emergency Planning and Business Continuity to the QAC. Audit by PwC Jan 2013. Results being compiled and will be reported to Trust Board (date to be agreed). Documented evidence from key critical suppliers has been collected to ensure that contracts include business continuity arrangements.	(c) On-going continual training of staff to deal with an incident. (a) Do not consider realistic testing of different failure modes for critical IT systems to ensure IT Disaster Recovery arrangements will be effective during invocation. (c) No clear definition of what makes a critical supplier and how a loss would impact on the Trust. No plan as to how we would manage a loss.	Training and Exercising events to involve multiple specialties/CMGs to validate plans to ensure consistency and coordination (11.13). Determine an approach to delivering a physical testing of the IT Disaster Recovery arrangements which have been identified as a dependency for critical services. Include assessment of the benefits of realistic testing of arrangements against the potential disruption of testing to operations. (11.2) Develop a plan and a better understanding of how a loss of critical suppliers will affect the Trust (11.12)	2x3=6	Aug 2014 COO Review Dec 2013 CIO Dec 2013 COO

	Emergency Planning Officer appointed to oversee the development of business continuity within the Trust.		Outcomes from PwC LLP audit identified that there is a programme management system in place through the Emergency Planning Officer to oversee. A year plan for Emergency Planning developed. Production/updates of documents/plans relating to Emergency Planning and Business Continuity aligned with national guidance have begun. Including Business Impact Assessments for all specialties. Plan templates for specialties now include details/input from Interserve	(c) not all the critical suppliers questioned provided responses (c) contracts aren't assessed for their potential BC risk on the Trust (c) Local plans for loss of critical services not completed due to change over of facilities provider (c) Plans have not been provided by Interserve as to how they would respond or escalate issues to the Trust.	Further work required to develop escalation plans and response plans for Interserve. (11.11)		Dec 2013 COO
	New policy to identify key roles within the Trust of those responsible for ensuring business continuity planning /learning lessons is undertaken.		Minutes/action plans from Emergency Planning and Business Continuity Committee. Any outstanding risks/issues will be raised through the COO.	No gaps identified.	No actions required.		
			New Policy on InSite Emergency Planning and Business Continuity Committee ensures that processes outlined in the Policy are followed, including the production of documents relating to business continuity within the service areas. 3 incidents within the Trust have been investigated and debrief reports written, which include recommendations and actions to consider. Issues/lessons feed into the development of local plans and training and exercising events.				

			Head of Operations and Emergency Planning Officer are consulted on the implementation of new IM&T projects that will disrupt users access to IM&T systems	(c) Do not always consider the impact on business continuity and resilience when implementing new systems and processes.	Further processes require development, particularly with the new Facilities and IM&T providers to ensure resilience is considered/ developed when implementing new systems, infrastructure and processes. (11.8)		Review Dec 2013 COO
				(a) Lack of coordination of plans between different service areas and across the specialties.	Training and Exercising events to involve multiple specialties/CMGs to validate plans to ensure consistency and coordination. (11.10)		Aug 2014 COO

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST – BOARD ASSURANCE FRAMEWORK NOVEMBER 2013

RISK NUMBER/ TITLE:	**RISK 12 FAILURE TO EXPLOIT THE POTENTIAL OF IM&T**
LINK TO STRATEGIC OBJECTIVE(S))	**a. - To provide safe, high quality patient-centred health care.** **d. - To enable integrated care closer to home**
EXECUTIVE LEAD:	Director of Finance and Business services

Principal Risk (What could prevent the objective(s) being achieved)	**What are we doing about it?** **(Key Controls)** What control measures or systems we have in place to assist secure delivery of the objective (describe process rather than management group)	**Current Score I x L**	**How do we know we are doing it?** **(Key Assurances of controls)** Provide examples of recent reports considered by Board or committee where delivery of the objectives is discussed and where the board can gain evidence that controls are effective.	**What are we not doing?** **(Gaps in Controls C) / Assurance (A)** What gaps in systems, controls and assurance have been identified?	**How can we fill the gaps or manage the risk better?** **(Actions to address gaps)**	**Target Score I x L**	**Timescale** When will the action be completed?
Failure to integrate the IM&T programme into mainstream activities	Managed Business Partner for IM&T services to deliver IT that will be a key enabler for our clinical strategy. IM&T now incorporated into Improvement and Innovation Framework	3x3=9	IM&T Board in place. Quarterly reports to Trust Board	No gaps identified	No actions required	3x2=6	
	Engagement with the wider clinical communities (internal) including formal meetings of the newly created advisory groups/ clinical IT. Improved communications plan incorporating process for feedback of information		CMIO(s) now in place, and active members of the IM&T meetings The joint governance board monitors the level of communications with the organisation	No gaps identified	No actions required		
	Engagement with the wider clinical communities (External). UHL CMIOs are added as invitees to the meetings, as are the clinical (IM&T) leads from each of the CCGs		UHL membership of the wider LLR IM&B board	No gaps identified	No actions required		

Benefits are not well defined or delivered	Appointment of IBM to assist in the development of an incentivised, benefits driven, programme of activities to get the most out of our existing and future IM&T investments Initial engagement with key members of the TDA to ensure there is sufficient understanding of technology roadmap and their involvement. The development of a strategy to ensure we have a consistent approach to delivering benefits Increased engagement and communications with departments to ensure that we capture requirements and communicate benefits Standard benefits reporting methodology in line with trust expectations		Minutes of the joint governance board, the transformation board and the service delivery board Benefits are part of all the projects that are signed off by the relevant groups	(c) the delivery programme is dependent on TDA approvals for some elements (c) ensure that all CMGs/ specialties have the approach to IM&T benefits as part of delivery projects (a) production of a standard report on the delivery of benefits	TDA approvals documentation to be completed (12.8)		Review Jan 2014 CIO

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST – BOARD ASSURANCE FRAMEWORK NOVEMBER 2013

RISK NUMBER/ TITLE:	**RISK 13 – FAILURE TO ENHANCE MEDICAL EDUCATION AND TRAINING CULTURE**
LINK TO STRATEGIC OBJECTIVE(S)	**e - To enjoy an enhanced reputation in research, innovation and clinical education.**
EXECUTIVE LEAD:	Medical Director

Principal Risk (What could prevent the objective(s) being achieved)	**What are we doing about it?** **(Key Controls)** What control measures or systems we have in place to assist secure delivery of the objective (describe process rather than management group)	Current Score I x L	**How do we know we are doing it?** **(Key Assurances of controls)** Provide examples of recent reports considered by Board or committee where delivery of the objectives is discussed and where the board can gain evidence that controls are effective.	**What are we not doing?** **(Gaps in Controls C) / Assurance (A)** What gaps in systems, controls and assurance have been identified?	**How can we fill the gaps or manage the risk better?** **(Actions to address gaps)**	Target Score I x L	**Timescale** When will the action be completed?
Failure to implement and embed an effective medical training and education culture with subsequent critical reports from commissioners, loss of medical students and junior doctors, impact on reputation and potential loss of teaching status.	Medical Education Strategy and Action Plan	4x3 = 12	Strategy approved by the Trust Board Strategy monitored by Operations Manager and reviewed monthly in Full team Meetings. Favourable Deanery visit in relation to ED Drs training	(c) Lack of engagement/awareness of the Strategy with CMGs.	Meetings to discuss strategy with CMGs (13.1)	3x2 = 6	Dec 2013 MD
	UHL Education Committee 'Doctors in Training' Committee established Education and Patient Safety		Professor Carr reports to the Trust Board Reports submitted to the Education Committee Terms of reference and minutes of meetings	(c) Attendance at the Committee could be improved. (c) Improved trainee representation on Trust wide committees (c) Improve engagement with other patient safety activities/groups	Relevance of the committee to be discussed at specialty/ CMG meetings (13.2) 'Build relationships with CMG Quality Leads. Establish links with LEG/QAC and QPMG. (13.4)		Dec 2013 MD Dec 2013 MD

	Quality Monitoring		Quality dashboard for education and training monitored monthly by Operations Manager, Quality Manager and Education Committee. Education Quality Visits to specialties Monitor progress against the Education Strategy and GMC Training Survey results	(a) Information is from diverse sources – the collation of information needs to be established (a) Lack of engagement with specialties to share findings from the dashboards (a) Do not currently ensure progress against strategic and national benchmarks (c) Inadequate educational resources	Introduce exit surveys for trainees Communicate feedback from the GMC training survey and LETB Visits via the Dashboard. (13.5) Attend CMG management meetings and liaise with specialties. (13.6) Monitor UHL position against other trusts nationally. (13.7) New Library/learning facilities to be developed at the LRI .(13.8)		Dec 2013 MD Dec 2013 MD Review Feb 2014 MD Apr 2014 MD
	Educational project teams to lead on education transformation projects		Project team meets monthly Favourable outcome from Deanery visit in relation to ED Drs training	(c) Implementation of the project within Acute Medicine needs to be improved.	Dr Hooper in post for Acute Medicine to implement project. (13.9)		Feb 2014 MD
	Financial Monitoring		SIFT monitoring plan in place	(c) Poor engagement with specialties in relation to implication of SIFT	Need to engage with the specialties to help them understand the implication of SIFT and their funding streams. (13.10)		Dec 2013 MD

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST

ACTION TRACKER FOR THE 2013/14 BOARD ASSURANCE FRAMEWORK (BAF)

Monitoring body (Internal and/or External):	Executive Team
Reason for action plan:	Board Assurance Framework
Date of this review	**November 2013**
Frequency of review:	Monthly
Date of last review:	October 2013

REF	ACTION	SENIOR LEAD	OPS LEAD	COMPLETION DATE	PROGRESS UPDATE	STATUS
1	**Failure to achieve financial sustainability**					
1.11	Ongoing discussions with commissioners about planned re-investment of the MRET deductions.	DFBS		Review October 2013	**Complete** (confirmed at TB meeting 28/11/13).	5
1.19	ESB will continue to meet every 6 weeks to ensure implementation of SLM across the Trust (expected Mar 2014)	DFBS		March 2014	On track.	4
1.20	Submit application for clinical coding to be included as a 2nd wave LIA pioneering team to involve clinicians.	DS	ADI	Review January 2014	On track. Successful with LIA application and upgraded to a 2nd wave LIA Enabling our People project with a focus on improving coding at the LRI.	4
2	**Failure to transform the emergency care system**					
2.7	Continue with substantive appts until funded establishment within ED is achieved.	COO	HO	Review ~~Sept Nov 2013~~ Jan 2014	Remains on track. Further review of progress Jan 2014.	4

Status key:	5	Complete	4	On track	3	Some delay – expect to completed as planned	2	Significant delay – unlikely to be completed as planned	1	Not yet commenced	0	Objective Revised

REF	ACTION	SENIOR LEAD	OPS LEAD	COMPLETION DATE	PROGRESS UPDATE	STATUS
2.9	CCG/LPT to increase capacity by use of Intermediate Care Services.	COO	HO	~~August~~ Review ~~October~~ ~~November 2013~~ January 2014	DTOCs reduced but not at level required yet. Additional community beds in City (24) and East (24) have been delayed and are now due to start in Dec 2013. Additional 19 IP beds for LPT also in process of being put in place. Review in January 2014 to ensure additional community beds in	3
3	**Inability to recruit, retain, develop and motivate staff**					
3.1	Revise and re-launch UHL reward and recognition strategy.	DHR	DDHR	~~October 2013~~ January 2014	A draft strategy is in place which has been further developed through 2 LiA events in September. The Recruitment and Retentions Strategy was presented to Executive Team on 5 November 13. There are some further updates to make before presentation to the Trust Board in December. The updated Strategy will be shared with staff side colleagues. The launch of the strategy is anticipated in January 2014. The action completion date has been amended to reflect this.	4

Status key:	5	Complete	4	On track	3	Some delay – expect to completed as planned	2	Significant delay – unlikely to be completed as planned	1	Not yet commenced	0	Objective Revised

REF	ACTION	SENIOR LEAD	OPS LEAD	COMPLETION DATE	PROGRESS UPDATE	STATUS
3.2	Take baseline from January and measure progress in relation to the success of recruitment events now that there is a structured plan for bulk recruitment. Identify a lead from each professional group to develop and encourage the production of fresh and up to date material.	DHR	DDHR	December 2013	Programme of Trust wide recruitment campaigns for Registered nurses and HCA's during 2013. Key actions have included Development and implementation of a Band 5 registered nurse and Band 2 HCA job swap to limit the number of internal moves from full recruitment processes. Attendance at 3 Registered Nurse jobs fairs in Manchester, London and Glasgow Development to a Nursing recruitment web page. Adverts have appeared on train platforms between Leicester, London and surrounding areas and use of social media as an advertising source has been utilised. LiA will support further development of all of the above for Nursing and other staff groups in UHL. International Recruitment campaigns are continuing to progress. A comprehensive rolling programme of advertising has been proposed for 2014.	4

Status key:	5	Complete	4	On track	3	Some delay – expect to completed as planned	2	Significant delay – unlikely to be completed as planned	1	Not yet commenced	0	Objective Revised

REF	ACTION	SENIOR LEAD	OPS LEAD	COMPLETION DATE	PROGRESS UPDATE	STATUS
3.3	Development of Pay Progression Policy for Agenda for Change staff.	DHR	DDHR	~~October~~ ~~November~~ December 2013	Presentation of proposal to ESB on 1st October. Work to finalise a Policy for discussion with staff side underway. Initial staff side comments acquired and specific meeting to discuss on 16 December 13. Pay Progression Policy to be considered at ESB on 3 December 2013.	3
3.4	Implementation of Recruitment and Retention Premia for ED staff.	DHR	DDHR	~~September~~ ~~October~~ November 2013	**Complete**. R&R premia approved by the Remuneration Committee for Consultants and Band 5 Nurses in ED, in line with certain qualifying criteria. For Consultants an agreed job plan was required and for the majority has been completed and the payments will be made in December pay. Band 5 Nurses receive their first payment after 6 months and will be reflected in January 2104 pay.	5
3.5	Ensure Statutory and Mandatory training is easy to access and complete with 75% compliance by reviewing delivery mode, access and increasing capacity to deliver against specific subject areas.	DHR	ADLOD	March 2014	Performance improved to 60%. First four newly designed e-learning packages have been completed:- All other e-learning packages will be available from the end of December 2013.	4
3.6	Consult and implement Pay Progression Policy	DHR	DDHR	November 2014	First stage of staff side consultation will take place at the JSCNC on 11.11.13. **NB: This action has been deleted from the BAF and will be deleted from future iterations of the action tracker as the action is incorporated in action 3.3.**	4

Status key:	5	Complete	4	On track	3	Some delay – expect to completed as planned	2	Significant delay – unlikely to be completed as planned	1	Not yet commenced	0	Objective Revised

REF	ACTION	SENIOR LEAD	OPS LEAD	COMPLETION DATE	PROGRESS UPDATE	STATUS
3.7	Update e-UHL records to ensure accuracy of reporting on a real time basis	DHR		March 2014	Work in progress with designing new system and completion of Project Documentation for review by IMT Project Board on 4 November 2013. Data from other systems has been migrated across to the e-UHL System to support accurate reporting. A Project Brief has been completed to reflect e-UHL System upgrade requirements and a Project Board has been established in taking forward this work.	4
3.8	Active recruitment strategy to recruit to current nurse vacancies including implementation of a dedicated nursing recruitment team	CN/ DHR		December 2013	Team leader appointed and new structure to be implemented from 2 December 2013.	4
3.9	Develop an employer brand and maximise use of social media to describe benefits of working at UHL	DHR		April 2014	First meeting of task and finish group taken place. Use of Linked-In and staff good news stories to describe benefits of working at UHL	4
3.10	Programme of induction and adaptation in development with Nursing education leads, timetabled to ensure capacity to support recruitment programme.	DHR		April 2014	Programme in development which covers induction, interim development and long term development. Includes dedicated older person's training course	4
4	**Ineffective organisational transformation**					

Status key:	5	Complete	4	On track	3	Some delay – expect to completed as planned	2	Significant delay – unlikely to be completed as planned	1	Not yet commenced	0	Objective Revised

REF	ACTION	SENIOR LEAD	OPS LEAD	COMPLETION DATE	PROGRESS UPDATE	STATUS
4.1	Review outputs from Chief Officers Group and strategic Planning Group to ensure gaps in current processes are being addressed	DS		Review Feb 2014	On track	4
5	**Ineffective strategic planning and response to external influences**					
7	**Failure to maintain productive and effective relationships**					
7.3	Invite PWC (Trust's Auditors) to offer opinion on the plan / talk to a selection of stakeholders.	DMC		January 2014	On track	4
8	**Failure to achieve and sustain quality standards**					
8.2	Women's CMG to work with Dr Foster and other trusts to better understand risk adjustment model related to the national quality dashboard.	MD		January 2014	On track	4
8.5	Active recruitment to ward nursing establishment so releasing ward sister for supervisory practice.	CN		September 2014	On going recruitment process in place and is likely to take 12 -18months. Deadline extended to reflect this.	4
8.10	Implementation of Electronic Patient Record (EPR)	CIO		2015	Currently developing the procurement strategy for the EPR solution	4
8.11	UHL to be involved in the DH review in to the use of the Safety Thermometer tool	CN		Review Dec 2013	Timescale DH dependent	4
8.12	Review of all deaths identified in low risk groups. Working with DFI to ensure data has been recorded accurately.	MD		Dec 2013	On track	4
9	**Failure to achieve and sustain high standards of operational performance**					
9.2	Re-configuration of surgical beds to create a 'protected area' for surgical patients or by use of independent sector.	COO	HO/CMGM Planned	~~November 2013~~ January 2014	Discussions with independent sector regarding sending elective surgical work to them. Paper written and presented to QAC and F&P. RAG rating changed to reflect delays to original completion date. Review progress in January 2014	3

Status key:	5	Complete	4	On track	3	Some delay – expect to completed as planned	2	Significant delay – unlikely to be completed as planned	1	Not yet commenced	0	Objective Revised

REF	ACTION	SENIOR LEAD	OPS LEAD	COMPLETION DATE	PROGRESS UPDATE	STATUS
9.8	Further development of backlog plans. RTT revised recovery plans to be submitted to commissioners 28/11/13. (Action reworded November 2013)	COO		~~August~~ ~~September~~ End of ~~October~~ November 2013	**Complete.** Formal recovery plan submitted to Commissioners	5
9.10	Outputs from IST initial capacity and demand review to inform recovery plan development	COO		~~November 2013~~	**Complete**	5
10	**Inadequate reconfiguration of buildings and services**					
10.1	Prioritisation of key areas within the clinical strategy for delivery *(Action reworded Nov 2013)*	MD		December 2013	On track.	4
10.2	Ensure success of FT Application (see risk 6 for further detail).	CEO		April 2015	Timetable subject to change due to changes in national approach. **NB: This action has now been deleted from the BAF as it was originally identified as the mechanism of securing funding for the reconfiguration. Capital funding will now be secured in line with action 10.3**	3
10.3	Secure capital funding to implement Estates Strategy.	DFBS		~~May 2013~~ ~~December 2013~~ March 2014	Work underway on capital planning around reconfiguration – SOC due for completion in March 2014 which will be the key vehicle to agree availability of capital funding.	3
10.5	Iterative development of strategic plans with specialities. Monitored by CMG and Executive Boards	MD		March 2014	On track	4
10.6	Reconfiguration programme to develop a strategic outline case which will inform the future estate strategy	DS		January 2014	On track	4
11	**Loss of business continuity**					

Status key:	5	Complete	4	On track	3	Some delay – expect to completed as planned	2	Significant delay – unlikely to be completed as planned	1	Not yet commenced	0	Objective Revised

REF	ACTION	SENIOR LEAD	OPS LEAD	COMPLETION DATE	PROGRESS UPDATE	STATUS
11.2	Determine an approach to delivering a physical testing of the IT Disaster Recovery arrangements which have been identified as a dependency for critical services. Include assessment of the benefits of realistic testing of arrangements against the potential disruption of testing to operations.	COO	CIO	~~September~~ Further review December 2013	Testing programme hasn't been developed but it is part of the work that IBM are doing to achieve ISO 22000. Currently awaiting update from CIO. Further review in December 2013	3
11.8	Further processes require development, particularly with the new Facilities and IM&T providers to ensure resilience is considered/ developed when implementing new systems, infrastructure and processes.	COO	EPO	~~July~~ ~~August~~ Review ~~October~~ ~~November 2013~~ December 2013	Work with IM&T has been completed. Delays are being encountered in developing agreed processes with Interserve. Briefed by NHS Horizons in terms of large capital projects. No progress with Interserve in terms of planned maintenance works. Meeting scheduled for 9.12.13	3
11.10	Training and Exercising events to involve multiple CMGs/specialties to validate plans to ensure consistency and coordination.	COO	EPO	August 2014	BCM training and exercising programme has been developed.	4
11.11	Further work required to develop escalation plans and response plans for Interserve.	COO	EPO	~~October~~ December 2013	EPO has not received any progress updates from Interserve. Draft escalation plan received and to be reviewed on 9.12.13	3
11.12	Develop a plan and a better understanding of how a loss of critical suppliers will affect the Trust	COO	EPO	~~October~~ ~~November 2013~~ December 2013	Draft plan due w/c 4th November. Final draft received some minor details to include, training and testing programme to be developed. Completion date changed to December 2013	3

Status key:	5	Complete	4	On track	3	Some delay – expect to completed as planned	2	Significant delay – unlikely to be completed as planned	1	Not yet commenced	0	Objective Revised

REF	ACTION	SENIOR LEAD	OPS LEAD	COMPLETION DATE	PROGRESS UPDATE	STATUS
11.13	Training and Exercising events to involve multiple CMGs/ specialties to validate plans to ensure consistency and coordination	COO	EPO	August 2014	On track	4
12	**Failure to exploit the potential of IM&T**					
12.8	TDA approvals documentation to be completed	CIO		~~October 2013~~ Review Jan 2014	How we procure the EPR solution has a material effect on how or if we proceed with TDA approval. This will be decided in the next two months	2
13	**Failure to enhance education and training culture**					
13.1	To improve CMG engagement facilitate meetings to discuss Medical Education Strategy and Action Plans with CMGs.	MD	AMD	December 2013/January 2014	Delayed response to meeting requests from CMGs.	3
13.2	Relevance of the UHL Education Committee to be discussed at CMG Meetings in an effort to improve attendance.	MD	AMD	December 2013/January 2014	Delayed response to meeting requests from CMGs.	3
13.4	Build relationships with CBU Quality Leads and establish links with LEG/QAC and QPMG in an effort to improve engagement with other patient safety activities/groups.	MD	AMD	December 2013/January 2014	Delayed response to meeting requests from CMGs.	3
13.5	Introduce exit surveys for trainees and communicate feedback from the GMC training survey and LETB Visits via the Dashboard.	MD	AMD	December 2013	On track.	4
13.6	Attend CMG management meetings and liaise with CMGs in an effort to improve engagement of CMGs.	MD	AMD	December 2013/January 2014	Delayed response to meeting requests from CMGs.	3

Status key:	5	Complete	4	On track	3	Some delay – expect to completed as planned	2	Significant delay – unlikely to be completed as planned	1	Not yet commenced	0	Objective Revised

REF	ACTION	SENIOR LEAD	OPS LEAD	COMPLETION DATE	PROGRESS UPDATE	STATUS
13.7	Monitor UHL position against other trusts nationally to ensure progress against strategic and national benchmarks.	MD	AMD	Review ~~October 2013~~ February 2014	Following further discussions with the LETB this data is not readily available. LETB to investigate how we can acquire this data.	2
13.8	New Library/learning facilities to be developed at the LRI to help resolve inadequate educational resources.	MD	AMD	~~October 2013~~ April 2014	Odames Ward has been identified and a project group has been set up. Currently this area is being used as a decant ward for Osborne patients. We understand that we can begin work on this in April 2014. The project group will continue to meet to ensure this stays on track.	2
13.9	Dr Hooper in post for Acute Medicine to implement project and improve Acute Medicine progress.	MD	AMD	February 2014	On track.	4
13.10	Need to engage with the CMGs to help them understand the implication of SIFT and their funding streams.	MD	AMD	December 2013/January 2014	Delayed response to meeting requests from CMGs.	3

Key

CEO	Chief Executive Officer
DFBS	Director of Finance and Business Services
MD	Medical Director
AMD	Assistant Medical Director
COO	Chief Operating Officer
DHR	Director of Human Resources
DDHR	Deputy Director of Human Resources
DS	Director of Strategy
ADLOD	Asst Director of Learning and Organisational Development
DMC	Director of Marketing and Communications
CIO	Chief Information Officer
CMIO	Chief Medical Information Officer

Status key:	5	Complete	4	On track	3	Some delay – expect to completed as planned	2	Significant delay – unlikely to be completed as planned	1	Not yet commenced	0	Objective Revised

EPO	Emergency Planning Officer
HPO	Head of Performance Improvement
HO	Head of Operations
CD	Clinical Director
CMGM	Clinical Management Group Manager
DDF&P	Deputy Director Finance and Procurement
FTPM	Foundation Trust Programme Manager
HTCIP	Head of Trust Cost Improvement Programme
ADI	Assistant Director of Information
FC	Financial Controller
ADP&S	Assistant Director of Procurement and Supplies
HoN	Head of Nursing
TT	Transformation Team
CN	Chief Nurse

Status key:	5	Complete	4	On track	3	Some delay – expect to completed as planned	2	Significant delay – unlikely to be completed as planned	1	Not yet commenced	0	Objective Revised

Appendix Three

BAF RISK SCORE MAP – NOVEMBER 2013

Likelihood ↓	Consequence				
	1	2	3	4	5
	Insignificant	Minor	Moderate	Major	Extreme
5 Almost Certain			10. Reconfiguration of buildings and services ⇧ (12-15)	3. Recruit, retain, develop and motivate staff ⇧ (16-20) 9. Operational performance ⇧ (12-20)	1. Financial sustainability ● 2. Emergency care system ●
4 Likely			11. Business continuity ⇧ (9-12)	4. Organisational transformation ⇧ (12 –16) 8. Achieve and sustain quality standards ● 6. FT status ● 5. Strategic planning and response to external influences ⇧ (12-16)	
3 Possible			12. IM&T ●	13. Medical Education and training culture ●	7. Productive and effective relationships ●
2 Unlikely					
1 Rare					

Key

- ● - No change in score from previous month.
- ⇧ - Risk score increased from previous month
- ⇩ - Risk score decreased from previous month
- ◈ - New risk

AREAS OF SCRUTINY FOR THE UHL BOARD ASSURANCE FRAMEWORK (BAF)

1) Are the Trust's strategic objectives S.M.A.R.T? i.e. are they :-

- **S**pecific
- **M**easurable
- **A**chievable
- **R**ealistic
- **T**imescaled

2) Have the main risks to the achievement of the objectives been adequately identified?

3) Have the risk owners (i.e. Executive Team) been actively involved in populating the BAF?

4) Are there any omissions or inaccuracies in the list of key controls?

5) Have all relevant data sources been used to demonstrate assurance on controls and positive assurances?

6) Is the BAF dynamic? Is there evidence of regular updates to the content?

7) Has the correct 'action owner' been identified?

8) Are the assigned risk scores realistic?

9) Are the timescales for implementation of further actions to control risks realistic?

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST

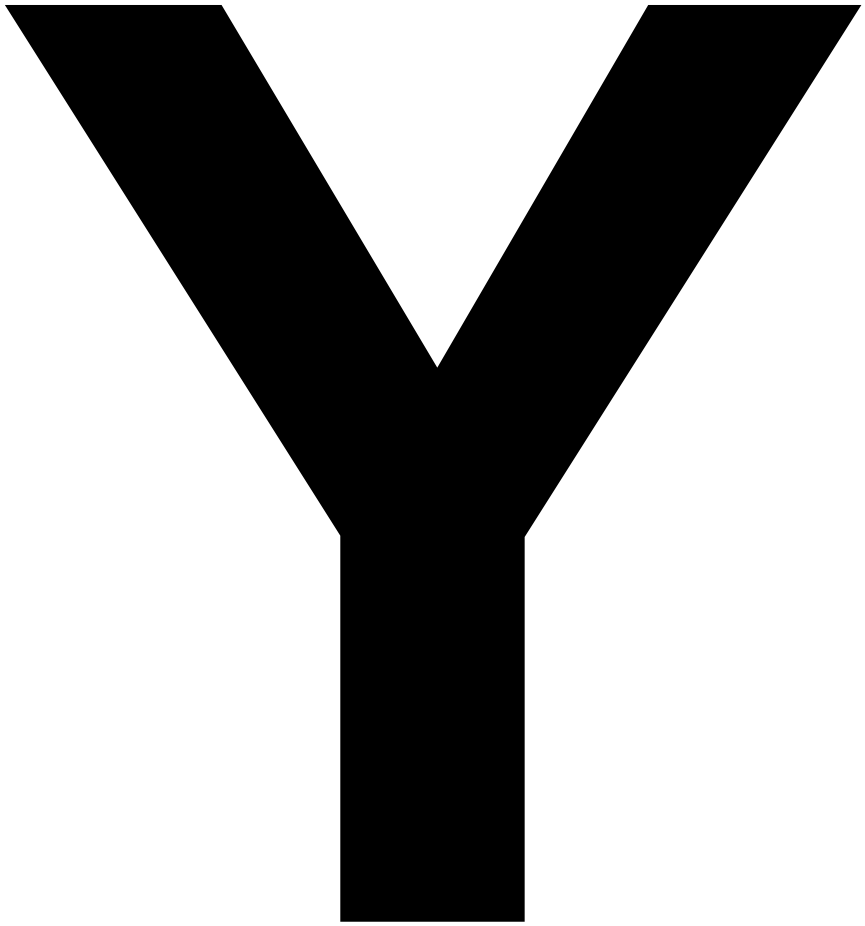
NEW EXTREME AND HIGH RISKS OPENED DURING THE PERIOD 1/11/13 - 30/11/13

REPORT PRODUCED BY: UHL CORPORATE RISK MANAGEMENT TEAM

Key

Red	Extreme risk (risk score 25)
Orange	High risk (risk score 15 - 20)
Yellow	Moderate risk (risk score 8 - 12)
Green	Low risk (risk score below 8)

Risk ID	CMG	Specialty	Risk Title	Opened	Review Date	Description of Risk	Risk subtype	Controls in place	Impact	Likelihood	Current Risk Score	Action summary	Target Risk Score	Risk Owner
2248	Clinical Support and Imaging	Medical Physics	Lack of IR(ME)R training records held across the Trust	14/11/2013	31/01/2014	Although the Trust Radiation Protection Policy states that "IRMER training records must be managed and maintained by individual Directorates (to be changed to Clinical Business Units in the current review) involved in the use of radiation" audits carried out routinely find that these training records are not sufficient, particularly for medical staff. Audits therefore suggest the policy is not being followed. **Causes** Current training records are poorly designed and / or incomplete / do not exist Inadequate or missing training records for IR(ME)R defined roles due to lack of compliance with the Trust policy in some areas. Staff working independently without reaching full competency No central records are kept of which staff have responsibilities under IRMER **Consequence** Lack of suitable training records may result in a failure to comply with standards set by regulatory and healthcare agencies (e.g. HSE / CQC). Failure at assessment might result in financial penalty and / or warning notices being issued. Non-compliance with national standards leading to enforcement action taken on the Trust following a routine inspection or follow up to an adverse event and consequent effects on the reputation of the Trust. Increased patient radiation doses due to lack of training. Increased staff doses due to lack of awareness of the potential doses if training is inadequate Potential damage to expensive equipment if training on how to use it is inadequate Management unable to easily identify which staff are trained to undertake a task involving radiation Breach of statutory duty Negative effect on the reputation of the Trust	Quality	There is a defined method of recording training across the Trust in the Trust Radiation Safety policy. Although this is working in some areas it is not working consistently in all areas. The issue has been raised at the Trust Radiation Protection Committee numerous times where representatives of each Division have been in attendance. This has not so far led to a an increase in compliance. Radiation Protection produced a specific plan of what is required to demonstrate compliance. Mock audit completed 2/12/13.	Major	Likely	16	Identify Trust staff with responsibilities under IRMER - due 31/12/2013 Investigate potential of using e-UHL to deliver a centralised record of IRMER training - due 31/12/2013 Introduce centralised training records for IRMER compliance - due 31/03/2014 Review training in the policy. due 01/04/2014 Ongoing monitoring of the effectiveness of the determined method of recording training will be detailed in the new policy. due 01/04/2014 CMG and service to manage and maintain records for the staff groups identified due 31/03/2014	4	MNO



Trust Board Paper Y

To:	**Trust Board**
From:	**Kate Bradley – Director of Human Resources**
Date:	**20 December 2013**
CQC regulation:	**Respecting and involving people who use services**

Title:	**Equality Agenda Progress Report**

Author/Responsible Director:
Deb Baker, Equality Manager and Kate Bradley, Director of Human Resources

Purpose of the Report:

To provide an update for the Trust Board on the equality work programme for 2013/14, changes to the internal assurance process related to the equalities agenda and recent changes to the national Equality Delivery System (EDS).

The Report is provided to the Board for:

Decision√		Discussion√	
Assurance√		Endorsement√	

Summary / Key Points:
This is the second of the bi-annual equality update to the Trust Board which details progress in relation to improving access to hospital care and receipt of fair treatment in all our services. In addition the report addresses our responsibilities in relation to the Public Sector Equality Duty (PSED). The paper includes an update on:

- Equality governance arrangements nationally, regionally and locally
- Progress with the 2013/14 equality work plan
- Audit of practice within our Clinical Management Groups (CMG)
- A summary of the key points of this years workforce monitoring report
- Suggested areas of focus for the April 2014/15 equality work programme

Equality Delivery System
The Equality Delivery System (EDS) has been revised and simplified by NHS England and is now referred to as EDS 2 (**Appendix 1**).The content remains largely the same and going forward the Clinical Commissioning Groups (CCG's) and the Clinical Support Unit (CSU) will be responsible for equality monitoring via the Quality Schedule.

Equality Action Plan 2013/14

The equality action plan (**Appendix 2**) is progressing well in all areas and is on track for completion by the end of March 2014. Key highlights include:

- The positive evaluation of attendees at the lesbian, gay, bisexual and transgender (LGB&T) conference held in the summer
- Successful engagement with the LGB&T community at the Leicester Pride event where we had an equality stand with Leicestershire Partnership Trust
- A new internal assurance group for Equality, Patient Experience and Engagement

- The development and dissemination of the Reasonable Adjustment Guidance for Managers and staff
- Increased referrals to the Acute Liaison Nurse service

The Equality Advisory Group (EAG) has supported and validated our self-assessed position of green and we are working with CCG equality leads across LLR to align our emerging priorities with theirs.

Audit of Equality Practice

Phase one of the qualitative audit of practice which was delayed because of the CMG restructure has been concluded. There is some evidence that services respond positively when a need for 'reasonable adjustment' is identified. For example extending a consultation slot to accommodate the needs of a deaf patient. However, this often occurs once the patient has arrived rather than as part of the appointment planning process. The review has demonstrated a need to have a more proactive and consistent approach to managing patients who present with additional needs. The nomination of a designated CMG equality and engagement lead, the revised terms of reference and renewed membership of the Equality, Engagement and Patient Experience Assurance Committee (**Appendix 3**) and the focus on patient care pathways should enhance services where improvements need to be made and ensure best practice is shared and implemented consistently.

Workforce Equality Review

The 2012/2013 workforce report has been completed with no significant variation from last year's report (**Appendix 4**). Broadly, Black Minority Ethnic (BME) and female representation remains static with a small increase in the number of female Consultants and BME representation at senior levels remains unchanged. In order to improve the validity of the data we are undertaking a revalidation exercise across the Trust that will include members of the Board. The levels of 'undeclared status' particularly for disability and sexual orientation have slightly improved but still remain low. The deep dive activity undertaken in respect of career progression for Band 6 BME members of staff does not suggest that there are any discriminatory practices at play but identified some valuable points for further consideration. The deep dive for this year will look at band 7 appointments.

Emerging Priorities 2014/15

The focus for 2014/15 will centre on the patient's journey using the care pathway review and due regard process as the means by which this achieved. To further embed equality the CMG Leads will provide assurance reports to their senior teams at least quarterly which in turn will form the basis of the quarterly Executive Assurance Committee report.

Recommendations:
To accept and agree the content of the report.

Previously considered at another corporate UHL Committee?
No, however, in future it has been agreed that the report will go to the Executive Assurance Committee.

Board Assurance Framework:	**Performance KPIs year to date:**
Risk 3	There is an equality indicator as part of the Quality Schedule requiring biannual reports.

Assurance Implications:
The equality programme is assessed for compliance with the Public Sector Duty annually via our web site.

Patient and Public Involvement (PPI) Implications:
The UHL Equality Advisory Panel provides external advice and support to the Equality Team. They attend not as individuals but as representatives from a wide range of local communities and are responsible for raising any community concerns with us. These concerns will be included in the 2013 equality annual report due to be published in April 2014. The terms of reference have been updated to include additional scrutiny for the end of year grading process for the Equality Delivery System 2 (EDS 2). A Patient Advisor and a member of the Advisory Group will sit on the newly developed Experience Equality and Engagement Assurance Committee. All equality related documents and action plans are published on the UHL web site. The equality lead is also involved with patients/ carers who raise equality related concerns often advising clinical staff on alternative methods of care delivery. A summary of the learning from the complaints received from patients and carers with a learning disability will be presented in the end of year annual report. Recommendations will be fed back to the Equality CMG leads.

Stakeholder Engagement Implications:
It is anticipated that the CCG's and CSU may require additional equality monitoring data in 2014. Further discussions are scheduled.

Equality Impact:
The overall intent of the equality work programme is to ensure equal access and fair treatment in all of our services. The emphasis for this year will be around the accessibility of patient care pathways, increased usage of the due regard process and enhanced internal monitoring via the newly developed Experience, Engagement and Equality Assurance Committee.

Information exempt from Disclosure:
None

Requirement for further review?
July 2014

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST

REPORT TO: **TRUST BOARD**
DATE: **20 DECEMBER 2013**
REPORT BY: **DEB BAKER, SERVICE EQUALITY MANAGER**
KATE BRADLEY, DIRECTOR OF HUMAN RESOURCES
SUBJECT: **EQUALITY AGENDA PROGRESS REPORT**

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1. INTRODUCTION

This is the second of the 2013/14 biannual equality updates to Trust Board to report on our progress with meeting the Public Sector Equality Duty (PSED) where we are required to:

- Eliminate unlawful discrimination, harassment and victimisation
- Advance equality of opportunity between different groups
- Foster good relations between different groups which are:

Race/ethnicity, Sex, Religion or belief, Gender Reassignment, Sexual orientation including lesbian, gay and transsexual people, Age, Marriage and Civil Partnership, Disability - learning disabilities, physical disability, sensory impairment and mental health problems

Following agreement from the Trust Board, UHL will publish by the 31st January the annual workforce monitoring report which is a statutory requirement.

2. THE PURPOSE OF THE PAPER

The Trust Board report includes an update on:

- The equality governance arrangements nationally, regionally and locally
- The 2013/14 equality work plan progress report
- An update of the Clinical Management Group (CMG) audit of practice
- A summary of the key points of this years workforce monitoring report
- Suggested areas of focus for the 2014/15 equality work programme

3. EQUALITY - NATIONALLY, REGIONALLY AND LOCALLY

NHS England has drafted its equality strategy the aims of which are to support the NHS in embedding equality of opportunity and reducing health inequalities with an emphasis upon co-production rather than performance monitoring. Early indications are that NHS England are not intending to dictate 'equality policy' but rather that the strategic direction for equality be determined, agreed and monitored on the basis of local health need and Trust priorities. The strategy indicates that Clinical Commissioning Groups (CCG's) and Clinical Support Units (CSU's) will have a more 'hands on' role in the equality monitoring of provider organisations than has previously been the case.

The early focus of NHS England has been to review and refresh the Equality Delivery System (EDS) which has now been officially launched and re branded EDS 2 (**Appendix 1**).

Whilst EDS 2 has not significantly changed from the original in terms of content, it has been simplified and remains a helpful tool to deliver our ethical and legal equality responsibilities. The four EDS 2 domains are:

Service Provision

- Better Health outcomes for all
- Improved Patient access and Experience

Workforce

- A representative and supported Workforce
- Inclusive Leadership

Our 2014 Equality work programme will be aligned to the EDS 2 domains as in previous years.

3.1 External Governance

The current Quality Schedule equality standard asks for a bi-annual equality progress report against our action plan, which in effect are the Trust Board updates. Early indications from the discussions held to date with the CCG suggest that we may be required to provide additional monitoring data. This could include patient experience feedback, patient safety, complaints and patient access i.e. emergency care, and cancer wait times broken down by protected characteristic. This has yet to be fully discussed but may form part of the forthcoming contract negotiations for 2014/15 that the Equality Manager will be involved in.

The requirement for the annual grading process for EDS 2 remains and requires an independent review of our self assessed grading to validate or refute it. Where there are differences the grading assigned by the external assessors needs to be adopted. Our equality work programme log (**Appendix 2**) was recently assessed by the Equality Advisory Group and the position being reported via this paper has been validated as green, achieved. A full end of year assessment as of 31st March will be reported in the equality annual report published on the external web site.

No formal reporting is required by NHS England other than our legal compliance information that is published on our web site annually on the 31st January.

3.2 UHL Governance

The equality work programme is monitored by the Human Resources Equality Group and Equality Advisory Group six weekly. In addition to this we have reviewed the patient experience, engagement and equality group and devised new terms of reference, membership and reporting requirements to enhance assurance and access for patients. The drafts of these are attached at **Appendix 3.** A quarterly equality report will be submitted to the Executive Quality Assurance Committee.

4. WORK PLAN PROGRESS LOG

Work is progressing well in all areas and is on track for completion by the end of March 2014. Notable highlights are:

- The positive evaluation of attendees at the lesbian, gay, bisexual and transgender conference held in the summer

- Successful engagement with the LGB&T community at the Leicester Pride event where we had an equality stand with the Leicestershire Partnership Trust. We had a mixture of experiences reported by patients at this event. The overriding theme was the that the attitude of some health professionals was not always positive
- A new assurance group for Equality, Patient experience and Engagement
- The completion of the first phase of the CMG equality review
- The launch of the Reasonable Adjustment guidance for staff and Managers
- A telephone interpreting pilot in the antenatal clinics
- Continued employment outcomes for the Leicester Works students
- The development and implementation of a new e learning training programme
- An increase in the numbers of people undertaking equality training from 37%- 59%

5. EMBEDDING EQUALITY – THE CMG REVIEW

Mainstreaming equality has been one of our main challenges for this year. Corporately we have processes in place and a varied programme of work. Within the EDS model each CMG should have responsibility for providing fair, accessible and individualised care to all of their patients.

As a starting point the Equality Manager has conducted a qualitative review of equality work and met with all of the CMG Managers to see how embedded equality principles was in everyday practice, with a view to a more systematic review being conducted in 2014 once the broad themes had been identified.

There were three lines of enquiry that the interviews were based around which were to:

- Understand how CMG services operate for all of our patients.
- Demonstrate how the CMG's 'reasonably adjust' their services to accommodate the needs of everyone.
- Explain how equality and inclusion issues are addressed within the CMG's.

5.1 Emerging Themes

5.1.1 Understand how their service operates for all of our patients

Across all CMG's there was genuine commitment to the principles of fairness, equality of access for patients, carers and visitors and equal opportunity for staff. Understanding what this looked like in terms of patient and staff outcomes was less well understood. An example being that patient feedback is generally assessed across the whole patient population. Rarely is there information that looks at satisfaction between groups, making targeted improvement difficult. This is an area requiring further work.

5.1.2 Demonstrate how they 'reasonably adjust' their service to accommodate the needs of everyone

The audit indicates that on a case by case basis this is done well. There is good evidence that the Learning Disability Service is well utilised across the Trust. We have many examples of good practice where a patient with complex care needs has been able to access a service as a result of reasonable adjustment. For example:

A patient with severe autism needed an ECG. Several attempts had been made by the GP unsuccessfully. The patient is unable to interact and becomes extremely agitated because of unfamiliarity with the environment, people etc. This generally results in destructive behaviour. Our specialist nurse worked with the ECG team and residential care staff and reduced as much external distraction as possible. A side room was allocated with only the ECG machine and a chair. Car parking was arranged as near to the room as possible and the patient was collected in a wheelchair by the care staff and the learning disability specialist nurse. The ECG staff were thoroughly briefed and interaction was kept to a minimum. The ECG was performed successfully and the patient left.

Without this intervention it is unlikely that the patient would have been able to comply and therefore would most likely not have had the diagnostic test. The aim of reasonable adjustment is to ensure that every effort is made to accommodate the most complex patients in order that they can get access to the health care they require.

For other protected groups it is often less well organised. Impact assessments or due regard tend only to be used when larger scale change or improvements are designed and implemented rather than as a routine element of care pathway design. This can result in some patients needs being overlooked. The test of any care pathway is ‘’if we get it right for the most vulnerable of our patient groups we are likely to get it right for everyone’’.

5.1.3 How are equality and Inclusion issues addressed within the CMG?

Again there is clearly an ambition to ‘get things right for patients’ however equality issues tended to be addressed when they arose. Equality tends not to feature regularly on CMG board meeting agendas, when it does the trigger is often a patient complaint or concern. That said there were some examples where services had adapted their provision to take account of a particular patient group. For instance Musculo-skeletal had developed ‘learning cards’ for the patients who had fractured their hips and had dementia or had English as their second language. This enabled the patients to participate in the rehabilitation element of their treatment plan. Maternity run a specialised clinic for pregnant women who have undergone genital mutilation.

5.1.4 Summary

Whilst there is both commitment and sign up to the principles of equality and inclusion some gaps remain in terms of how we evidence that access to and delivery of care is in fact equitable for all. The good news is that there is no evidence at present to suggest that access is directly denied on unreasonable grounds for any protected group. That said we do have some issues of consistency in relation to how far a service may or may not go to make the patient journey smoother for our more vulnerable/complex patients. Bed pressures, staffing levels and attitude are clearly major factors in determining how well or not services are flexed to accommodate patients with differing and or additional needs. A more systematic review of current pathways should deliver a better understanding of what is required to ensure that all of our patients achieve the best possible health outcome that they can.

5.1.5 Recommendation

To support phase two of the review, which, is to assess with the Equality CMG Lead the most commonly used care pathways and ensure reasonable adjustments are integrated where required.

6. Workforce Monitoring Report

We are required as part of the Public Sector Equality Duty to annually collect, analyse and publish our workforce data by:

- Our overall workforce profile
- Pay differences
- Recruitment
- Number of staff leaving Staff leaving
- Number of Disciplinary and Grievance cases
- Access to training

This is shown at **Appendix 4**. The data is analysed by gender, age, ethnicity, religion and belief, sexual orientation and disability.

6.1 Key Workforce Priorities Identified for 2013

- There was a higher than average number of males and individuals from a BME background employed on fixed term contracts
- Representation for women and BME staff at a senior level remains our biggest challenge (8a and above)
- Benchmarking some of our workforce data with other similar Trusts
- To develop guidance for staff on ‘’reasonable adjustment’’
- To audit band 6 staff to identify any perceived/real blocks to career progression for BME staff

6.2 2012- 2013 Workforce Report Findings

Broadly, representation has remained the same and again there have been some interesting anomalies identified that warrant further investigation.

We identified 5 areas of focused work as a result of last year’s data analysis. In terms of the benchmarking we have started to do our representation for all protected groups is favourable. The other Trusts also face similar challenges in terms of BME representation at senior levels. We need to continue our investigations into short term contracts and the prevalence of BME Staff within the figures.

On the positive side we have seen an increase in the number of female Consultants, a reduction in the number of ‘unknowns’ for disability. In addition the Reasonable Adjustment guidance has been disseminated which will hopefully ease some of the anxiety staff feel as a result of experiencing health problems that have ongoing implications.

In terms of the deep dive activity conducted last year, whilst not all was conclusive and further work needs to be done. The results did provide some assurance that our Human Resources processes do not discriminate against our staff from protected groups. The band six career progression work survey report confirmed this.

As with previous reports the numbers of undeclared or undefined status remains significant this includes Trust Board member’s data. Accurate assessment of representation is therefore difficult in some areas. To this end we are conducting a revalidation exercise and would like to include the Trust Board in order that we can

comply with the Department of Health's memorandum on Governance procedures. It recommends regular reviews of the composition of the Board to ensure that its appropriately diverse in terms of all of the protected characteristics which are gender, age, ethnicity, disability, religion and belief and sexual orientation. Because of the gaps in data it is difficult to accurately report our position.

Finally limitations remain in terms of the data that is recorded and collected. However having completed a second years report using this format we are in a stronger position to identify where the gaps are and what action needs to be taken to address them. This will be included in the 2014/15 equality work plan.

6.3 2014 Workforce Key Priorities

- Workforce data revalidation/exercise to be completed
- To conduct some further analysis for those BME staff appointed into band 7 positions
- To identify our Human Resources data recording activity to identify where we are unable to generate accurate equality reports
- Adopt best practice data collection and analysis through benchmarking with East Midlands colleagues
- Conduct a deep dive into the number of LGBT staff represented in disciplinaries

7. AREAS OF FOCUS FOR 2014 - 2015

Following the first phase of the CMG review there is clear commitment and sign up to the principles of equality and inclusion, however some gaps remain in terms of how we evidence that access to and delivery of care is equitable for all.

The focus for 2014 will therefore centre on the patient's journey using the care pathway review and due regard process as the means by which this achieved. To further embed equality the CMG leads will provide assurance reports to their senior teams at least quarterly.

8. SUMMARY

UHL continues to declare legal compliance with the Public Sector Equality Duty and has a range of activities and processes to evidence our position. In addition we are meeting all of our external requirements via the Quality Schedule and the Learning Disability Self Assessment Framework.

There is no doubt that the principles of equality are well understood by most staff in the Trust. What is more difficult to evidence is the extent to which the principles of equality are fully embedded into everyday thinking and practice at all levels. This will be the main focus of this years work plan.

9. RECOMMENDATION

The Trust Board is asked to note and agree the content of the report.

Appendix 1

A refreshed Equality Delivery System for the NHS: EDS2

Making sure that everyone counts
November 2013

At the heart of EDS2 are 18 outcomes, against which NHS organisations assess and grade themselves. They are grouped under four goals, as shown in the table on the following page. These outcomes relate to issues that matter to people who use, and work in, the NHS. Among other things they support the themes of, and deliver on, the NHS Outcomes Framework, the NHS Constitution, and the Care Quality Commission's key inspection questions set out in "Raising standards, putting people first - Our strategy for 2013 to 2016". The "Outcomes and gradings" tables shown on pages 18 to 35 identify which national policy initiatives each outcome relates to and helps to deliver.

NHS organisations are advised to assess and grade their performance across all EDS2's outcomes, except for when there is a compelling reason for being selective. Each year, starting in 2014, NHS England will identify one EDS2 outcome where it believes concerted national effort is required in order for the NHS to improve its equality performance. Guidance and support will be provided for delivery on this outcome, and good practice will be shared. On rare occasions organisations may wish to focus on a subset of the 18 outcomes where there is local support for doing so, and local evidence that indicates that a focus on particular outcomes will be beneficial.

NHS organisations are encouraged to express EDS2's outcomes in their own words and communicate them effectively to all local audiences, as they see fit. NHS England will share local adaptations of these outcomes with NHS organisations. An Easy Read version of the EDS will be produced and made available to the NHS.

These outcomes relate to issues that matter to people who use, and work in, the NHS.

The goals and outcomes of EDS2

Goal	Number	Description of outcome
Better health outcomes	1.1	Services are commissioned, procured, designed and delivered to meet the health needs of local communities
	1.2	Individual people's health needs are assessed and met in appropriate and effective ways
	1.3	Transitions from one service to another, for people on care pathways, are made smoothly with everyone well-informed
	1.4	When people use NHS services their safety is prioritised and they are free from mistakes, mistreatment and abuse
	1.5	Screening, vaccination and other health promotion services reach and benefit all local communities
Improved patient access and experience	2.1	People, carers and communities can readily access hospital, community health or primary care services and should not be denied access on unreasonable grounds
	2.2	People are informed and supported to be as involved as they wish to be in decisions about their care
	2.3	People report positive experiences of the NHS
	2.4	People's complaints about services are handled respectfully and efficiently
A representative and supported workforce	3.1	Fair NHS recruitment and selection processes lead to a more representative workforce at all levels
	3.2	The NHS is committed to equal pay for work of equal value and expects employers to use equal pay audits to help fulfil their legal obligations
	3.3	Training and development opportunities are taken up and positively evaluated by all staff
	3.4	When at work, staff are free from abuse, harassment, bullying and violence from any source
	3.5	Flexible working options are available to all staff consistent with the needs of the service and the way people lead their lives
	3.6	Staff report positive experiences of their membership of the workforce

Inclusive leadership	4.1	Boards and senior leaders routinely demonstrate their commitment to promoting equality within and beyond their organisations
	4.2	Papers that come before the Board and other major Committees identify equality-related impacts including risks, and say how these risks are to be managed
	4.3	Middle managers and other line managers support their staff to work in culturally competent ways within a work environment free from discrimination

Appendix 2

University Hospitals of Leicester NHS Trust

Progress of Equality Delivery System actions arising from the UHL equality plan December 2013

1. Better Outcomes For All.				
Action	**Lead**	**By When**	**Progress Update December 2013**	**RAG Status***
Ensure that the Due Regard analysis is undertaken on all improvement schemes. If an adverse impact is anticipated /identified this needs to be noted and reported to the Service Improvement Board. Further advice may be required before progressing the scheme	Service Improvement Innovation Project Leads	April 2014	The monitoring process is in place. Project leads have been trained and the diabetes project, moving some patients from hospital to GP practices has a completed the due regard analysis as does the Ambulatory care project. No adverse impacts have been identified some recommendations have been provided. The numbers of assessments received have been disappointing. This suggests that the due regard process isn't as well embedded as it could be. Appointments have been made with the CMG managers to undertake a baseline audit of equality activity. Due Regard assessment will be included in the discussion. All CMG interviews with the Managers have taken place and the themes identified.	4
Produce a UHL Equality Strategy once the national strategy and Equality Delivery System 2 is	Equality Lead	February 2014	The national strategy is due in October 2013. The national and regional equality structures have now	4

launched		December 2013	been identified. Equality team to meet with the regional lead for the national update in October 2013. The regional lead attended the equality leads meeting and reported that the ED strategy had been delayed. The Regional leads agreed to undertake some benchmarking in the following areas: 1. Learning and development data and or access to training, 2. Capability and grievances 3. Staff survey outcomes 4. Exit numbers The Regional Strategy has been drafted.	
Undertake an audit to assess how embedded equality is into everyday practice Develop required actions to inform next years equalit work programme and address any identified gaps	Clinical Management Group Leads Equality Team	~~August 2013~~ November 2013 April 2014	The audit template has been developed. Due to the reconfiguration of the Divisions the audit date has been reset for November 2013. CMG interviews due to commence and be completed in November. Findings to be reported in the Trust Board report December 2013. CMG qualitative review concluded.	5
2. Improved Access and experience				
Implement a training awareness programme for staff on hate crime to better support patients accessing emergency care	LPT, EMAS, the Equality Lead UHL	April 2014	Some sessions held for staff within ED, delivered by the local Police lead for hate crime. Training not completed. The script for the e learning package has been drafted and reviewed. Awaiting draft 2 of the programme.	4

			No further progress.	
Develop clinical guidance for the care of a bariatric patient. This is as a result of several complaints having been received	Bariatric Care Steering Group	~~December 2013~~ January 2014	The steering group has been established and all current issues identified. A briefing paper describing the issues and required actions to resolve them to be presented to the Nursing Executive Committee in ~~November 2013.~~ January 2014. A solution has been identified and actioned for the provision of a specialised trolley to transport deceased patients to the mortuary.	3
Work in partnership with other agencies to identify the local mental health priorities for Leicestershire and Rutland	Equality Lead	~~October 2013~~ The date for publication has been altered by the Public health Lead December 2013	Data required from UHL has been provided to the Public Health Lead.A Draft report has been completed.	3 (changed from green to yellow from previous update)
3. Empowered, engaged and well supported staff				
Produce an annual workforce and patient metrics report as part of our compliance with the Public Sector Equality Duty	Equality Team	December 2013	Format agreed. The report is to be agreed by the Trust Board in December before the publication on the web site in January 2014. Agreement secured at the November regional equality leads meeting that local Trusts will benchmark some of their workforce and patient data with one another. The next meeting is December 4th 2013. Initial benchmarking undertaken.	5

Increase the number of people receiving ED training which is mandatory	Equality Team	December 2014	Data is monitored annually and reported in the annual equality workforce monitoring report. Latest figures suggest we are at the same point as last year in terms of numbers of people accessing training which on average is250 per month. Overall compliance is however 45% compared to Safeguarding which is 70%. The increased emphasis upon completion of mandatory training and the launch of the new ED online programme should help to increase the level of compliance. Numbers of people who have completed their Equality training has increased from 37% to over 59%.	4
Develop a bespoke ED e-learning package to be managed internally.	Equality Team, e-UHL Team, OBC media	November 2014	Initial package developed, next stage editing in progress Product launched in October 2013.	5
Develop 'top tips' for the faith and non faith provision of care for patients to increase staff awareness. These will be made available on the equality resource page on Insite	Equality Team	January 2014	The working group is convened. Members of the public will be invited to contribute at the Annual Public Meeting on the 19th September 2013. Feedback received from event.	4
To improve the food provision for Muslim staff in the restaurants as currently vegetarian food is the only option for Muslim members of staff As per discussion	Interserve and Horizons	~~September~~ December 2013	A staff engagement group has been established and we have agreed that we will identify a sandwich provider with the appropriate certification but that we will be unable to provide a hot halal option for staff. The preferred supplier originally identified no longer provides non stunned meat. An alternative has to be identified. Interserve are doing a site visit of a potential alternative supplier and will report back at the November meeting.	4

			No suitable provider has been identified to date.	
Develop clear guidance in respect of learning support for staff with Dyslexia and Dyscalculia	Nurse Education, Equality and Training lead	February 2014	A task and finish group has been established to review the current arrangements. Clearer advice for Education Leads, Managers and staff is required and will be developed by the group A paper to be presented to the Nursing Executive shortly by the Education Team. No progress.	4
Undertake a revalidation of staff's personal details.	Workforce Lead	TBC	Equality Lead has met with the workforce Lead. Funding of 5K needs to be identified. Equality Lead to confirm the costing with the Workforce Lead before agreeing the commencement date. Agreement secured. To include revalidation of the Trust Board due to new appointments. Work will be completed by March 31st 2014.	4
3. Inclusive leadership				
Actions	**Lead**	**By when**	**Progress Update**	**RAG**

Act on the findings of the 2012 workforce report. The 2012 workforce monitoring report and Band 6 leadership questionnaire identified the following areas warranting further work and are: -Over the age of 40 you fair well from application to short listing, this position is reversed at appointment -There is a higher than average number of males and individuals from a BME background are employed on fixed term contracts - Look at a selection of applications, short listing and appointments for band 7 recruitment	Recruitment Lead	December 2013	Deep dive work scheduled to review the age profile of a sample of applications through the application process for a range of different graded posts. Deep dive work scheduled to review the BME backgrounds of applicants applying for and subsequently being successful in fixed term posts. Then compare this data to a sample of permanent roles. Review a sample of band 7 recruitment activity across the equality groups to identify if any area appears to be disproportional. Results included in the annual 2013 workforce monitoring report.	5
Maintain the Leicester Works programme and secure permanent positions for as many students as possible	Equality Team	September 2014		4

Both numerical and colour keys are to be used in the RAG rating. If target dates are changed this must be shown using ~~strikethrough~~ so that the original date is still visible.

RAG Status Key:	***5***	***Complete***	***4***	***On Track***	***3***	***Some Delay – expected to be completed as planned***	***2***	***Significant Delay – unlikely to be completed as planned***	***1***	***Not yet commenced***

Appendix 3

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST

Patient Experience, Equality and Engagement Assurance Committee Terms of Reference

1. To develop, review and endorse key performance patient experience, equality and engagement indicators for University Hospitals of Leicester NHS Trust and performance manage their implementation.

2. To review and endorse the Trust Annual report and Annual Quality schedule and any associated work.

3. The purpose of the Patient Experience, Equality and Engagement Group (is to provide an assurance framework to support and monitor) activity across the Trust.

4 To act as a monitoring hub for reports and feedback from CMG's relating to Equality, Engagement and Patient Experience.

5. To monitor and support the Trust's compliance with the relevant legislation national policy, guidelines, Clinical Management Group action plans and progress reports relating to Patient Experience, Equality and Engagement

6. To provide advice to the Trust Board on issues relating to Equality Experience and Engagement. In particular, to highlight the existence of any current or potential risks.

7. To provide a forum to review the effectiveness of collaboration and communication across all Clinical Management Groups to ensure robust practice. Including the dissemination of lessons from patient experience and equality complaints.

8. To review and endorse any policies, guidelines and procedures relating to Engagement, Experience and Equality activity.

9. To receive and approve monthly CMG assurance reports feedback.

10. To disseminate national, regional and local policy and guidelines on issues relevant to equality, engagement and experience.

Appendix 3a

Trust Patient Experience, Equality and Engagement Assurance Committee Membership

Chair Director of Nursing
Vice Chair Deputy Medical Director
Senior Nurse for Patient Experience
Equality Manager
Patient and Public Involvement and Membership Manager
Patient Adviser
One member of the Equality Advisory Group
Patient Safety representative (complaints)
Allied Health Professional

Frequency of meetings:	Monthly
Reporting mechanisms:	EEEAC will report to the Trust Board
Other internal reporting mechanisms	Human Resources Senior Equality meeting - Equality Manager Biannual reports to the Trust Board The Nursing Executive Team Head of Nursing Patient Experience
Circulation of minutes:	Membership To be confirmed

Appendix 3b

University Hospitals of Leicester
Clinical Management Group Report for experience, equality and engagement

Clinical Management Group……..

Clinical Management Group PPI / Equality/ Patient Experience Leads ……

Month and Year ……..

Legal and External Reporting Requirements

Engagement
Section 242(1B) of the National Health Service Act 2006 states that [NHS Trusts] must make arrangements as respects health services for which it is responsible, which secure that users of those services, whether directly or through representatives, are involved in:

(a) The planning of the provision of services
(b) The development and consideration of proposals for changes in the way services are provided
(c) Decisions to be made by that body affecting the operation of those services

Equality
To meet the requirements of the Equality Public Sector Duty the Trust needs to:

- Eliminate unlawful discrimination, harassment and victimisation
- Advance equality of opportunity between different groups
- Foster good relations between different groups

Patient Experience Feedback
Application of the Friends and Family Test score across specifically defined areas and gathered from a minimum of 20% discharge footfall. Improvements as laid out in the Quality Commitment which is the trust's response to patient feedback.

Supporting evidence / data

Evidence required	R	A	G	Reporting Timeframe	Comments
Standard : The patient's view is reflected in the planning and provision of services					
Evidence of patient representation in CMG Board / committees					
PPI priorities identified (service developments / key projects / annual planning priorities / complaints data / survey data) and informing annual PPI / Equality plan.					
Actions identified in the annual plan are on track					
Opportunities for involvement communicated and advertised					
PPI leads have attended training / development in PPI					
Number of staff who have completed equality training					
Patient representative progress assessment completed					
Evidence of the outcomes/ impact of PPI activity					
Evidence of completed / ongoing involvement					
Due regard proformas completed for all Service developments /changes for workforce and service developments					
Standard: Individuals peoples health needs are assessed and met in appropriate ways					
Use of interpreting					

Documented record of any reasonable adjustments made to a patients care i.e. referral to learning disability specialist nurse					
Complaints analysis discussed at the CMG Board					
Patient experience feedback analysed by gender, age and ethnicity					
Quality account reports					
People, carers and communities can readily access hospital community health or primary care services and should not be denied access on unreasonable grounds					
Patient metrics reports					
Patient Experience Surveys completed by carers and relatives					
Flexible visiting for carers and relatives					
When people use NHS services their safety is prioritised and they are free from mistakes , mistreatment and abuse					
Evidence that patients detained under the mental health act (where applicable) are provided with information regarding their rights					
Numbers of people trained on hate crime					
People report positive experiences of the NHS					
LD annual complaints analysis included in the LD annual report					
All wards need to achieve 20% return rate for their surveys					
Identify wards not achieving target number of surveys (20%)					
Identify all wards with a Friends and Family Test score below 50 and identify agreed actions					
Identify 3 improvements within CMG that have resulted from patient feedback each month					
Progress against the quality commitment is monitored and actions agreed					

PES Question	Jan 14	Feb 14	March 14	April 14	May 14	June 14	July 14	August 14	Sept 14	Oct 14	Nov 14
Assistance to toilet											
Call button											
Involved in Care											
Medication Side Effects											
Problem / danger											
Who to contact											

Report completed by

Please submit monthly returns by xxxxx to

Workforce Equality and Diversity

Monitoring Report

2012-2013

University Hospitals of Leicester NHS
NHS Trust

Caring at its best

a

Contents

Executive Summary Equality Workforce Monitoring Report 2012-2013

The Workforce monitoring report has been presented to the Trust Board as to comply with our Legal Duty we need to publish the data against the nine protected characteristics that are:

- Disability
- Sex
- Race
- Age
- Sexual Orientation
- Religion or Belief
- Marriage and Civil Partnerships
- Pregnancy and Maternity
- Gender Reassignment

Currently we only routinely collect staff data on disability, age, race, religion and belief, sex, and sexual orientation. We are awaiting Government confirmation as to whether we will be expected to extend our data collection to all of the nine characteristics in the future.

In line with our requirements under the Public Sector Equality Duty we have collected, analysed and published our workforce data by:

- Overall workforce profile
- Pay
- Recruitment
- Staff leaving
- Disciplinary and Grievance
- Training

Key Headlines

The total head count of staff remains comparatively stable. We have however seen some changes within our staff groups with a significant number of staff from Estates and Ancillary having transferred to Interserve. There has been a small increase in staff in additional clinical services and medical and dental. Reassuringly our overall profile remains unchanged.

The more detailed data indicates:

- A higher than expected representation of staff involved in the disciplinary process who either have declared a disability, identify as LGB or are aged 41-50 yrs.
- A reduction in the ‘unknown’ status in areas of disability, sexual orientation and religion and belief although not sufficient to draw firm conclusions from data.
- The continued challenge of representation at senior level.

Limitations of the Data

Whilst we have staff data available in some areas there remain some limitations.

- We continue to be unable to fully report on training as current recording of e-UHL training data does not allow for protected characteristic breakdown. We are therefore unable to draw any concrete conclusions around training.

- Due to limitations of the current reporting processes for recruitment the data does not enable a direct comparison of data sets but gives an indication of trends. This is due to data for applicants applying and shortlisted has been extracted from NHS Jobs, and appointed data is extracted from the Electronic Staff Record. This leads to some discrepancies due to time delays from shortlisting to successful applicants starting and a discrepancy in reports if appointed applicant is an internal candidate.
- The period reported for recruitment is October 2012-September 2012 (due to limitations in reporting on NHS jobs) and excludes junior doctors.

Top Priorities identified in 2011-2012

In last year's Workforce Report we identified five top priorities as part of our ongoing action plan. Below is an update of how we have progressed:

- **To establish benchmarks with similar acute Trusts so we can consider our performance in line with others and where possible work jointly to resolve issues**.

The regional Equality leads continue with this piece of work to establish a systematically agreed data set across region, with the aim of establishing three top priorities. In order to reassure ourselves that our overall representation is consistent with other Acute Trust's an initial benchmarking of workforce data was carried out. The results indicate (see Appendix A) that our declaration rates are greater than neighbouring Trusts and our overall representation is favourable.

- **To understand why a higher proportion of males and individuals from a BME background are employed on fixed term contracts.**

Our leaver's data indicated that individuals from a BME background employed on fixed term contracts were over represented. Initial deep dive work into this on a sample of posts both fixed term and permanent has indicated that although a higher percentage of individuals from a BME background apply for fixed term posts (51% vs 67%) at the point of shortlisting there is no difference (46% vs 47%).

In order to reassure ourselves that our complete recruitment process is fair we need to complete further analysis on those appointed into positions. This is not recorded on NHS jobs so there is no automatic flow of reporting currently to achieve this. We will look at a sample of posts to verify the reason for the fixed term contract.

- **To develop guidance for staff on ''reasonable adjustment''.**

This piece of work was undertaken to continue to enhance support for staff with a disability or long term health condition. The guidance was developed through the Disability Advisory steering group alongside colleagues from Human Resources. The guidance has been circulated to staff and managers and is available on our internal website for all to access. It is hoped it will support a pro-active attitude to making reasonable adjustments for staff where needed and ensure a standardised approach throughout the Trust.

- **To audit band 6 staff to identify any perceived /real blocks to career progression for BME staff.**

This piece of work was undertaken due to the decreased representation of female and BME staff in senior positions in the Trust as evidenced in our previous annual workforce report. The aim was to investigate career aspirations of band 6 staff and if there were any perceived barriers unique to particular groups that were preventing career progression.

The findings suggest that there is no indication of direct discrimination evident between men and women, ethnic groups or differing age groups which are acting as barriers to career progression.

Common themes were identified across all groups as to the perceived barriers to progression including availability of suitable positions, access to development opportunities and access to additional training.

It is recommended that in order to further validate the findings of this report appointment's to band 7 and above and exit data of staff leaving for promotion should also be reviewed and analysed.

- **To ensure equality data is consistently embedded in all data recording across the Trust, with clear explanation and reassurance given on how the data will be utilised.**

The data in this years report demonstrates improvements in some reporting areas.

In order to provide clarity and ensure all data is captured correctly reporting of disciplinary and grievance data has been reviewed and changed slightly to last year making any comparisons difficult. It has however resulted in the ability to report across protected characteristics in detail for the first time.

For next year we wish to identify our Human Resources data recording activity to identify where we are unable to generate accurate equality reports. Actions will then need to be agreed as to the way forward.

Section 1 – Disability

We know from the Office of National Statistics that 19% of people of working age have a disability but only about half of these are in work (approx 8.5%).

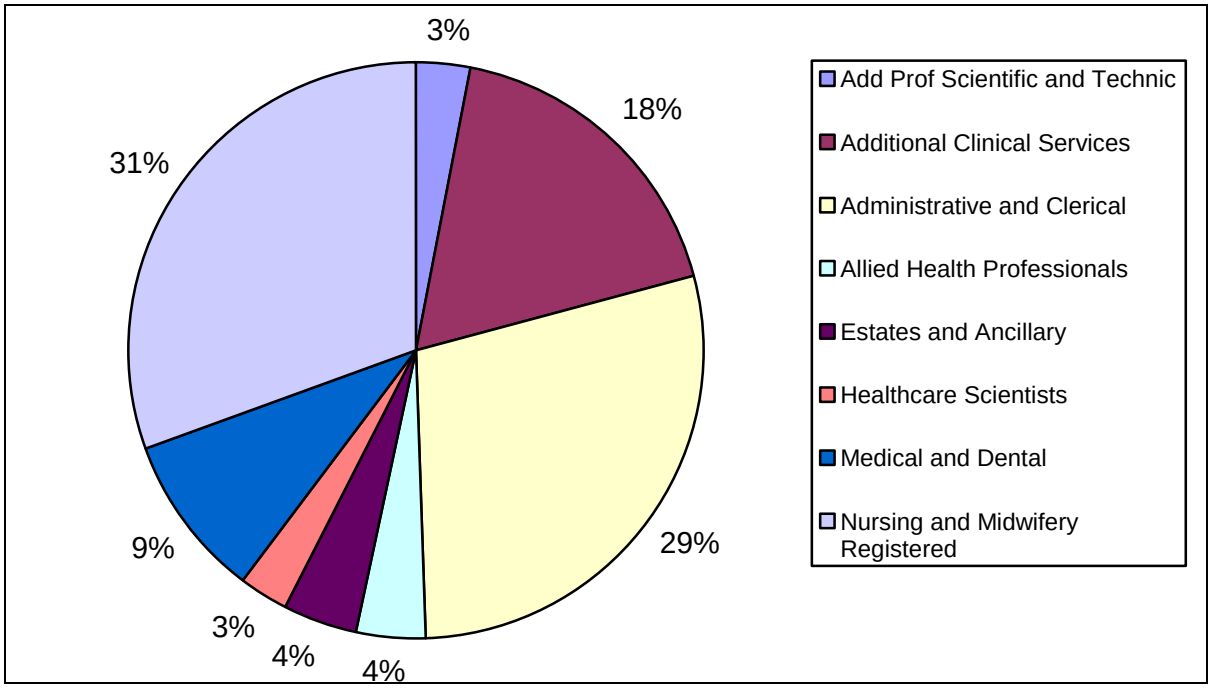
1.1 Disability profile of staff in post.

Year ending	2013	2012	% of change
No	56.8%	51.6%	+5.2%
Yes	1.4%**	1.1%	+0.3%
Choose not to declare	5.8%	0.7%	+5.1%
Unknown	36%	47%	-11%

** 1.4% represents **159 staff**

The data demonstrates that we have reduced the percentage of staff whose disability status was unknown by 11%. This reduction is reflected in the increase in all other categories including those declaring a disability. This pattern is not seen in other local Trusts, with their percentage of unknown disability status ranging from 67% – 84%. Despite this the % staff that have declared themselves as having a disability in these Trusts varies from 0.9% to 1.8% and therefore remains consistent with UHL's data.

Comparison of the Percentage of disabled staff in each staff group.

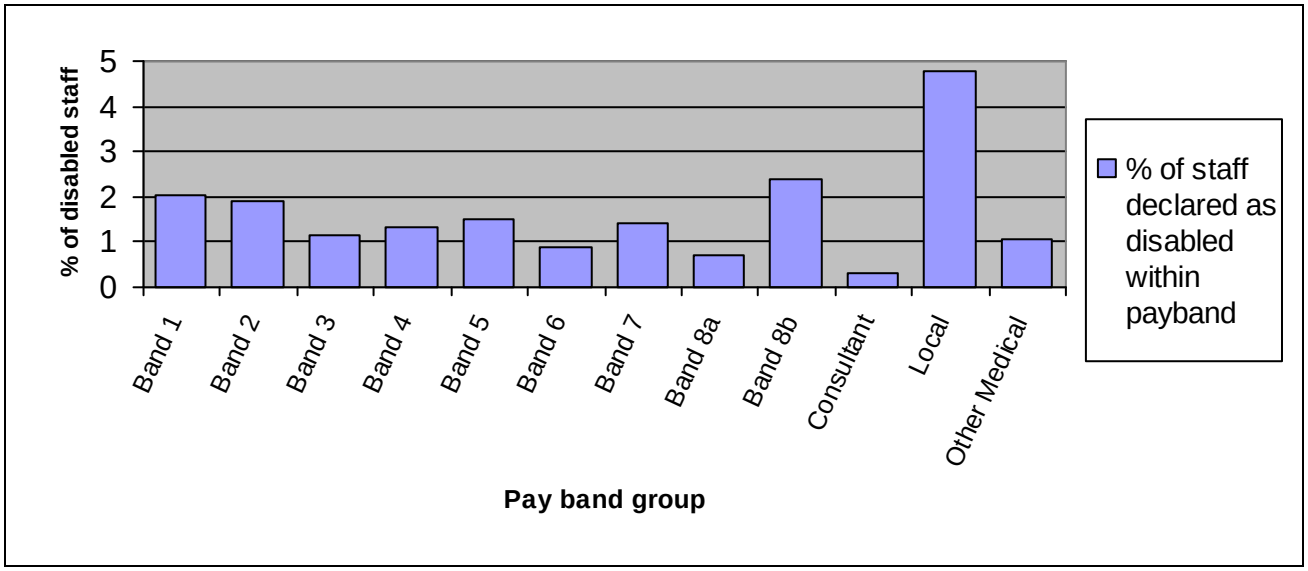


When compared to our previous year's data we can see some changes in the representation of disabled staff within some staff groups:

- Increase of 7% in Medical and Dental – this group has reduced their undeclared status but remain under represented in relation to their workforce numbers.
- Decrease of 7% in Administrative and clerical – in terms of head count there is no change and are over represented in relation to their workforce numbers.

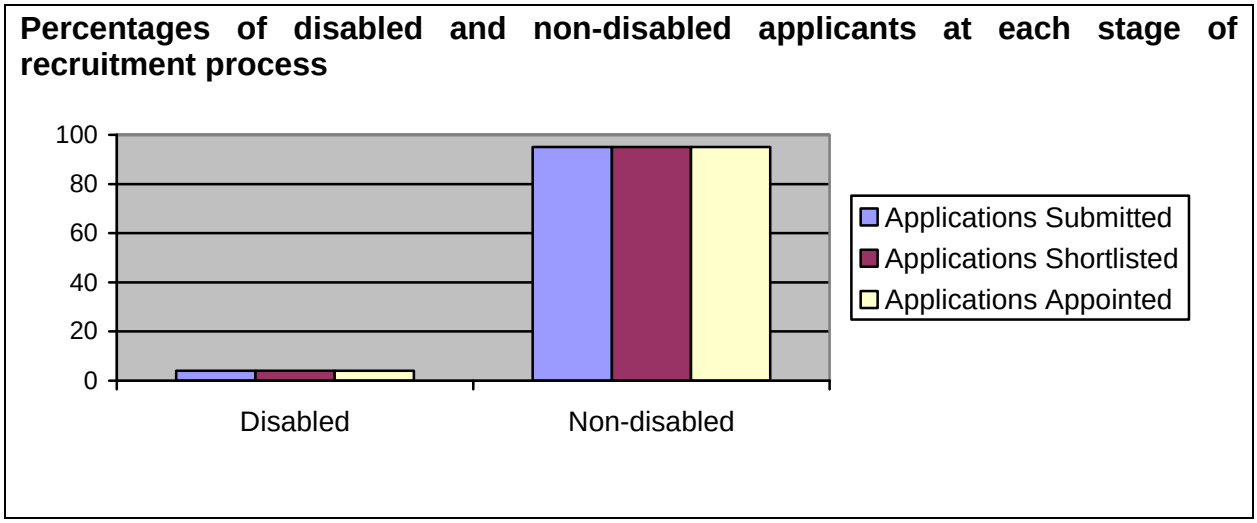
- Decrease of 5% in Estates and Ancillary staff – this group have seen an overall reduction in headcount due to employee transfers.

1.2 Disability and Pay



The data shows the percentage of disabled staff within band 5, band 8b, other medical and those on a local pay band have increased. All other bands remain broadly consistent with last year's data.

1.3 Disability Profile at Recruitment



The trend in the data shows that there is no discrimination shown to applicants that declare a disability throughout the recruitment process.

1.4 Disability of Staff Leaving

31 staff who left the Trust declared themselves as disabled, this equates to 1.7% of the total staff turnover. This is an increase on last year; however 0.5% of these staff were involved in the employee transfer. Taking this into account the data suggest that disabled staff are not over represented in staff leaving the Trust.

1.5 Disciplinary and Grievance

2.8% of staff who have been involved in a disciplinary investigation declared a disability. This suggests a higher number of individuals who declare a disability have been involved in a disciplinary process in relation to workforce representation.

The number of grievances brought this year has reduced to 12; we are unable to meaningfully report this data for disability.

1.6 Disability and Access to Training

Courses	Disability					
	Yes		No		Undefined / Undisclosed	
Leadership (EMLA)	0	-	107	100%	0	-
Leadership (UHL)	0	-	82		73	
Short Courses	7	1.3%	300	57%	215	41%
QCF's	2	3%	63	97%	0	-
Apprentices	0	-	39 *	100%	0	-

* 4 Apprentices did register as having learning difficulties.

Summary

Within the organisation we have continued to see an increase in staff declaring whether they have a disability. The number of staff is comparable to other acute Trusts. There remains however approximately one third of the workforce who's status is unknown and therefore remain unable to draw any firm conclusions from the data.

The data we have demonstrates:

- We have staff declaring a disability in all staff groups and across most pay bands with the exception senior staff of band 8c-9.
- There is no discrimination within the recruitment process with 4% of new starters declaring a disability.
- There was a slight increase in staff with a disability leaving the Trust but this appears to be accounted for by staff within an employee transfer process.
- There is an over representation of disabled staff who have been involved in a disciplinary procedure.
- No staff declaring a disability has undertaken a leadership course although UHL data in this area is incomplete.

Key actions

- To deep dive into the disciplinary data to establish why we maybe seeing increased representation in staff declaring a disability.
- To continue to encourage staff to declare their disability status through the forthcoming ESR refresh.
- To deep dive into the staff groups recording a low percentage of staff with a disability to ensure there is no indirect discrimination.
- To continue to develop support for staff with disabilities to become an employer of choice.

Section 2 – Sex (formally referred to as gender)

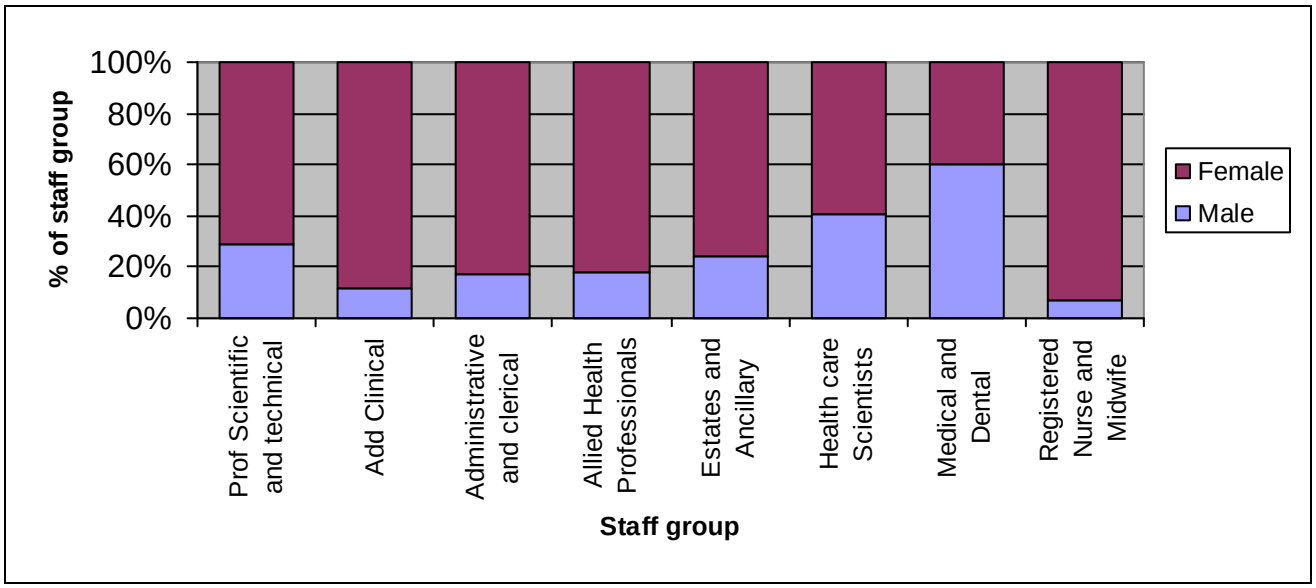
Under the Equality Act (2010) the term ''sex'' has replaced gender.

2.1 Sex profile of staff in post.

	2013	2012	% of change
Female	79.2%	78.5%	+0.7%
Male	20.8%	21.5%	-0.7%

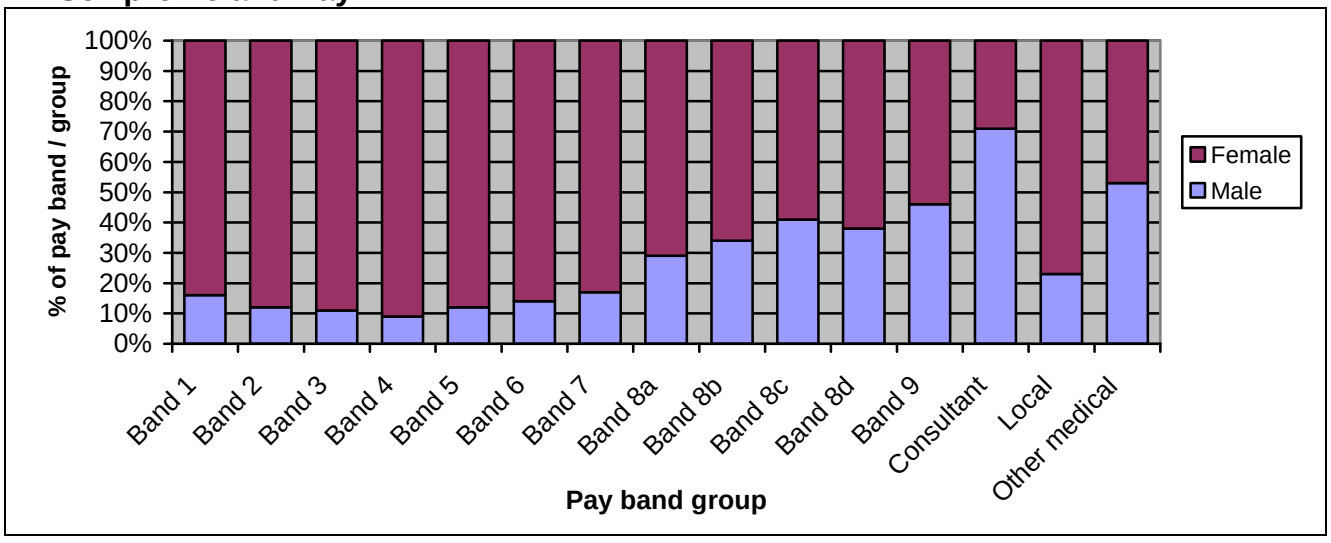
The data shows a small percentage rise in female staff compared to last years data. The broad workforce split of 80% female and 20% male is seen in the data of all but one of the other Acute Trusts used for comparison.

Sex as a proportion of staff group



There has been a 15% decrease in male staff and corresponding increase in female staff in the Estates and Ancillary following a significant employee transfer from this group of staff. The data demonstrates consistency in all other staff groups with last years data.

2.2 Sex profile and Pay



The data continues to demonstrate the overall trend of decreasing female representation and increasing male representation as a proportion as the pay band increases.

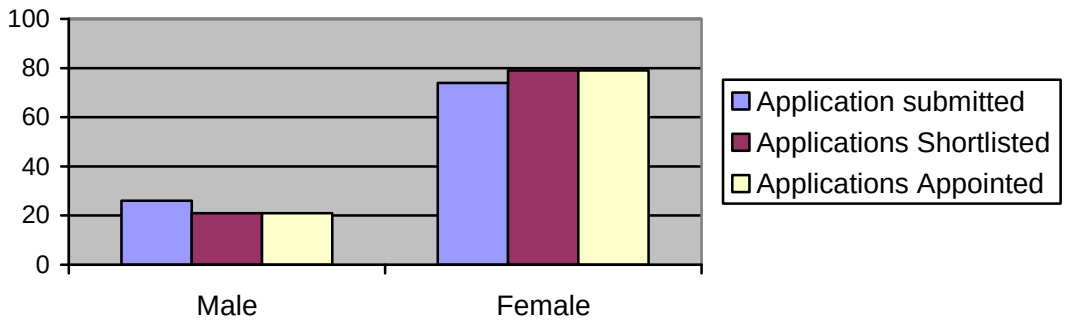
When compared to last years data there is:

- A decrease in the percentage of male representation in bands 1-4.
- An increase in male representation at band 8D and local pay band.
- Stability in all other pay bands.
- A 2% increase in female consultant appointments

"Local" pay bands include staff on the previous Trust payscales, apprentices and senior management.

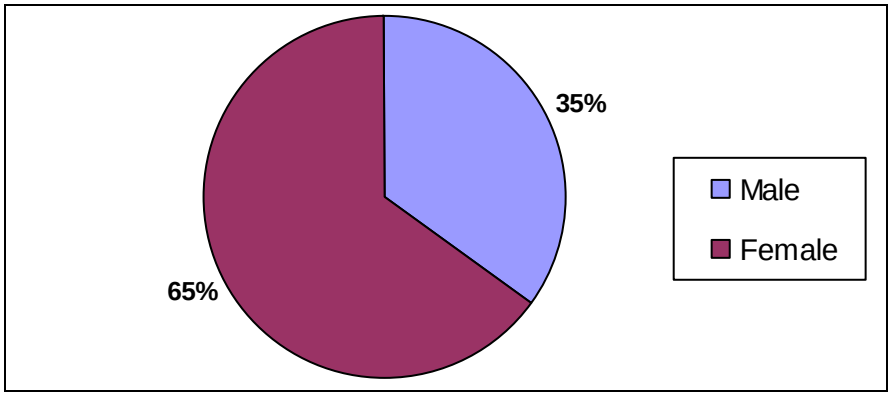
2.3 Sex Profile at Recruitment

Percentages of the sex of applicants at each stage of recruitment process



The trend in data indicates that less male applicants are shortlisted from applications submitted. The appointment from shortlist however is consistent for both sexes indicating no discrimination.

2.4 Sex of Staff Leaving

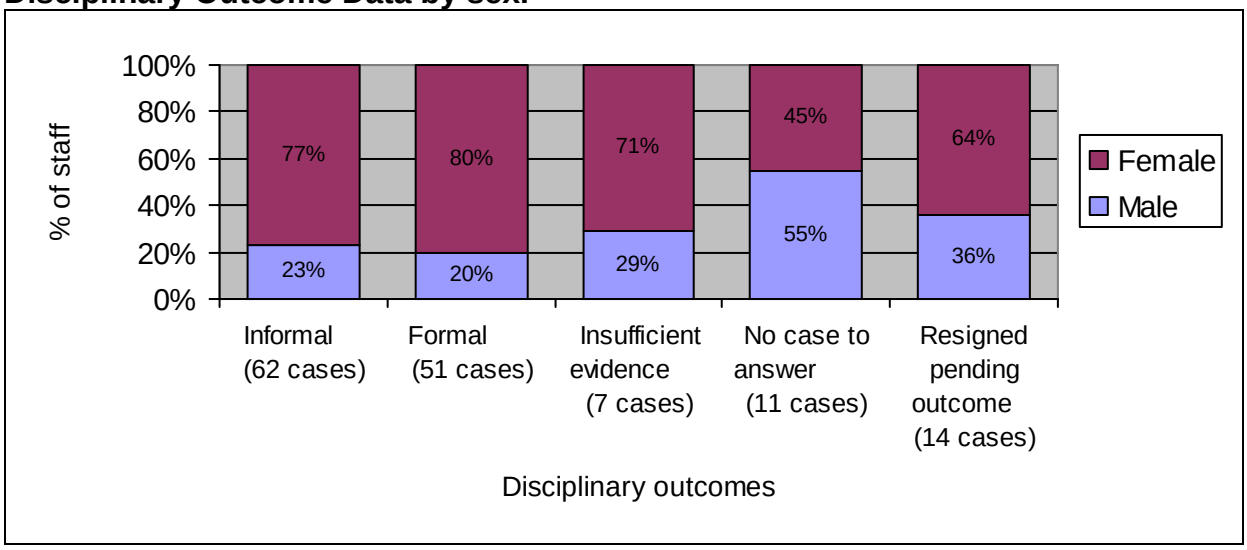


There is no change this year in the percentage of each gender leaving the Trust. This indicates that more male staff than expected based on representation have left the Trust. Further analysis of the data indicates that we continue to see over representation of male staff in ‘end of contracts’ and this year within the employee transfer process.

2.5 Sex Profile and Disciplinary and Grievance

A total number of 145 disciplinary cases and 12 grievance cases were concluded during 2012-2013.

Disciplinary Outcome Data by sex.



The data suggests that the sex representation in both informal and formally concluded cases was consistent with total workforce representation. There is an increased representation of male staff where it was deemed there was no case to answer or staff choosing to resign before a conclusion was reached. It should be noted however that the number of cases in these areas are small.

Grievance Outcome Data by sex

	Total cases	Female		Male	
Upheld	4	4	100%	0	-
Not upheld	8	7	87.5%	1	12.5%

The data demonstrates over representation of female staff bringing a grievance however the total numbers are so small no meaningful conclusions can be drawn from this.

2.6 Sex Profile and Access to Training

Courses	Sex			
	Male		Female	
Leadership (EMLA)	50	46%	57	53%
Leadership (UHL)	24	16%	131	84%
Day Courses	77	15%	445	87%
QCF's	12	18%	53	81%
Apprentices	11	28%	28	71%

The data demonstrates that more female staff are attending leadership courses at UHL compared with those attending the East Midlands Leadership Academy (EMLA) programmes. The difference in representation on the courses maybe due to only senior staff accessing leadership courses at EMLA, whereas internal leadership courses are accessible to staff across the banding structure. An under representation

of males is also seen in our attended day courses and those undertaking a qualification credit framework (QCF).

Summary

The sex makeup of or total workforce has remained consistent with previous data, and comparable with other acute Trusts.

The detailed data demonstrates:

- A continued stability in sex representation in all staff groups, with the exception of Estates and Ancillary where there is a reduction in male representation following an employee transfer from this group.
- An overall trend of decreasing female representation and increasing male representation, as a proportion, as the pay band increases.
- During recruitment more female staff are shortlisted from application, but from shortlist to appointment there is no difference between the sexes.
- There is an over representation of male staff leaving the Trust.
- The percentages of sexes involved in informal and formally concluded disciplinary cases is consistent with total workforce representation.
- An under representation of male staff undertaking internally attended training.

Key Actions

- To further investigate the nature of the fixed term contracts which see a higher proportion of male staff leaving the Trust.
- Investigate how widely flexible working options are accessed at consultant level.

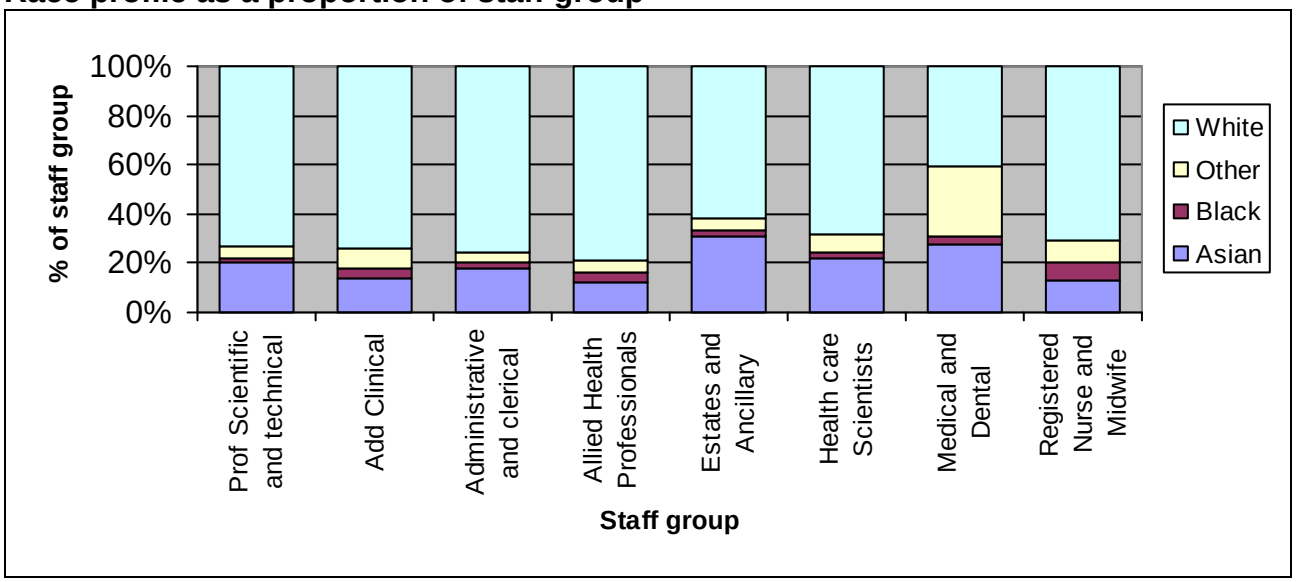
Section 3 – Race

3.1 Race Profile of Staff in Post.

	2013	2012	Percentage of change
Asian	17%	19%	-2%
Black	4%	4%	-
Other	11%	6%	+5%
White	68%	71%	-3%

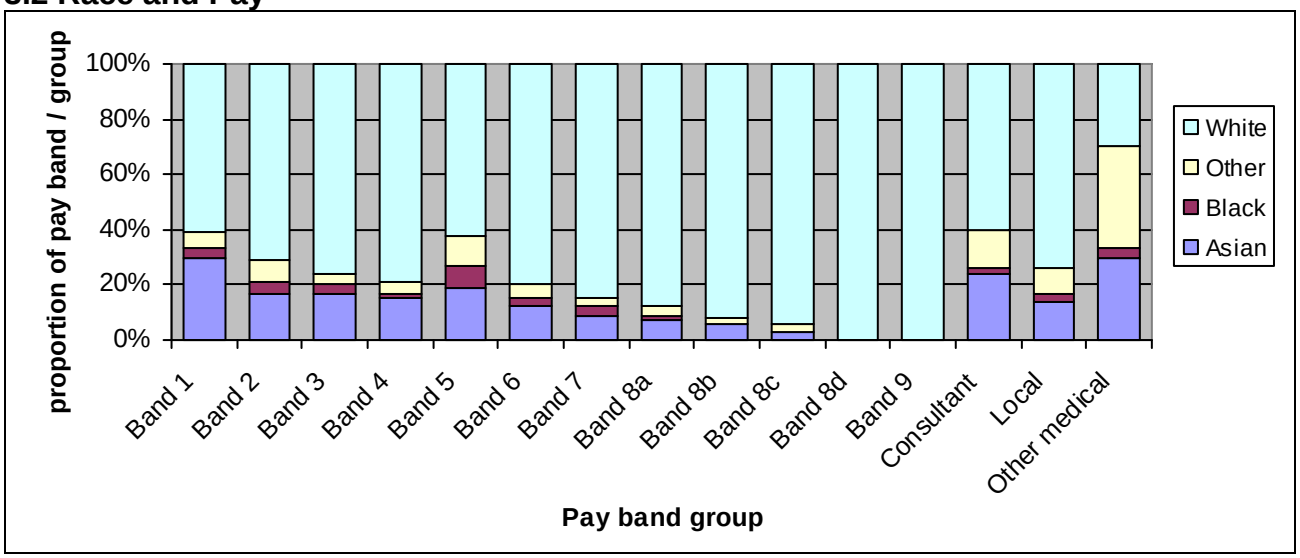
The data indicates an increase in our BME representation from 29% last year to 32% this year. This percentage is higher than any of the other Trusts used for comparison with other Trusts ranging from 12 -28%.

Race profile as a proportion of staff group



The data indicates a significant change in the racial makeup of medical and dental staff, with the percentage of staff that falls within the 'Other' category increasing by 18% while representation of staff from a White, Asian or Black racial profile all fell.

3.2 Race and Pay

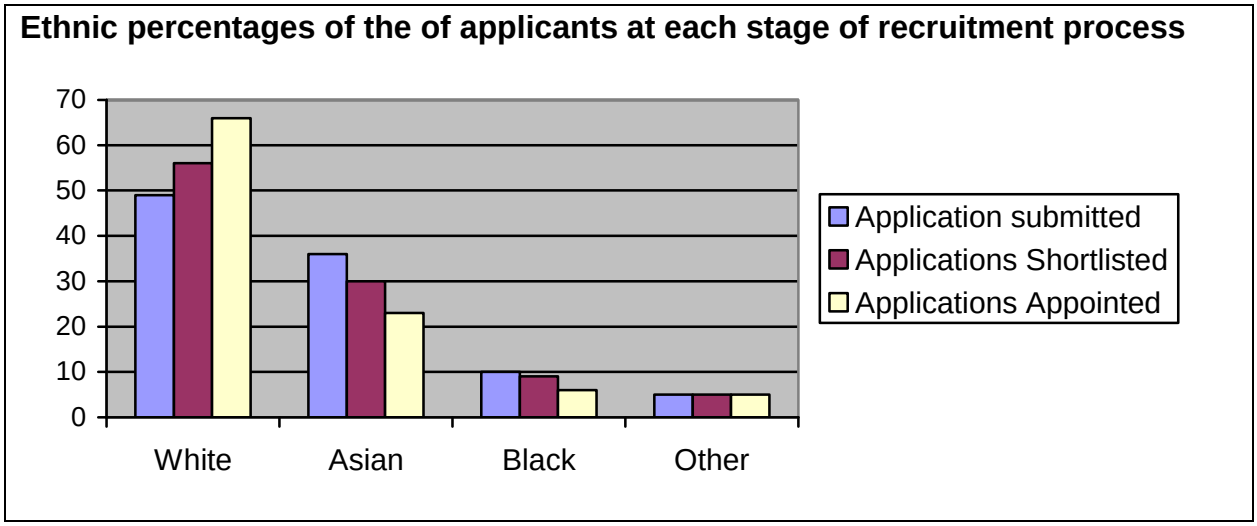


The data demonstrates two significant changes when compared to last years data:

- In 'Band 1' there is a percentage decrease of staff from an Asian and Black background.
- In 'other medical' there is a percentage decrease in staff from an Asian background and an increase in staff from within the 'other' category.

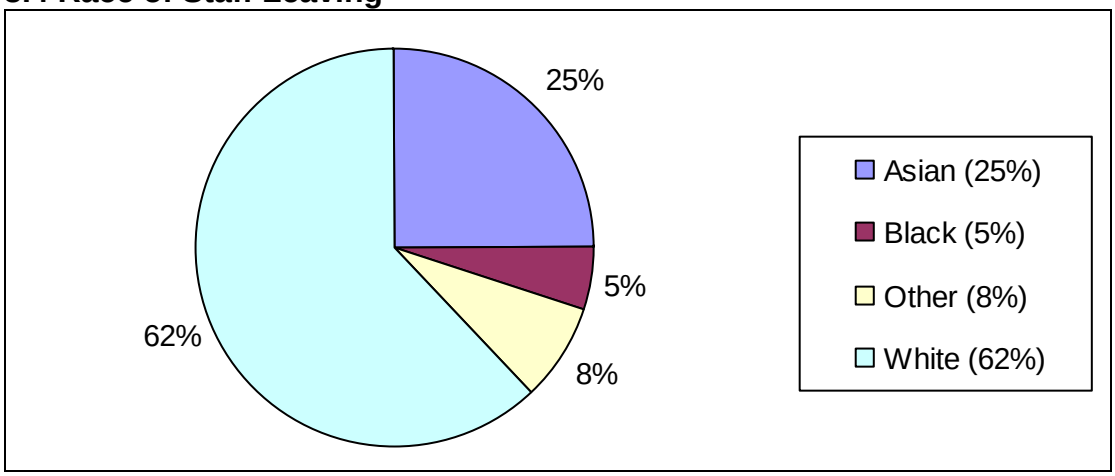
3.3 Race Profile at Recruitment

Ethnic percentages of the of applicants at each stage of recruitment process



As was evident last year the data trends continue to suggest that applicants from a White background are more successful through the application process, with a higher percentage appointed in relation to initial applications. The reverse is true for applicants from an Asian or Black background.

3.4 Race of Staff Leaving

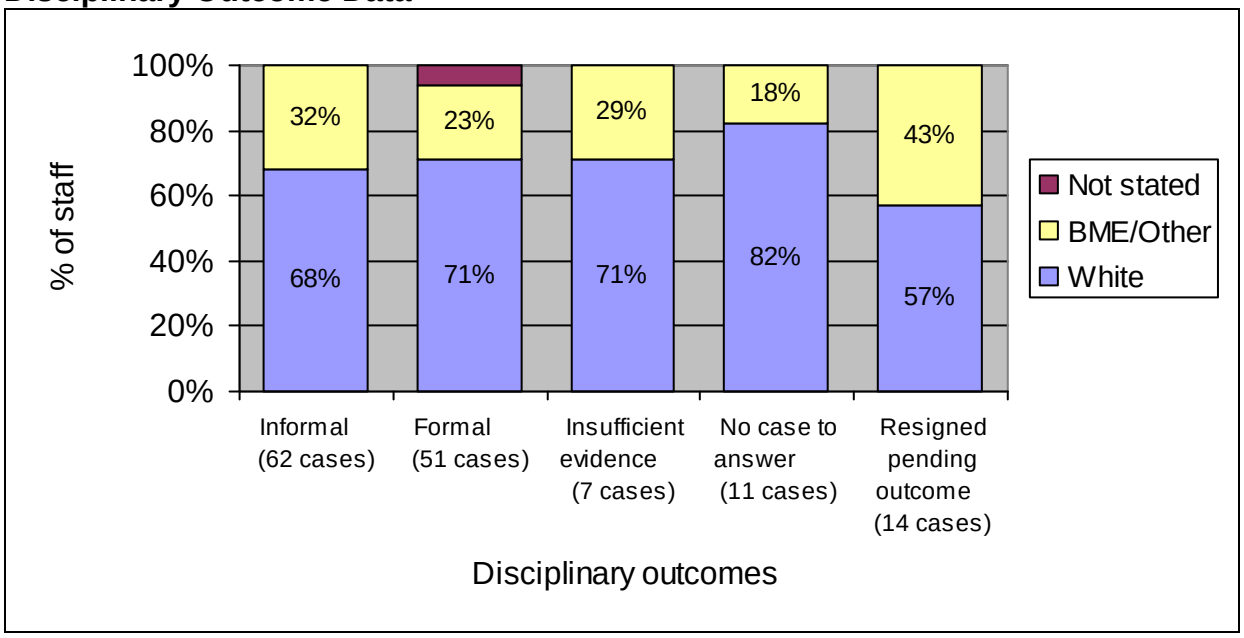


The data indicates that there is an over representation of Asian staff leaving the Trust. Initial investigations show this is particularly evident amongst staff whose employment was transferred, who were working on a fixed term contracts and those whose role involves external rotation (usually medical staff in training).

3.5 Disciplinary and Grievance by Race

A total number of 145 disciplinary cases were concluded during 2012-2013.

Disciplinary Outcome Data



The data indicates that BME staff are not over represented in any group of disciplinary outcomes except those who choose to resign before the case was concluded. The small numbers in this group however do not allow any meaningful conclusions to be drawn from this.

Grievance Outcome Data

	Total cases	**White**		**BME/Other**	
Upheld	4	1	25%	3	75%
Not upheld	8	7	87.5%	1	12.5%

As the total numbers of grievances is small we cannot draw any meaningful conclusions at this time. The data does however demonstrate that a higher percentage of grievance cases brought by non-white staff were upheld.

3.6 Ethnicity and Access to Training

Courses	**Ethnicity**					
	White		BME /Other		Undefined/ Undisclosed	
Leadership (EMLA)	60	56%	18	17%	29	27%
Leadership (UHL)	120	77%	32	21%	3	2%
Short Courses	429	82%	76	15%	17	3%
QCF	53	82%	12	18%	0	-
Apprentices	26	67%	13	33%	0	-

Our broad race profile for staff is reflected in those who undertook an apprenticeship. In all other areas of training recorded there is a under representation of non-white staff accessing training.

Summary

The data indicates a rise in our BME representation within the workforce as a whole.

The detailed data demonstrates:

- A continued stability in BME representation in all staff groups, with the exception of Medical and dental which indicates the percentage of staff that falls within the 'Other' category increasing by 18%.
- An overall trend of decreasing representation of staff from a BME background (with the exception of band 5) as the pay band increases.
- Within medical staff we see an over representation of staff from a BME background in relation to total workforce figures.
- During the recruitment process staff from a white background are more successful than individuals from an Asian or Black background.
- There is an over representation of BME staff leaving the Trust this is particular evident amongst staff from an Asian background. Some of this is due to rotation of medical staff and this year's employee transfer process.
- The racial background of staff involved in the disciplinary process is what we would expect from our workforce population.
- An under representation of staff from a BME background attending training.

Key Actions

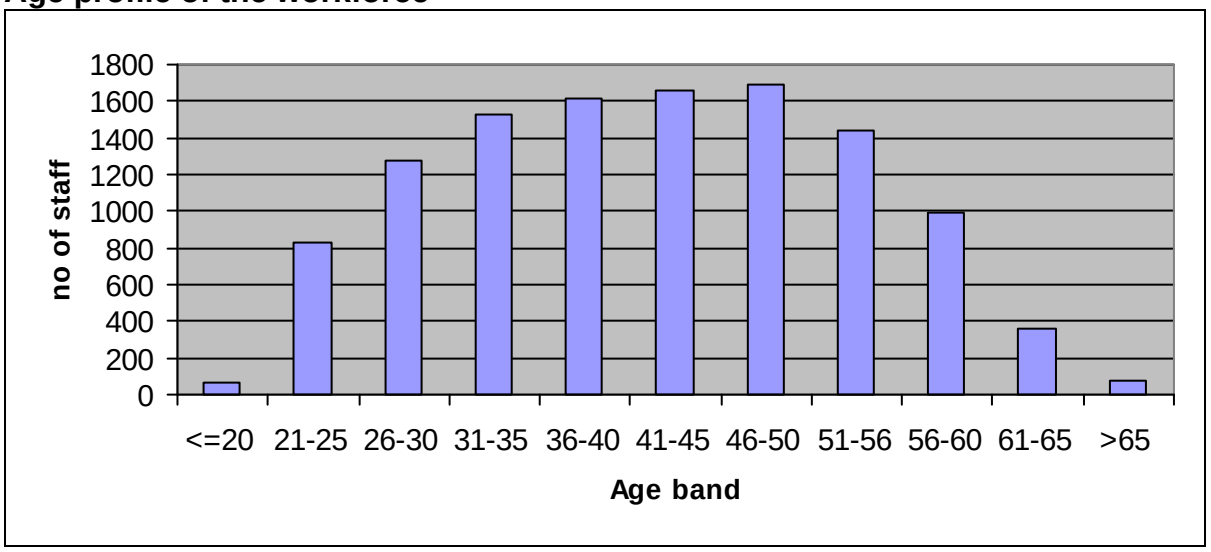
- To investigate why some staff groups have poor BME representation.
- To examine why white staff appear to be more successful at interview.
- To further investigate the nature of fixed term contracts which see a higher proportion of BME staff leaving the Trust.
- To understand why and consider actions to address low representation of BME staff at senior levels.

Section 4 – Age

4.1 Age profile of staff in post.

	2013	2012	% of change
<20 yrs	0.6%	0.4%	+0.2%
21-25yrs	7%	7%	-
26-30yrs	11%	11%	-
31-35yrs	13%	13%	-
36-40yrs	14%	14%	-
41-45yrs	14%	15%	-1%
46-50yrs	15%	15%	-
51-55yrs	13%	13%	-
56-60yrs	9%	9%	-
61-65yrs	3%	3%	-
>65yrs	0.6%	0.6%	-

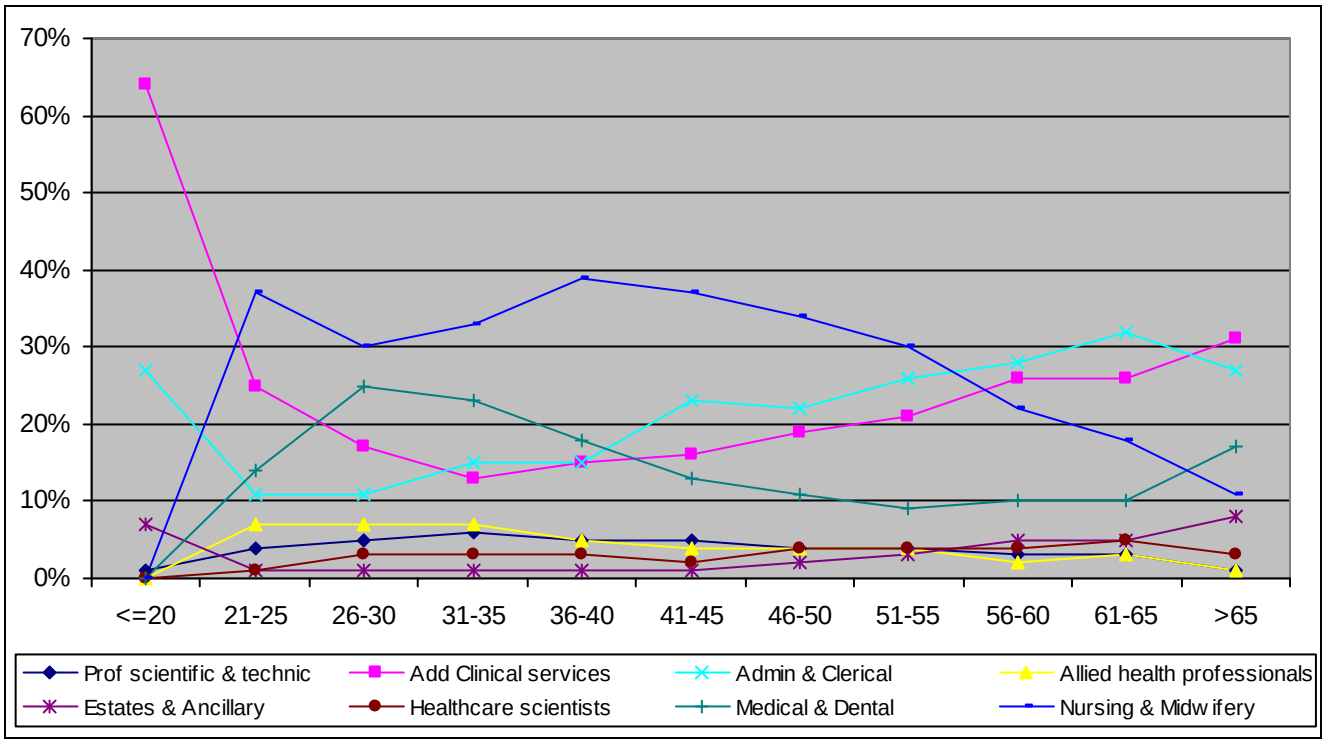
Age profile of the workforce



The age profile of staff has remained stable over the last twelve months with data demonstrating a normal distribution across age groups with the majority of staff falling between 36 -50yrs.

UHL's age profile is consistent with other acute Trusts, with the exception of an acute Trust in the north of the country who's profile indicates lower trends of staff <40yrs and higher of staff with aged >41yrs.

Age profile of staff groups.

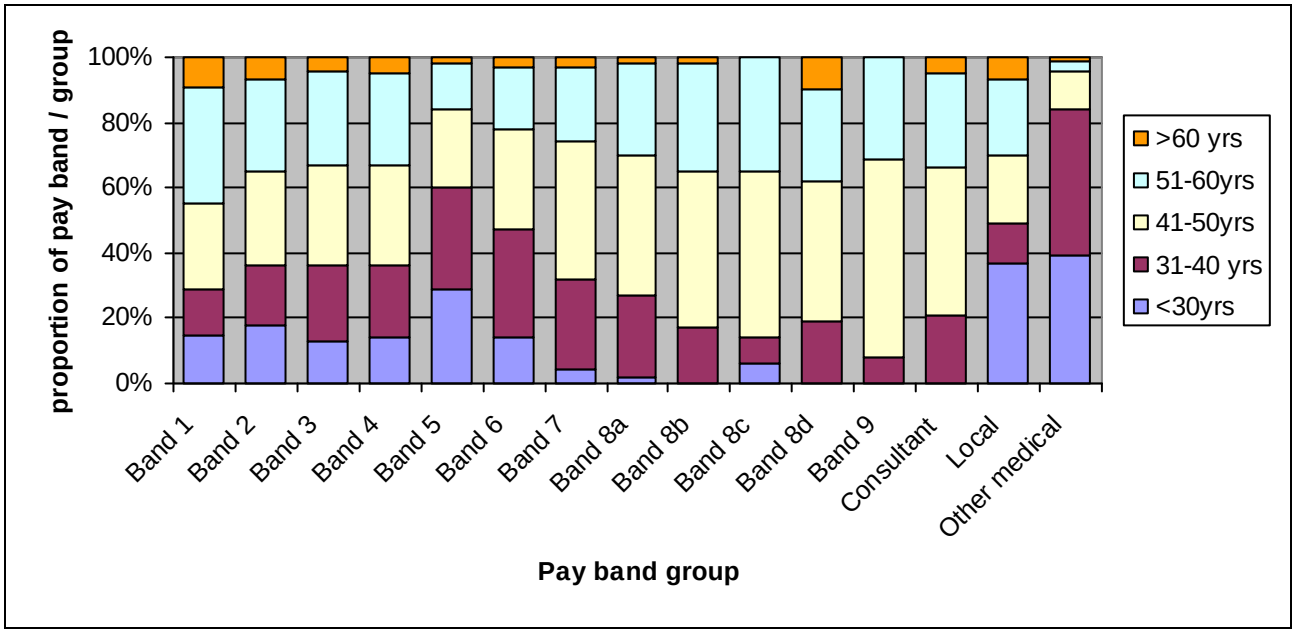


In this years report we have reported staff groups different and therefore we are unable to make direct comparisons with last years data.
The data shows:

- A large percentage of staff that provides additional clinical services is under the age of 25yrs.

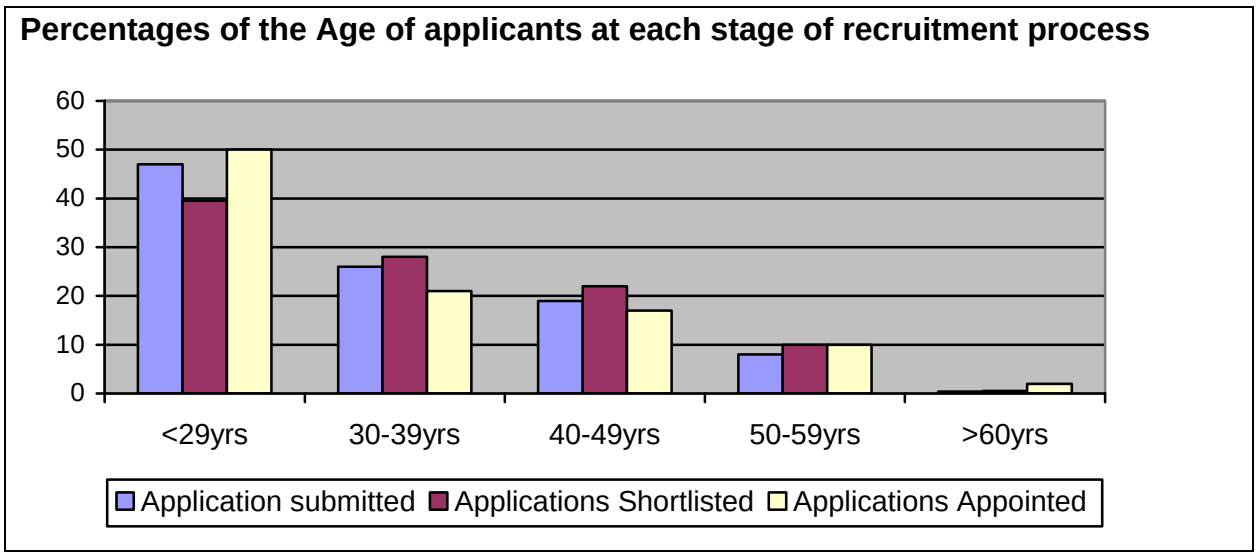
- The majority of our nursing and midwifery staff is between the ages of 25-50 yrs.
- Medical and dental staff peak between 26 -35yrs consistent with numbers of junior staff.
- The percentage of admin and clerical staff increases through each age bracket from 30yrs with a similar pattern seen in staff that provide additional clinical services.
- All other staff groups are reasonably equally represented from the age of 21-65yrs.

4.2 Age and Pay



The data continues to show good age representation across all bands, with the expected fewer younger staff (aged< 30yrs) in senior positions.

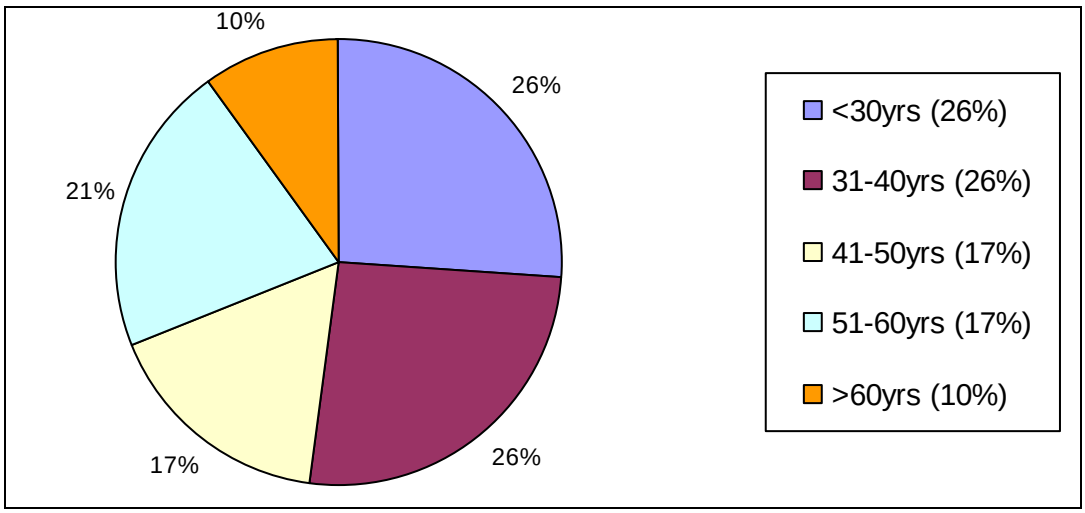
4.3 Age Profile at Recruitment



The majority of applicants come from staff aged less than 29yrs, with high percentages of those shortlisted being appointed. The number of applicants decreases with age. The data trends suggest that a higher number of those aged

between 30-59yrs are shortlisted from application but only those between 50-59yrs see the same percentage appointed.

4.4 Age of staff leaving

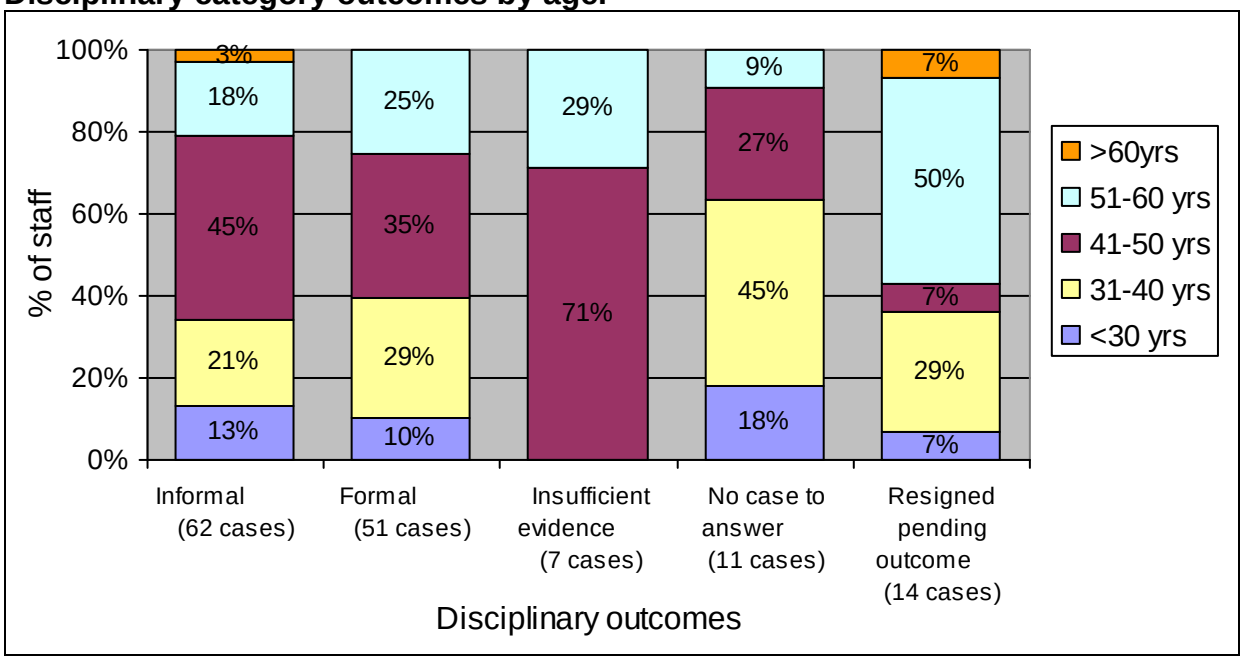


This year's data shows an increase of staff between the ages of 41-60yrs leaving the Trust. Further investigation shows that 68% of staff involved in the employee transfer fell within these age groups.

4.5 Disciplinary and Grievance

A total number of 145 disciplinary cases were concluded during 2012-2013.

Disciplinary category outcomes by age.



The data shows that:

- There is a higher than expected representation of staff aged 41-50yr involved in disciplinary cases.
- There is a higher than expected representation of staff aged 31-40yr involved in disciplinary cases where it is found that there is no case to answer**.

- There is a higher than expected representation of staff above the age of 51yrs that choose to resign before an outcome in determined**.

**NB numbers in these categories are small.

Grievances

	Total cases	**31-40yrs**		**41-50yrs**		**51-60yrs**		**>60yrs**	
Upheld	4	1	25%	2	50%	1	25%	0	-
Not upheld	8	1	12.5%	0	-	6	75%	1	-

As the total numbers of grievances overall is small we cannot draw any meaningful conclusions at this time. The data does however demonstrate that 58% of grievances were brought by staff aged between 51-60yrs with the majority of them not being upheld.

4.6 Age and access to Training

	<20yrs	20-30yrs	30-40yrs	40-50 yrs	50-60yrs	>60yrs
QCF learners	0	19	17	21	8	0
Apprentices	9	24	5	1	0	0

*Age is not recorded for Leadership or UHL day courses.

Summary

The data indicates stability in our age profile across the workforce with the peek of staff between 36 -50 yrs of age.

The detailed data demonstrates:

- A representation of all age bands across staff groups with a particularly high percentage of staff under 25yrs employed in additional clinical services.
- Within the recruitment process staff under the age of 29yrs are most prominent with a high percentage of applicants being appointed, this trend is not seen in any other age group.
- Expected patterns in the age profile of staff leaving the Trust with an over representation in staff aged <30yrs as many are in training posts or >60 yrs as individuals retire.
- There is over representation of staff aged between 41-50 yrs within our disciplinary processes.

Key Actions – Points to consider

- To deep dive into why and increased number of staff aged 41-50yrs are involved in disciplinary processes.

Section 5 – Sexual Orientation

In a 2010 survey by the Office of National Statistics 95% of those questioned identified themselves as heterosexual, 1% identified as Gay or Lesbian, 0.5% as Bisexual and the remaining 3.5% as other or do not know. This would suggest that individuals who identify as LGB total 1.5%.

5.1 Sexual Orientation Profile of Staff in Post.

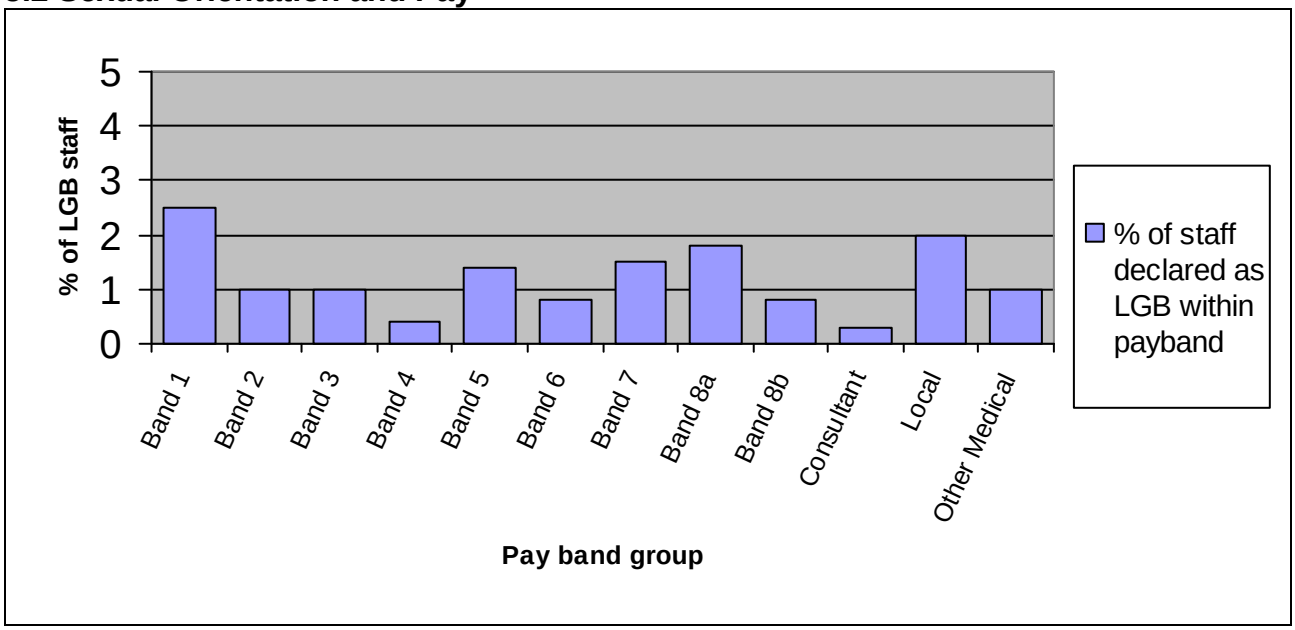
	2013	2012	% of change
Bisexual	0.49%	0.47%	+0.02%
Gay	0.37%	0.34%	+0.03%
Heterosexual	53.19%	44.3%	+8.9%
Lesbian	0.23%	0.24%	+0.01%
Do not wish to declare	13.2%	7.8%	+5.4%
Unknown	32.6%	46.9%	-14.3%

* 127 staff declared as LGB = 1.1% staff population this is significantly higher than neighbouring Trusts.

The data shows that this year we have seen a decrease in staff with an undefined sexual orientation status. This is mainly reflected in an increase in 'heterosexual' and those who 'do not wish to disclose' their sexual orientation, the number of staff who identify themselves as lesbian, Gay or bisexual (LGB) remains stable.

There are staff that have identified themselves as LGB in all staff groups. The percentages within each staff group ranging between 0.7%-2.2%.

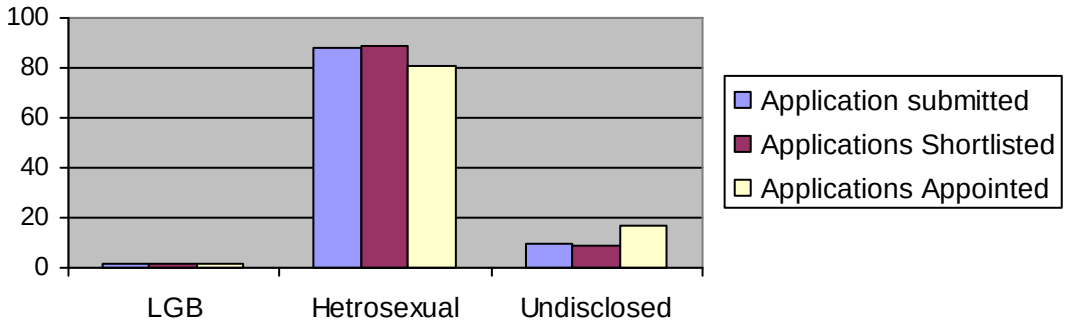
5.2 Sexual Orientation and Pay



There is a broadly equal spread of staff that identifies themselves as LGB in all pay bands, except for senior bands of 8C, 8D and 9 where no staff identify as LGB.

5.3 Sexual Orientation Profile at Recruitment

Percentages of the sexual orientation of applicants at each stage of recruitment process



The data shows that a number of applicants did not disclose their sexual orientation; therefore it is difficult to draw any firm conclusions. From the data available the trends suggest that applicants who declare the sexual orientation as LGB are equally successful through each stage of the recruitment process. Where as those who declare their sexual orientation as heterosexual faired worse at application.

5.4 Sexual Orientation of staff leaving

Of staff that left the Trust 1.1% (21) declared their sexual orientation as LGB. Of these 43% left due to employee transfer.

5.5 Disciplinary and Grievance

4% of staff involved in a disciplinary process declared their sexual orientation as LBG this is above the average total staff population. As the total number of grievances are so small (12), no trends are able to be identified.

5.6 Sexual Orientation and Access to Training

Courses	Sexual Orientation					
	LGB		Heterosexual		Undefined/ Undisclosed	
Leadership (EMLA)	2	2%	12	11%	93	87%
Leadership (UHL)	1	1%	82	53%	72	46%
Day Courses	13	2%	294	56%	215	41%
QCF's	Not currently recorded					
Apprentices	Not currently recorded					

A representative number of LGB staff are attending training.

Summary

The data indicates a representation within the workforce as a whole.

The detailed data demonstrates:

- We have staff identifying as LGB in all staff groups and across most pay bands with the exception senior staff of band 8c-9.

- There is no discrimination within the recruitment process with 2% of new starters identifying as LGB.
- There is an over representation of staff identifying as LGB who have been involved in a disciplinary procedure.

Key Actions – Points to consider

- To deep dive into the disciplinary data to establish why we maybe seeing increased representation of staff that identify as LGB.
- To continue to encourage staff to declare their sexual orientation through the ESR refresh.

Section 6 – Religion or Belief

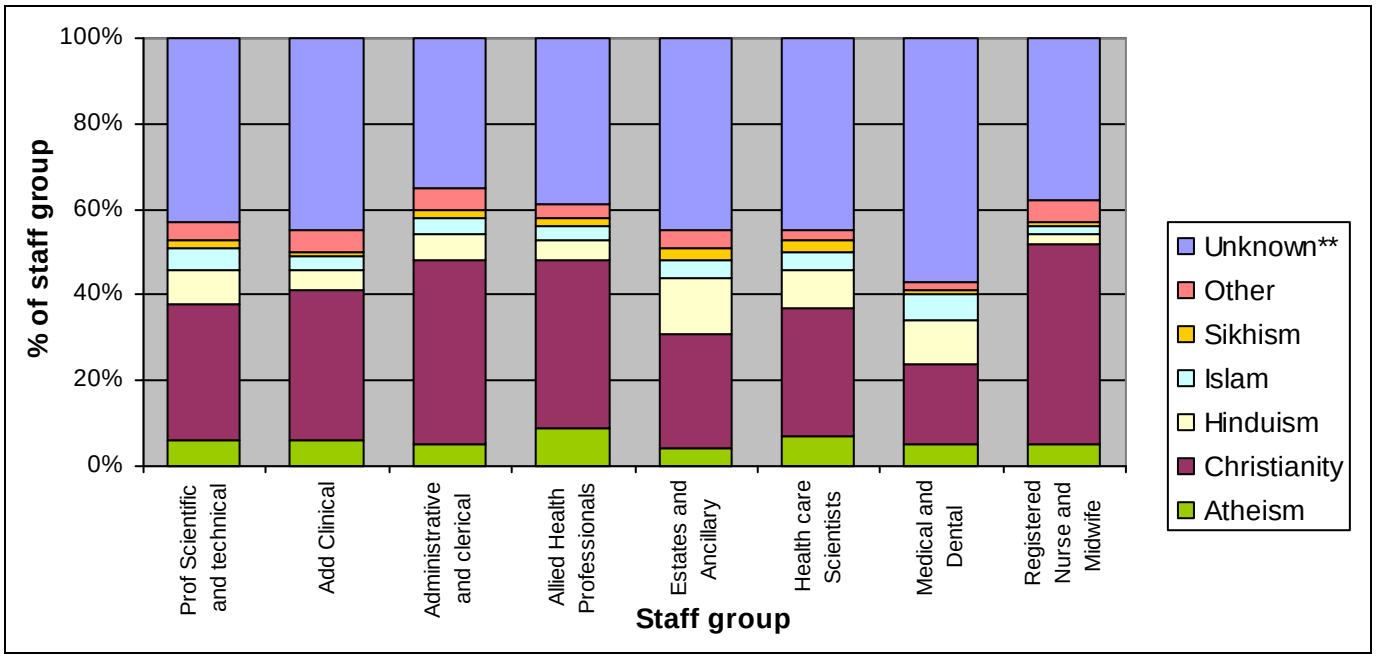
The Equality Act defines ‘’religion’ as ‘’any religion’’, and ‘’belief’’ as ‘any religion or religious or philosophical belief’. This includes all major religions, as well as less widely practised ones. The terms ‘’religion’ and ‘belief’’ in the context of the act also apply if you do not follow any religion or belief.

6.1 Religion or Belief Profile of Staff in Post.

	March 2013	March 2012
Atheism	5.4%	3.8%
Buddhism	0.3%	0.1%
Christianity	38%	33%
Hinduism	5.4%	4.6%
Islam	3.3%	2.4%
Jainism	0.1%	0.1%
Judaism	0.1%	0.06%
Sikhism	1.3%	1.1%
Other	4%	2.5%
Undefined	31%	46%
Not wish to disclose	12%	6%

**data obtained from the 2011 census.

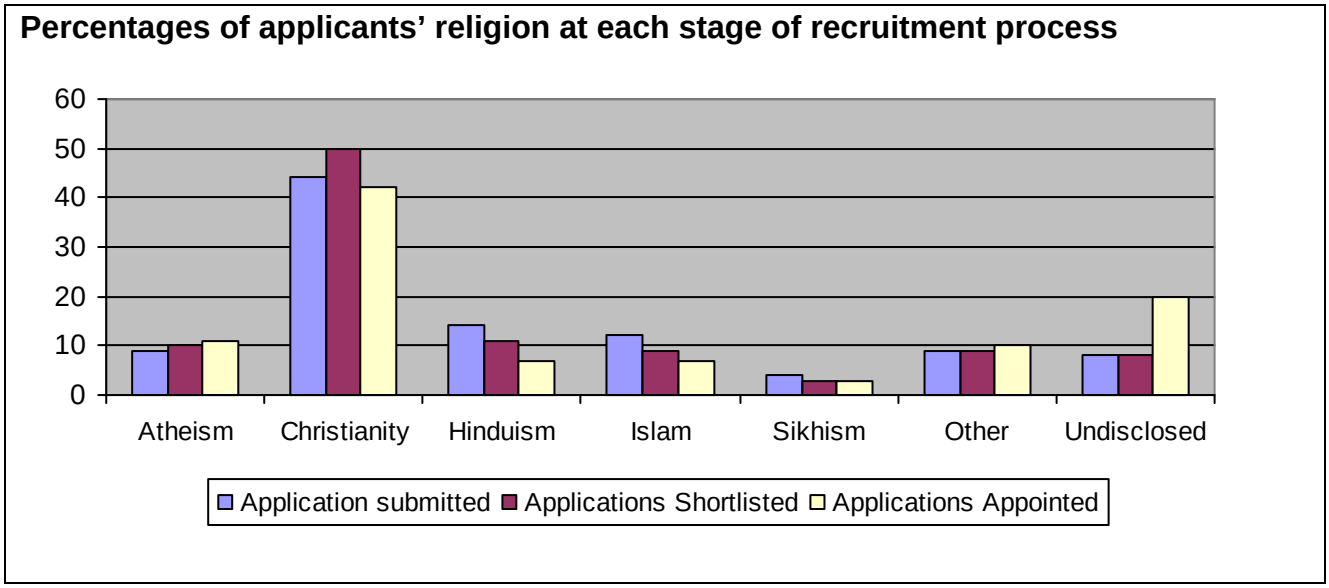
There is a broad range of beliefs amongst staff. The data shows that we have reduced the number of staff who’s religious or belief profiles were undefined by 15%, with most groups demonstrating a percentage increase this year. The representation at UHL favourably compares to neighbouring Trusts.



****** Unknown included both staff who does not wish to declare their religion/belief and those who have an undefined status.

The data demonstrates that staff with a broad range of beliefs is found within each staff group. In most groups however over 40% of individuals beliefs are unknown making comparisons with the local population more difficult.

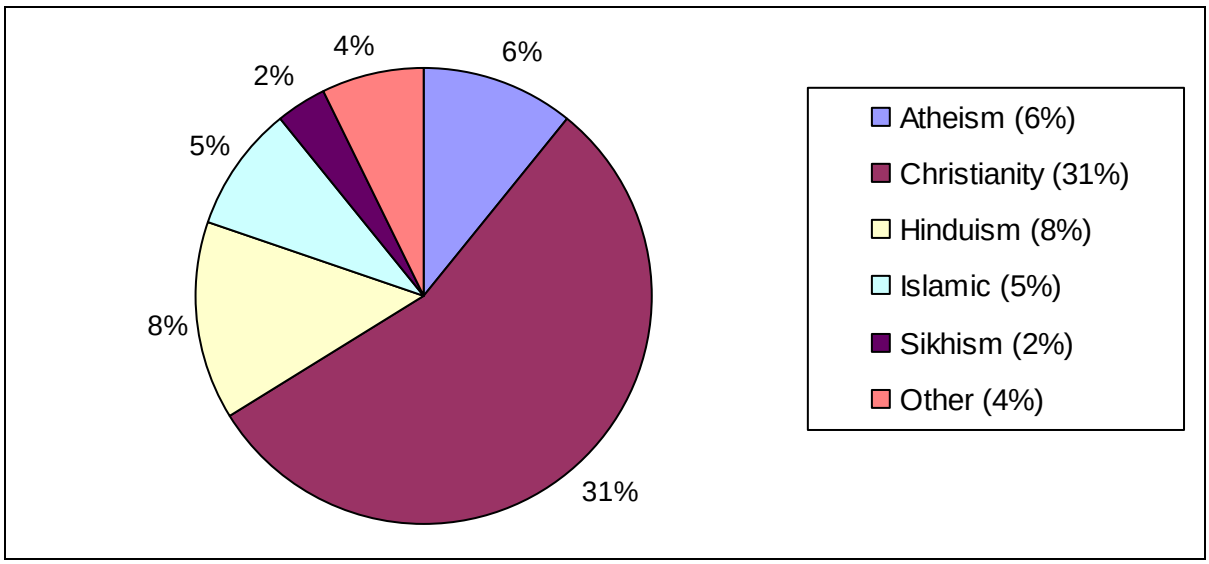
6.2 Religion or Belief Profile at Recruitment



The data shows that a number of applicants did not disclose their beliefs especially at appointment; therefore it is difficult to draw any firm conclusions. The data trends suggest that a lower percentage of applicants are shortlisted who have a Hindu, Islamic or Sikh faith.

This pattern is not unique to UHL with similar recruitment trends seen in the other NHS Acute Trusts used for comparison.

6.3 Religion or belief of staff leaving



We have seen a percentage increase in all belief groups leaving the Trust, this maybe the result of increased declaration of belief. Those with a Hindu or Islamic belief are higher than would be expected if compared with the staff population figures. Further investigation indicates that staff from these two groups alongside those from a Sikh faith were greater represented amongst the staff involved in the employment transfer when compared to the staff population.

6.4 Disciplinary and Grievance

From the total data reported on Disciplinary actions no religious/ belief group appears to be disproportionately represented.

As the total number of grievances are so small (12), no trends are able to be identified.

6.5 Religion or Belief and Access to Training

	Leadership		Day Courses	
Atheism	15	6%	30	6%
Christianity	66	25%	238	46%
Hinduism	3	1%	13	2%
Islam	5	2%	7	1%
Sikhism	6	2%	6	1%
Other	4	1%	18	3%
Unknown **	163	62%	210	40%

***This data is not currently collected for apprentices or staff undertaking QFC's.

**** Unknown included both staff who does not wish to declare their religion/belief and those who have an undefined status.

Summary

The data indicates a rise in our representation across all religion and beliefs within the workforce as a whole.

The detailed data demonstrates:

- There is representation of all religions and beliefs across all staff groups in half of the groups however there remains a unknown status of at least 40%

- Through the recruitment process staff from who follow the Hindu or Islamic religion appear to fair less well with decreasing percentages seen at each stage.
- There is an over representation of staff from who follow the Hindu or Islamic religion leaving the Trust. Some of this maybe explained due to rotation of medical staff and this year's employee transfer process.

Key Actions – Points to consider

- To encourage staff to declare their religion / belief
- To continue to encourage staff to declare their religion or belief status through ESR refresh.
- To investigate why individuals with an Islamic or Hindu belief fair less well at the shortlisting stage of recruitment.
- To improve our data collection around religious belief at the appointment stage of recruitment.

The following three sections are additions under the Equality act (2010) and minimal data is currently collected. A decision needs to be made as to what data we need to collect in the future.

Section 7 – Marriage and Civil Partnership

7.1 Marital status of staff in post.

	March 2013	March 2012
Civil Partnership	0.3%	0.3%
Divorced	5.5%	6%
Legally Separated	1.3%	1%
Married	58%	59%
Single	30%	28%
Widowed	0.7%	1%
Unknown	4.3%	5%

Section 8 – Pregnancy & Maternity

8.1 Maternity Leave of Staff in Post.

	Number of staff	Days taken
Female	681	110,591

Section 9 – Gender Reassignment.

Data is recorded in this area but not reported due to low numbers with the possibility of breach of confidentiality.

Summary

Little data is currently collected on these three elements

Key Actions

- To decide what information around these three areas needs to be reported.
- To establish appropriate data sets and methods for collection.

Report Summary

Broadly representation has remained the same and again there have been some interesting anomalies identified that warrant further investigation.

We identified 5 areas of focused work as a result of last year's data analysis. In terms of the benchmarking we have started to do our representation for all protected groups is favourable. The other Trusts also face similar challenges in terms of BME representation at senior levels. We need to continue into our investigations into short term contracts and the prevalence of BME Staff.

On the positive side we have seen an increase in the number of female consultants, a reduction in the number of 'unknowns' for disability. In addition the Reasonable Adjustment guidance has been disseminated which will hopefully ease some of the anxiety staff feel as a result of experiencing health problems that have ongoing implications.

In terms of the deep dive activity conducted last year, whilst not all was conclusive and further work needs to be done. The results did provide some assurance that our Human Resources processes do not discriminate against our staff from protected groups. The band six career progression work survey report confirmed this.

Finally we do still have limitations in terms of the data that is recorded and collected. However having completed a second years report using this format it feels as though we are in a much better position to identify where the gaps are and what we need to do to address them. This is going to form part of the work plan for 2014 and phase one will be reported in the July 2014 update.

Top Priorities

- To conduct some further analysis for those BME staff appointed into band 7 positions.

- To identify our Human Resources data recording activity to identify where we are unable to generate accurate equality reports.

- Adopt best practice data collection and analysis through benchmarking with East Midlands colleagues.

- Conduct a deep dive into the number of disabled and LGB staff represented in disciplinaries.

Appendix A

Workforce Benchmarking Data 2012-2013

Disability % of Trust Staff					
	UHL	**NUH**	**Derby**	**UHB**	**PAT**
Yes	1.4	1.83	0.89	1.94	1.32
No	56.8	15.8	15.8	59.7	22.2
Not declared	5.8	2.5	-	38.4	72.3
Undefined	36	67	53.9	-	4.10

Sex % of Trust Staff					
	UHL	**NUH**	**Derby**	**UHB**	**PAT**
Female	79	78	82	72	79
Male	20	22	18	28	21

Race % of Trust Staff					
	UHL	**NUH**	**Derby**	**UHB**	**PAT**
Asian	17	6	9	13	8
Black	4	3	3	8	2
Chinese		0.5	0.4	1	0.4
Mixed		1	1	2	1
White	68	74	78	71	87
Other	11	1	1	4	1
Not declared		14	3	1	0.2
Undefined			4	-	-
BME Total	32	12	15	28	13

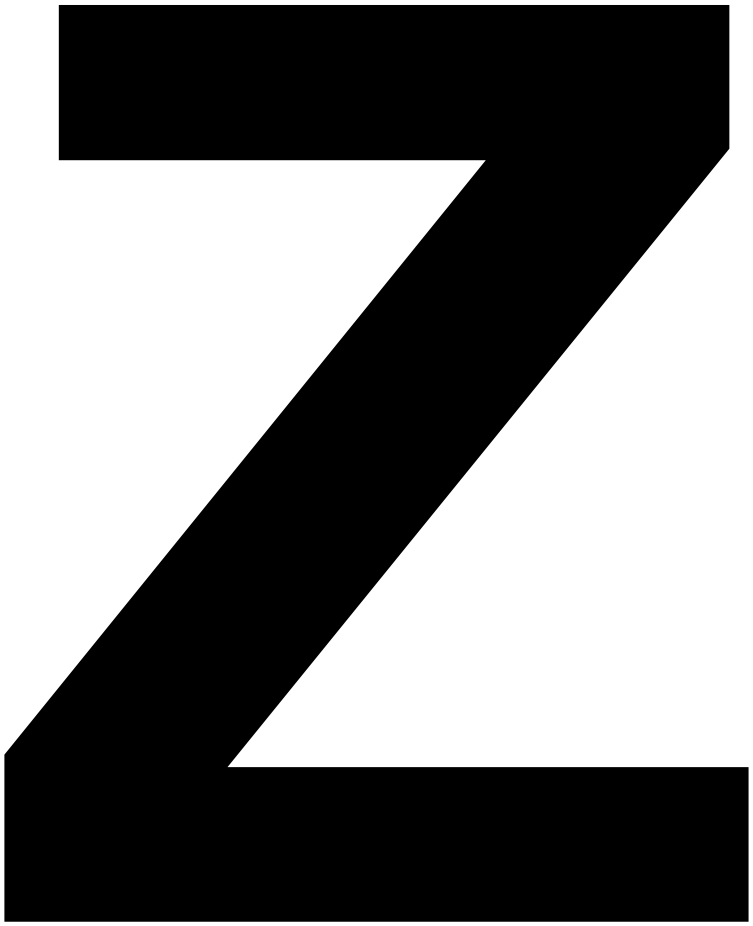
Age % of Trust Staff					
	UHL	**NUH ***	**Derby**	**UHB**	**PAT**
<30 yrs	19	-	20	20	15
31-40 yrs	27	-	26	27	22
41-50 yrs	29	-	30	28	32
51-60 yrs	21	-	20	20	26
>60 yrs	4	-	4	5	5

*Use different age brackets therefore unable to use as comparison.

Sexual Orientation % of Trust Staff					
	UHL	**NUH**	**Derby**	**UHB**	**PAT**
Bisexual	0.49	0.19	0.1	0.5	0.13
Gay	0.37	0.33	0.26	0.61	0.37
Heterosexual	53.2	31.5	32.1	59	34.3
Lesbian	0.23	0.23	0.12	0.31	0.23
Undefined	32.6	59.1	63.9	-	2.7
Do not wish to disclosed	13.2	8.5	-	39.4	62.2
LGB	1.09	0.75	0.48	1.42	0.73

Religion / belief % of Trust Staff					
	UHL	**NUH**	**Derby**	**UHB**	**PAT**
Atheism	5.4	4.8	3.5	5.7	3.5
Buddhism	0.3	0.2	0.1	0.4	0.1
Christianity	38	21	22	41	22.5
Hinduism	5.4	0.7	0.4	2.6	0.4
Islam	3.3	0.7	0.8	3.7	0.8
Jainism	0.1	-	-	0.04	-
Judaism	0.1	0.07	-	0.1	-
Sikhism	1.3	0.3	0.8	2	0.8
Other	4	2.9	3.4	5	3.4
Undefined	31	60	68	-	68
Not wish to disclose	12	10		39	

UHL = University Hospitals of Leicester NHS Trust.
NUH = Nottingham University Hospitals NHS Trust.
Derby = Derby Hospitals NHS Foundation Trust.
UHB = University Hospitals Birmingham NHS Foundation Trust.
PAT= The Pennine Acute Hospitals NHS Trust.



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

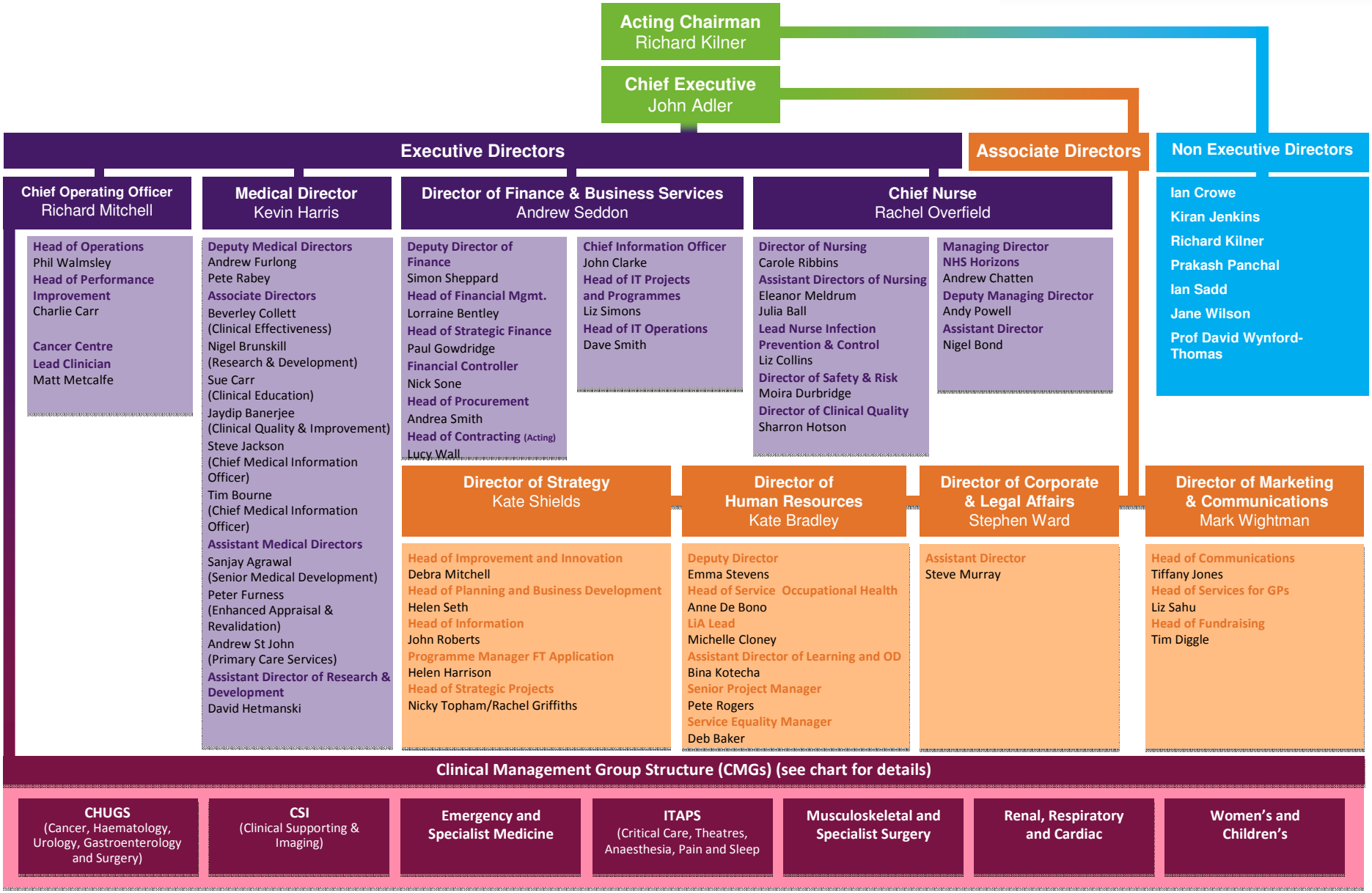
18 December 2013

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)

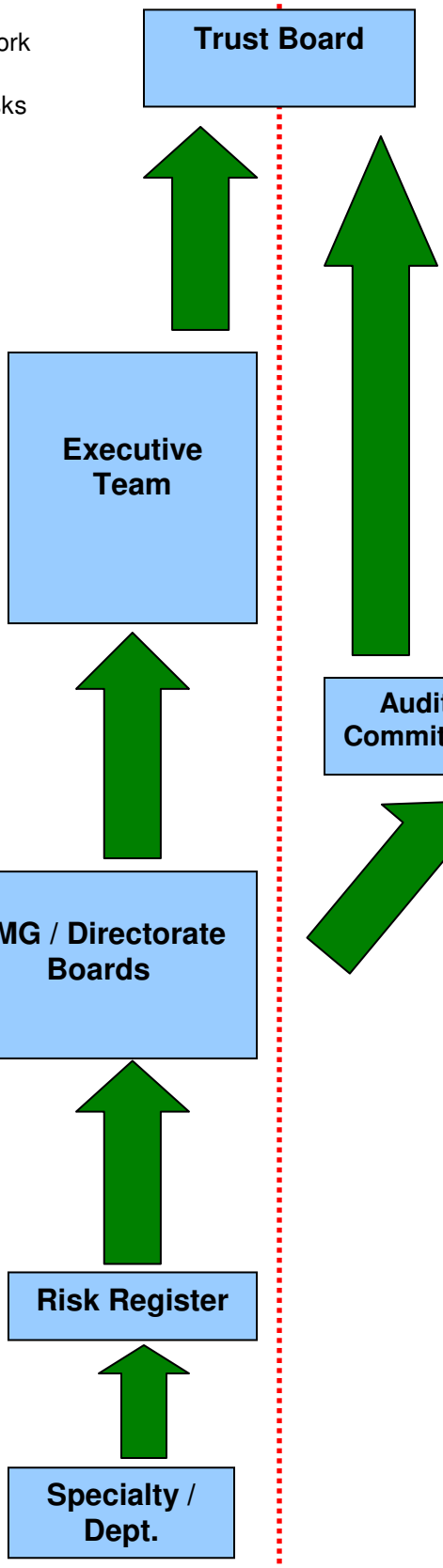
Appendix: B

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

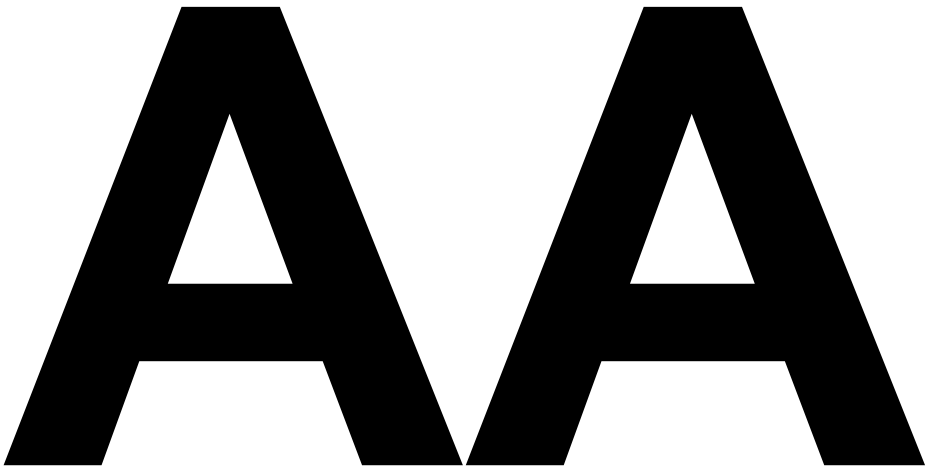
CMG Quarterly Development meetings
Foundation Trust Programme Board
Innovation and Improvement Framework Board
LLR Better Care Together Programme Board
Research and Development Executive
Site Reconfiguration Programme Board

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


AA

Trust Board Paper AA

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

Title:	**TRUST BOARD CALENDAR OF BUSINESS**

Author/Responsible Director: Director of Corporate and Legal Affairs

Purpose of the Report: To invite the Trust Board to consider and approve an updated calendar of business.

The Report is provided to the Committee for:

Decision	√	Discussion	√
Assurance		Endorsement	√

Summary / Key Points: The Trust Board calendar of business has been updated and is presented to the Board for comment and approval.

Recommendations: The Trust Board is invited to consider and approve the updated calendar of business attached at Appendix A.

Subject to any comments and changes made by the Trust Board, the updated calendar of business will be implemented forthwith.

Previously considered at another corporate UHL Committee? Trust Board last considered and approved its calendar of business on 30 May 2013.

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

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

Assurance Implications: N/A

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 Trust Board will be invited to review its calendar of business again at its meeting in March 2014.

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST

REPORT TO: **TRUST BOARD**

DATE: **20 DECEMBER 2013**

REPORT BY: **DIRECTOR OF CORPORATE AND LEGAL AFFAIRS**

SUBJECT: **TRUST BOARD CALENDAR OF BUSINESS**

---

1. INTRODUCTION

1.1 At its meeting on 30th May 2013 (Minute 143/13/2 refers), the Trust Board approved a calendar of business for its meetings.

1.2 The purpose of this report is to invite the Trust Board to consider and approve an updated calendar of business. The updated version is attached at Appendix A.

2. BACKGROUND

2.1 It is good practice for Boards to explicitly discuss and decide how they allocate their time, not only within a given meeting but over the period of the Board's year.

2.2 To this end, at its meeting on 30th May 2013 (Minute 143/13/2 refers), the Trust Board approved a calendar of business.

2.3 There have been a number of developments during the course of 2013 which, together, make it timely for the Trust Board to review its calendar of business:-

- Executive Director portfolios have changed following the appointment of a Chief Operating Officer, Chief Nurse and Director of Strategy : the calendar of business has accordingly been updated to reflect the new allocation of responsibilities and it identifies each Director responsible for the submission of specific reports to the Trust Board;

- the Quality and Performance report has been expanded so that, each month, the Trust Board is now able to track:-

    - the performance of Facilities Management Services;

    - performance against the Quality Commitment;

    - performance against IM&T service delivery standard;

    - statutory and mandatory training compliance;

- the status of healthcare contract queries.

- the implementation of the Trust's Innovation and Improvement Framework : the updated calendar of business now provides for quarterly updates to the Trust Board on the implementation of the Framework.

2.4 As the Trust Board is aware, discussions continue on reinvigorating the Better Care Together Programme (BCT). The updated calendar of business appended to this report anticipates quarterly updates to the Trust Board on the progress of the Programme.

2.5 At its development session on 17th October 2013, the Trust Board also expressed a wish to consider further its oversight of health and safety and health and safety statutory compliance.

2.6 To recap, the Chief Nurse is the Executive Director with lead responsibility for health and safety. The Chief Nurse chairs the Trust's Health and Safety Committee, which meets quarterly and which now reports to the recently established Executive Quality Board. In turn, the Executive Quality Board acts as a forum through which reports are provided to the Quality Assurance Committee of the Trust Board.

2.7 The Health and Safety Committee has established a number of sub-committees to assist it in oversight of the Trust's health and safety responsibilities : these include the:-

- Fire Committee
- Radiation Protection Committee
- Waste Committee
- Water Safety Committee

2.8 It is proposed to continue with the current arrangements whereby the Chief Nurse, via the Director of Safety and Risk, reports quarterly to the Quality Assurance Committee on health and safety management.

2.9 As will be seen from the updated calendar of business attached at Appendix A, it is also proposed that these arrangements will be strengthened via the submission annually of the Health and Safety Annual Report to the Trust Board (in June each year), to include an annual review of health and safety statutory compliance with particular focus on fire safety, radiation protection, waste management and water safety management.

2.10 Again, to strengthen the Board's ability to seek and obtain assurance on a range of responsibilities upon which reports are submitted regularly to the Quality Assurance Committee (via the Chief Nurse/Executive Quality Board), it is proposed that the Trust Board also receives in the future Annual Reports on the discharge of the Trust's responsibilities in relation to:-

- Complaints management
- Infection prevention and control
- Safeguarding
- Emergency preparedness

2.11 The Annual Report on discharge of the Trust's Security Management responsibilities is currently presented (in line with NHS Directions) at the Audit Committee annually by the Local Security Management Specialist, and it is proposed that this arrangement continue.

3. CONCLUSION AND RECOMMENDATION

3.1 The Trust Board is invited to consider and approve the updated calendar of business attached at Appendix A.

3.2 Subject to any comments and changes made by the Trust Board, the updated calendar of business will be implemented forthwith.

Stephen Ward
Director of Corporate and Legal Affairs

17th December 2013

Appendix A - Trust Board Calendar of Business

	QUARTER 1		
	APRIL	**MAY**	**JUNE**
QUALITY, SAFETY AND GOVERNANCE	• Quality report (Q&P report) (CN) • Review of SRR / BAF (CN) • Quality Assurance Committee – Minutes (JW) • Register of Directors' Interests (DCLA) • Register of Seals (DCLA) • Patient story (CN)	• Quality report (Q&P report) (CN) • Review of SRR / BAF (CN) • Quality Assurance Committee – Minutes (JW) • Approval of annual report and accounts (DFBS) • Approval of external audit plan (DFBS) • Approval of annual Quality Account (CN) • Approval of Annual Governance Statement (CE/DCLA) • Patient story (CN)	• Quality report (Q&P report) (CN) • Review of SRR / BAF (CN) • Quality Assurance Committee – Minutes (JW) • Audit Committee – Minutes (KJ) • Patient story (CN) • Equality governance : six month review (DHR) • Approve Annual Quality Account (CN) • Annual Health and Safety Report/Annual Review of statutory compliance • <u>Annual Reports</u> Complaints Infection Prevention and Control Safeguarding Emergency Preparedness
STRATEGY AND DEVELOPMENT	• Chief Executive – monthly update report (CE) • Better Care Together Progress report (CE)	• Chief Executive – monthly update report (CE) • Risk Management Policy Annual Review (CN)	• Chief Executive – monthly update report (CE) • Listening into action update (DHR) • IMT Strategy Update (DFBS)
PERFORMANCE MANAGEMENT	• Financial performance (Q&P report) (DFBS) • Emergency Care (COO) • Over-sight self-certification return (DCLA) • Finance and Performance Committee – Minutes (RK) • Progress against annual plan priorities Q4 (DS) • Improvement and Innovation Framework quarterly update (DS)	• Financial performance (Q&P report) (DFBS) • Emergency Care (COO) • Over-sight self-certification return (DCLA) • Finance and Performance Committee – Minutes (RK)	• Financial performance (Q&P report) (DFBS) • Emergency Care (COO) • Over-sight self-certification return (DCLA) • Finance and Performance Committee – Minutes (IR) • Workforce and Organisational Development – quarterly review (DHR) • Research, development and medical education – quarterly review (MD)

	QUARTER 2		
	JULY	**AUGUST**	**SEPTEMBER**
QUALITY, SAFETY AND GOVERNANCE	• Quality report (Q&P report) (CN) • Review of SRR / BAF (CN) • Quality Assurance Committee – Minutes (JW) • Patient story (CN)	• Quality report (Q&P report) (CN) • Review of SRR / BAF (CN) • Quality Assurance Committee – Minutes (JW) • Patient story (CN)	• Quality report (Q&P report) (CN) • Review of SRR / BAF (CN) • Quality Assurance Committee – Minutes (JW) • Patient story (CN) • Review of stakeholder engagement strategy (DMC)
STRATEGY AND DEVELOPMENT	• Chief Executive – monthly update report (CE) • Better Care Together progress report (CE)	• Chief Executive – monthly update report (CE)	• Chief Executive – monthly update report (CE) • Listening into action update (DHR) • IMT Strategy Update (DFBS)
PERFORMANCE MANAGEMENT	• Financial performance (Q&P report) (DFBS) • Emergency Care (COO) • Over-sight self-certification return (DCLA) • Finance and Performance Committee – Minutes (RK) • Progress against annual plan priorities Q1 20/3/14 (DS) • Improvement and Innovation framework – quarterly update (DS)	• Financial performance (Q&P report) (DFBS) • Emergency Care (COO) • Over-sight self-certification return (DCLA) • Finance and Performance Committee – Minutes (RK)	• Financial performance (Q&P report) (DFBS) • Emergency Care (COO) • Over-sight self-certification return (DCLA) • Finance and Performance Committee – Minutes (RK) • Workforce and Organisational Development – quarterly review (DHR) • Research, development and medical education – quarterly review (MD)

	QUARTER 3		
	OCTOBER	**NOVEMBER**	**DECEMBER**
QUALITY , SAFETY AND GOVERNANCE	• Quality report (Q&P report) (CN) • Review of SRR / BAF (CN) • Quality Assurance Committee – Minutes (JW) • Patient story (CN)	• Quality report (Q&P report) (CN) • Review of SRR / BAF (CN) • Quality Assurance Committee – Minutes (JW) • Patient story (CN) • Results of Annual Reputation Audit (DMC)	• Quality report (Q&P report) (CN) • Review of SRR / BAF (CN) • Quality Assurance Committee – Minutes (JW) • Patient story (CN) • Equality Governance – Six month review (DHR)
STRATEGY AND DEVELOPMENT	• Chief Executive – monthly update report (CE) • Better Care Together progress report (CE)	• Chief Executive – monthly update report (CE)	• Chief Executive – monthly update report (CE) • Listening into Action Update (DHR) • IM&T Strategy Update (DFBS)
PERFORMANCE MANAGEMENT	• Financial performance (Q&P report) (DFBS) • Emergency Care (COO) • Over-sight self-certification return (DCLA) • Finance and Performance Committee – Minutes (RK) • Progress against annual plan priorities Q2 (DS) • Innovation and Improvement Framework quarterly update (DS)	• Financial performance (Q&P report) (DFBS) • Emergency Care (COO) • Over-sight self-certification return (DCLA) • Finance and Performance Committee – Minutes (RK)	• Financial performance (Q&P report) (DFBS) • Emergency Care (COO) • Over-sight self-certification return (DCLA) • Finance and Performance Committee – Minutes (RK) • Workforce and organisational development – quarterly review (DHR) • Research, development and medical education – quarterly review (MD)

	QUARTER 4		
	JANUARY	**FEBRUARY**	**MARCH**
QUALITY, SAFETY AND GOVERNANCE	• Quality report (Q&P report) (CN) • Review of SRR / BAF (CN) • Quality Assurance Committee – Minutes (JW) • Patient story (CN) • Local Clinical Excellence Awards Annual Report (DHR)	• Quality report (Q&P report) (CN) • Review of SRR / BAF (CN) • Quality Assurance Committee – Minutes (JW) • Patient story (CN)	• Quality report (Q&P report) (CN) • Review of SRR / BAF (CN) • Quality Assurance Committee – Minutes (JW) • Annual cycle of business for Trust Board (DCLA) • Approval of Annual Operational Plan and Trust priorities (DS) • Patient story (CN)
STRATEGY AND DEVELOPMENT	• Chief Executive – monthly update report (CE) • Better Care Together Progress Report (CE)	• Chief Executive – monthly update report (CE)	• Chief Executive – monthly update report (CE) • Listening into action update (DHR) • IM&T Strategy Update (DFBS)
PERFORMANCE MANAGEMENT	• Financial performance (Q&P report) (DFBS) • Emergency Care (COO) • Over-sight self-certification return (DCLA) • Finance and Performance Committee – Minutes (RK) • Progress against annual plan priorities Q3 (DS) • Improvement and Innovation Framework quarterly review (DS)	• Financial performance (Q&P report) (DFBS) • Emergency Care (COO) • Over-sight self-certification return (DCLA) • Finance and Performance Committee – Minutes (RK)	• Financial performance (Q&P report) (DFBS) • Emergency Care (COO) • Over-sight self-certification return (DCLA) • Finance and Performance Committee – Minutes (RK) • Workforce and organisational development – quarterly review (DHR) • Research, development and medical education – quarterly review (MD)

KEY

DFBS	Director of Finance and Business Services
COO	Chief Operating Officer
CN	Chief Nurse
MD	Medical Director
DCLA	Director of Corporate and Legal Affairs
CE	Chief Executive
DHR	Director of Human Resources
DMC	Director of Marketing and Communications
DS	Director of Strategy

KJ	Kiran Jenkins, Non-Executive Director
RK	Richard Kilner, Non-Executive Director
JW	Jane Wilson, Non-Executive Director

BB

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST

Trust Board Bulletin – 20 December 2013

The following report is attached to this Bulletin as an item for noting, and is circulated to UHL Trust Board members and recipients of public Trust Board papers accordingly:-

- **Updated Clinical Management Structure** – Lead contact point Ms K Bradley, Director of Human Resources, (0116 258 8726) – **paper 1**.

It is intended that these papers will not be discussed at the formal Trust Board meeting on 20 December 2013, unless members wish to raise specific points on the report.

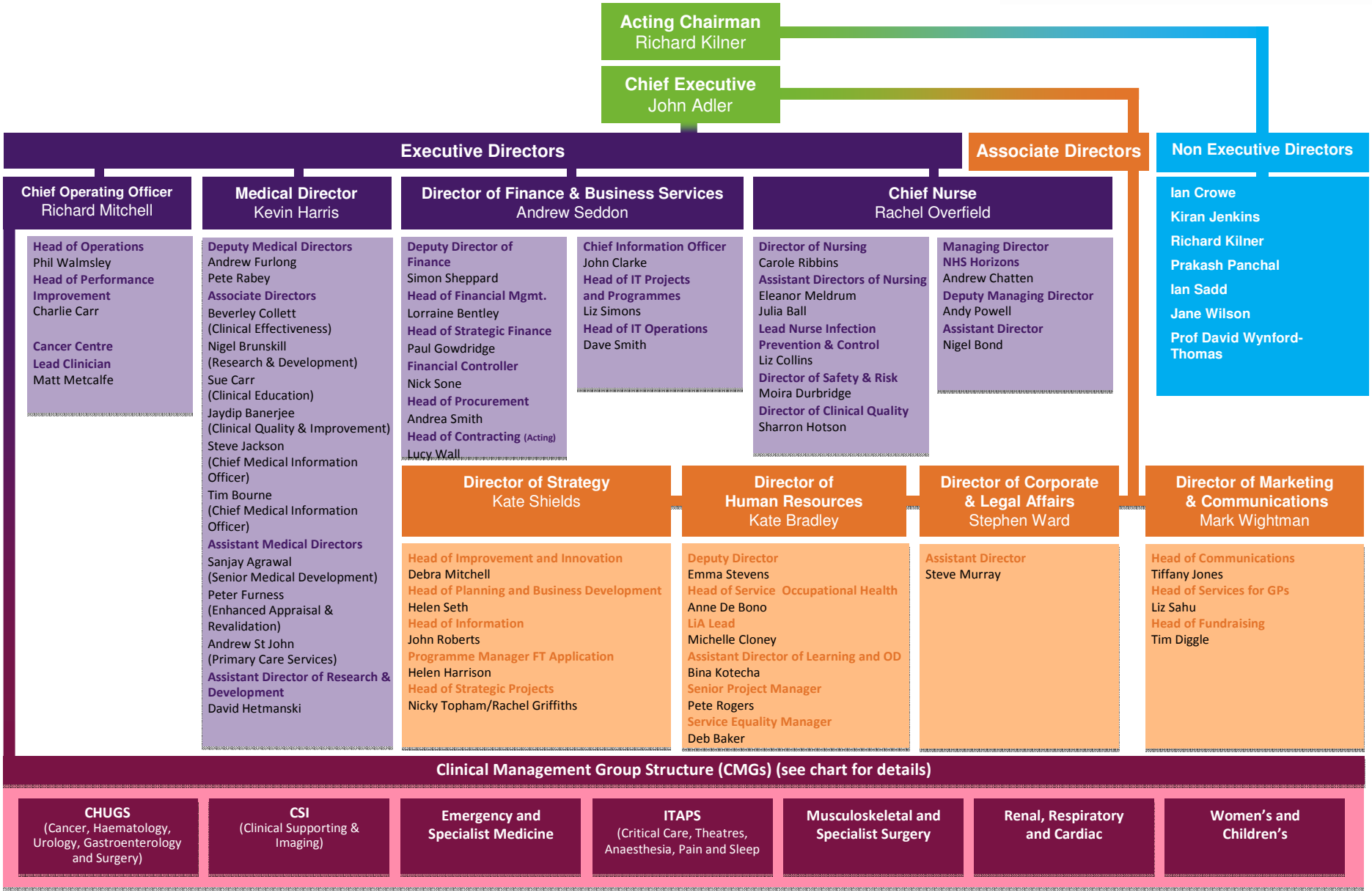
This approach was agreed by the Trust Board on 10 June 2004 (point 7 of paper Q). Any queries should be directed to the specified lead contact point in the first instance. In the event of any further outstanding issues, these may be raised at the Trust Board meeting with the prior agreement of the Chairman.

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)