UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST

TRUST BOARD

MEETING TO BE HELD ON THURSDAY 28 NOVEMBER 2013 FROM 10.30AM IN THE CUMULUS ROOM, DIABETES CENTRE OF EXCELLENCE, LEICESTER GENERAL HOSPITAL

Public meeting commences at 1pm

AGENDA

Please take papers as read

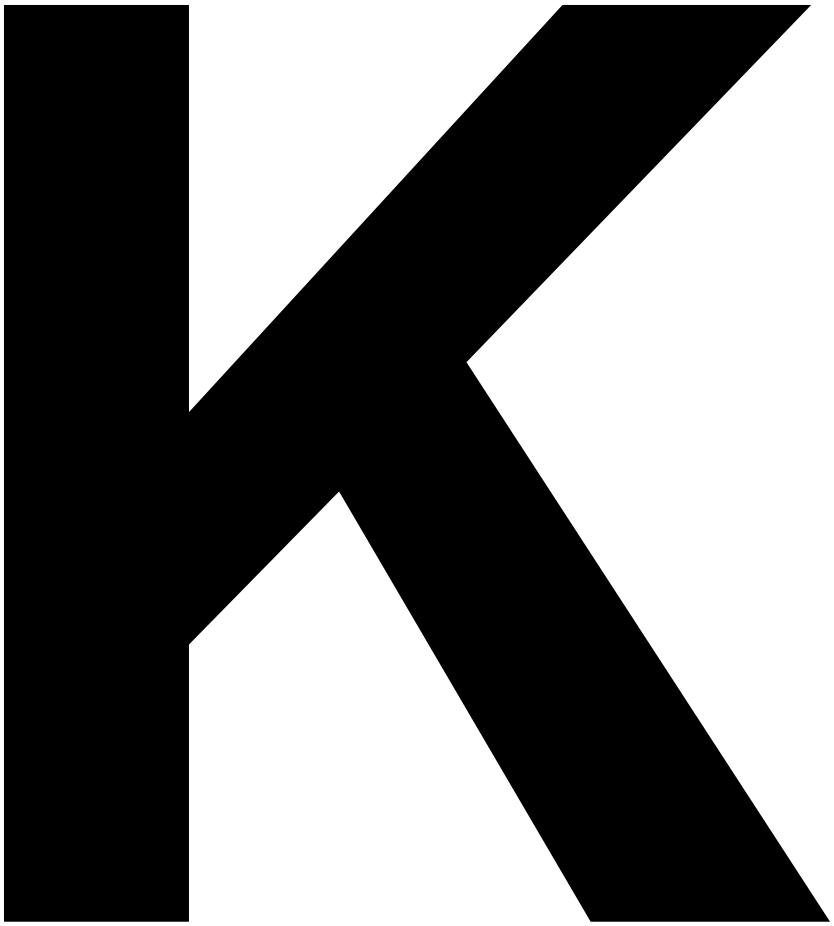
Item no.	Item	Paper ref:	Lead	Discussion time
1.	**EXCLUSION OF THE PRESS AND PUBLIC** It is recommended that, pursuant to the Public Bodies (Admission to Meetings) Act 1960, the press and members of the public be excluded from the following items of business, having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest (items 1-12).			-
2.	**APOLOGIES AND WELCOME** To receive any apologies for absence.	**-**	**Acting Chairman**	10.30am – 10.35am
3.	**DECLARATIONS OF INTERESTS** Members of the Trust Board and other persons attending are asked to declare any interests they may have in the business on the agenda (Standing Order 7 refers). Unless the Trust Board agrees otherwise in the case of a non-prejudicial interest, the person concerned shall withdraw from the meeting room and play no part in the relevant discussion or decision.			-
4.	**ACTING CHAIRMAN'S AND CHIEF EXECUTIVE'S OPENING COMMENTS**	**-**	**Acting Chairman and Chief Executive**	10.35am – 10.40am
5.	**CONFIDENTIAL MINUTES** Confidential Minutes of the 31 October 2013 meeting and 17 October 2013 Trust Board Development Session. *For approval*	**A & A1**	**Acting Chairman**	10.40am – 10.45am
6.	**MATTERS ARISING** Confidential action log from the 31 October 2013 Trust Board meeting. *For approval*	**B (to follow)**	**Acting Chairman**	10.45am – 10.50am
7.	**REPORTS BY THE DIRECTOR OF FINANCE AND BUSINESS SERVICES** *Commercial interests and prejudicial to the conduct of public affairs*	**C & C1 (to follow)**	**Director of Finance and Business Services**	10.50am – 11.20am
8.	**REPORTS BY THE DIRECTOR OF HUMAN RESOURCES** *Personal information and prejudicial to the conduct of public affairs*	**D & D1**	**Director of Human Resources**	11.20am – 11.30am
9.	**REPORT BY THE DIRECTOR OF STRATEGY** *Commercial interests and prejudicial to the conduct of public affairs*	**E**	**Director of Strategy**	11.30am – 11.40am
10.	**REPORT BY THE MEDICAL DIRECTOR** *Prejudicial to the conduct of public affairs*	**F & F1**	**Medical Director**	11.40am – 12noon

11.	**REPORTS FROM BOARD COMMITTEES**			12noon – 12.05pm
11.1	**AUDIT COMMITTEE** Confidential Minutes of the 12 November 2013 meeting for noting. P*rejudicial to the conduct of public affairs*	**G** **(to follow)**	**Audit Committee Chair**	
11.2	**FINANCE AND PERFORMANCE COMMITTEE** Confidential Minutes of the 30 October 2013 meeting for noting. *Commercial interests and prejudicial to the conduct of public affairs*	**H**	**Ms J Wilson, Non-Executive Director**	
11.3	**QUALITY ASSURANCE COMMITTEE** Confidential Minutes of the 29 October 2013 meeting for noting. *Prejudicial to the conduct of public affairs*	**I**	**Quality Assurance Committee Chair**	
12.	**ANY OTHER BUSINESS**	**-**	**Chairman**	12.05pm – 12.10pm
Lunch break from 12.10pm to 1pm prior to commencing the public section of the meeting				
13.	**DECLARATION OF INTERESTS**	**-**	**Acting Chairman**	-
	Members of the Trust Board and other persons attending are asked to declare any interests they may have in the business on the public agenda (Standing Order 7 refers). Unless the Trust Board agrees otherwise in the case of a non-prejudicial interest, the person concerned shall withdraw from the meeting room and play no part in the relevant discussion or decision.			
14.	**DIABETES MEDICINE – PRESENTATION BY PROFESSOR M DAVIES** The Medical Director to introduce this item.	**J** **Presentation (to follow)**	**Medical Director**	1pm – 1.20pm
15.	**ACTING CHAIRMAN'S AND CHIEF EXECUTIVE'S OPENING COMMENTS**		**Acting Chairman/ Chief Executive**	1.20pm – 1.25pm
16.	**MINUTES**			
	Minutes of the 31 October 2013 Trust Board meeting. *For approval*	**K**	**Acting Chairman**	1.25pm – 1.30pm
17.	**MATTERS ARISING**			
	Action log from the 31 October 2013 meeting. *For approval*	**L** **(to follow)**	**Acting Chairman**	1.30pm – 1.35pm
18.	**REPORTS BY THE CHIEF EXECUTIVE**			
18.1	**MONTHLY UPDATE REPORT – NOVEMBER 2013** *For discussion and assurance*	**M**	**Chief Executive**	1.35pm – 1.40pm
18.2	**EMERGENCY FLOOR – OUTLINE BUSINESS CASE** *For discussion and approval*	**N**	**Chief Executive**	1.40pm – 2pm
19.	**CLINICAL QUALITY AND SAFETY**			
19.1	**CONTRASTING EXPERIENCES** *For discussion and assurance*	**O** **Presentation**	**Chief Nurse**	2pm – 2.15pm
19.2	**UPDATE ON LLR RESPONSE TO FRANCIS, AND UHL RESPONSE TO KEOGH AND BERWICK REVIEWS**	**P**	**Chief Nurse**	2.15pm – 2.25pm

	For discussion and assurance			
19.3	**CLWYD REPORT ON NHS COMPLAINTS** *For discussion and assurance*	**Q**	**Chief Nurse**	2.25pm – 2.35pm
20.	**RISK**			
20.1	**BOARD ASSURANCE FRAMEWORK – UPDATE** *For discussion and assurance*	**R**	**Chief Nurse**	2.35pm – 2.45pm
21.	**HUMAN RESOURCES**			
21.1	**CLINICAL MANAGEMENT STRUCTURE** *For discussion and assurance*	**S**	**Director of Human Resources/Chief Operating Officer**	2.45pm – 2.55pm
22.	**QUALITY AND PERFORMANCE** *For assurance*			
22.1	**MONTH 7 QUALITY, PERFORMANCE AND FINANCE REPORT** *For assurance* ***Consideration of this item will be structured as follows:-*** The **Non-Executive Director Chair** of the **Quality Assurance Committee** will be invited to comment verbally on the month 7 position, as considered at the meeting held on 27 November 2013 (the Minutes of which will be presented to the 20 December 2013 Trust Board). Minutes of the 29 October 2013 **Quality Assurance Committee** meeting are also attached for noting and endorsement of any recommendations. **Ms J Wilson, Non-Executive Director** to be invited to comment verbally on the month 7 position, as considered at the **Finance and Performance Committee** meeting held on 27 November 2013 (the Minutes of which will be presented to the 20 December 2013 Trust Board). Minutes of the 30 October 2013 **Finance and Performance Committee** meeting are also attached for noting and endorsement of any recommendations. **Lead Executive Directors** will then be invited to comment on their respective sections of the month 7 report, specifically:- (a) **Chief Nurse** – patient safety and quality, quality commitment, patient experience and facilities management performance; (b) **Medical Director** – mortality rates; (c) **Chief Operating Officer** – operational performance and exception reports, (d) **Director of Human Resources** – staff appraisal, sickness absence and statutory and mandatory training compliance, and (e) **Director of Finance and Business Services** – Month 7 financial re-forecast.	**T** **T1** **T2** **T3 (to follow)**	 **Quality Assurance Chair** **Ms J Wilson, Non-Executive Director** **Lead Executive Directors** **Chief Nurse** **Medical Director** **Chief Operating Officer** **Director of Human Resources** **Director of Finance and Business Services**	2.55pm – 3.25pm
22.2	**EMERGENCY CARE PERFORMANCE AND RECOVERY PLAN** *For discussion and assurance*	**U (to follow)**	**Chief Operating Officer**	3.25pm – 3.40pm

22.3	**NHS TRUST OVER-SIGHT SELF CERTIFICATION** *For discussion and approval*	**V**	**Director of Corporate and Legal Affairs**	3.40pm – 3.45pm
23.	**GOVERNANCE**			
23.1	**UHL EMERGENCY PREPAREDNESS, RESILIENCE AND RESPONSE SELF-ASSESSMENT** *For discussion and assurance*	**W**	**Chief Operating Officer**	3.45pm – 3.55pm
23.2	**RESULTS OF REPUTATION AUDIT** *For discussion and assurance*	**X**	**Director of Marketing and Communications**	3.55pm – 4.05pm
24.	**REPORTS FROM BOARD COMMITTEES**			
24.1	**AUDIT COMMITTEE** Minutes of the 12 November 2013 meeting for noting.	**Y (to follow)**	**Audit Committee Chair**	
25.	**TRUST BOARD BULLETIN – NOVEMBER 2013**	**Z (paper 1 to follow)**	**-**	
26.	**QUESTIONS FROM THE PUBLIC RELATING TO BUSINESS TRANSACTED AT THIS MEETING**	**-**	**Acting Chairman**	4.05pm – 4.25pm
27.	**ANY OTHER BUSINESS**	**-**	**Acting Chairman**	4.25pm – 4.30pm
28.	**DATE OF NEXT MEETING**			
	The next Trust Board meeting will be held on **Friday 20 December 2013** from 9.00am in Seminar Rooms 2 and 3, Clinical Education Centre, Glenfield Hospital – *please note change of date.*	**-**		

Kate Rayns
Trust Administrator



UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST

MINUTES OF A MEETING OF THE TRUST BOARD, HELD ON THURSDAY 31 OCTOBER 2013 AT 9.30AM IN SEMINAR ROOMS A & B, CLINICAL EDUCATION CENTRE, LEICESTER GENERAL HOSPITAL

Present:
Mr R Kilner – Acting Trust Chairman
Dr K Harris – Medical Director
Mr R Mitchell – Chief Operating Officer
Ms R Overfield – Chief Nurse
Mr P Panchal – Non-Executive Director
Mr I Sadd – Non-Executive Director
Mr A Seddon – Director of Finance and Business Services and Acting Chief Executive
Ms J Wilson – Non-Executive Director (excluding part of Minute 266/13/2)

In attendance:
Dr T Bentley – Leicester City CCG Representative (from Minute 271/13)
Mr C Blainey – Empath Finance Director (for Minute 265/13/2)
Ms K Bradley – Director of Human Resources (excluding part of Minute 266/13/2)
Mr E Charlesworth – Healthwatch Representative (from Minute 271/13)
Ms R Doyle – Meaningful Activities Co-Ordinator, Patient Experience Team (for Minute 277/13/1)
Mr T Flanagan – Empath Commercial Director (for Minute 265/13/2)
Mr R Manton – Risk and Safety Manager (for Minute 278/13/1)
Mrs K Rayns – Trust Administrator
Mr T Sanders – Managing Director, West Leicestershire CCG (for Minute 272/13)
Dr P Shaw – Empath Managing Director (for Minute 265/13/2)
Mr B Teasdale – Clinical Lead, Emergency Department (for Minute 272/13)
Mr S Ward – Director of Corporate and Legal Affairs
Mr M Wightman – Director of Marketing and Communications

ACTION

259/13 EXCLUSION OF THE PRESS AND PUBLIC

Resolved – that, pursuant to the Public Bodies (Admission to Meetings) Act 1960, the press and members of the public be excluded during consideration of the following items of business (Minutes 259/13 – 270/13), having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest.

260/13 APOLOGIES AND WELCOME

Apologies for absence were received from Mr J Adler, Chief Executive, Col (Retd) I Crowe, Non-Executive Director, Ms K Jenkins, Non-Executive Director and Professor D Wynford-Thomas, Non-Executive Director.

The Acting Chairman welcomed Mr I Sadd, Non-Executive Director to his first meeting of the UHL Trust Board and noted that Mr A Seddon, Director of Finance and Business Services was attending in the capacity of Acting Chief Executive.

261/13 DECLARATIONS OF INTERESTS IN THE CONFIDENTIAL BUSINESS

There were no declarations of interest in the confidential business being discussed.

262/13 ACTING CHAIRMAN'S AND ACTING CHIEF EXECUTIVE'S OPENING COMMENTS

Resolved – that this Minute be classed as confidential and taken in private accordingly, on the grounds that public consideration at this stage could be prejudicial to the effective conduct of public affairs.

263/13 CONFIDENTIAL MINUTES

Resolved – that the confidential Minutes of the Trust Board meeting held on 26 September 2013 and the 16 September 2013 Trust Board Development Session be confirmed as a correct record.

264/13 CONFIDENTIAL MATTERS ARISING REPORT

Resolved – that this Minute be classed as confidential and taken in private accordingly, on the grounds that public consideration at this stage could be prejudicial to the effective conduct of public affairs.

265/13 REPORTS BY THE DIRECTOR OF FINANCE AND BUSINESS SERVICES

Resolved – that this Minute be classed as confidential and taken in private accordingly, on the grounds of commercial interests and that public consideration at this stage could be prejudicial to the effective conduct of public affairs.

266/13 REPORTS BY THE DIRECTOR OF HUMAN RESOURCES

Resolved – that this Minute be classed as confidential and taken in private accordingly, on the grounds of personal information and that public consideration at this stage could be prejudicial to the effective conduct of public affairs.

267/13 REPORT BY THE MEDICAL DIRECTOR

Resolved – that this Minute be classed as confidential and taken in private accordingly, on the grounds of personal information and that public consideration at this stage could be prejudicial to the effective conduct of public affairs.

268/13 REPORT BY THE DIRECTOR OF CORPORATE AND LEGAL AFFAIRS

Resolved – that this Minute be classed as confidential and taken in private accordingly, on the grounds of personal information and that public consideration at this stage could be prejudicial to the effective conduct of public affairs.

269/13 REPORT BY THE ACTING CHAIRMAN AND THE DIRECTOR OF CORPORATE AND LEGAL AFFAIRS

Resolved – that this Minute be classed as confidential and taken in private accordingly, on the grounds of personal information and that public consideration at this stage could be prejudicial to the effective conduct of public affairs.

270/13 REPORTS FROM BOARD COMMITTEES

270/13/1 Finance and Performance Committee

Resolved – this Minute be classed as confidential and taken in private accordingly, on the grounds that public consideration at this stage could be prejudicial to the effective conduct of public affairs.

270/13/2 Quality Assurance Committee

Resolved – that the confidential Minutes of the Quality Assurance Committee meeting held on 25 September 2013 be received and noted.

270/13/3 Remuneration Committee

Resolved – that the confidential Minutes of the Remuneration Committee held on 26 September 2013 be received and noted.

271/13 DECLARATIONS OF INTERESTS IN THE PUBLIC BUSINESS

There were no declarations of interests relating to the public items being discussed.

272/13 EMERGENCY CARE

The Acting Chairman noted a change to the running order of the agenda, advising that agenda items 15, 24.2 and 24.3 had been amalgamated.

272/13/1 CCG Perspective on Emergency Care and the Collaborative Hub

Mr T Sanders, Managing Director, West Leicestershire CCG attended the meeting to brief the Board on the work of the Collaborative Emergency Care Hub, noting that he had recently assumed the lead role for this work on behalf of the 3 local CCGs. He summarised the emergency care position in the middle of Summer 2013 when UHL had been ranked as one of the poorest performing Trusts in the country, together with UHL and health economy wide actions that were being taken to respond to concerns and deliver a recovery plan. These recovery actions were continuing to be progressed, but by mid-September 2013 it had become apparent that this approach would not wholly address the current challenges.

On 19 September 2013, the Collaborative Hub had been formed as a vehicle for "changing the conversation" and developing a more collaborative approach to problem solving. Direct input was now provided by Commissioners, community based services and transport providers to support UHL and the focus on the consistent application of the Trust's internal systems and processes had been strengthened. A series of 5 rapid improvement workshops had been held over a 3 day period involving a wide range of both clinical and non-clinical staff and printed copies of the rapid improvement work programme were tabled at the meeting. The work programme was structured to focus on (1) inflow, (2) ED/specialty working, (3) ward practice, (4) operational issues, and (5) multi-agency integration.

CCG management resources had been aligned with key workstreams and intensive work was underway to identify where the additional winter funding (£10m for the local health economy) would be spent to deliver the maximum benefits. Outline plans for this funding were due to be considered at a meeting of the Collaborative Hub later that afternoon. Members noted the benefits of constructive relationships that were being formed, and the progress being made with TTO medications, specialty engagement and internal discharge processes. Significant input by the Chief Nurse in respect of discharge processes had been very welcome. Mr Sanders provided his view that the Collaborative Hub was focusing on the most appropriate plans and that this focus was likely to continue for the next 6 months.

In discussion following the presentation, Board members raised the following comments and queries:-

(a) Ms J Wilson, Non-Executive Director recorded her support of the new collaborative approach and queried how the underlying causes behind a recent 8% increase in admissions would be addressed within the work programme and whether there were any opportunities to "smooth" patient inflow. In response, the CCG Managing Director reported on plans to identify appropriate actions to reduce inflow (eg improved management of long term conditions in the community) and he confirmed that these

would be built into the work programme by Easter 2014. Action 1.1 on the work programme made reference to an analysis of patient inflow strands by time of day and feedback to the referring GP was one of the expected outcomes. Dr T Bentley, CCG representative reported on arrangements to improve the timing of admissions arising from the Emergency Assessment Service;

(b) the Director of Marketing and Communications provided feedback from recent Overview and Scrutiny meetings and a King's Fund conference where discussions had taken place regarding winter capacity plans and care of the frail elderly in the context of the current out of hours arrangements for GP services. He queried the scope for GPs to contact their most at risk patients to provide them with key health messages to prevent their condition deteriorating to such a point that they required an acute admission. In response, Dr T Bentley, CCG representative reported on the risk stratification processes already in place which included MDT meetings and regular appointments with their most at risk patients. The CCG Managing Director commented upon future opportunities to develop a more systematic (red flag) approach in this area, and

(c) Ms J Wilson, Non-Executive Director queried what arrangements would be put in place to reduce admissions amongst UHL's most frequently attending patients and noted in response that the engagement work was still taking place to support this workstream. Implementation arrangements would be discussed at a meeting of the inflow working group to be held on 4 November 2013.

Resolved – that the presentation and subsequent discussion on Emergency Care and the work of the Collaborative Hub be noted.

272/13/2 UHL Emergency Department (ED)

The Chief Operating Officer introduced Dr B Teasdale, ED Clinical Lead who had attended the meeting to provide a presentation on UHL's ED performance from a clinician's perspective. Dr Teasdale tabled copies of a briefing paper outlining the context of recent changes to ED processes, the work undertaken by the Emergency Care Action Team (ECAT) and the Collaborative Hub. He particularly highlighted the following key areas of activity and focus:-

(a) changes to the physical ED environment, including the completion of the ambulance handover area, additional resuscitation bay accommodation, a dedicated psychiatry assessment area, and plans to increase paediatric accommodation within the existing paediatric footprint;
(b) successful recruitment to vacant nursing posts – by the end of 2013, all but 9 of the vacant posts were expected to be filled;
(c) the medical workforce recruitment strategy closely aligned with the departmental development plan, "ED pillars" and attendance levels, with the aim of achieving sustainable reductions in locum staffing, and
(d) the further actions required to deliver sustained improvements in ED performance, including a relentless and consistent approach to achieving meaningful patient flows, improving interactions with support services and specialty teams, and robust delivery of individual and team performance objectives.

Resolved – that the presentation on UHL's Emergency Department be noted.

272/13/3 Emergency Department Performance Report

The Chief Operating Officer introduced paper Y, providing an overview of the Trust's performance against the 95% 4 hour target and ED quality indicators, noting that September 2013 performance stood at 89.5% and the year to date performance was 87.84%. Performance during October 2013 had been variable, although 1 week of compliant performance had been delivered (week ending 13 October 2013).

The Chief Operating Officer reported on the continued actions underway in order to (1) reduce rates of attendances and admissions, (2) accelerate the arrangements for safe and timely discharge, and (3) address gaps in staffing rotas. He noted the cultural changes required within the organisation to consistently adhere to internal processes for a full 20 day period in order to demonstrate the sustainable benefits to the system.

The Acting Chairman noted constraints surrounding acute bed capacity and Dr T Bentley, CCG representative provided feedback from the General Practice perspective, noting that:-

- Bed Bureau referrals were not now channelled through ED and this was welcomed;
- an appropriate focus was being maintained on improving access to primary care services and Commissioners were monitoring GP out of hours performance. The CCG Managing Director commented that there was no reliable system to gather feedback on access to out of hours GP services, hence the reliance upon patient experience and GP Practice appraisal data;
- feedback to GPs on admissions data, inappropriate referrals and frequently attending patients was considered helpful;
- admissions avoidance measures were being built into patient pathways, but the GP helpline, choose and book service and protected education and learning time for GPs would all help to support this work;
- improved GP access to patient records via System 1 was required;
- GPs needed to be informed of patient discharges in a timely manner and good quality discharge planning was considered crucial in this respect;
- the District Nurse service had been reconfigured within Leicester City, and
- support was being provided by the Intensive Community Support Service in respect of managing patients' conditions safely in the home environment.

The CCG Managing Director commented that 3 of the 5 Collaborative Hub workstreams were considered to be within UHL's control and he expressed concern that more progress had not been made with these prior to intervention by the Hub. The Acting Chairman responded by highlighting opportunities to reduce delayed transfers of care to non-acute providers. He queried the approval process for UHL's winter capacity plan noting a material shortfall in bed capacity relative to the activity modelling and the negative impact of having the equivalent of between 1 and 2 wards full of patients not requiring acute care services waiting in UHL beds for alternative care arrangements. The CCG Managing Director also reported on the CCG arrangements for supporting continuing health care, through appropriate access and use of community hospital and LPT beds and provision of hospital transport, suggesting that available community bed capacity and transport arrangements were not always utilised effectively by UHL.

Discussion also took place regarding the following issues:-

(a) opportunities to reconcile differing views on bed capacity modelling at that afternoon's Collaborative Hub meeting. The CCG Managing Director particularly challenged the Trust's ability to staff any additional capacity beds appropriately (once these had been agreed);
(b) clear accountability arrangements for compiling an accurate daily list of patients ready for discharge which would alleviate the need for nursing staff from each ward area to attend bed management meetings 3 or 4 times per day;
(c) the benefits of the recently re-instated Elderly Frailty Unit (EFU) and the longer term aim to co-locate this unit alongside the ED under future reconfiguration plans;
(d) progress with the medications element of discharge processes – the Medical Director advised of the results of a recent pilot which aimed to provide TTOs within 30 minutes, and
(e) the expected benefits of the provision of a separate 4-chaired area for streaming patients requiring mental health support.

Resolved – that the monthly update on ED performance (paper Y) be received and noted.

272/13/4 Winter Bed and Capacity Planning

The Chief Operating Officer introduced paper Z, providing an overview of additional bed capacity and other capacity changes required to manage patient flows and expected increases in demand between 1 December 2013 and 31 March 2014. An updated briefing paper for the Urgent Care Working Group was circulated as an additional appendix to paper Z. Trust Board members noted that the Acting Chairman and the Chief Executive would be presenting the Winter Plan to the Trust Development Authority (TDA) for approval during week commencing 4 November 2013.

Mr E Charlesworth, Healthwatch Representative, made reference to the Healthwatch letter of concern, a copy of which was appended to paper Z. He commended the workstreams already being implemented but he highlighted opportunities to commence discharge planning or transfer of care arrangements as soon as patients arrived in the Trust and for these arrangements to be communicated effectively.

Resolved – that the reports on winter bed and capacity planning for 2013-14 (paper Z) be received and noted and the Winter Plan for 2013-14 be endorsed. **COO**

273/13 ACTING CHAIRMAN'S AND ACTING CHIEF EXECUTIVE'S OPENING COMMENTS

The Acting Chairman welcomed Mr I Sadd, Non-Executive Director and Dr T Bentley, co-opted non-voting CCG representative to the meeting. He drew members' attention to the following issues:-

(a) the Trust Board had earlier endorsed the appointment of Mr E Charlesworth as a non-voting co-opted member representing the Leicester, Leicestershire and Rutland Healthwatch organisations and he invited Mr Charlesworth to join Trust Board members around the table for the remainder of this meeting and for future meetings;
(b) the Director of Finance and Business Services was attending this meeting in the capacity of Acting Chief Executive;
(c) presentations had already been provided on the emergency care system and he had requested the Medical Director to provide a short presentation to support the UHL mortality report (Minute 277/13/4 below refers), and
(d) Executive Directors had been asked to improve the presentation of future Trust Board reports (and their accompanying cover sheets) to adopt a more concise and clear style.

The Acting Chief Executive highlighted the following issues for particular attention:-

(i) UHL's mortality rates had been re-based following changes in the comparative positions, and this would be explained in more detailed during the Medical Director's presentation (Minute 227/13/4 below refers);
(ii) the Care Quality Commission had assessed the Trust at a level 1 and an inspection was now expected early in 2014 (Minute 277/13/2 below refers), and
(iii) the implications of the Trust's half year end financial position for 2013-14 would be considered later in the agenda (Minute 281/13/1 below refers).

Resolved – that the verbal information provided by the Acting Chairman and the Acting Chief Executive be received and noted.

273/13/1 Appointments to Board Committees and Changes to the Empath and NHS Horizons Boards

The Director of Corporate and Legal Affairs introduced paper K, seeking Trust Board approval for the following appointments arising from the appointment of Mr R Kilner as

Acting Chair, Mr I Sadd as Non-Executive Director and Ms R Overfield as Chief Nurse:-

(a) Mr R Kilner, Acting Chair to temporarily stand down from membership of the Audit Committee and the Empath Board (while Acting Chair) and the Director of Finance and Business Services be appointed temporarily as the Trust's representative on the Empath Board;
(b) Mr I Sadd, Non-Executive Director be appointed to the membership of the Audit Committee, Charitable Funds Committee and the Finance and Performance Committee (succeeding Mr P Panchal, Non-Executive Director on the latter Committee); **DCLA**
(c) Mr P Panchal, Non-Executive Director be appointed as Chair of the Charitable Funds Committee;
(d) Ms K Jenkins, Non-Executive Director be appointed to the membership of the Quality Assurance Committee;
(e) confirmation of the voting and non-voting membership of the Charitable Funds Committee (as set out in paper K), and
(f) the appointment of the Chief Nurse to the membership of the NHS Horizons Board (succeeding the Director of Finance and Business Services).

Resolved – that (A) the proposed appointments to Board Committees, the Empath Board and the NHS Horizons Board be endorsed (as detailed in paper K), and

(B) the Director of Corporate and Legal Affairs be requested to amend the membership and terms of reference for the Audit Committee, Charitable Funds Committee, Finance and Performance Committee and Quality Assurance Committee accordingly. **DCLA**

274/13 MINUTES

Resolved – that the Minutes of the Trust Board meeting held on 26 September 2013 (paper L) be confirmed as a correct record.

275/13 MATTERS ARISING FROM THE MINUTES

Paper M detailed the status of previous matters arising, particularly noting those without a specific timescale for resolution. In discussion on the matters arising report, the Board received updated information in respect of the following items:-

(a) item 3 – Minute 249/13/1 of 26 September 2013 – the Medical Director advised that the appointment of CMG education leads was expected to be completed over the next 2 to 3 weeks and that meanwhile, the CMG management teams had been made aware of requirements for SIFT expenditure reports to be provided to the Associate Medical Director for Clinical Education;

(b) item 5 – Minute 251/13/1(c) of 26 September 2013 – the Chief Nurse advised that none of the delays in processing urgent Estates requests had been escalated to SUI status or logged as a health and safety concern. However, there had been occasions when the patient environment had not been as expected;

(c) item 6 – Minute 252/13/1 of 26 September 2013 – the Chief Nurse had not yet met with Ms K Jenkins, Non-Executive Director to consider the monitoring arrangements for risk 4 on the Board Assurance Framework; **CN**

(d) item 7 – Minute 222/13/2 of 29 August 2013 – the expected report consolidating the common themes arising from the Berwick and Keogh reviews and the Francis Inquiry had been withdrawn from today's agenda on the grounds that it did not respond to all of the Board's questions. The report would now be considered at the next Quality Assurance Committee meeting prior to presentation to the November 2013 Trust Board; **CN**

(e) item 8 – Minute 227/13/1 of 29 August 2013 – the Director of Marketing and Communications advised that the recently appointed CMG leaders had been invited to nominate their accountable leads for PPI engagement. The responses received to date indicated that this role might be undertaken by the lead nurse, but this option would be discussed in more detail at the forthcoming CMG time out on 1 November 2013; **COO/ DHR**

(f) item 9 – Minute 227/13(2) of 29 August 2013 – the Acting Chairman reflected on his consideration of opportunities to invite contributions from members of the public during the course of Trust Board meetings. He recognised the following key points:-

- the commitment demonstrated through regular attendance at Trust Board meetings by members of the public;
- the positive step taken today in appointing a non-voting co-opted representative from Healthwatch to the Trust Board;
- the distinction between a public Board meeting and a Board meeting which was held in public, and
- opportunities to invite questions at the start of each meeting or in writing in advance of each meeting,

concluding that questions would continue to be invited at the end of each meeting from the public gallery, but that any questions raised were expected to be made explicit from the outset without any lengthy pre-amble;

(g) item 10 – Minute 194/13 of 25 July 2013 – an updated Trust Board calendar of business and programme of Trust Board development would be presented to the 20 December 2013 Trust Board meeting; **DCLA**

(h) item 11 – Minute 199/13/1 of 25 July 2013 – the results of the Equality Audit would be included in the quarterly Workforce and Organisational Development update to be presented to the Trust Board on 20 December 2013, and **DHR**

(i) item 12 – Minute 167/13/3 of 27 June 2013 – the Chief Executive had advised that there was not likely to be a further LLR-wide response to the Francis Inquiry.

Resolved – that the update on outstanding matters arising and the associated actions above, be noted. **NAMED EDs**

276/13 REPORTS BY THE ACTING CHIEF EXECUTIVE

276/13/1 Monthly Update Report – October 2013

The Acting Chief Executive introduced paper N, the Chief Executive's monthly summary of key issues. Noting that separate reports featured elsewhere on the Trust Board agenda in respect of financial performance and facilities management service provision, he drew members' attention to the following issues:-

(i) Emergency Care performance (as detailed in the reports and presentations received under Minute 272/13 above);
(ii) confirmation of the TDA's recently published level 4 (material issue) performance rating for the Trust, and
(iii) publication of Monitor's 2014-15 tariff consultation document.

Resolved – that the Chief Executive's monthly update report for October 2013 be received and noted.

277/13 CLINICAL QUALITY AND SAFETY

277/13/1 Contrasting Experiences – the Role of the Meaningful Activity Facilitator

The Chief Nurse introduced paper O detailing the arrangements for this new role which was being trialled currently on wards 19, 32 and 37 at the LRI as part of the Quality Commitment workstream for improving the care for older people in hospital. The activities provided were aimed to support hospital inpatients suffering from dementia by providing them with cognitive stimulation to support their physical, sensory and psychological well-being.

Ms R Doyle, Meaningful Activities Co-Ordinator attended the meeting to provide Board members with an insight into her role and demonstrated some of the practical ways in which patients had been made to feel more at ease in the hospital setting. Members noted the wide ranging benefits that psychological improvements had made in terms of reducing agitation and breaking down cycles of behaviour which were acting as a barrier to providing effective care.

Trust Board members commended this excellent initiative and thanked Ms Doyle for attending the meeting. The following comments and queries were raised:-

(a) the Director of Marketing and Communications suggested that Professor A Burns, the National Lead for Dementia Care might be interested to hear about this workstream, following his recent presentation at the King's Fund Silver Book Summit. The Chief Nurse agreed to contact Professor Burns accordingly; **CN**
(b) Mr P Panchal, Non-Executive Director welcomed this initiative in the context of changing population demographics, suggesting that appropriate investment from core NHS funds be sought urgently following the detailed evaluation of patient outcomes evidence in January 2014;
(c) the Acting Chairman queried the scope to provide weekend meaningful activity support as part of the wider implementation arrangements;
(d) the Medical Director sought further information on the training that Ms Doyle had received to undertake this role. In response, Ms Doyle reported on the extensive learning she had received through practical experience, other ward based HCAs, challenging behaviour courses, dementia training, seminars on dementia friendly environments, a visit to another Trust in Bradford, liaison with Age UK and the Alzheimer's Society and her own research. The Medical Director noted opportunities to develop a more structured approach to the future training programme for this role;
(e) the Chief Nurse confirmed that the person specification and job description were being formalised with a view to implementation of the wider roll out of this service;
(f) the Director of Finance and Business Services recognised the tangible benefits of moderating patients' behaviour, noting that preventing the downward spiral of challenging behaviour would also impact upon improved patient experience and reduced length of stay for affected patients, and
(g) the Director of Human Resources noted the enthusiasm with which the meaningful activities programme was being delivered and undertook to share this positive development with colleagues from the Leicestershire Partnership NHS Trust at the next meeting of the LLR Workforce Group. **DHR**

<u>Resolved</u> – that (A) the presentation on meaningful activities for dementia patients be received and noted, and

(B) the Chief Nurse and the Director of Human Resources be requested to highlight this positive initiative to the National Lead for Dementia Care and the LLR Workforce Group (respectively). **CN/ DHR**

277/13/2 <u>Care Quality Commission (CQC) Intelligent Monitoring</u>

The Chief Nurse and the Medical Director introduced paper P, briefing the Trust Board on the new CQC surveillance model and the outcome of the October 2013 review which had identified 5 risks and 5 elevated risks for UHL out of the 150 indicators analysed.

Consequently the Trust had been placed in risk category 1 (the highest risk rating) and would now be 1 of 19 trusts to be inspected as part of the wave 2 inspection programme being carried out between January and March 2014.

The Medical Director summarised the Trust's response to the risks and elevated risks (as set out in section 4.2 of paper K), particularly noting the importance of accurate clinical coding in respect of death rates from low risk diagnosis groups and the maternity outlier alert in respect of puerperal sepsis and other puerperal infections. In addition, the Director of Human Resources highlighted the statistical anomaly surrounding staff transfers to the outsourced IM&T and Facilities Management providers, noting that these had contributed to the Trust's composite risk rating for staff turnover.

The Healthwatch representative sought and received assurance that significant progress was being made with the areas of risk identified by the CQC and that robust plans were in place to address any remaining concerns.

Resolved – that (A) the briefing paper on the outcome of the CQC intelligent monitoring process be received and noted, and

(B) further reports be provided to the Quality Assurance Committee and the Trust Board regarding the arrangements for the forthcoming CQC inspection. **CN**

277/13/3 Update on LLR Response to Francis Inquiry and UHL Response to Keogh and Berwick Reviews

Resolved – that the expected update on responses to the Francis Inquiry and the Keogh and Berwick reviews be deferred to the November 2013 Trust Board meeting. **CN**

277/13/4 UHL Mortality Review Report – Saving Lives Update

Paper R provided a detailed summary of UHL's current and historical mortality performance and the actions being taken under the "Saving Lives" workstream of the Quality Commitment which aimed to save an extra 1,000 lives over the next 3 years. The Trust Board noted that UHL's Hospital Standardised Mortality Ratio (HSMR) for 2012-13 was 101 – slightly above the average of 100, but within the expected range. Within the Trust level data, there were differences between the hospital sites which were noted to be 114 for Leicester Royal Infirmary, 81 for Leicester General Hospital and 82 for Glenfield Hospital.

In addition, the Medical Director provided a presentation reminding members of the various ways in which mortality rates were measured and the national correlation between hospital sites with and without accident and emergency facilities. Copies of the presentation slides were circulated to Trust Board members following the meeting. In discussion following the presentation:-

(a) Ms J Wilson, Non-Executive Director referred to the "tree chart" provided in section 7.3 of paper R (showing the diagnosis groups contributing to the Trust's HSMR) and sought additional information regarding the areas for future focus. In response, the Medical Director advised that the size of each diagnosis box and the depth of the colour indicated the number of deaths and the relative risk (respectively). He briefed members on the arrangements already in place to divert appropriate respiratory admissions to Glenfield Hospital and similar proposals for patient streaming within the chest pain pathway. These proposals were currently awaiting approval by the East Midlands Ambulance Service (EMAS). He also stressed the importance of accurate clinical coding within each diagnosis and noted that HMSR did not take into account patient acuity (ie the severity of the condition);
(b) Ms J Wilson, Non-Executive Director also sought and received additional information regarding the arrangements for improving performance in respect of responding to

sepsis, and noted that this was being progressed as a new Critical Safety Action and would be escalated accordingly;

(c) Dr T Bentley, CCG representative noted the impact of some "end of life" patients being coded with the diagnosis of pneumonia and then being transferred to the appropriate end of life pathways. He reported on the arrangements for improving end of life care plans for those patients who chose to die outside of the hospital setting;

(d) the Medical Director advised that frail elderly patients approaching the end of their life were often diagnosed with urinary tract or chest infections but this was not always the primary cause of death;

(e) the Chief Nurse highlighted the contribution that good nursing leadership and appropriate nurse to bed staffing ratios could make in improving patient outcomes;

(f) Mr P Panchal, Non-Executive Director challenged whether the Trust's 4 hour ED performance had contributed to the elevated HSMR data on the LRI site, and

(g) in response to a query raised by the Acting Chairman, the Medical Director confirmed that elective mortality on the LGH site was within the expected range. **MD**

<u>Resolved</u> – that (A) the update on UHL's mortality be received and noted, and

(B) reports on UHL's Mortality and progress with the Saving Lives workstream continue to be presented to the Trust Board for assurance. **MD**

277/13/5 <u>Nursing Workforce Update</u>

The Chief Nurse introduced paper S, providing an overview of UHL's nursing workforce position following recent ward staffing reviews which had resulted in additional investment of £5.9m being built into ward nursing budgets. Table 4 on page 5 of the report detailed the number of reported nurse vacancies each month over the last 12 months and members noted that as at the end of September 2013, there had been 500 vacant posts. Staff turnover rates and the current recruitment schedule were provided at appendix 5 and appendix 6 respectively.

The Chief Nurse expressed her view that approximately half of these vacancies would be filled by March 2014 and use of bank and agency nurses was expected to continue in the interim period. In parallel, arrangements were being made to free up more nursing time on the wards and any gaps in shifts were being monitored twice daily (including weekends). A copy of a recent report to the Executive Strategy Board was also appended to paper S, outlining the criteria for wards requiring special support. In discussion on the nursing workforce update, the Board noted:-

(a) the work taking place to increase visibility of ward staffing levels to patients and visitors on the wards via notice boards at the entrance which stated the ward level establishment and the actual number of staff on duty for each shift;

(b) that name badges were being ordered for all nurses to wear on their lapel as a Listening into Action "quick win". These badges would help to clearly identify individuals and their position held. The Medical Director advised that colour coding had been recently introduced for medical staff ID badges and lanyards;

(c) that many other Trusts were also undertaking overseas nursing recruitment campaigns due to national shortages of trained nurses, and

(d) the recruitment campaigns and associated training courses offered with a view to attracting qualified nurses back into the profession following a career break.

Ms J Wilson, Non-Executive Director confirmed that the Quality Assurance Committee would be monitoring the nursing workforce position on a regular basis and she queried what the process would be for monitoring the wider workforce. The Acting Chairman undertook to consider these governance arrangements with the Chief Executive at his next 1 to 1 meeting. **ACTING CHAIR**

Resolved – that (A) the update on the UHL Nursing Workforce be received and noted, and

(B) the Acting Chairman be requested to consider the governance arrangements for monitoring the Trust's wider workforce with the Chief Executive outside the meeting. **ACTING CHAIR**

277/13/6 Deed of Gift Donation for Scalp Cooling Package

The Director of Marketing and Communications presented paper T, which sought Trust Board approval (as Corporate Trustee) to accept a deed of gift from the national Breast Cancer Charity "Walk the Walk" for up to £250,000 to enable the Chemotherapy service to purchase approximately 15 scalp cooling caps. The cooling caps were designed to reduce hair loss for patients undergoing chemotherapy.

Resolved – that (A) the Deed of Gift from the Breast Cancer Charity "Walk the Walk" for the purchase of scalp cooling caps (as set out in paper T) be endorsed, and

(B) the Acting Chairman be authorised to sign the Deed of Gift and apply the Trust's seal accordingly. **ACTING CHAIR**

278/13 RISK

278/13/1 Board Assurance Framework (BAF) Update

The Chief Nurse presented the latest iteration of UHL's BAF (paper U) and Mr R Manton, Risk and Safety Manager attended the meeting for this item. The Board noted that there had been no new risks added to the BAF this month, but an additional risk relating to ward level staffing would be included for consideration at the 28 November 2013 meeting. In respect of the 3 risks selected for detailed consideration at today's meeting, the Trust Board noted the following information:-

- risk 12 – failure to exploit the potential of IM&T – the Director of Finance and Business Services reported that a number of IT systems were nearing the end of their life and that replacement systems were currently being considered. Confirmation was provided that the ERDM and EPR projects were progressing appropriately now that the Trust's Chief Medical Information Officers were both in post;
- risk 13 – failure to enhance education and training culture – the Acting Chair queried whether there were opportunities to revise the likelihood rating for this risk but the Medical Director suggested that this might be premature as good progress was being made by the CMG teams towards identifying their education leads and improving engagement in education and training issues, and
- risk 1 – failure to achieve financial sustainability – the Director of Finance and Business Services advised that discussion on this risk would take place later in the agenda (Minute 281/13/1 below refers).

The Risk and Safety Manager reported that the action relating to section 1.17 in the action tracker provided at appendix 2 had now been completed and that this would be reflected in the next iteration of this report.

Resolved – that (A) the Board Assurance Framework (presented as paper U) be received and noted, and

(B) a new risk surrounding ward level staffing be included in the BAF report to be presented to the 28 November 2013 Trust Board meeting. **CN/RSM**

279/13 HUMAN RESOURCES

279/13/1 Implementation of the Clinical Management Structure

Further to Minute 248/13/1 of 26 September 2013, paper V provided a progress report on the implementation of the new Clinical Management Groups (CMGs), noting that recruitment to the CMG Clinical Leads, General Managers and Heads of Nursing was largely complete and that the supporting structures underneath that level were being finalised within the next phase of the work plan. A facilitated event was being held for the CMG leaders on 1 November 2013 in order to establish the objectives and expectations and identify any developmental support that might be required to achieve them. A copy of the updated risk assessment was provided at appendix 1.

The Acting Chairman queried whether there had been sufficient visibility externally of the new CMG arrangements, noting that Dr T Bentley, CCG representative did not recall seeing any communications on this theme. The Director of Marketing and Communications confirmed that an article had been included in the last GPs' newsletter and that a new organisation chart was being tested which might be capable of providing photographs alongside the names of key post holders.

Resolved – that (A) the update on implementation of UHL's Clinical Management Group structure be received and noted;

(B) a final report on the implementation of the new Clinical Management Structure be provided to the 31 October 2013 Trust Board meeting. **DHR**

280/13 RESEARCH AND DEVELOPMENT

280/13/1 Quarterly Update on Research and Development

Further to Minute 198/13/1 of 25 July 2013, Professor N Brunskill, Director of Research and Development attended the meeting to introduce paper W, the quarterly update on research and development activities and current related challenges. Members noted that UHL featured in the NIHR "first division" (out of 4) in respect of high-class clinical research activity outputs and the Trust was working hard to retain this ranking. 111 new clinical trials had been reported for quarter 1 and recruitment to portfolio trials was progressing well with 5505 patients already recruited against the year-end target of 8381. The monthly NIHR activity report was appended to paper W for members' information.

The Trust currently hosted 3 Biomedical Research Units (BRUs), the Collaboration for Leadership in Applied Health Research and Care (CLAHRC) for the Leicestershire, Northamptonshire and Rutland area and the East Midlands Clinical Research Network (EMCRN). A Clinical Director for the EMCRN was due to be appointed during November 2013. Confirmation was provided that effective patient and public involvement took place in respect of research. Section 3 of paper W set out the challenges in supporting the BRUs to achieve their stated objectives and create a credible application for the NIHR Biomedical Research Centre. The R&D Office was noted to be working with the new Clinical Management Group teams to appoint R&D leads to embed the R&D culture within the Trust.

The Acting Chairman sought specific examples of any support services which might be limiting the Trust's ability to deliver the full R&D potential. In response, the Director of R&D highlighted some of the challenges previously experienced in respect of Pharmacy and Imaging services, although the new CMG structure was expected to support improved partnership working. The Chief Operating Officer undertook to advise the Clinical Supporting and Imaging CMG management team of these concerns. **COO**

Finally, the Medical Director highlighted the Trust Board's accountability (as the host Trust) for monitoring performance of the EMCRN and he agreed to liaise with the Director of Corporate and Legal Affairs to ensure that future quarterly reports to the Trust Board

properly described how the Trust was discharging its responsibilities in this regard.

<u>Resolved</u> – that (A) the quarterly update on Research and Development be received and noted (paper W refers);

(B) the Chief Operating Officer be requested to advise the Clinical Supporting and Imaging CMG management team of concerns raised by the Director of Research and Development, and **COO**

(C) the Director of Research and Development be requested to ensure that future quarterly reports properly described how the Trust was discharging its responsibilities for monitoring performance of the EMCRN. **DR&D/ MD**

281/13 QUALITY AND PERFORMANCE

281/13/1 <u>Month 6 Quality, Performance and Finance Report</u>

Paper X, the quality, performance and finance report for month 6 (month ending 30 September 2013) advised of red/amber/green (RAG) performance ratings for the Trust, and set out performance exception reports in the accompanying appendices. Ms J Wilson, Non-Executive Director and Quality Assurance Committee (QAC) Chair briefed Trust Board members on the following points, as considered at the 29 October 2013 QAC meeting:-

- the UHL Quality Commitment was due to be formally re-launched at the November 2013 QAC meeting and a schedule of Trust Board presentations would be prepared, and
- the Clwyd report on complaints handling was due to be considered in depth by the Executive Team and the QAC.

The Acting Chief Executive noted a correction to the table of NTDA indicators provided on page 2 of paper X, advising that there had been no maternal deaths during the 2013-14 year to date. The Medical Director reported on a Never Event involving human error in selection of the correct lens for a patient undergoing an ophthalmology procedure. Once the investigation had been completed, a detailed report would be presented to the QAC on this Never Event.

Papers X1 and X2 provided the Minutes of the QAC and Finance and Performance Committee meetings held on 25 September 2013 for noting.

The Chief Nurse reported on the quality and patient safety issues outlined in section 3 of paper X, noting that trends relating to pressure ulcer incidence and patient falls were reducing, but Clostridium Difficile performance remained challenging although this was within the agreed threshold. Dr T Bentley, CCG representative queried the impact of the discharge experience workstream being 4 months behind schedule and noted that this delay referred to the patient experience survey process rather than the discharge process itself which was being progressed through the Quality Commitment.

Ms J Wilson, Non-Executive Director reported verbally on the Finance and Performance Committee's consideration of the Trust's month 6 operational performance position at the meeting held on 30 October 2013. Noting that the meeting had been chaired by the Acting Chairman, she drew the Board's attention to the following key issues:-

- recovery plans provided in respect of the Trust's Ophthalmology service and the backlog of clinic letters;
- operational performance for admitted and non-admitted 18 weeks RTT, and
- continued improvements in performance against cancer targets. She commended the significant contribution of Mr M Metcalfe, Cancer Centre Lead Clinician in this respect and highlighted opportunities for organisational learning from this improvement process.

The Chief Operating Officer reported on the key operational performance issues reflected in section 5 of paper X, highlighting the actions to address 6 key challenges within the Ophthalmology service, RTT backlogs, cancelled operations and emergency care activity. A plan was being developed in order to outsource some elements of elective care activity to the private sector. Cancer performance targets had all been met with the exception of the 2 week wait symptomatic breast cancer target (although 2 additional patients being seen within their 2 week thresholds would have resulted in this target being delivered for September 2013). Confirmation was provided that all cancer targets had been achieved for October 2013.

The Director of Marketing and Communications commented that issues relating to the Ophthalmology service had been raised regularly at the quarterly meetings held between UHL and Healthwatch and the Chief Nurse suggested that the forthcoming CQC visit was likely to focus upon patient care aspects of this high volume service.

The Director of Human Resources reported on section 6 of paper X, highlighting disappointing performance in respect of appraisal rates and the discussions underway with the CMG and Corporate Directorate teams to understand the causes and seek assurance of recovery plans. Three new e-learning packages were due to be launched to support improvements in statutory and mandatory training compliance. Discussion took place regarding the expected seasonal variation in sickness absence rates, progress with the flu vaccination programme and the definition of front line clinical staff – as the Trust was expected to vaccinate at least 75% of this staff group. A correction to page 28 was noted, in that the number of UHL staff receiving counselling from Amica was almost 100 (not 1,000 as stated).

The Director of Finance and Business Services briefed members on the status of contractual queries as highlighted in section 7 of paper X, noting the different levels of penalties being enacted for service line penalties for individual specialties and the organisation wide penalties resulting in 2% of the overall contract being levied.

Section 8 of paper X reported performance against the Facilities Management key performance indicators and provided an update on the process to review and implement improvements with a particular focus on cleaning and ward level patient catering. The Chief Nurse advised that changes to the style of reporting would be implemented for the November 2013 Trust Board meeting to evidence trends over the past 6 months. She noted that, recently, there had been some evidence of improved service delivery.

A range of meal deal options had been introduced to mitigate concerns regarding the pricing structure of retail catering, staff only areas had been created within the restaurants and progress towards re-instating the water coolers was being made. The Board sought and received assurance that the quality of patient meals was good and this had been confirmed by patient satisfaction surveys. However, menus were being further reviewed to adopt more of the options which suited steam heating methods best.

Paper X3 provided the results of the September 2013 Patient Led Assessment of the Care Environment (PLACE). Members noted that a contractual issue was being followed up to address the 2 hour window for delivering patient meals to the ward, which was compliant contractually but was considered too wide for patient experience and operational reasons. Key actions arising from the PLACE results were due to be considered at a meeting with Interserve and Horizons on Monday 4 November 2013.

Section 9 of the report provided highlights of the IM&T service delivery. The Director of Finance and Business Services invited any questions on this section, noting that a more robust set of indicators would be introduced for the November 2013 Trust Board meeting.

Ms J Wilson, Non-Executive Director reported verbally on the Finance and Performance Committee's consideration of the Trust's month 6 financial performance position at the meeting held on 30 October 2013, noting that the year to date income and expenditure position was £16m adverse to plan and that approximately £15m of additional funding assumed within the Annual Operational Plan would not now be forthcoming. The Committee had recommended that the Board considered a month 7 re-forecast at the 28 November 2013 meeting to include a careful consideration of all available options to deliver a break-even year end position and an appropriate recognition of any associated quality and patient safety implications.

The Director of Finance and Business Services reminded Board members of the context of the current challenges within the healthcare environment and the substantial changes made recently to the Commissioning side of the NHS. He particularly highlighted challenges related to Specialised Commissioning which equated to approximately 1/3 of UHL's potential activity. Members noted that the Trust's income lines remained flat and operational expenditure continued to overspend in the areas of pay and non-pay with substantial sums being incurred for ED and non-contracted staffing. Pay costs were beginning to reduce although not in line with the Trust's financial recovery plans.

The Director of Finance and Business Services tabled copies of paper X4 at the meeting, providing an assessment of the Trust's half year review of financial performance and setting out recommendations for the forecast outturn. The Executive Performance Board and the Finance and Performance Committee had review the projected position alongside the Trust's statutory duty to achieve a break-even position. It had been agreed that a further review of the CMG and Corporate recovery plans would be held in November 2013 and that a reforecast would be prepared for further discussion with the NTDA and submission to the 28 November 2013 Trust Board meeting. During the discussion on paper X4, the Board:-

(i) considered any potential requirements for public consultation in respect of proposed recovery actions;
(ii) queried the significance of the £3m penalties for readmissions and whether other Trusts had been affected by similar levels of penalties, and
(iii) challenged the scope for UHL to seek financial reimbursement for delayed transfers of care to non-acute providers.

<u>Resolved</u> – that (A) the quality, performance and finance report for month 6 (month ending 30 September 2013) be noted;

(B) the Director of Finance and Business Services be requested to present the 28 November 2013 Trust Board meeting with a range of options to address the in-year and longer term financial position and the related risks; **DFBS**

(C) the Trust shares the revised position and the underlying assumptions with the TDA and seeks advice regarding the revised forecast; **CE/DFBS**

(D) the Minutes of the 25 September 2013 Quality Assurance Committee meeting (paper X1) be received and noted, and

(E) the Minutes of the 25 September 2013 Finance and Performance Committee meeting (paper X2) be received and noted.

281/13/2 <u>NHS Trust Over-Sight Self Certifications</u>

The Director of Corporate and Legal Affairs introduced UHL's self certification returns for August 2013 (paper AA refers) and invited any comments or questions on this report. The Director of Finance and Business Services noted the comments provided in section 10 (relating to ED and RTT performance) and he queried the scope to include some additional **ACTING CHAIR/**

wording within section 6 regarding the recommendation for the Trust Board to receive a month 7 re-forecast at the 28 November 2013 meeting. **ACTING CE**

Subject to the above amendment, the October 2013 self certification against Monitor Licensing Requirements (appendix A), and Trust Board Statements (appendix B) were endorsed for signature by the Acting Chairman and the Acting Chief Executive and submission to the TDA accordingly.

Resolved – that subject to additional wording regarding the proposed month 7 re-forecast, the NHS Trust Over-Sight Self Certification returns for October 2013 be approved for signature by the Acting Chairman and Acting Chief Executive, and submitted to the TDA as required. **ACTING CHAIR/ ACTING CE**

281/13/3 Annual Operational Plan (AOP) Quarter 2 Review

Paper BB provided a high level overview of performance against the actions identified in the Trust's 2013-14 AOP and the Director of Finance and Business Services recorded his appreciation to Ms H Seth, Head of Planning and Business Development for preparing this report.

Ms J Wilson, Non-Executive Director sought additional information regarding the arrangements for sharing the contents of this report with the wider workforce and members of the public. The Director of Marketing and Communications responded by highlighting the separate engagement work in relation to emergency care and financial performance, confirming that this report featured on the Trust's external website alongside the other public Trust Board papers. Board members expressed their views that the Trust's progress was worthy of note in the Annual Report and the Chief Executive's monthly briefings.

Resolved – that (A) the quarter 2 AOP progress report (paper BB) be received and noted, and

(B) consideration be given to including extracts from the report within the Trust's Annual Report and the monthly Chief Executive's briefings. **DMC**

282/13 TRUST BOARD BULLETIN – OCTOBER 2013

Resolved – that the Trust Board Bulletin report containing declarations of interest, Trust Board meeting dates for 2014 and a briefing note on the Keogh review (paper CC) be received for information.

283/13 QUESTIONS AND COMMENTS FROM THE PUBLIC RELATING TO BUSINESS TRANSACTED AT THIS MEETING

The following question was received from Mr G Smith, Patient Adviser, regarding the business on the Trust Board meeting agenda:-

- was the Trust aware that the slow progress in determining the accountable leads for patient and public involvement (PPI) within the new clinical management structure communicated the message that this was seen as a low priority within the organisation?

In response to this question, the Director of Marketing and Communications noted that this was the third occasion that the requester had raised this particular issue and that separate correspondence had already taken place on this issue. He provided assurance that the senior CMG leadership team had been appointed as the first phase and that upon completion of this phase, the new CMG leaders had been asked to identify the appropriate leads within their own CMG. The Acting Chairman noted that a similar process had been adopted for appointing the research and development and education leads. It was also

noted that PPI leadership would also be considered at the facilitated CMG event to be held on 1 November 2013.

Resolved – that the comments above and any related actions, be noted.

284/13 ANY OTHER BUSINESS

Resolved – that there were no items of any other business.

285/13 DATE OF NEXT MEETING

Resolved – that (A) the next Trust Board meeting be held on Thursday 28 November 2013 in the Cumulus Room, Diabetes Centre of Excellence, Leicester General Hospital, and

(B) the rescheduled date for the December 2013 Trust Board meeting be noted as Friday 20 December 2013 in Seminar Rooms 2 and 3, Clinical Education Centre, Glenfield Hospital.

The meeting closed at 4.28pm

Kate Rayns,
Trust Administrator

Cumulative Record of Members' Attendance (2013-14 to date):

Name	Possible	Actual	% attendance	Name	Possible	Actual	% attendance
R Kilner (Acting Chair from 26.9.13)	8	8	100	R Overfield	2	2	100
J Adler	8	7	88	P Panchal	8	7	88
T Bentley*	7	3	43	I Reid	4	4	100
K Bradley*	8	6	75	C Ribbins	4	4	100
I Crowe	4	3	75	I Sadd	1	1	100
S Dauncey	1	1	100	A Seddon	8	8	100
K Harris	8	8	100	J Tozer*	3	2	66
S Hinchliffe	2	2	100	S Ward*	8	8	100
M Hindle (Chair up to 26.9.13)	7	7	100	M Wightman*	8	7	
K Jenkins	8	7	88	J Wilson	8	7	88
R Mitchell	4	4	100	D Wynford-Thomas	8	3	38

* non-voting members

University Hospitals of Leicester NHS Trust

Trust Board Paper L

Progress of actions arising from the Trust Board meeting held on Thursday 31 October 2013

Item No	Minute Reference	Action	Lead	By When	Progress Update	RAG status*
1	277/13/1	Meaningful Activities initiative for dementia patients to be highlighted to the National Lead for Dementia Care and the LLR Workforce Group.	CN/DHR	28.11.13	**Verbal update to be provided at the 28 November 2013 Trust Board.**	
2	277/13/5	Acting Chairman and Chief Executive to consider the governance arrangements for monitoring the Trust's workforce.	Acting Chair/CE	28.11.13	**Verbal update to be provided at the 28 November 2013 Trust Board.**	
3	280/13/1(b)	Chief Operating Officer to provide feedback to the CSI CCG regarding arrangements for Pharmacy and Imaging Services to support R&D workstreams.	COO	28.11.13	**Verbal update to be provided at the 28 November 2013 Trust Board.**	
4	280/13/1(c)	Future R&D reports to describe how the Trust was discharging its responsibilities for monitoring EMCRN performance.	MD/DR&D	30.1.14	To be incorporated into the next quarterly report on R&D issues.	4
5	281/13/1	Month 7 financial reforecast and range of options to address the in-year and longer term financial position to be presented to the November 2013 Trust Board. Revised position and the underlying assumptions to be shared with the TDA and appropriate advice to be sought	DFBS	28.11.13	Scheduled on the 28 November 2013 Trust Board agenda.	4
6	281/13/2	Additional wording to be included in the Over-Sight returns relating to the month 7 reforecast prior to submission to the TDA.	DCLA/Acting Chair/CE	31.10.13	Actioned.	5
7	281/13/3	Consideration to be given to including extracts from the AOP Q2 review within the annual report and CE briefings.	DMC	28.11.13	Extracts covering progress against quality and performance standards included within the November 2013 Chief Executive's briefing submitted to this meeting.	5

Matters arising from previous Trust Board meetings

Item No	Minute Reference	Action	Lead	By When	Progress Update	RAG Status*
26 September 2013						
8	249/13/1	Letters requesting expenditure reports for SIFT resources to be re-circulated to the new CMG education leads.	MD/AMD	31.10.13	CMG management teams have been informed of the requirements, pending the	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***

Item No	Minute Reference	Action	Lead	By When	Progress Update	RAG Status*
					appointment of CMG education leads.	
9	251/13/1(c)	Chief Nurse to explore whether any of the delays in processing urgent Estates requests had resulted in any patient quality or safety issues.	CN	31.10.13	Assurance provided at 31 October 2013 Trust Board that no SUIs or Health and Safety concerns had arisen from delays.	5
10	252/13/1	Chief Nurse to respond to Ms K Jenkins outside the meeting regarding the monitoring arrangements for risk 4.	CN	~~31.10.13~~ 28.11.13	**Verbal report to be provided on 28 November 2013.**	
29 August 2013						
11	222/13/2	Consolidated report on the common themes arising from Berwick, Keogh and Francis Reviews to be presented to the September 2013 Trust Board meeting.	MD/CN	~~26.9.13~~ 28.11.13	Report re-scheduled on the 28 November 2013 Trust Board agenda to allow for additional input by the Chief Nurse.	5
12	227/13(1)	Mechanism for Patient and Public Involvement to be clarified within the new Clinical Management Structure.	COO/DHR/DMC	~~26.9.13~~ 28.11.13	Verbal report provided at the 31 October 2013 meeting. **Verbal report to be provided on 28 November 2013.**	4
13	227/13(2)	Chairman to update the Trust Board on the consideration of opportunities for members of the public to contribute to Trust Board discussions during the course of the meeting.	Chairman	~~26.9.13~~ 31.10.13	Acting Chairman confirmed at the 31 October 2013 Trust Board meeting that questions from stakeholders and members of the public relating to items on the Board agenda would continue to be raised at the end of each meeting.	5
25 July 2013						
14	194/13	Updated Trust Board calendar of business to be circulated to Trust Board members.	DCLA	~~30.8.13~~ ~~30.9.13~~ 20.12.13	Updated Trust Board calendar of business to be submitted to the Trust Board on 20 December 2013.	4
15	199/13/1	The results of the Equality Audit to be provided to the Trust Board in December 2013, with any urgent issues being highlighted to the Audit Committee Chair in the interim period.	DHR	30.12.13	To be included in the quarterly Workforce and OD Trust Board update scheduled on the 20 December 2013 Trust Board agenda.	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***

Trust Board Paper M

To:	**Trust Board**
From:	**CHIEF EXECUTIVE**
Date:	**28 November 2013**
CQC regulation:	N/A

Title:	**MONTHLY UPDATE REPORT – NOVEMBER 2013**

Author/Responsible Director: Director of Corporate and Legal Affairs

Purpose of the Report: To brief the Board on key issues and identify important changes or issues in the external environment.

The Report is provided to the Committee for:

Decision		Discussion	√
Assurance	√	Endorsement	

Summary / Key Points: The report identifies a number of key Trust issues and important changes or issues in the external environment.

Recommendations: The Board is asked to consider the report, and the impact on the Strategic Direction and Board Assurance Framework (if any) and decide if updates to either are required.

Previously considered at another corporate UHL Committee? No

Strategic Risk Register: No	**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: None

Requirement for further review? The Chief Executive will report monthly to each public Board meeting.

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST

REPORT TO: **TRUST BOARD**

DATE: **28 NOVEMBER 2013**

REPORT BY: **CHIEF EXECUTIVE**

SUBJECT: **MONTHLY UPDATE REPORT – NOVEMBER 2013**

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1. In line with good practice (as set out in the Department of Health Assurance Framework for Aspirant Foundation Trusts : Board Governance Memorandum), the Chief Executive is to submit a written report to each Board meeting detailing key Trust issues and identifying important changes or issues in the external environment.

2. For this meeting, the key issues which the Chief Executive has identified and upon which he will report further, orally, at the Board meeting are as follows:-

(a) the Trust's financial position as at month 7 2013/14;

(b) emergency care performance; the emergency floor development; and the end of phase 1 urgent and emergency care review report published on 13th November 2013 by NHS England, "Transforming Urgent and Emergency Care Services in England";

(c) the forthcoming Care Quality Commission (CQC) inspection, which will commence on Monday, 13th January 2014;

(d) the ongoing review of the Trust's FT timeline which is being led by Ms Kate Shields, newly appointed Director of Strategy, who took up her post on 4th November 2013;

(e) the NHS Strategic and Operational Planning Guidance published on 4th November 2013 by the NHS Trust Development Authority, NHS England, Monitor and the Local Government Association;

(f) the 'refreshed' Government Mandate to NHS England : 2014-15, published on 12th November 2013;

(g) the Government's full response to the 290 recommendations made by Robert Francis QC following the public inquiry into the failings at Mid Staffordshire NHS Foundation Trust, published on 19th November 2013.

3. The Trust Board is asked to consider the Chief Executive's report and, again, in line with good practice, consider the impact on the Trust's Strategic Direction and decide whether or not updates to the Trust's Board Assurance Framework are required.

John Adler
Chief Executive

20th November 2013

N

Trust Board Paper N

To:	**Public Trust Board**
From:	**Chief Executive**
Date:	**28 November 2013**
CQC regulation:	**All applicable**

Title: Emergency Floor Outline Business Case

Author/Responsible Director: Nicky Topham- Project Director, Chris Turner- Project Manager, John Adler- Chief Executive

Purpose of the Report:
Following the Trust Board Development session on 21st November, this paper is being presented to request that the Trust Board:

- **Approve** The Emergency Floor Outline Business Case.
- **Delegate** authority to the Chief Executive to decide on the pace at which we mobilise enabling works - in consultation with the Acting Chair and having regard to the views of the NTDA - and with a report on the outcome to be notified to the Trust Board at the earliest opportunity
- **Support** the project team progressing the Full Business Case post internal OBC approval and prior to NTDA formal approval to maintain programme.

The Report is provided to the Trust Board for:

Decision	X	Discussion	
Assurance		Endorsement	

Summary / Key Points:

1. Attached is the Outline Business Case (OBC).
2. The project was initiated following feedback from ECIST and identifying drivers for change.
3. Clinical model was developed and agreed in full liaison with all Emergency Floor lead clinicians and approved by the Project Steering Group and Board, as well as being shared with the Urgent Care Board.
4. The Schedules of Accommodation have been worked up using current and projected activity data and objectively challenged by independent Health Care Planners.
5. Room size comparisons indicate a significant change between that currently utilised and that proposed. There has been deviation to Health Building Notes to ensure value for money whilst maintaining clinical functionality and flexibility in design.
6. The SOC was submitted for approval in July 2013 to the NTDA and projected a required emergency floor space of approximately 7,200m^2 in line with an affordability envelope of £38 – 43m excluding enabling works.
7. Feedback from the NTDA expressly requires an OBC, including enabling works. This was a

deviation in procurement to that outlined at SOC stage, where the NTDA endorsed a route straight through to the Full Business Case.

8. The Better Care Together Programme commissioned Mckinsey's to undertake a financial modelling exercise, which challenged the Health Community to reduce emergency admissions by 30%. This is felt to be too dramatic a reduction:
    - The single front door has already deflected all "minor injuries and illnesses" into the Urgent Care Centre setting so a significant left shift has already occurred.
9. Activity modelling has therefore been carried out using Emergency Department attendances and assessment activity (emergency admissions) separately to reflect the different trends in each.
    - For Emergency Department activity three scenarios were modelled: low (demographic growth only, c10% over 10 years), high (historic trend growth, c50% over ten years), and medium, as a halfway house (30% over 10 years).
    - Capacity has been modelled on the basis of the three scenarios and on current practice (current treatment times).
    - Capacity is provided to meet the requirement for medium growth with current practice, but also meets high growth provided improvements in treatment times are delivered (i.e. efficiencies).
    - The improvements in treatment time are expected to be driven by the model of care for the Emergency Floor (collocation of the Emergency Department with assessment, diagnostic imaging, pathology, pharmacy).
    - The high growth scenario is slightly tempered by playing in a 30% left shift of Urgent Care Centre activity into the community. However, this is a relatively small number compared to the overall growth in everything else (majors, minors, paeds, resus) so the net impact remains for the high scenario to have a greater overall Emergency Department workload than the medium scenario.
    - A left shift is not played into the assessment scenarios, which otherwise work in a similar fashion as above, except with slightly different growth rates (15%, 25% & 35%). However, there may be other patients who attend via ambulance (frail elderly) who could perhaps be treated in their own setting (remain in nursing home etc) but community services need to deliver this to prevent admissions. Current levels of attendances have therefore been used until such time as alternatives exist. In addition the number of Emergency Frailty Beds have increased to try to turn this population round at the front door negating admission to hospital so will be better able to deal with this group in the new build (currently 8 EFU beds, increasing to 16 beds in new model).
10. As part of the OBC process, a long list of 7 options was developed for clinical and technical appraisal, and as a consequence a short list of 3 was defined.
11. A full clinical, technical and financial appraisal was undertaken on the short list of options to identify a preferred option for detailed development at Full Business Case stage.
12. The preferred option was identified as 3A – Extension of current Emergency Department toward the Victoria building, incorporating demolition of the Langham Wing and Chapel.
13. This solution has the added advantage that wards can be added to it with additional floors providing flexibility for the future.
14. The OBC financial appraisal has indicated a whole project cost of approximately £48m representing works costs of £40m (including £4m pre construction fees) and enabling costs of £8m. This has potential to equate to a potential loan value of approximately £36m in conjunction with a £12m capital programme investment (for fees and enabling).

15. The preferred option has a far less complex approach to enabling works required, in comparison to the Balmoral option and as a consequence has significant financial and programme benefits.
16. Initial meetings on the preferred option with the Highways department have been very positive, with an agreed approach to widen the remit and incorporate a site wide parking solution. Interserve are developing an 'enterprise solution' for car parking, the commercial viability for which will be known in January. The Full Business Case for the parking solution will be developed by June, in line with Emergency Floor FBC.
17. Enabling works for the preferred option have been packaged into a number of different Work Packages to enable delivery and management:
    - Modular Ward (x1) development to replace Fielding Johnson
    - Relocation of Urgent Care Centre to outpatient 1 and 2 Clinics
    - Relocation of outpatient 1 and 2 Clinics to Modular accommodation pending the new hub
    - Utilisation of Oliver Ward, St Marks and St Lukes to provide office accommodation (currently housing medical records and IT equipment)
    - Re-utilisation of Diabetes outpatient accommodation for clinical genetics
    - Refurbishment of the old Linac Bunker for use
    - Re-opening of original Victorian entrance
    - Demolition of the chapel (potential risk in programme with Victorian Society and League of Nurses – need to retail artefacts)

18. Enabling works are to be funded from the UHL capital programme, and have been programmed for delivery between 2013/14 and 2014/15. This is possible with a revision in the current capital programme.
19. With approval to proceed before the Full Business Case is approved,, the delivery of the Enabling Works can be phased with completion in line with the project's programmed start date.
20. The project will be delivered in 2 phases – phase 1 will be the new Emergency Department, phase 2 will deliver the assessment areas.
21. Proceeding with enabling as soon as the OBC is approved by the Trust Board would result in delivery of phase 1, the new Emergency Department by October 2015:
    - Waiting for NDTA approval of the OBC would mean delivery in December 2015
    - Waiting for NDTA approval of the FBC will result in a July 2016 delivery of the Emergency Department.
    - Phase 2 would be delivered April 2016, August 2016 and January 2017.

22. The Trust Board will recall the discussion regarding the early delivery of the enabling schemes at the Trust Board Development Session; dialogue continues with the NTDA. So as not to delay progress with delivery of the Emergency Floor, the Board are recommended to delegate authority to the Chief Executive and having regard to the views of the NTDA to decide on the pace at which we mobilise works with regards to the enabling works - in consultation with the Acting Chair; with a report on the outcome to be notified to the Trust Board at the earliest opportunity. This will include consideration of:
    - The UHL capital programme
    - Confirmation of the level of risk being taken by undertaking the enabling works early

23. Once approved by the Trust Board, this OBC will be presented to the three CCG Trust Boards and the Urgent Care Board in December, whilst being forwarded to the NTDA for support.

Recommendations:

The Trust Board is asked to:

- **Approve** The Emergency Floor Outline Business Case.
- **Delegate** authority to the Chief Executive to decide on the pace at which we mobilise works with regards to the enabling works - in consultation with the Acting Chair and having regard to the views of the NTDA and with a report on the outcome to be notified to the Trust Board at the earliest opportunity
- **Support** the project team progressing the Full Business Case post internal OBC approval and prior to NTDA approval to maintain programme.

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

Resource Implications (e.g. Financial, HR)

Assurance Implications:

Patient and Public Involvement (PPI) Implications

Healthwatch and the Better Care Together Board, OSCs and Urgent Care Board, NTDA and NHS England.

Equality Impact Due regard assessment needed at project design stage

Information exempt from Disclosure

For further review?

Decision taken by Chief Executive in consultation with Acting Chair and having regard to the views of the TDA on early enabling works to be reported back to the Board, Full Business case to be reviewed in July 2014.

CAPITA

Interserve

University Hospitals of Leicester NHS
NHS Trust

property and infrastructure | health

Outline Business Case

Emergency Floor

November 2013

Version FINAL

Issue date 18th November 2013

Document Quality Management

Title	OBC Emergency Floor
Date	18/11/2013
Prepared by	Marianne Graham, Senior Consultant, Capita
Checked by	Michael Rope, Associate Director, Capita
Authorised by	Chris Turner, Director, Capita

Document History

Version	Date Issued	Brief Summary of Change	Author
1.0	24/09/13	Template	M Graham
1.1	1/10/13	Work in progress issued to C Turner Including draft Strategic Case (not formatted), with Strategic Case extracted to allow C Turner to issue for comment	M Graham
1.2	3/10/13	Input trust confirmed objectives and benefits and key deliverables. Draft Commercial case and Management Case	M Graham
1.3	4/10/13	Update strategic case for distribution	M Graham
1.4	8/10/13	Input weighted scores and complete the non financial component of economic case	M Graham
1.5	14/10/13	Input clinician feedback on strategic case	M Graham
1.6	15/10/13	Revise management case, commercial case and exec summary	M Graham
1.7	21/10/13	Exec Summary update	M Graham
1.8	23/10/13	Input Commercial case input	M Graham
1.9	28/10/13	Review and update strategy case re CQC standards	M Graham
1.10	31/10/13	Rework strategic case to show strategic case in two docs v1.10 and 1,10 without summarised strategic case appendix	M Graham
1.11	04/11/13	Format, QA, update exec summary and appendix	M. Graham
1.12		Update Appendix	M Graham
1.13	08/11/13	Input internal feedback and additional comments for client review	M Graham
1.14	11/11/13	Client review and input changes	M Graham
1.15	13/11/13	Formatting and input additional changes from client	M Graham
1.16	14/11/13	Final input of information and Trust feedback	M Graham
1.17	14/11/13	Additional iterations	M Graham
1.18	15/11/13	Addition of draft financial analysis	M Rope/ V Chalmers
1.19	15/11/13	Further iterations - typographical checks/updated commercial case	M Graham
1.20	15/11/13	Further iterations	M Rope
1.21	17/11/13	Final iterations, document check & internal sign off	C Turner
1.22	18/11/13	Final amendments from v1.21 checks	M Graham/M Rope

Contents

Figures and Tables

1 | Executive Summary

1.1 Introduction

This Outline Business Case (OBC) is for the redevelopment of the Emergency Department (ED), creating a new emergency floor on the Leicester Royal Infirmary site of University Hospitals of Leicester NHS Trust (UHL/The Trust). It proposes to develop an emergency floor concept that will address the demand challenges faced by both ED and assessment services, with the intention of developing a future proofed solution that will flexibly meet future demand over the next 10 years.

The Trust is one of the largest teaching Trusts in the country and operates across three main sites; Leicester Royal Infirmary, Leicester General Hospital and the Glenfield Hospital, and is the only acute Trust serving the diverse local population of Leicester, Leicestershire and Rutland (LLR); equating to approximately 1 million residents.

Figure 1A University Hospitals of Leicester NHS Trust Sites

Glenfield Hospital

Leicester General Hospital

Leicester Royal Infirmary

Leicester Royal Infirmary provides Leicestershire's only accident and emergency service (ED). The hospital has approximately 890 beds and is the base for the Trusts Children's Hospital and Urgent Care Centre (UCC).

In 2012 the Trust identified a number of services requiring redevelopment/development across their three sites to ensure ongoing enhancement and maintenance of essential health services to the local community. The Trust set up a Reconfiguration Programme Board to provide an integrated and strategic approach to developing, implementing and monitoring the delivery of the Trust reconfiguration plans. The UHL has ensured that this programme is significantly aligned to the Trust's Integrated Business Plan and its associated Foundation Trust application processes.

This business case focuses on the Emergency Floor Reconfiguration project. It highlights that current arrangements do not meet the current demands or the projected requirements over the next 5-10 years. Whilst process redesign has been undertaken within the existing footprint and built environment, it highlights that there is still an issue with the size of the emergency floor in its entirety and that it is deemed inadequate to cope with the demand. This OBC highlights the urgent need for change to the physical estate to create an emergency floor in order to improve patient flows, staff efficiencies, capacity issues and adjacencies.

1.2 Strategic Case

1.2.1 The Strategic Context

The Trust has seven organisational objectives which are:

- Provide safe, high quality, patient-centred healthcare
- Provide joined up emergency care
- To be the provider of choice
- Integrated care closer to home
- Enhanced reputation in research, innovation and clinical education
- To be a professional, passionate and valued workforce
- Sustainable, high performing NHS Foundation Trust

These objectives are underpinned by the following Investment objectives of this project:

- To provide the Trust with increased capacity for emergency services to meet the demands of population growth, changing service models and improved efficiency targets
- To increase the productivity of emergency care at LRI
- To develop a centre of excellence, enhancing the Trust's reputation for training, service delivery and treatment, through the provision of a centralised service in modern accommodation
- To ensure that the changing needs and expectations of a growing population are met in line with Trust clinical strategy and national guidance standards
- To provide an ED that is compliant with NHS building guidance standards
- To improve the clinical effectiveness and safety of urgent and emergency care service across Leicester
- To improve the clinical adjacencies of services to optimise clinical safety and reduce clinical risk
- To facilitate the modernisation of services, including streamlining patient pathways and efficient working practices providing an ED that ensures adequate infrastructure and capacity for supporting services that are conducive to the needs of a modern workforce
- To equip the ED to respond effectively to existing and known commissioning requirements, as well as to respond flexibly to future changes in service direction and demand
- To improve the environment and the experience of users (patients, visitors and staff) of Leicester Royal Infirmary Hospital Accident and Emergency Department
- To provide a solution that is aligned to the Trust DCP plan and Trust organisation as a whole
- The development will be delivered on time with minimal disruption to current service delivery

Each of the project objectives has been formulated based upon the drivers for change and national, regional and local strategic directions, promoting efficiencies in practice and ensuring statutory and national targets are achieved.

National, Regional and Local Strategies, Programmes and Guidance

National and Regional strategies and programmes affecting the provision of Emergency care services at LRI site are set out in Section 2 and include:

National

- Health and Social Care act 2012
- Quality, Innovation, Productivity and Prevention (QIPP) Programme
- Department of Health Emergency Department Clinical Quality Indicators
- NHS Operating Framework
- Care Quality Commission: Five Domains of Quality
- Transforming Urgent and Emergency Care services in England: Urgent and Emergency Care Review, End of Phase 1 Report, NHS England November 2013
- High Quality Care for all, Now and for Future Generations: Transforming Urgent and Emergency Care Services in England June 2013
- Future Hospital: Caring For Medical Patients, Royal College of Physicians (September 2013)
- HBN 15-01 Planning and Design Guidance: Accident and Emergency Departments (April 2013)
- Royal College of Paediatric and Child Health 'Standards for Children and Young People in Emergency Care Settings' [third edition] 2012[1]
- The Silver book – National Guidance 'Quality Care For Older People With Urgent and Emergency Care Needs, June 2012
- Guidance for Commissioning Integrated Urgent and Emergency Care A 'whole system' approach, July 2013[2]

Regional

- CCG out of hospital strategies
- Joint Strategic Needs Assessment (JSNA)
- Emergency Care Network

Local

- Better Care Together Strategy 2012-2022
- Trust Strategy 2012 -2022
- Trust Estate strategy and Estate Transformation Plan
- Foundation Trust

1.2.2 The Case for Change

Emergency Medicine is the secondary care specialty which provides immediate care for patients of all ages presenting with illness and injury of all severities. In order to

[1] www.rcpch.ac.uk/system/files/protected/page/Intercollegiate%20Emegency%20Standards%202012%20FINAL%20WEB.pdf

[2] http://www.rcgp.org.uk/news/2013/july/~/media/Files/Policy/A-Z-policy/Urgent-emergency-care-whole-system-approach.ashx

provide the level of high quality emergency care and assessment services that comply with regulatory standards expected of the Trust, it is essential that the Trust ensures that its patients and staff can work and receive treatment in a safe environment and that patient treatment is efficient and timely in its delivery.

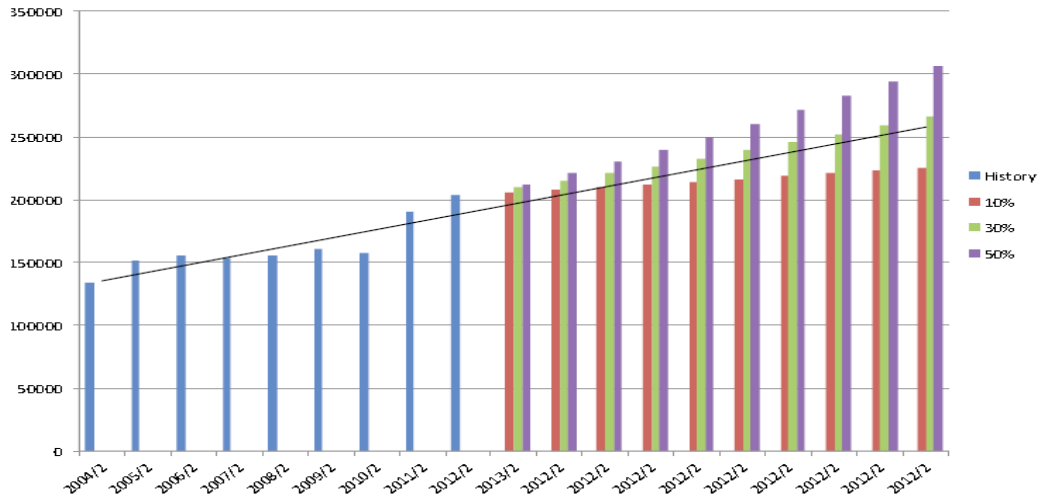
In doing so, provision of adequate capacity to support the functions of emergency services delivery and enhanced quality of care is required. Section 2.13 – 2.15 details the case for change.

Capacity and Demand

The Trust is now in a position where lack of capacity cannot support Trust business needs and growing activity requirements. UHL has experienced a rise in attendances to its ED. Section 2.9 illustrates that UHL's performance is well below the target 95%. This reflects poor quality of care for patients, reduced clinical effectiveness, and an unacceptable delay in treatment, increased clinical risk and compromised patient safety.

The department serves annual attendances of approximately 200,000; including urgent care services. 52,000 of the annual attendances are ambulance patients which are seen through a 16 cubicled majors area. Figures suggest there is a 5-6% annual growth of emergency attendances at the Trust. The table below outlines this growth over a 10 year period up to 2012/13 and projects forwards on the basis of the three ED growth scenarios detailed above (10%, 30%, 50% growth over 10 years).

Figure 1B Activity Growth up to 2012/13



Quality of Care

In order to provide the level of high quality emergency care that is expected of a tertiary referral Trust, it is essential for the Trust to ensure that its emergency services is designed to accommodate the care needs of patients accessing emergency care, their relatives and carers and the staff.

The current challenges to the service, current demand, future demand and environmental issues are affecting the quality of care provided. These quality issues are outlined in Section 2.15 and are considered within the framework of the five domains of quality as defined by the Care Quality Commission (CQC). These five domains are:

- Safety
- Effectiveness
- Caring
- Responsive to people's needs
- Well led at organisational, hospital and service level

Efficiency

The current ED efficiencies are impacted on by wait time and capacity availability and current department layout and size. This has a significant impact when it relates to resuscitation Emergency Decision Unit (EDU) and Elderly Frail Unit (EFU) services, therefore compromising patient safety and quality of care. The current location of the Medical Assessment Unit (MAU) on the 5th floor of the Balmoral Wing is unsuitable for efficiencies in patient flows. It is essential that this service be provided on the same floor as the ED and be provided with additional capacity to enhance efficiencies and meet demand. Development of a single floor ED will provide the Trust with the opportunity to meet its strategic clinical objectives and optimise key clinical adjacencies and clinical requirements for the next 10 year period.

Section 2.13 outlines the case for change that relates to efficiencies in care.

1.2.3 Drivers for Change

The following are key drivers for change:

- The increasing demand for emergency services is greater than the current capacity can provide. Historic trends in growth suggest a 5% annual growth in ED activity and 3.5% annual growth in assessment unit activity
- Requirement for single floor Emergency and Assessment Department that incorporates key adjacencies and presence of diagnostics and assessment unit services on the same floor. This enables implementation of the developed model of care for both adults and children accessing ED
- Changes in the local and national demographics combined with the Trust's plan to remain an emergency care centre for Leicester is impacting on increased emergency care demand
- The Trust requires additional capacity to reflect NHS national guidance. The emergency floor project reduces the risk of compromising compliance of other standards of care such as quality, infection control, emergency and urgent care standards and commissioning standards

- The requirement to address the 4 hour target and ambulance to trolley transfer will have a significant impact on Trust financial performance if capacity issues are not resolved
- Redevelopment and increased capacity will provide opportunities for the Trust to fulfil the Trusts overall strategic transformation programme

1.3 Economic Case

An economic appraisal of the Emergency Floor redevelopment options has been completed in accordance to the Capital Investment Manual and requirements of Her Majesty's Treasury's (HMT) Green Book (A Guide to Investment Appraisal in the Public Sector). A long list of options were compiled and then this was appraised to identify a short list of options to take forward into a full appraisal process.

1.3.1 The Long List

The long listed options considered in this business case are as follows:

Table 1.1 Long List

Option	Description
0	Do Minimum - Ensure critical backlog maintenance is undertaken and review clinical processes & procedures
1A	Balmoral Building – Existing 1st floor refurbishment with some assessment provision elsewhere (inc courtyard infill & extension)
1B	Balmoral Building – Existing 1st floor and ground floor refurbishment hot floor/assessment floor
1C	Balmoral Building – Existing floor refurbishment with displacement of radiology
2A	Jarvis Building – Demolition of Jarvis building and part new build/part refurbishment existing floor
2B	Jarvis Building - Demolition of Jarvis building and new build
2C	Jarvis Building - Demolition of Jarvis building and new build ED and refurbish assessment on single floor
3A	Victoria Building – Demolition of Victoria building and part new build/part refurbish assessment on single floor
3B	Victoria Building - Demolition of Victoria building and new build
4	Sandringham Building – refurbishment of 2 floors Sandringham building and new build extensions

Option	Description
5	Havelock Street Car park – New build 2 storey development on Havelock Street car park
6	Knighton Street Car park - New build 2 storey development on Knighton Street car park
7	Victoria Building Staff Car park - New build 2 storey development on Victoria Street car park

The long list of options where then work shopped by the project team to progress this list to a viable short list of options.

1.3.2 The Short List

The shortlisted options taken forward into this OBC are as follows:

Table 1.2 Short List

Option 0	Do Minimum - Ensure critical backlog maintenance is undertaken and review clinical processes & procedures
Option 1A	Balmoral Building – Existing 1st floor refurbishment with some assessment provision elsewhere (inc courtyard infill & extension)
Option 2C	Jarvis Building - Demolition of Jarvis building and new build ED and refurbish assessment on single floor
Option 3A	Victoria Building – Demolition of Victoria building and part new build/part refurbish assessment on single floor

1.3.3 Qualitative Benefits - Preferred Option

The shortlisted options were appraised against benefit criteria to establish a preferred option. The key benefits that would be delivered by the Emergency Floor redevelopment and against which the options were appraised are:

- To implement a design solution that provides a safe emergency care service that ensures capacity and flexibility for current and future demands of patients requiring emergency care
- Improve patient pathway management reducing the clinical risk and discomfort through the emergency care pathway
- Support and consolidate the provision of emergency floor concept at LRI
- Ensures that the service model of care is delivered in line with National ,Trust and local health economy KPI's
- Patient safety is enhanced, and clinical risk is reduced

- Where possible ensures that the service is developed in line with NHS Guidance interims of HBN, HTM, national and Trust policy and local health economy policy in terms of capacity provision
- Quality of care is enhanced, in terms of the model of care, and seamless pathways of care and patient flows
- The built environment enhances clinical practice that support clinical effectiveness, improved patient outcomes and patient safety
- Provides enhanced departmental relationships and clinical adjacencies that support clinical effectiveness and improved patient outcomes
- Ensures facilities are future proofed and adaptable to the changing needs of the health economy
- Improved privacy and dignity provisions for all patients
- Consolidates existing services & provides clinical expertise whilst realising the Emergency Floor concept
- Improved patient access through a single front door
- Enhances patient, visitor and staff safety through the built environment
- The design solution minimises the impact of the construction process on the site and therefore delivery of the Trust core services
- Option enables future proofing of the physical ED environment aligned to DCP future expansion needs
- The enabling moves will facilitate the Emergency Floor programme whilst minimising delay to delivery
- Reduces complexity and sequence dependency of enabling moves
- Maintains blue light access throughout whole build process

The scores for each option to deliver the project benefits are outlined below.

Table 1.3 Raw Scores

Criteria	Option			
	0	1A	2C	3A
To implement a design solution that provides a safe emergency care service that ensures capacity and known flexibility for current and known future demands of patients requiring emergency care	1.00	7.00	5.00	7.50
Improve patient pathway management reducing the clinical risk and discomfort through the emergency care pathway.	1.00	7.50	5.00	7.00
Support and consolidate provision of emergency floor concept at LRI	1.00	7.50	7.00	7.50
Ensures that the service model of care is delivered in line with National, Trust and local health economy KPIs	1.00	7.50	6.00	7.50
Patient safety is enhanced, and clinical risk is reduced.	1.00	6.50	7.50	7.50
Where possible ensures that the service is developed in line with NHS Guidance in terms of HBN, HTM, national and Trust policy and local health economy policy in terms of capacity provision	1.00	6.00	8.00	8.00
Quality of care is enhanced, in terms of the model of care, and seamless pathways of care and patient flows.	1.00	8.00	6.00	7.50

Criteria	Option			
	0	1A	2C	3A
The built environment enhances clinical practice that support clinical effectiveness, improved patient outcomes and patient safety	1.00	8.00	6.00	8.00
Provides enhanced departmental relationships and clinical adjacencies that support clinical effectiveness and improved patient outcomes	1.00	8.00	6.00	8.00
Ensures facilities are future proofed and adaptable to the changing needs of the health economy	1.00	6.00	7.00	8.00
Improved Privacy and dignity provisions for all patients	1.00	6.00	8.00	8.00
Consolidates existing services & provides clinical expertise whilst realising the Emergency Floor concept	1.00	8.00	6.00	7.50
Improved patient access through a single front door process	2.00	9.00	9.00	9.00
Enhances patient, visitor and staff safety through the built environment	1.00	7.50	8.00	8.00
The design solution minimises the impact of the construction process on the site and therefore delivery of the Trust core services	7.18	4.64	3.54	4.91
Option enables future proofing of the physical ED environment aligned to DCP future expansion needs	1.00	4.00	6.00	8.00
The enabling moves will facilitate the Emergency Floor programme whilst minimising delay to delivery	10.00	4.00	7.50	7.00
Reduces complexity and sequence dependency of enabling moves	10.00	4.00	7.50	7.00
Maintains blue light access throughout whole build process	8.00	6.00	5.00	7.50
	51.18	**131.74**	**129.64**	**148.71**
Rank	**4**	**2**	**3**	**1**

These scores were then weighted in the ratios as applied to the original raw scores. The results are shown in Table 3.17 Section 3 of this document.

1.3.4 Key Findings of the Economic Appraisal

The overall financial summaries of the three options based on the cash flows input to the Generic Economic Model (GEM) are as follows:

Table 1.4 Key Results of Economic Appraisals

Option	Appraisal period	NPC £ 000	Risk Adjusted £ 000	Risk Adjusted NPC £ 000
Do Minimum	60 years	1,297,886.6	109.0	1,299,093.6
Option 1A Balmoral	60 years	1,276,086.1	1,207.0	1,277,293.1
Option 2C Jarvis	60 years	1,272,779.4	1,268.0	1,274,047.4
Option 3A Victoria	60 years	1,272,084.7	1,253.0	1,273,337.7

1.3.5 Economic Appraisal Conclusion

The option which offers the best value for money is the one with the lowest NPC and EAC. This is the preferred option from a purely financial perspective.

Option 3A has the lowest in both cases and is therefore the preferred option.

1.3.6 Overall Findings Preferred Option

As identified above the preferred option from both a financial and non financial perspective is option 3A Victoria.

This option offers the best value for money as it has the lowest NPC and is the most effective solution based on the non financial review.

As can be seen from the table the second ranked option from the qualitative appraisal is option 1A Balmoral. We have therefore, for the switching point assessed the point at which this option becomes the preferred based on the NPC per point.

Analysis shows that the costs of the preferred option would need to increase by 12% before option 1A becomes the preferred option.

Table 1.5 Summary of Economic and Value for Money Appraisal

Criteria	Option			
	0	1A	2C	3A
Raw scores	51.18	131.74	129.64	148.71
Weighted Scores	2.27	6.74	6.27	7.54
Rank (non-financial)	4	2	3	1
Net present cost (NPC) (£k)	1,299,094	1,277,293	1,274,047	1,273,338
NPC per point score (£k)	572,288	189,509	203,197	168,878
Rank (VFM)	4	3	2	1
Rank	**4**	**2**	**3**	**1**

1.4 Commercial Case

1.4.1 Procurement Strategy

The scheme will be procured through UHL's framework partnership with Interserve Facilities Management (IFM). The framework for major projects has been set up to mirror the Procure 21+ (P21+) framework principles for the delivery of construction projects.

The P21+ framework was initiated in July 2012 and is available to NHS organisations in England. It is the Department of Health's preferred method of procurement for new builds and refurbishments on the NHS estate. Procure 21+ and its predecessor Procure 21 have over £5bn worth of schemes registered. The Department of Health has stated that P21+ schemes are providing value for money solutions to over 200 NHS Trusts.

Whilst the LLR FMC partnership is bespoke to UHL, and therefore outside the P21+ framework, it offers the same value for money assurances on construction. This is through adherence to an agreed schedule of professional services rates, and use of overhead and profit recovery percentages that reflect recognised P21+ pricing structures. structures.

Value for money considerations over business case and design development during the early stages of projects have been assured through the procurement of the partnership with IFM, under which professional services rates have been benchmarked against the current OGC framework for such services.

1.4.2 Potential for Risk Transfer

The LLR Framework has a single comprehensive risk management process, which the Trust will be using. The Emergency Floor Project Senior Responsible Officer (SRO) and IFM act as joint owners of the joint project Risk Register for this scheme, responsibility for risks identified in it are then to be allocated and identified on the associated risk register. The risk of cost overrun is transferred to IFM once the GMP has been agreed and construction stage commenced.

1.5 Financial Case

The Financial Case sets out the financial implications for the Trust in terms of capital expenditure and cash flow, income and expenditure account and borrowing.

1.5.1 Capital Costs

The capital costs have been determined by the Design Team technical advisors and summarised below.

Table 1.6 Summary of Capital Costs

Capital Costs	Option 3A Victoria (£)
Construction	23,643,192
Fees	6,344,090
Equipment	1,635,853
Decant	7,840,866
Planning Contingency	1,586,707
Sub Total	**41,050,708**
Optimism bias	3,411,420
Inflation	3,466,908
Total	**47,929,036**

The capital expenditure profile is set out below:

Table 1.7 Summary of Capital Expenditure

UHL ED Floor	2013/14 £	2014/15 £	2015/16 £	2016/17 £	2017/18 £	TOTAL £
Capital Expenditure	8,323,572	13,848,153	24,480,266	1,106,701	170,344	47,929,036

1.5.2 Revenue Costs

These are described in detail in the Financial Case (Section 5) but broadly comprise the pay and non-pay costs and other allocated direct costs

1.5.3 Financing

The Trust will be undertaking several capital projects in the next few years and it is anticipated that the capital expenditure for this scheme will be as follows:

Table 1.8 Sources and applications of funds

UHL ED Floor	2013/14 £	2014/15 £	2015/16 £	2016/17 £	2017/18 £	TOTAL £
Capital Expenditure	8,323,572	13,848,153	24,480,266	1,106,701	170,344	47,929,036
Funded By:						
PDC/Public Loan		9,927,720	24,480,266	1,106,701	170,344	35,685,031
Trust Resources	8,323,572	3,920,433				12,244,005
Total Funding	8,323,572	13,848,153	24,480,266	1,106,701	170,344	**47,929,036**

The impact of the scheme on the Trust's Income & Expenditure account is as follows:

Table 1.9 Income & Expenditure Impact – Trust Resources & Exceptional PDC

Impact of Scheme	2014 /15 £k	2015 /16 £k	2016 /17 £k	2017 /18 £k	2018 /19 £k	2019 /20 £k	2020 /21 £k	2021 /22 £k	2022 /23 £k
Reduction in Agency costs			-1,693	-1,693	-1,693	-1,693	-1,693	-1,693	-1,693
Reduction in Staff Costs			-416	-416	-416	-874	-874	-1,357	-1,357
Change in depreciation	-170	-170	711	1,005	1,005	1,005	1,005	1,005	1,005
Additional FM costs			127	127	127	127	127	127	127
Change in Rate of return	-89	-89	962	932	897	862	827	792	756
Total impact	-259	-259	-309	-44	-79	-572	-607	-1,127	-1,162

The key sensitivities are the expectations of growth together with the additional revenue and the Trust's ability to realise the savings it has identified.

Below we have modelled the impact on additional income of 1% less growth pa than forecast. As can be seen this has a significant impact on the additional income levels.

However in response to this scenario the Trust would be able to reduce its recruitment of additional staff.

Table 1.10 Impact of 1% less Growth

	2014/15 £k	2015/16 £k	2016/17 £k	2017/18 £k	2018/19 £k	2019/20 £k	2020/21 £k	2021/22 £k
Income Growth Assumption	676	1,374	2,094	2,837	3,604	4,395	5,212	6,055
Income Growth at 1% less pa	465	940	1,425	1,922	2,429	2,947	3,477	4,018

We have also modelled the impact of the Trust not achieving the savings in staff due to moving to the upper quartile in staffing for the ED and not fully achieving its target reduction in agency staff

As can be seen this will have a major impact on the affordability. However the Trust is currently developing a workforce plan so as to ensure it has a robust strategy to achieve the savings.

Table 1.11 Impact of not Achieving Staff Savings

	2014/15 £k	2015/16 £k	2016/17 £k	2017/18 £k	2018/19 £k	2019/20 £k	2020/21 £k	2021/22 £k
Reduction in Agency Costs	0	0	-1,693	-1,693	-1,693	-1,693	-1,693	-1,693
Reduction in Staff Costs	0	0	-416	-416	-416	-874	-874	-1,357
Impact	0	0	1,055	1,055	1,055	1,283	1,283	1,525

1.5.4 Impact on the Balance Sheet

The proposed expenditure will have the impact on the Trust balance sheet as shown in the table below.

Table 1.12 Impact on Trust Balance Sheet

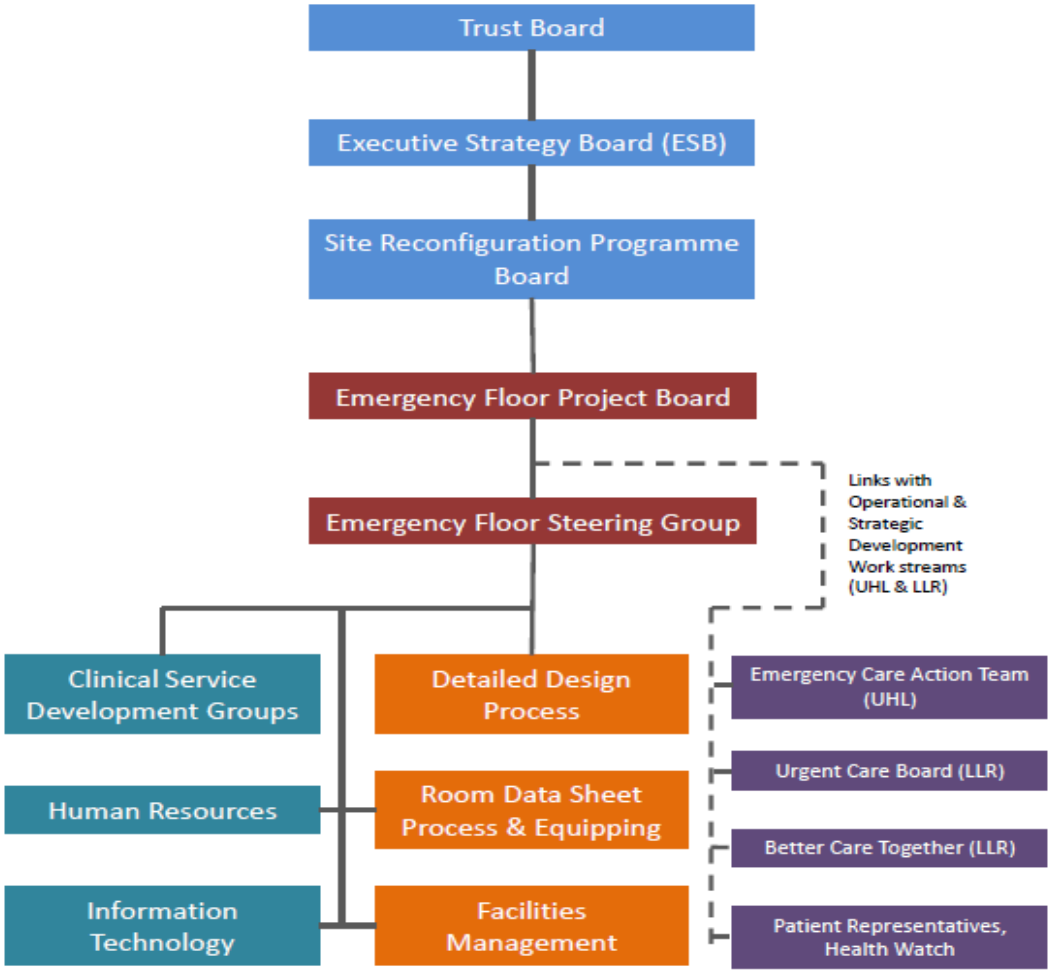
Balance Sheet	2013 /14	2014 /15	2015 /16	2016 /17	2017 /18	2018 /19	2019 /20	2020 /21	2021 /22	2022/23
Assets Under Construction	8,323,572	13,848,153	24,480,266	1,106,701	170,344					
Impairments on new building coming into use (DV likely revaluation)				-17,024,301						
Impairment on partial demolition of Victoria based m2	-2,472,646									
Depreciation				-711,445	-1,005,283	-1,005,283	-1,005,283	-1,005,283	-1,005,283	-1,005,283
Change to Fixed Assets	-2,472,646			30,022,946	29,188,007	28,182,723	27,177,440	26,172,157	25,166,873	24,161,590
Impact on Balance Sheet	-2,472,646									
Rate of return on assets				1,050,803	1,021,580	986,395	951,210	916,025	880,841	845,656

1.6 Management Case

1.6.1 Project Management Arrangements

The project will be managed reflecting national guidance[3] and the Trust's own Capital Governance Framework, as shown in the diagram below:

Figure 1C Governance Framework



[3] Capital Investment Manual 'Managing Capital Projects' (Department of Health); PRINCE2 (Office of Government Commerce); Managing Successful Programmes (Office of Government Commerce/ Efficiency & Reform Group)

The programme anticipated completion is set out below:

Table 1.13 Project Milestones

Milestone	Date
Preparation of Outline Business Case	October/ November 2013
Outline Business Case circulated to Executive Team for review	18th November 2013
Outline Business Case presented to Executive Team	19th November 2013
Outline Business Case circulated to Trust Board for review	21st November 2013
Outline Business Case presented to Trust Board Development	21st November 2013
Outline Business Case presented for Trust Board approval	28th November 2013
Outline Business Case sent to the NTDA	December 2013
Outline Business Case presented to CCGs & UCB	December 2013
NTDA approval of the Outline Business Case	February 2014
Commence Full Business Case	February 2014
Commence enabling works	March 2014
Full Business Case presented for Trust Board approval	June 2014
Full Business Case sent to the NTDA	July 2014
NTDA approval of the Full Business Case	September 2014
Enabling works completed/ commence construction phase	December 2014
Handover	July 2016
Trust Commissioning Period	July/ August 2016
Trust Operational	August 2016

1.6.2 Benefits Realisation and Risk Management

The delivery of benefits will be managed through the Programme Board. A copy of the project benefits realisation plan is attached at Appendix11. This sets out who is responsible for the delivery of specific benefits, when they will be delivered and how achievement of them will be measured.

The Trust ensures through the involvement of its employees, that risk management serves as a mechanism for risk reduction. Also, by taking a proactive approach to managing risk exposure, the Trust ensures protection of its patients, staff, visitors, assets and reputation. This project will be managed in that context.

1.6.3 Post Project Evaluation Arrangements

The outline arrangements for post project evaluation review (PER) have been established in accordance with best practice. These arrangements are outlined in Section 6.9.

1.7 Recommendation

The Trust Board is recommended to approve this business case for submission to the NTDA.

Signed: .....

Senior Responsible Owner

Date: .....

Senior Responsible Owner
Project Team

2 | The Strategic Case

2.1 Introduction

This document sets out University Hospitals Leicester NHS Trusts (hereafter referred to as 'the Trust' or 'UHL') proposals to invest in a fit for purpose, modern emergency floor for the provision of emergency services at its Leicester Royal Infirmary (LRI) site.

In line with the national concern about the ability of emergency services to cope with demand, UHL has experienced a rise in attendances to its Emergency Department (ED). This has resulted in many patients waiting for excessive periods and performance being well below the standard 95% (week ending 3rd November and 10th November 2013 it was 87.8% and 90.2% respectively)[4]. This reflects poor quality of care for patients, reduced clinical effectiveness, an unacceptable delay in treatment and increased clinical risk and compromised patient safety.

UHL has instigated a number of short term measures to improve performance, such as the addition of adult assessment beds to alleviate current pressures. Whilst process redesign is being undertaken within the existing footprint and built environment, there is still an issue with the size of the current ED and associated assessment areas in its entirety and is deemed totally inadequate to cope with the demand by the Emergency Care Intensive Support Team (ECIST). Appendix 1a highlights the ECIST review of the LRI ED.

Their findings (review undertaken in March 2013) identified that 12,600 patients are seen annually in a 6 bedded resuscitation area and 52,000 ambulance patients through a 16 cubicled majors area. Inadequate space results in patients being lined up in trolleys in the open floor space in majors and doubled up in cubicles. Size and poor adjacencies therefore inhibit the Trust's ability to smoothly move patients through the department and associated floors assessment areas. In addition, the Medical Assessment Unit (MAU) is currently on the 5th floor of the Balmoral building and there is no access to x-ray of CT services within the ED, all of which further hinders efficiency.

As a consequence, there is an urgent need for change to the physical estate currently supporting the ED and associated assessment areas in order to improve patient flows, staff efficiencies, capacity issues and adjacencies.

This business case highlights the current arrangements for provision of emergency services, projected requirements over the next 5 to10 years and proposes a preferred option as a solution.

[4] UHL NHS Trust Emergency Care 4hour Performance Trajectory 2013 – Refer to Appendix 3d

2.2 Structure and Content of the Document

This business case has been prepared using the agreed standards and format for business cases, as set out in DH guidance and HM Treasury Green Book. The case comprises the following key components:

- **The Strategic Case section** | This sets out the strategic context and the case for change, together with the supporting investment objectives for the scheme
- **The Economic Case section** | This demonstrates that the organisation has selected the choice for investment which best meets the existing and future needs of the service and optimises value for money (VfM)
- **The Commercial Case section** | This outlines the content and structure of the proposed deal
- **The Financial Case section** | This confirms funding arrangements and affordability and explains any impact on the balance sheet of the organisation
- **The Management Case section** | This demonstrates that the scheme is achievable and can be delivered successfully to cost, time and quality

Part A: The Strategic Context

2.3 Introduction

This section provides an overview of the context in which the Trust provides its services and the strategic guiding principles, directives and policies that ensure clinical qualities standards are met. The intention is to provide an overview of the Trust, its strategic objectives and the highlight current emergency care service delivery and set the context for this business case. It also provides an overview of the driving policies and guidance documents at National, Regional and Local level.

2.4 Organisational Overview and Background

2.4.1 University Hospital Leicester NHS Trust

UHL is one of the largest teaching hospitals in the country and operates across three main sites; the Leicester Royal Infirmary, Leicester General Hospital,, and the Glenfield Hospital and is the only acute Trust serving the diverse local population of Leicester, Leicestershire and Rutland (LLR); equating to approximately 1 million residents. The majority of the population is split as follows:

- Leicester City – population 304,722
- Leicestershire County and Rutland – population 685,100

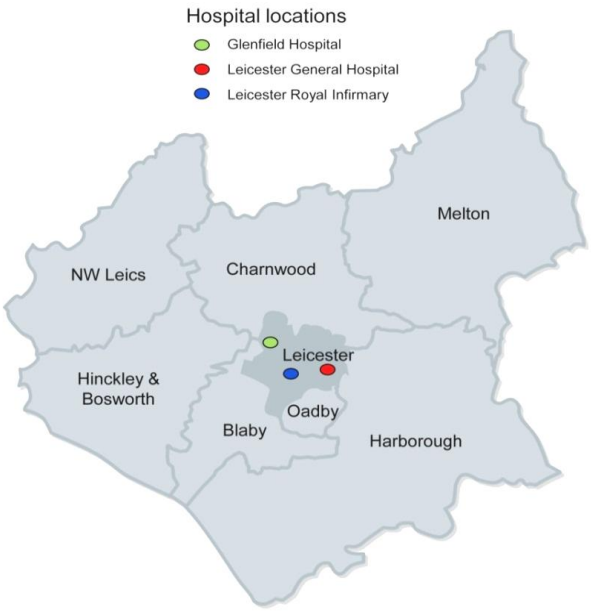


Figure 2A University Hospitals of Leicester NHS Trust Locations

The Trust provides a wide range of services across its three main sites; these are summarised in the following table:

Table 2.1 Trust Services

Leicester Royal Infirmary		Leicester General Hospital	Glenfield Hospital
General Surgery	Vascular Surgery	Elective Orthopaedics	Paediatric Oncology
Gastroenterology	Plastic Surgery	Urology	Cardiothoracic Surgery
Trauma	Clinical Haematology	Nephrology	Respiratory Medicine
Obstetrics	Dermatology	Renal transplantation	Breast Surgery
Emergency Gynaecology	Infectious Diseases	End Stage Renal Failure	Breast Screening
Well babies	Genetics	Sports Medicine	Orthodontics
Rheumatology	Genito-urinary Medicine	Neurology	Restorative Dentistry
Diabetes &Endocrinology	Immunology	Obstetrics	Adult Cardiology
Adult and Paediatric A&E	Stroke Medicine	Planned Gynaecology	Clinical Support Services
Acute Medicine	Elderly Medicine	Elective Gynaecology	
Paediatric Medicine & Surgery	Clinical Support Services	Clinical Support Services	
Oncology & Radiology	Central Pathology	Emergency Surgery	
Ears, Nose & Throat (ENT)	Emergency Surgery	Hepatobiliary	
Ophthalmology		Diabetes Centre of Excellence	
Maxillofacial Surgery			

2.4.2 Clinical Management

The Clinical Management is structured into seven management groups, with each group led by a senior consultant in the role of director. The seven Clinical Management Groups (CMGs) are as follows:

- Cancer, Haematology, GI Medicine and Surgery
- Emergency and Specialist Medicine
- Musculoskeletal and Specialist Surgery
- Professional Services, Imaging, Medical Physics and Empath
- Cardiac, Renal and Respiratory
- Critical Care, Theatres, Anaesthetics, Pain and Sleep
- Women's and Children's

Each director has a clinical background and works in a clinical environment as well as providing overall leadership for the CMG. Alongside the director the CMG's each have a head of nursing and a CMG manager. Across the three management groups there are fifteen core service lines. Each of these is led by a clinician, senior nurse and manager.

The clinical management of the organisation is supported by the following corporate directorates:

- Marketing and Communications
- Medical
- Finance and Business Services
- Human Resources and Learning and Organisational Development
- Operations
- Nursing
- Strategy including Capital projects
- Corporate and Legal Affairs
- IMT
- Facilities Management

2.4.3 Activity & Finance

During 2012/ 13 UHL delivered 10,841 babies, and treated 102,800 inpatients, 80,900 day cases and 763,427 outpatients.

Currently the Trust has approximately 10,000 staff based in substantive whole time equivalent (WTE) posts. In addition there are 1,075 active volunteers, volunteering across a range of services including the Royal Voluntary Service (RVS), Chaplaincy and other groups such as the Radio Fox team.

UHL financial results for 2011/ 12 and 2012/ 13 show that the Trust made a surplus of £88k and £91k respectively. Details for future years are set out in the financial case section of this document.

2.5 Trust Vision

The Trust has developed a vision to be achieved over the next five years. This vision is to become a successful, patient centred hospital that is internationally recognised for placing quality, safety and innovation at the centre of service provision.

The Trust will build on it's strengths in specialised services, research and teaching; offering faster access to high quality care, developing staff and improving patient experience. The Trust refers to this vision as 'Caring at its best'. The Trust recognises the challenges facing the organisation which are the consequence of significant external challenges which include:

- The financial pressures facing public sector organisations
- Rigorous regulation of healthcare providers
- Changes in the wider health and political landscape
- Focus on choice and greater patient and community involvement

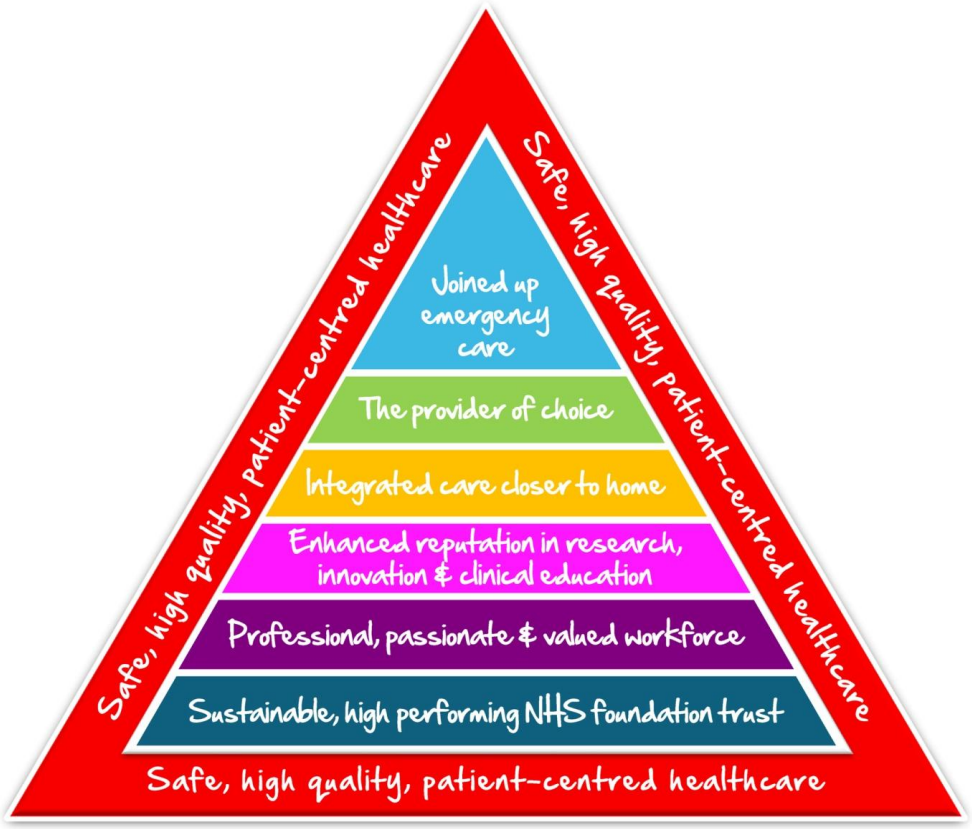
2.6 Trust Strategic Objectives

Each year the Trust sets corporate objectives, identifying the key short term goals necessary in progressing towards its vision of 'Caring at its best'. The Trust's current corporate objectives are:

1. Provide Safe, high quality, patient-centred healthcare
2. Provide joined up emergency care
3. To be the provider of choice
4. Integrated care closer to home
5. Enhanced reputation in research, innovation and clinical education
6. To be a professional, passionate and valued workforce
7. Sustainable, high performing NHS Foundation Trust

The diagram below reflects these objectives acknowledging objective 1 as the overarching objective.

Figure 2B Corporate Objectives



Each element of the objectives and supporting strategy are performance managed by the Trust Board, as a result of the Quality and Performance report which contains the NTDA indicators.

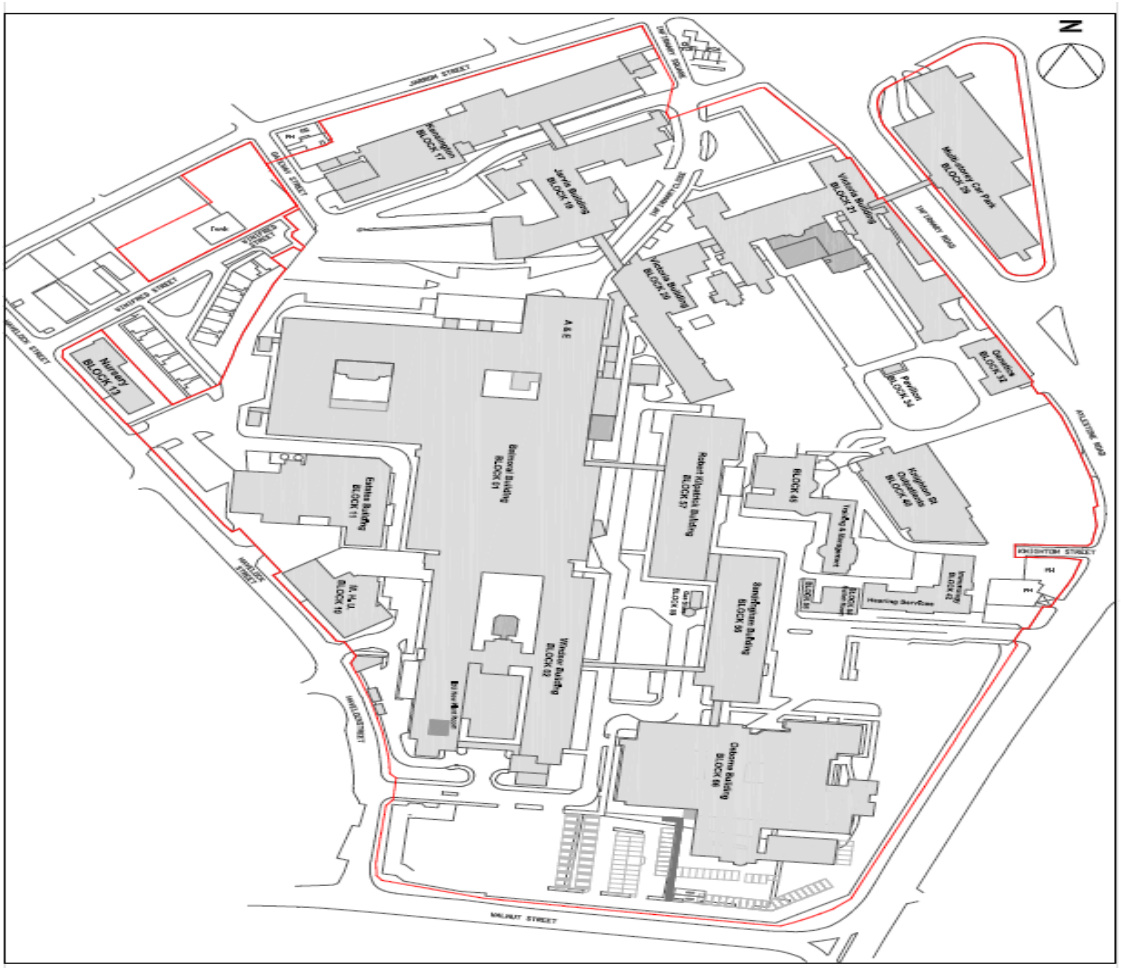
2.7 The Leicester Royal Infirmary Site

Leicester Royal Infirmary provides Leicestershire's only accident and emergency service (ED). The hospital has approximately 890 beds. The LRI hospital site is illustrated below in Figure 2B.

2.7.1 Site Ownership

The land in the ownership of the LRI is highlighted below.

Figure 2C Current Site Plan



2.8 Site Specific Constraints

The site is heavily occupied with access points for the Emergency Floor Reconfiguration specifically constrained from the one way road system and lay out of the site

Options for construction are severely limited due to the highly developed nature of the current site.

Any construction will take place on a fully operational site, and the sequencing and project timetable will be constrained by the need to maintain safe operations at all times.

2.9 Background to the Redevelopment Requirement for Emergency Care

Over the past 8 years there has been increasing concern within the Trust that the demands placed on emergency services exceed capacity. An indication of this problem is an increase in attendances to its ED, which has been growing at around 5% per annum (including the Urgent Care Centre). This has resulted in many patients waiting for excessive periods; UHL's performance is well below the standard 95% % (week ending 3rd November and 10th November 2013 it was 87.8% and 90.2% respectively)[5]. This manifests itself in reduced quality of care for patients, reduced clinical effectiveness, an unacceptable delay in treatment, increased clinical risk and compromised patient safety. In a similar fashion, emergency admissions to the Trust have been growing at around 3.5% per annum, creating similar pressures on assessment bed stock.

The Trust has established a Site Reconfiguration Programme to deliver an overarching Strategic Outline Case which as a consequence, various capital projects will be delivered across the Trust. The Emergency Floor reconfiguration sits within this programme. In June 2013 a Strategic Outline Case for the Emergency Floor was submitted setting out the key strategic drivers and objectives for the proposed project.

Additionally, UHL has submitted its trajectory for improvement to the NHS Trust Development Authority (NTDA) which was agreed by the Trust Board as part of the Trust's Annual Operating plan. However, poor performance may result in significant financial penalties which will impact on the Trust's ability to deliver a financial balance with potential fines of £600k per month and a potential fine of £3.25m for penalties associated with transfer from ambulance trolley to bed.

The Trust has undertaken demand forecasting to understand the 10-year projected demand for ED and associated assessment unit services. This forecasting was based on the consideration of three scenarios for future activity (refer to Section 3).

The table below outlines the conclusion of this work showing the projected growth in ED attendances over the next 10 years. The three scenarios are based on:

- low: demographic growth (as per ONS data), 11% over 10 years
- medium: intermediate growth scenario, 31% over 10 years
- high: historic trend in growth (c.5% per annum overall), 46% over 10 years

These scenarios have been abbreviated to 10%, 30% and 50% growth over 10 years for planning purposes for the ED and associated assessment areas of the scheme.

[5] UHL NHS Trust Emergency Care 4hour Performance Trajectory 2013 – Refer to Appendix 3d

Table 2.2 Projected Activity Growth (ED attendances)

Percentage Growth 2012/13 - 2022/23	Paeds	Eyes	Majors	Minors	Resus	Grand Total	UCC	All inc. UCC
Low Scenario	12%	9%	14%	-32%	16%	12%	75%	11%
Medium Scenario	32%	29%	34%	-20%	36%	32%	108%	31%
High Scenario (inc. shift)	77%	49%	54%	-8%	56%	52%	86%	46%

Similar work has been undertaken for the assessment unit capacity, with three scenarios being generated as follows:

- low: demographic growth (based on ONS data), 11% over 10 years
- medium: intermediate growth scenario, 25% over 10 years
- high: historic trend in growth (c.3.5% per annum), 35% over 10 years;

These scenarios have similarly been abbreviated to 15%, 25% and 35% growth over 10 years for planning purposes for the adult assessment areas of the scheme

Demand analysis work outlined has been initiated in order to address the need for increased capacity and the requirement for emergency services to be compliant with National, regional and local standards to provide a safe and accessible service that enhances the Trust' performance plans.

Section 2.14 details the impact demand issues have on the capacity and service provision.

2.10 Existing Arrangements

The current ED and associated assessment areas was originally designed to serve annual attendances of approximately 100,000. Current service activity, including urgent care services, is over 200,000 attendances to ED (160,000) & UCC (40,000) per annum, and the proposed Emergency Floor development is expected to cater for the medium growth scenario in emergency services of up to 270,000 attendances.[6] Adult emergency admissions at LRI are currently in the region of 24,000 per annum (excluding stroke and oncology which do not use the emergency floor facilities), and the new Emergency Floor is expected to cater for the medium growth scenario of up to 30,000 admissions on the basis of the current Average Length Of Stay (ALOS) (or higher with an improved ALOS).

The reasons for the increased pressure on LRI's emergency services can be summarised as follows:

[6] University Hospitals of Leicester NHS Trust LRI Emergency Services Design Operational Policy 2013

- The local community is an ageing population and there has been growth in the number of frail patients and those suffering from dementia, UTIs and D&V, demanding an increase in isolation facilities[7].
- UHL's emergency services supports a population of approximately 1 million, making the LRI the largest emergency services department in the country
- There is no other emergency floor within a 25 mile radius
- The way the out of hour's service has developed across the community has increased pressure on EDs

There is an unusual double peak in daily activity between early afternoon and the evening; unlike other centres it is unique in that the second peak is higher than the first with the highest attendances between 8pm and 10pm. At any one hour of the day, there may be between 1 to 16 attendances in any area of the department. There can be at least 40 patients attending the department per hour for 3 or more hours at a time.

Whilst there has been a successful recruitment drive at LRI for all levels of staff, the unit remains short-staffed and has to place a heavy reliance on agency staff, which is further exacerbated by the poor environment resulting in a difficulty recruiting. This is a contributing factor to the worsening financial performance.

The final 2012/13 year to date 4 hour wait figure for UHL, including the Urgent Care Centre (UCC), was 91.9% of attendances. In response to a consistent underachievement of the 4 hour target, new clinical roles were introduced and a new pathway commenced in November 2011 called 'Right Place, Right Time'. This initially resulted in a considerable improvement in the Trust's emergency service performance. However, following a number of challenging weeks of activity (with ED attendances 5% higher and emergency admissions 7% higher in the final quarter (2012/13 compared to the same period last year) achievement of the 4 hour target deteriorated (week ending 3rd November and 10th November 2013 it was 87.8% and 90.2% respectively)[8].

The Emergency Care Action Team (ECAT) was set up by the Trust in response to ongoing 4 hour target underachievement and options to address capacity issues. ECAT has implemented a number of strategies via development of an Action Plan (Refer to Appendix 1b) that is focussed on improving ED performance and patient experience via operational improvements and investing in a capital project to develop an Emergency Floor solution.

Whilst ongoing operational improvements are being made to current emergency service processes, the proposed investment and development of the Emergency Floor is the Trust's strategic response to ensure that there is sustained delivery of the emergency process. In conjunction with primary care, UHL will develop joined up emergency care by improving models of care both outside and within the hospital setting. For those who have to attend hospital, care will be provided in an environment designed to deliver a better patient experience and better quality outcomes.

[7] University Hospitals of Leicester NHS Trust LRI Emergency Services Design Operational Policy 2013

[8] UHL NHS Trust Emergency Care 4hour Performance Trajectory 2013 – Refer to Appendix 3d

The space, adjacencies and quality of accommodation provided for emergency care at LRI is unsuitable and does not comply with current national guidelines. The following outlines current status:

- **Access**: Patients currently experience poor patient journey when accessing emergency care and UCC departments. There is a dislocation of front door access relating to booking in and assessment within reception at the UCC and then a further booking process required at the ED when a patient is redirected there
- **Paediatrics**: UHL needs to meet the NSF for Children and Young People standards relating to separate entry, discrete space and child friendly environment. The department currently has limited cubicles that do not meet the need of current attendances
- **Majors**: Currently there are 16 majors spaces. The provision does not meet demand with the following consequential issues:
  - Patient safety– is compromised with severely non-compliant space around the bed for major incident and patient access
  - Doubling up of cubicles with chairs to house more than one patient at a time. Chairs used are currently those allocated to patient relatives and are intended for patient use (12 chairs are currently used)
  - The corridors leading out of majors are continuously blocked by patients in trolleys or chairs in an attempt to meet capacity
  - Privacy and dignity for patients is severely compromised
  - Compliance with infection control standards is compromised by limited space
  - Patient satisfaction is challenged, as is any opportunity for a sustainable enhancement of the patient experience
  - Cubicle space to accommodate incoming ambulance arrivals is insufficient, contributing to the current delays with ambulance handovers into the unit
- **Resuscitation**: There are 6 bays and each are significantly undersized with non compliant space around the bed for service delivery
- **Minors**: These are significantly undersized compromising patient flows with the overall numbers slightly underprovided. It is important to note that ‘minors’ attendances at LRI ‘minors’ tend to be of a higher acuity (fractures/significant soft tissue injuries) than the nearby walk in centres at Loughborough (x1) Leicester City Centre (x2). This is due to patients with lower acuity minor injuries choosing to be seen at those centres (approx 150,000 between those three walk in centres), leaving the higher acuity work being treated at LRI ED
- **Imaging**: There is currently no dedicated emergency imaging suite; patients are required to attend the main imaging department reducing efficiencies and patient experience and safety
- **Mental Health**: There is a need to meet requirements relating to a dedicated area (inclusive of own WC) that can be secured off from the rest of the department. Section 136 requirements need consideration.
- **Emergency Decision Unit (EDU)**: The space provided is currently 50% undersized
- **Elderly Frail Unit (EFU)**: The space provided is currently 50% undersized

- **Medical Assessment**: There is an essential need to provide a triage and assessment service adjacent to the emergency floor for GP referred patients to enhance patient flows through the department to improve working relationships, processes and clinical effectiveness. Assessment beds are currently provided on 5th floor of the Balmoral Building

The ED current capacity provision is summarised below:

Table 2.3 Current Capacity Provision

Name	Service	Capacity
Majors	Patients with potentially serious conditions or are too unwell to be able to walk without help. Most patients in this area will have been brought in by ambulance	16 spaces (plus 12 chairs in doubled up cubicles
Minors and UCC	Less serious illnesses or injuries and functions similar to an NHS Walk-In Centre or Minor Injuries Unit. Patients will be assessed and treated by Emergency Nurse Practitioners, physiotherapy practitioner and ED doctors. The ED review clinic, in which patients with certain soft tissue injuries are reassessed, is held in this space 3 times per week	21 spaces
Resuscitation	This area for specialist equipment and space for patients with life-threatening illnesses, such as heart attacks or severe breathing problems, as well as major injuries.	6 spaces
Paediatrics	Emergency services for children and young people under the age of 16. Cared for by specially trained staff. Unwell or severely injured children are treated in the main resuscitation room	12 spaces
Ophthalmology	Eye emergency services (currently located at Level 1 Windsor)	4 spaces

2.11 Strategy

This business case, and the associated corporate and project objectives, are supported by a number of significant strategic documents and programmes. It provides an overview of the driving policies and guidance documents at National, Regional and Local level that can provide context and support the case for change in relation to increasing capacity and providing modern accessible emergency services. These range from national and local strategies and programmes, to national and local standards and guidance. The relevant documents and programmes are set out below.

2.11.1 National Strategies, Programmes and Guidance

The National programmes and guiding policies are summarised below. A more detailed summary with references can be found in Appendix 1c.

Table 2.4 National Strategies, Programmes and Guidance

NATIONAL	
Health and Social Care Act 2012	The government's Health and Social Care Bill outlines the future commissioning arrangements across the NHS
Department of Health Emergency Department Clinical Quality Indicators	The Revisions to the NHS Operating Framework for 2010/ 11 signalled the intention to replace the 4 hour waiting time standard for EDs with more clinically relevant indicators. The clinical quality indicators for the ED have been designed to present a comprehensive and balanced view of the care, and accurately reflect the experience and safety of patients and the effectiveness of the care they receive. These indicators support patient and public expectations of high quality emergency services and allow EDs to demonstrate their ambition to deliver consistently excellent services which continuously improve.
Care Quality Commission	The Care Quality Commission (CQC) implemented 5 domains of quality care[9] to assess provision of care against. These domains are defined as Safety, Effectiveness, Caring, Responsive to people's needs and well led organisation In addition the CQC have recently implemented an intelligent monitoring approach to give inspectors a clear picture of the areas of care that need to be followed up within an NHS acute trust.

[9] http://www.cqc.org.uk/sites/default/files/media/documents/20130503_cqc_strategy_2013_final_cm_tagged.pdf

NATIONAL	
NHS Operating Framework	The Operating Framework for the NHS in England 2012/13[10] sets out the business and planning arrangements for the NHS. 2011/12 saw the introduction of a set of clinically led indicators to allow a more rounded view to be taken of the performance of emergency services. Those indicators will continue to be in place during 2013/14 for local use, and will be published locally for patients and the public. The ability for local commissioners to impose fines through the national contract will continue. In judging performance nationally, the Department of Health (DH) will use the operational standard of 95% of emergency patients being seen within 4 hours.
Transforming Urgent and Emergency Care Services in England: Urgent and Emergency Care Review, End of Phase 1 Report, High Quality Care For All, Now and for Future Generations, NHS England November 2013	NHS England has completed phase one of their review of urgent and emergency care in England, which proposes a fundamental shift in how urgent care and emergency services are delivered. It aims to introduce two levels of hospital based emergency centre with specialist services in larger units The report highlights the need for. It the importance of emergency services being able to provide access to the very best care for the most seriously ill and injured patients, 24 hours a day and 7 days a week. The review highlights five key elements to ensure success of implementing the reviews proposal of a two tiered emergency centres
High Quality Care for All, now and for Future Generations: Transforming Urgent and Emergency Care Services in England June 2013	NHS England have implemented an initiative that focuses on high quality care for all, now and for future generations. This initiative focuses on how emergency services can deliver the best outcomes for patients and the community in the future
Future Hospital: Caring for Medical Patients, Royal College of Physicians (Sept 2013)	RCP established the Future Hospital Commission, an independent group tasked with identifying how hospital services can adapt to meet the needs of patients, now and in the future. Its report, Future Hospital: Caring for Medical Patients sets out their vision and recommendations.
Quality, Innovation, Productivity and Prevention (QIPP)	QIPP is a large-scale transformational program for the NHS. It involves all NHS staff, clinicians, patients and the voluntary sector. The purpose is to improve the quality of care the NHS delivers and deliver £20billion of efficiency savings by 2014-15, which will then be reinvested into frontline care.

[10] Department of Health (2011, Nov). The Operating Framework for the NHS in England 2012-13.

NATIONAL	
HBN 15-01 Planning and Design Guidance: Accident and Emergency Departments (April 2013)	HBN 15-01 provides guidance on design considerations for the built environment in ED areas. These areas include designated clinical spaces such as minors, majors, resuscitation, mental health, children's and adult spaces and other hospital locations that are key to adjacency requirements, as well as the support facilities that underpin these areas. The guidance outlines the emerging principles in planning facilities for emergency care people such as user requirements and their views, location and departmental factors.
Royal College of Paediatric and Child Health 'Standards for children and young people in emergency care settings' [third edition] 2012[11]	This guidance document replaces the 'redbook' guidance and sets out the minimum standard requirements for how children in emergency settings should be treated - covering areas from service design and environment to staff training and safeguarding. It also contains specific standards against which healthcare providers can be measured.
The Silver book – National Guidance 'Quality Care For Older People With Urgent and Emergency Care Needs, June 2012	This national guidance document addresses the care for older people during the first 24 hours of an urgent care episode. It outlines the urgent care needs of older people and the competencies required to meet these needs. It states that the older person's care needs must be delivered within the first 24 hours and as part of a whole systems strategy. This document outlines current clinical guidance and suggested standards[12.]
Guidance for commissioning integrated URGENT & EMERGENCY CARE - A 'whole system' approach, July 2013[13]	This guidance document focuses on the interdependencies between services. It describes what urgent and emergency care is, why it is important to commissioners, And the need have a holistic system in terms of commissioning urgent and emergency care. It provides guidance on how to ensure integrated 24-hour urgent and emergency care focussing on consistency, quality, safety and improved patient experience. How patient pathways can be streamlined.

[11] www.rcpch.ac.uk/system/files/protected/page/Intercollegiate%20Emegency%20Standards%202012%20FINAL%20WEB.pdf

[12] www2.le.ac.uk/departments/cardiovascularsciences/people/conroy/docs/SILVER_BOOK_FINAL.pdf

[13] http://www.rcgp.org.uk/news/2013/july/~/media/Files/Policy/A-Z-policy/Urgent-emergency-care-whole-system-approach.ashx

2.11.2 Transforming Urgent & Emergency Care Services in England: Urgent & Emergency Care Review, End of Phase 1 Report - Potential Impact on UHL

Recent publication of NHS England's (November 2013) end of Phase 1 Report relating to transforming urgent and emergency care across England, highlights particular relevance to this section and therefore summarised sperately and highlighted within the main body of this OBC below. Refer to Appendix 1c for detailed outline of addional Nationalguiding documents and strategies.

Hospital EDs are set to be reclassified, with between 40 and 70 offering a higher level of staffing and expertise. Sir Bruce Keogh has proposed that existing accident and emergency departments are designated as either "emergency centres" or "major emergency centres" − although these titles could change.

Major emergency centres will be large units and will provide a range of highly specialised services delivering the very best outcomes for patients. Specifically noted is the ability to treat heart attacks and stroke patients.

In accordance with the above, UHL is likely to be designated a "major emergency centre", with the LRI supporting the emergency floor and Glenfield Hospital providing highly specialised cardiac care. Work will need to be undertaken to understand how much additional work this may bring to LRI from neighbouring hospitals rebadged as "emergency centres". Since the closest ED is approximately 25 miles away, it is possible the LRI already deals with much of this work. However, this will need to be tested when there is a better understanding of how services are to be configured locally.

There is a recommendation for the ED and Urgent Care Centre's to be collocated when it comes to delivering emergency services, which has already been clinically modelled as part of the proposed LRI Emergency Floor project, however, there will be renewed impetus to avoid patients coming to the LRI site in the first place.

This could be expected to reduce workload at the UCC/ Minors end of the clinical spectrum, and the projects Health Care Planners have factored an approximation of this into the "high" scenario through the inclusion of a "left shift into the community". Again, this will need to be tested with Commissioners with regards their thoughts on how this will be delivered.

On balance there will be two pressures:

1. An outward shift of less acute care
2. An inwards shift of more complex care.

These may or may not balance each other out, and work will need to be undertaken to understand the overall impact of these factors. The focus of the Health Care Planners and associated Emergency Floor Project Team has always proposed generic flexible accommodation to respond to changing shifts in acuity, workload and case mix. The design solution now needs to ensure that this is delivered and that facilities remain as generic as possible to deal with changing demand.

The second phase of the review will now look at the issues in more detail. It is unclear when it will report.

2.11.3 Regional Strategy/Guidance

CCG Out of Hospital Strategies

There are three LLR CCGs across Leicester: all three have agreed to commission major provider contracts collaboratively. The three CCGs are:

- Leicester City
- West Leicestershire
- East Leicestershire & Rutland

When developing commissioning plans, the following goals were agreed:

- To improve health outcomes
- To improve the quality of healthcare services
- To use our resources wisely

During 2012/13 the key transformation programmes developed were:

- Proactive Care
- Emergency and Urgent Care
- Capacity and capability in Primary Care
- Community Hospitals: The way forward

It is important to note all CCGs were contacted by the Trust during the SOC process to obtain support for the Emergency Floor Reconfiguration project.

Joint Strategic Needs Assessment (JSNA)

The development of a Joint Strategic Needs Assessment (JSNA) is a requirement from the DH that is placed upon the Directors of Public Health, Adult and Children's Services in all boroughs. The JSNA provides a systematic method for reviewing the health and well-being needs of a population, taking account of those groups or individuals whose needs are not being met, who are experiencing poor outcomes, or for whom special arrangements may be necessary.

It aims to understand both short-term needs (3 to 5 yrs) and long-term needs (5 to 10 yrs) and service requirements for patients in a given population.

The JSNA for Leicester is relevant to this business case setting health themes that suggest that implementation of key strategies should reduce non-elective admissions and therefore reduce demand for ED services at RFI. For example Older Persons strategy, non emergency 111 phone, out of hours care.

Emergency Care Network

The Leicester, Leicestershire & Rutland (LLR) Emergency Care Network (ECN) role is to put in place measures to improve urgent care across LLR. Outlined below are some of the key initiatives the network is implementing:

- **Emergency Response** - specialised services in fewer hospitals (emergency dept, specialised services such as trauma, stroke, primary angioplasty, vascular/ emergency surgery, and emergency ambulance service). These ED centres will be operational 24/7 with full and continuous cover.
- **Urgent Care System** - A key priority for improving urgent care is to improve patient flows across the whole system with all agencies involved in delivering urgent care working effectively together. This is governed by the LLR Emergency Care Network, which is chaired by Leicester City CCG on behalf of the local health and social care community. An integrated approach utilising reworked Urgent Care criteria such as agreed range of urgent care services (cuts, stings, etc), alcohol and substance misuse, crisis resolution, (mental health and social care), see & treat and hear & treat.
- **Integrated Health & Social Care System** – consistent standards, shared protocols, timely flow, integrated workforce, training and education, care networks. Access will be determined by local demand.
- **NHS 111** - In Sept 2013 the Trust became part of the LLR-wide NHS 111 programme, a new service introduced to make it easier for patients to access local NHS healthcare services when they need medical help fast but it isn't a 999 emergency. Demand on UHL's emergency services is anticipated to further increase as a result of the new NHS '111' service being introduced. The service has been launched in other areas of the country already and early indications point to increased attendance rates at EDs as a result.
- **EMAS Local Response** - Building on a successful pilot, the CCG continues to work closely with EMAS to deflect and reduce inappropriate secondary care activity. This will be achieved by an innovative pathway to keep patients within the care of general practice, where is it is safe and appropriate to do so, thereby avoiding an unnecessary journey to hospital.

2.11.4 Local Strategy

Better Care Together Strategy 2012-2022

Working together, LLR health and social care teams have developed this strategy to provide integrated, high quality services, delivered in local community settings where it is appropriate to do so, whilst improving the emergency and acute care provided to the people of the area.

The Better Care Together Strategy is relevant to this business case; it provides the framework to improve current emergency and acute care across LLR, whilst aiming to reduce acute attendance and promote care closer to home.

Trust Strategic Direction 2012 -2017

UHL Trust Strategy outlines the overall Trust aims, and highlights the clinical service aims of the Trust for the next 10 years. This strategy is supported by a set of enabling strategies such as, Estate Strategy, Quality Improvement Strategy, Education and Research Strategy and Workforce Strategy.

The crux of this strategy is to expand and develop key specialist services. The Better Care Together Programme and the Site Reconfiguration Programme will be instrumental in this delivery, driving up quality, enabling integrated patient flows and keeping costs down. The Emergency Floor project needs to be in a position to provide the appropriate capacity and level of care for this strategy to succeed.

The 10 year strategy sets out the Trust's vision for the future built around delivering healthcare that is of high quality, safe, compassionate and affordable.

The key corporate objectives are:

- Safe high quality patient centred health care
- 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

The Emergency Floor reconfiguration project is a key element in delivering these objectives.

UHL Reconfiguration Programme – Strategic Outline Case

In support of the strategic direction, UHL are currently developing a Strategic Outline Case which will identify option for future site reconfiguration in line with the Trusts Clinical Reconfiguration Strategy.

All options being assessed will maintain the LRI as the main emergency site and as such the Emergency Floor project will support the Strategic Outline Case.

A paper was supported by the Executive Strategy Board on the 5th November 2013 describing the Options Appraisal process proposed to be undertaken, the scoring mechanism and the format of each of the required forums. The Strategic Outline Case will be due for completion and submission to the Trust Board for approval at its March 2014 meeting.

Trust Estate Strategy and Estate Transformation Plan 2013

The quality and fitness for purpose of the NHS Estate and the services that maintain it are integral to delivering high quality, safe and efficient care (Treasury Value for Money Update 2009). It is also an area of significant spend; the budget for Estates and FM Services across the Trust in 2012/ 2013 was £31m.

Over the last two and a half years the LLR Health Community has worked together to better understand the collective capacity and estate challenge facing local organisations. Informed by jointly commissioned analysis, the local health community has committed to a strategy to simplify, standardise and share the delivery of core Estates/ FM services and to work together in reducing the collective asset base by 20%, better utilising the residual space and capacity footprint and improve the quality of the physical environment.

Efficient estate solutions will improve frontline service provision as well as achieving improved utilisation of the estate and unlocking its embedded value. This is possible by delivering a high quality clinical and working environment for patients and staff, resulting in better levels of productivity, flexibility and patient satisfaction. This will also support cross-divisional strategies that maximise optimisation of the estate resources across UHL.

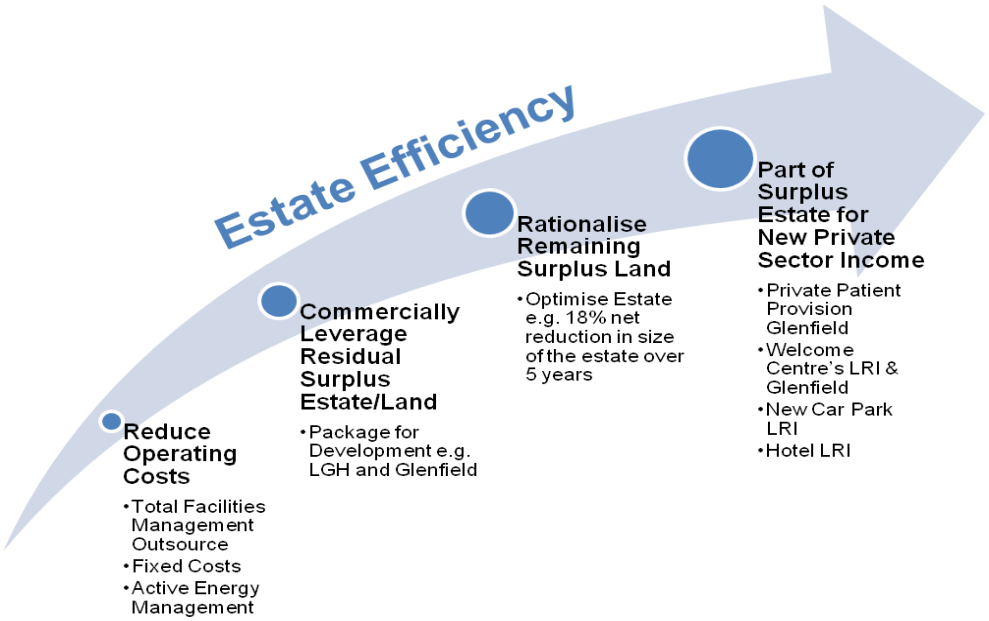
The Trust identifies the need for flexibility to move from being a constraint to an enabler for change. UHL is developing a Hospitals Estate Transformation Plan which is based on a strategic framework that consolidates the estate, develops new facilities, disposes of surplus land and buildings and encourages third party partnerships that will raise income for the Trust. This will be a cornerstone of service reconfiguration and improved utilisation of the Trust's estate. This must be balanced by organisational and public expectations about the provision of highly specialised services alongside local access to primary and secondary care, in the context of high levels of public support for the associated hospitals. It is in this context that the opportunity for significant and far reaching estate transformation will be determined.

The Transformation Plan will;

- Underpin the strategic direction
- Support the clinical strategy
- Support the strategic outline case for the whole site reconfiguration
- Show a clear implementation programme over five years for transformation with tangible benefits
- Improve the patient and staff built environment, investing in improved facilities and infrastructure; greatly aiding recruitment and retention
- Identify capital development to unlock the embedded value of Trust assets and support its ability to deliver clinical transformation and achieve QIPP efficiency savings

The following illustrates the cycle of estate transformation incorporating review, consultation, investment, rationalisation, development and ultimate delivery of schemes to meet the Trusts strategic and service objectives.

Figure 2D Estate Transformation Cycle



The Estates Transformation Plan sets out detailed strategies for its three main hospital sites. The Emergency Floor project is considered key in this plan in supporting the Trusts service strategies specifically for the LRI.

2.12 Summary

Key national and regional business strategies suggest that the urgent and unscheduled care environment in the NHS is changing significantly, with a number of initiatives underway to reduce ED attendances and non-elective admissions across LLR.

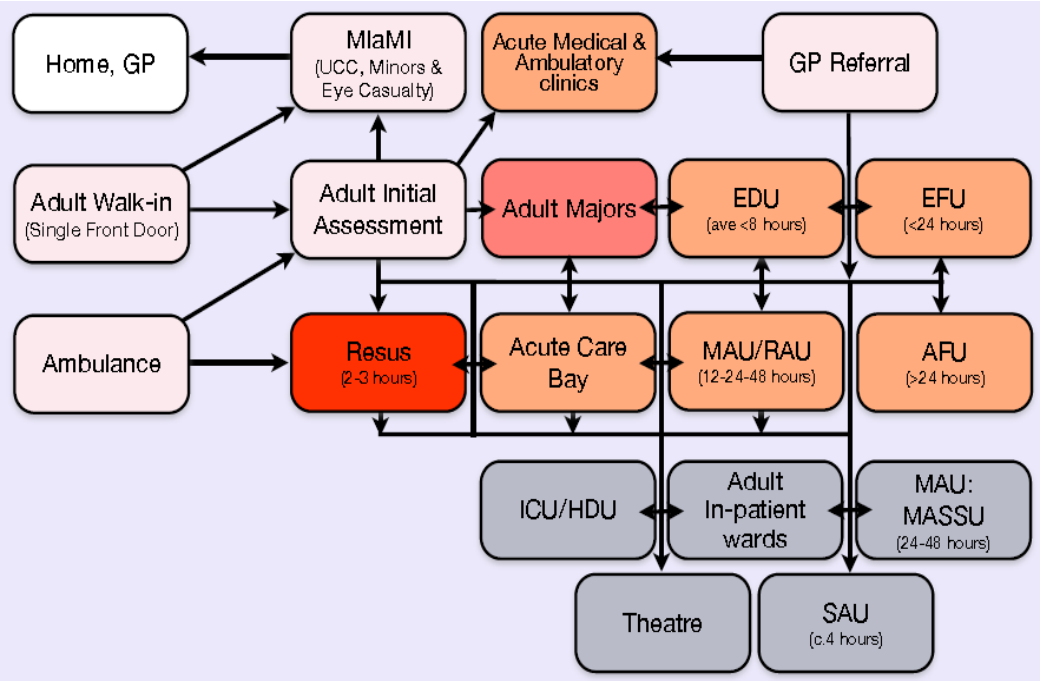
At the same time, the Better Care Together Programme and the integrated transformation programme are underway which identify how and where acute care is provided. LRI emergency services have an important role to play in supporting UHL and the entire health economy with increased activity projected, highlighting LRI as a main emergency service provider for the region. LRI emergency services will also be significant in meeting the two Trust strategic programmes, the challenges and opportunities, a key driver for investing in its long-term success.

Part B: The Case for Change

2.13 Introduction

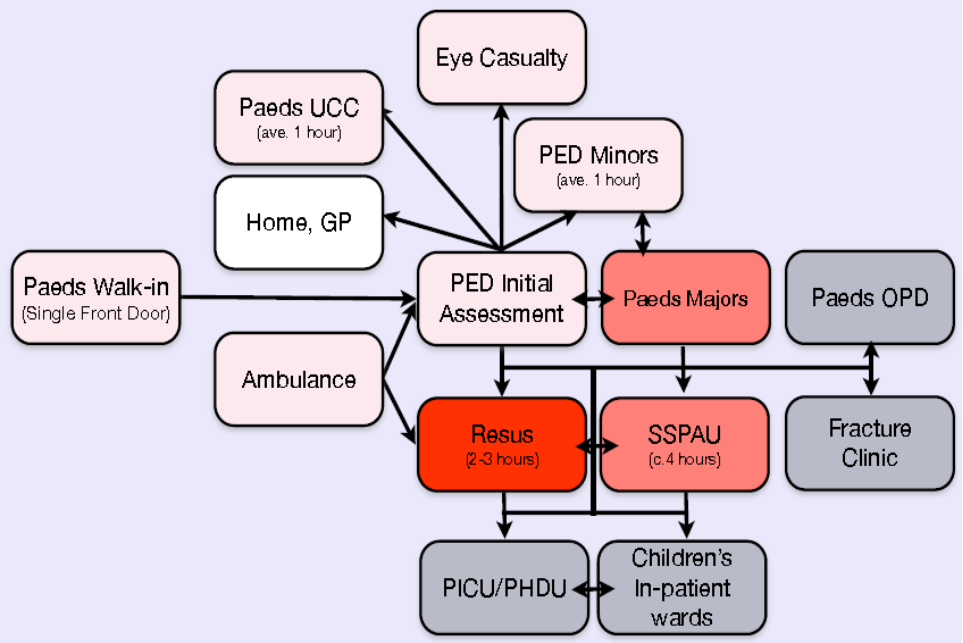
The purpose of this section of the business case is to outline the strategic case for change. Emergency Medicine is a secondary care specialty which provides immediate care for patients of all ages presenting with illness and injury of all severities[14]. The Trust clinicians have developed specific Models of Care for both Adult and Children's emergency services to be implemented into the proposed Emergency Floor development, providing new ways of working, improved process flows, improved efficiencies and continued safe care. Appendix 3a details the model of care, however they are outlined in the following diagrams.

Figure 2E Adult Model of Care



[14] The College of Emergency (2011, February). What is Emergency Medicine? A guide.

Figure 2F Paediatric Model of Care



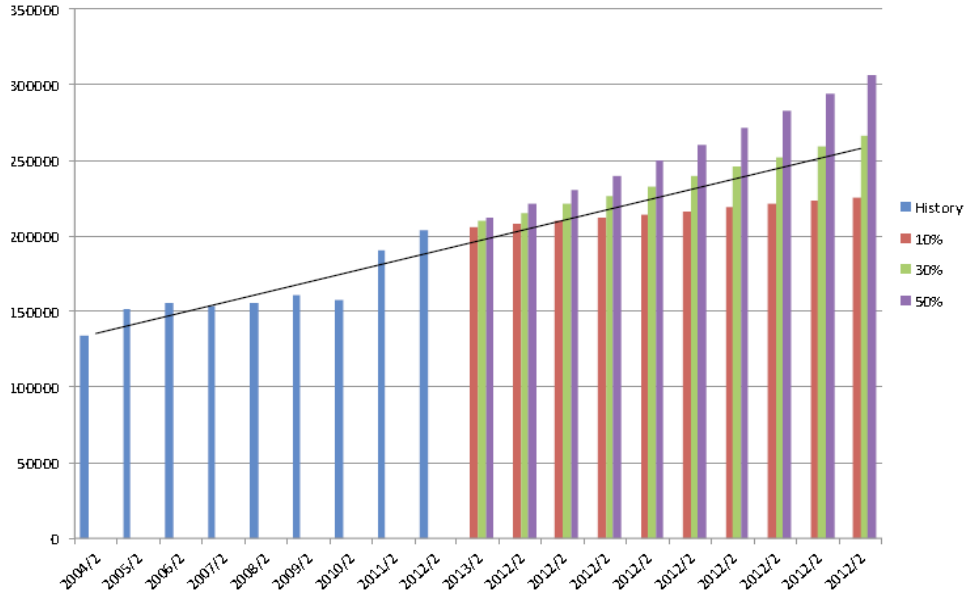
The Trust is expected to provide high quality emergency care and assessment services to comply with regulatory standards. It also needs to ensure that its patients and staff can receive treatment and work in a safe environment and that patient treatment is efficient and timely in its delivery. In doing so, provision of adequate majors cubicles, mental health, minors, imaging, resus, paediatrics, medical assessment and supporting infrastructure accommodation/ environment to support the specific service delivery requirements relating to the associated emergency and assessment care will be required.

2.14 Capacity and Demand

In line with national concern about the ability of emergency services to cope with demand, UHL has experienced a rise in attendances to its emergency services. Section 2.9 which demonstrated UHL's performance is well below the standard 95%. This reflects poor quality of care for patients, reduced clinical effectiveness, and an unacceptable delay in treatment, increased clinical risk and compromised patient safety.

The department currently serves annual attendances of approximately 200,000; including urgent care services. 52,000 of the annual attendances are ambulance patients which are seen through a 16 cubicled majors area. Figures suggest there is a 5-6% annual growth of emergency attendances at the Trust. The table below outlines this growth over a 10 year period up to 2012/13 and projects forwards on the basis of the three ED growth scenarios detailed above (10%, 30%, 50% growth over 10 years).

Figure 2G Activity Growth up to 2012/13



The Trust has undertaken extensive work projecting ED activity across the next 10 year period. The projected 10 year increase has been determined utilising a three scenario methodology (refer to Section 3). The three scenarios are:

- Baseline Scenario, this is based on ONS projections of population growth, and reflects the changes to the organisation of minors & UCC services implemented in 2013 with the commencement of a single front door policy for all adult walk-in attenders. This is factored in both as a one-off adjustment to the 2012/13 dataset and a further shift of future activity to the UCC from minors
- Medium Scenario, this is an intermediate scenario between the high and low growth rate projections
- High Scenario, this is based on historic trend in ED attendances

The table 2.5 and 2.6 below reflects the three scenario growth assumptions across specialty areas and the overall projected activity over the next 10 years. The increase will require additional capacity to deliver emergency services across the next 10 years.

Table 2.5 Scenario Projected Growth Across ED Specialty Areas

	Paeds	Eyes	Majors	Minors	Resus	Grand Total	UCC	All inc. UCC
Demographic Growth	12%	9%	14%	8%	16%	12%	10%	11%
Uplift for Medium Growth	20%	20%	20%	20%	20%	20%	20%	20%
Uplift for High Growth (Historical)	20%	20%	20%	20%	20%	20%	20%	20%
UCC Front Door Immediate				-40%			65%	0%
UCC Share of Future Growth				-16%			26%	
Left shift to Primary Care							-30%	-5%
Children UCC to ED	25%						-25%	0%
Base Scenario	**12%**	**9%**	**14%**	**-32%**	**16%**	**12%**	**75%**	**11%**
Medium Scenario	**32%**	**29%**	**34%**	**-20%**	**36%**	**32%**	**108%**	**31%**
High Scenario (inc. shift)	**77%**	**49%**	**54%**	**-8%**	**56%**	**52%**	**86%**	**46%**

For modelling purposes for the ED the scenarios have been abbreviated to low (10%), medium (30%) and high (50%).

The final 2012/ 13 year to date 4 hour wait figure for UHL, including the UCC, was 91.9% of attendances. In response to a consistent underachievement of the 4 hour target, new clinical roles were introduced and a new pathway commenced in November 2011 called ‘Right Place, Right Time’. This initially resulted in a considerable improvement in the Trust’s ED performance.

However, following a number of challenging weeks of activity (with ED attendances 5% higher and emergency admissions 7% higher in the final quarter compared to the same period last year) achievement of the 4 hour target deteriorated. This is a contributing factor to the worsening financial performance and impact on achieving the Trust strategic plans.

It is important to acknowledge that the Trust has implemented the models of care that focuses on a single door entry point whereby patients present to UCC first and then referred to the ED. Although this initially seemed to improve performance the ability to achieve the 4 hour target is limited. This is primarily due to the current capacity requirements.

The increasing attendance levels creates increased demand for major cubicles, minor cubicles and resuscitation beds and ultimately impacts on waiting times. Inadequate space and the inadequate size of the department currently results in patients waiting on trolleys queuing in the open floor space in the majors area. As well as compromising patient privacy & dignity, this inhibits the Trust’s ability to move patients smoothly through the emergency pathway and creates an unnecessary infection control risk.

In addition to the activity projections, the Trust has also undertaken activity analysis relating to hourly arrival percentiles. The 95th percentile number of hourly arrivals across the entire unit is in the region of 40 patients/hour. On rare occasions this volume may recur for two or three hours at a time. The analysis has focussed on treatment and wait times associated at each stage of the journey. The table below outlines percentile hourly arrivals for each clinical area. For the purposes of planning the new department, the capacity requirement has been based on 95th percentile hourly arrivals. Appendix 3b provides more statistical detail relating to waits and activity.

Table 2.6 Current Hourly ED Arrival Percentiles

Eye Casualty

Percentile	Pts/Hr
98%	14
95%	11
90%	10
50%	5
Mean	6

Minors

Percentile	Pts/Hr
98%	14
95%	12
90%	11
50%	6
Mean	6

UCC exc. ED double counts

Percentile	Pts/Hr
98%	14
95%	12
90%	11
50%	6
Mean	6

Resus

Percentile	Pts/Hr
98%	5
95%	4
90%	3
50%	2
Mean	2

Children

Percentile	Pts/Hr
98%	12
95%	10
90%	9
50%	4
Mean	5

Majors

Percentile	Pts/Hr
98%	14
95%	12
90%	11
50%	7
Mean	7

All UCC inc. ED double counts

Percentile	Pts/Hr
98%	17
95%	14
90%	12
50%	6
Mean	6

Department exc. UCC

Percentile	Pts/Hr
98%	38
95%	34
90%	32
50%	21
Mean	19

It is important to note that efficiencies are impacted by the extent that patients occupy clinical spaces – resus bays, majors cubicles, etc – purely for the purpose of waiting (e.g. waiting for diagnostics or transfer, rather than for clinical intervention).

In addition to capacity it is essential that adjacency requirements are considered and the associated impact on efficiencies and patient experience. This is particularly relevant for both the Medical Assessment Unit (MAU) and Diagnostic services.

Assessment

MAU is currently on the 5th floor of the Balmoral Building. This location creates inefficiencies in patient flows. It is essential that this service be provided on the same floor as the ED with additional capacity to enhance efficiencies and meet demand. The assessment unit provides a medical decisions unit that is essential in providing an extension of care to the resuscitation, diagnostic and treatment. The unit also receives referrals direct from G.Ps which, at times, will be referred to the ED for treatment.

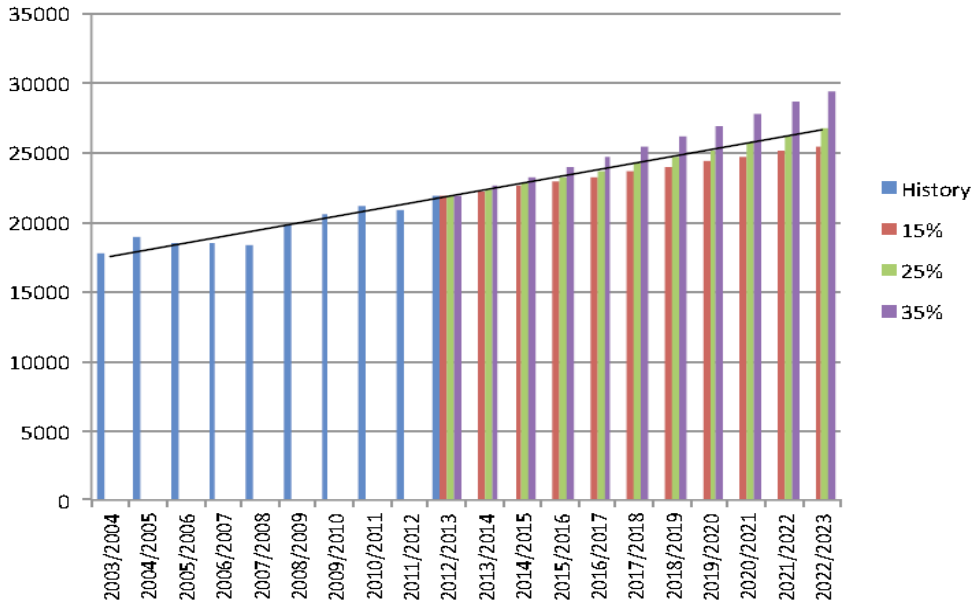
MAU activity has recently been growing at around 3.5% annually (Refer to Appendix 3a) and the adjacency to the ED will assist in managing this growth rate by streamlining patient pathways and flows.

As with the ED flows, work has been undertaken to model the projected number of emergency medical admissions, with three scenarios being generated as follows:

- Low: demographic growth (based on ONS data), 11% over 10 years;
- High: historic trend in growth (c.3.5% per annum), 35% over 10 years;
- Medium: intermediate growth scenario, 25% over 10 years.

These scenarios have been abbreviated to 15%, 25% and 35% growth over 10 years for planning purposes for the adult medical assessment areas of the scheme.

Figure 2H Historic & Projected Assessment Unit Activity (LRI Adult Medical Emergency Admissions, excludes Stroke & Oncology)



Diagnostics

The existing ED and MAU has no dedicated emergency imaging suite. When ED patients require diagnostic services they are required to attend the main imaging department and at times require a porter and/or nurse to transport the patient to these facilities.

The requirement for a rapid, reliable diagnostic imaging service as part of the emergency patient pathway is increasing, with growing demand for the assessment of patients with trauma, stroke, and other conditions in line with national guidance. It is likely that demand for cross-sectional imaging will continue to grow and this proposal incorporates a strategy for future enlargement of capacity.

The pathway of care can be overlaid on this whole-system approach, and it has four key stages:

- Identification of the need for care (by self, by carer, by professional, by other)
- Assessment of need (by telephone, by face to face)
- Initiation of right response (emergency response, urgent response, rapid/ moderate response and integrated health and social care) – outlined in more detail below
- Follow through to closure (episode complete, planned follow-up, on-going care)

A diagnostic hub that is central for all patients within the Emergency Floor will provide improved patient flows and reduce the time to diagnose patients. Staff efficiencies will also be enhanced by gaining back the time that staff spend each day escorting patients to the main imaging department. Appendix 3b outlines the capacity requirements and based on intermediate growth suggests 265 CT and 2,141 plain films per week in ten years' time (in comparison to 200 and 1,650 currently).

In a similar fashion, the project envisages satellite pathology and pharmacy facilities in order to provide local diagnostic testing and pharmacy dispensing. It is expected that the physical proximity of these facilities will engender truly multi-disciplinary working within the emergency service, as well as improving the turnaround times for pathology tests and the dispensing of medications.

The overall increase in demand at the ED and associated Assessment Unit is comprised of a number of key drivers that include:

Local Demographic Factors

- The local community is an ageing population and there has been growth in the number of frail patients and those suffering from dementia
- LRI 'minors' attendances tend to be of a higher acuity (fractures/significant soft tissue injuries) than the nearby walk in centres at Loughborough (x1) Leicester City Centre (x2). This is due to patients with lower acuity minor injuries choosing to be seen at these centres (approx 150,000 between the three walk in centres), leaving the higher acuity cases to be treated at LRI ED
- UHL's emergency services serves a population of approximately 1 million, making it one of the largest emergency services departments in the country
- There is no other ED within a 25 mile radius
- The local community lack confidence in the GP out of hour's service which has increased pressure on EDs
- The local community has one of the highest birth rates in the country, generating additional paediatric workload

Service Development Factors

The proposed Emergency Floor project will be a significant driver in the Trust's LRI site wide reconfiguration plans. The development will immediately begin to address the sites lack of clear demarcation with regards access/ egress arrangements for staff, public, patients and blue light, by creating a 'hot' end to the LRI site.

Currently the hospitals main entrance is immediately adjacent to the drop off point and access to the ED and associated assessment areas, which provides very little privacy and dignity for patients and their families. There are also considerable health and safety issues with regards the number of people in the vicinity in conjunction with ambulances and other vehicles operating in and around the same area.

The proposed development will separate blue light access/ egress away from what will eventually become the main entrance. A site wide parking solution will also be

developed in parallel, with an immediate aim to alleviate vehicular congestion in and around the site during peak times.

2.15 Quality of Care

The following outlines specific issues across the current ED and associated assessment areas requiring change to meet demand requirements set out above, meet future activity and more specifically what the Trust needs to implement to achieve strategic requirements relating to quality.

As indicated throughout this document, there are various elements of the physical environment of the existing ED and supporting clinical areas that are unsatisfactory and compromise the emergency services clinical quality indicators and may lead to an impact on safety and a negative experience for patients, carers and staff. For example:

- Flows through the ED are poor; it is cramped and not fit for purpose
- Limited space for provision of an adequate number of majors cubicles compromises many elements of care and patient experience, particularly:
  - Patient safety
  - Privacy and dignity
  - Infection control
  - Patient pathways
  - Ability to meet ED targets, including the 4 hour wait and the ambulance handover target

It is important to consider this within the framework of the five domains of quality as defined by the Care Quality Commission (CQC)[15]. These five domains are:

1. Safety
2. Effectiveness
3. Caring
4. Responsive to people's needs
5. Well led at organisational, hospital and service level

[15]http://www.cqc.org.uk/sites/default/files/media/documents/20130503_cqc_strategy_2013_final_cm_tagged.pdf

Table 2.7 Quality of Care by CQC Domain

Department	CQC Domain
ED Front Door: In line with current guidance (DH and CEM) there is a requirement for one front door for adult patients presenting for emergency treatment. All patients would be assessed on arrival and directed to the appropriate level of care; i.e. acute medical clinics, UCC, minors or majors and resuscitation. A separate front door is required for paediatric cases in line with National Service Framework (NSF) for Children and Young People A dedicated ambulance entrance would also be provided.	Safety Responsive to people's needs Caring Effectiveness
Paediatrics: UHL needs to meet the NSF for Children and Young People standards relating to discrete space and child friendly environment. The department will require an increase in cubicle numbers to cater for the attendances (refer to Appendix 3b) and the proposed growth, and will incorporate a short stay facility, including the potential shift of paediatric emergency care from an adjacent hospital. A dedicated paediatric single front door will ensure a child-focused approach to emergency care for children.	Safety Responsive to people's needs Caring Effectiveness Well led at organisational, hospital and service level
Majors: Currently there currently 16 majors spaces; with additional ad-hoc chairs doubling up in cubicles and the ED corridor. Activity/ capacity analysis carried out (Refer to Appendix 3b) demonstrates that there should be a minimum of 32 majors cubicles in order to serve the attendances. The proposed change will provide the following: • Patient safety– providing compliant space around the bed for major incident and patient access. • Privacy and dignity for patient. • Compliance with infection control standards. • Patient satisfaction and sustainable enhancement of the patient experience. • Cubicle space to accommodate ambulance arrivals to the Trust, addressing the current delays with ambulance handovers into the unit.	Safety Responsive to people's needs Caring Effectiveness Well led at organisational, hospital and service level
Resuscitation: There is a need to improve efficiencies and increase the capacity from 6 spaces to 12 spaces (including paeds)	Safety Responsive to people's needs Caring Effectiveness Well led at organisational, hospital and service level
EDU: There is a need to increase capacity to ensure efficiencies in flows across the emergency care pathway. Activity analysis indicates this service requires 13 beds, 3 chairs	Safety Responsive to people's needs Caring Effectiveness Well led at organisational, hospital and service level

Department	CQC Domain
EFU: There is a need to increase capacity to ensure efficiencies in flows across the emergency care pathway. Activity analysis indicates this service requires 16 beds	Safety Responsive to people's needs Caring Effectiveness Well led at organisational, hospital and service level
Minors: There is a need to improve patient efficiencies and staff flows within the minors area of the ED, though significantly undersized the overall numbers slightly underprovided.	Safety Responsive to people's needs Caring Effectiveness Well led at organisational, hospital and service level
Diagnostics: There is currently no dedicated emergency imaging suite; patients are required to attend the main imaging department. A diagnostic hub that is central for all patients within the ED will provide improved patient flows and reduce the time to diagnose patients. Staff efficiencies will also be enhanced by gaining back the time that staff spends each day escorting patients to the main imaging department.	Safety Responsive to people's needs Caring Effectiveness Well led at organisational, hospital and service level
Mental Health: There is a need to meet requirements relating to a dedicated area (inclusive of own WC) that can be secured off from the rest of the department. Consideration regarding provision of as separate entry/ exit to the department in order to enhance compliance to Section 136 requirements is essential. Capacity work undertaken by the Trust reflects a requirement of 3 rooms (within EDU area)	Safety Responsive to people's needs Caring Effectiveness Well led at organisational, hospital and service level
Medical Assessment: There is an essential need to provide a triage and assessment service adjacent to the ED and diagnostics to enhance patient flows through the department, with the benefit of improved working relationships, processes and clinical effectiveness for patients.	Responsive to people's needs Caring Effectiveness Well led at organisational, hospital and service level

In addition to these domains, the CQC implemented an 'Intelligent Monitoring' approach (October 2013) to assess which Trusts will be visited first in the next wave of CQC inspections. This approach is based on 150 indicators that look at a range of information including patient experience, staff experience and statistical measures of performance for example whether a Trust is hitting the accident and emergency (A&E) 4 hour wait target. The Trust is then banded between 1 and 6 (Band 1 represents a higher risk than Band 6). UHL is currently banded by the CQC as Band1 and therefore representing a high risk with ED performance viewed as a key indicator in this banding.

The CQC will be undertaking an inspection visit in January 2014, with specific areas for inspection to be confirmed.

To improve on this banding the proposed Emergency Floor project will contribute significantly in improving on these quality indicators.

Difficulty Recruiting and Staffing Specialist Medical Roles

Nationally, there is a declining medical workforce specialising in the area of emergency medicine. Whilst there has been a successful recruitment drive at LRI for all levels of staff, the unit remains short-staffed and has to place a heavy reliance on agency staff, which is further exacerbated by the poor environment resulting in a difficulty recruiting.

Whilst ongoing operational improvements are being made to ED processes, the proposed investment and development of the Emergency Floor is the Trust's strategic response to ensure that there is sustained delivery of the emergency care. For those who have to attend hospital, care will be provided in an environment designed to deliver a better patient experience and better quality outcomes.

Future proofing of emergency care provision and changes in patient activity in line with national and regional models of care make it timely for the Trust to review and identify options for enhanced emergency care provision at the LRI, as well as the environment it's delivered in.

The Trust believes that some of the barriers to recruitment and retention of specialist ED staff are as follows:

- Inadequate working environment leading to substandard patient care and increased risk of adverse incidents. This in turn impacts on staff and presents risk of staff stress and increased sick leave
- Inadequate training facilities based on limited capacity and flexibility of emergency care infrastructure

A consolidated centralised unit, to meet capacity will contribute to attracting emergency medicine staff to the Trust.

The above case for change relating to both capacity and quality manifests itself into what ultimately becomes a far from satisfactory patient experience; in May 2013 patient complaints hit an all-time high, with the receipt of 30 formal complaints as a consequence of service received from the ED.

Summary

Redevelopment of the emergency care facilities would allow the Trust to meet the current demand and capitalise upon the options to develop improve services, reduce wait times, thereby securing and improving Trust performance. It will also provide the Trust with the opportunity to meet its strategy to achieving the Trusts reconfiguration plans. Redevelopment of the ED and associated assessment areas, to provide a single Emergency Floor, will allow for the consolidation of specialist staff, would create a modern fit for purpose unit in line with national guidance and best practice; which is essential in achieving other standards and efficiencies in patient pathways, clinical synergies and quality of emergency care service delivery. It will also achieve all the quality needs for the patient and the pathways served by this service.

2.16 Investment Objectives

In the context of the above and the Trust's Corporate objectives outlined in Section 2.6 above, the investment objectives for this project are detailed below. It is important to note that these objectives are aligned to the Critical Success Factors outlined in Section 3.2.

Table 2.8 Project Objectives

Critical Success Factor: Business Need	
Investment objective	1. To provide the Trust with increased capacity for emergency services to meet the demands of population growth, changing service models and improved efficiency targets. 2. To increase the productivity of emergency care at LRI 3. To develop a centre of excellence, enhancing the Trust's reputation for training, service delivery and treatment, through the provision of a centralised service in modern accommodation.
Critical Success Factor: Strategic Fit	
Investment objective:	4. To ensure that the changing needs and expectations of a growing population are met in line with Trust clinical strategy and national guidance standards 5. To provide an ED that is compliant with NHS building guidance standards
Critical Success Factor: Quality	
Investment objective	6. To improve the clinical effectiveness and safety of urgent and emergency care service across Leicester: 7. To improve the clinical adjacencies of services to optimise clinical safety and reduce clinical risk.
Critical Success Factor: Sustainability, Service Modernisation, Value for Money	
Investment objective	8. To facilitate the modernisation of services, including streamlining patient pathways and efficient working practices providing an ED that ensures adequate infrastructure and capacity for supporting services that are conducive to the needs of a modern workforce.
Critical Success Factor: Meeting Commissioners' intentions for healthcare services	
Investment objective	9. To equip the ED to respond effectively to existing and known commissioning requirements, as well as to respond flexibly to future changes in service direction and demand. 10. To improve the environment and the experience of users (patients, visitors and staff) of Leicester Royal Infirmary Hospital Accident and ED
Critical Success Factor: Achievability	
Investment objective	11. To provide a solution that is aligned to the Trust DCP plan and Trust organisation as a whole. 12. The development will be delivered on time with minimal disruption to current service delivery

The table below details the key deliverable for each objective.

Table 2.9 Key Deliverables

Project Objective	Key Deliverable	Link with Strategy
To provide the Trust with increased capacity for emergency services to meet the demands of population growth, changing service models and improved efficiency targets.	Meet target to provide efficiency in patient throughput and times to be seen and diagnosed Infection Control standards met	QIPP Trust Strategy Emergency Care Standards Commissioning intentions
To increase the productivity of emergency care at LRI	Targets met relating to patients wait times and time for diagnosis	QIPP Trust Strategy Emergency Care Standards Commissioning intentions
To develop a centre of excellence, enhancing the Trust's reputation for training, service delivery and treatment, through the provision of a centralised service in modern accommodation.	ED will reflect specialised staff with emergency care expertise and increased recruitment /retention level	QIPP Trust Strategy Commissioning intentions
To ensure that the changing needs and expectations of a growing population are met in line with Trust clinical strategy and national guidance standards	Meet Guidance standards	Health Building Notes Estate Strategy QIPP Trust Strategy Emergency Care Standards Commissioning intentions
To provide an ED that is compliant with NHS building guidance standards	Meets NHS building guidance standards	Health Building Notes Estate Strategy
To improve the clinical effectiveness and safety of urgent and emergency care service across Leicester:	Model of Care reflects seamless pathways and reduced waiting times	QIPP Trust Strategy Commissioning intentions
To improve the clinical adjacencies of services to optimise clinical safety and reduce clinical risk.	Meet adjacency target	QIPP Trust Strategy Commissioning intentions
To facilitate the modernisation of services, including streamlining patient pathways and efficient working practices providing an ED that ensures adequate infrastructure and capacity for supporting services that are conducive to the needs of a modern workforce.	Adjacency requirements are met	QIPP Trust Strategy Emergency Care Standards Commissioning intentions
To provide an ED that ensures adequate infrastructure and capacity for supporting services that are conducive to the needs of a modern workforce	New Emergency care facilities will be compliant with Health Building notes and emergency care standards	QIPP Trust Strategy Emergency Care Standards Commissioning intentions

Project Objective	Key Deliverable	Link with Strategy
To equip the ED to respond effectively to existing and known commissioning requirements, as well as to respond flexibly to future changes in service direction and demand.	New Emergency care facilities will be compliant with Health Building notes and emergency care standards	QIPP Trust Strategy Commissioning intentions
To improve the environment and the experience of users (patients, visitors and staff) of Leicester Royal Infirmary Hospital Accident and Emergency Department	New Emergency care facilities will be compliant with Health Building notes and emergency care standards	QIPP Trust Strategy Emergency Care Standards Commissioning intentions
To provide a solution that is aligned to the Trust DCP plan and Trust organisation as a whole.	Option selected will be derived through option appraisal that considers associated benefits relating to minimum disruption	QIPP Trust Strategy Emergency Care Standards Commissioning intentions
The development will be delivered on time with minimal disruption to current service delivery	Emergency care project will be delivered with minimal disruption during project	QIPP Trust Strategy Emergency Care Standards

2.17 Design Quality and Philosophy

The design will reflect the importance of flexibility, quality and will be informed by the latest design guidance where appropriate. It will be a contemporary building, respectful of locally sensitive areas. The building will not affect statutory and non-statutory designated sites.

2.18 Summary

2.18.1 Drivers for Change

The following are key drivers for change:

- The increasing demand for emergency services is greater than the current capacity can provide. Historic trends in growth suggest a 5% annual growth in ED activity and 3.5% annual growth in assessment unit activity
- Requirement for single floor Emergency and Assessment Department that incorporates key adjacencies and presence of diagnostics and assessment unit services on the same floor. This enables implementation of the developed model of care for both adults and children accessing emergency services
- Changes in the local and national demographics combined with the Trust's plan to remain an emergency care centre for Leicester is impacting on increased emergency care demand

- The Trust requires additional capacity to reflect NHS national guidance. The Emergency Floor project reduces the risk of compromising compliance of other standards of care such as quality, infection control, emergency and urgent care standards and commissioning standards
- The Trust needs to be in a position to be named as a 'Major Emergency Centre' as outlined in the Urgent and Emergency Care Review November 2013 – End of Phase 1 Report (Keogh)
- The requirement to address the 4 hour target and ambulance to trolley transfer will have a significant impact on Trust financial performance if capacity issues are not resolved
- Redevelopment and increased capacity will provide opportunities for the Trust to fulfil its strategic redevelopment programme

2.18.2 Energy Efficiency

The preferred option design solution will enhance and improve on overall energy efficiencies, contributing to the NHS sustainability targets of reduce 2007 carbon footprint by 10% by 2015.

2.18.3 Future Flexibility

Consideration of increased demand will provide opportunity for a solution that is flexible in functionality and that can provide capacity for current demand whilst enabling realisation of the 10 year capacity requirement.

A core component of the design solution will be a generic approach to clinical space which will allow the usage of suites of clinical spaces to be flexed in response to changing demand, pathways and clinical practice.

2.18.4 Conclusion

The drivers for change set out above form the basis of the strategic importance the Trust attaches to the redevelopment of emergency care department at Leicester Royal Infirmary. The drivers for change have been recognised in the project objectives.

In the context of the national, regional, local and Trust strategies, alongside the current configuration with the associated lack of capacity and the condition of the current ED and associated assessment areas, it is clear that investment is required to achieve the project objectives. The proposals outlined in this OBC provide a range of options that will enable the Trust to achieve these aims.

2.19 Potential Business Scope and Key Service Requirements

The Trust is seeking to resolve the shortcomings of its existing ED facility through the development of a purpose-built facility for the provision of emergency care.

The following key service requirements have been identified to meet the current business needs:

- Increased capacity to meet current and future emergency service related activity
- Enhanced clinical adjacencies to facilitate better access to related core emergency care facilities and improved process flows
- Improved access to diagnostics (imaging and pathology)
- Improved environment
- Improved retention and recruitment
- Aligns with the Trusts redevelopment strategic plans

The main components of the required scope for the new Emergency Floor are:

- Urgent Care Centre
- Ambulance Entrance
- Resuscitation
- EDU
- EFU
- Majors
- Minors
- Plaster Suite & Procedure Room
- Diagnostic Imaging
- Paediatrics
- Assessment/Treatment Facilities
- Support Accommodation
- Seminar Room
- Staff Facilities
- Offices
- Simulation facilities

Summary

The lack of physical space and capacity in both clinical and non-clinical areas within the ED is affecting its performance in meeting the 4 hour standard and ambulance turnaround times, as well as the overall patient experience currently received. It also creates a significant safety risk when Majors and Resuscitation facilities are over capacity (up to and over 200% in Q4 2012).

The current ED facility also lacks flexibility to accommodate any further increases in activity due either to population growth and/or reconfiguration reflected within Trust redevelopment plans. As Leicester Royal Infirmary consolidates its role as a centre for emergency care across LLR, existing facilities will be stretched even further.

2.20 Main Benefits Criteria

Table 2.9 below shows how the benefit criteria link to the project objectives.

Table 2.10 Investment Objectives and Benefits

Investment Objective	Benefit Criteria
To provide the Trust with increased capacity for emergency services to meet the demands of population growth, changing service models and improved efficiency targets.	To implement a design solution that provides a safe emergency care service that ensures capacity and flexibility for current and future demands of patients requiring emergency care
To increase the productivity of emergency care at LRI	Improve patient pathway management reducing the clinical risk and discomfort through the emergency care pathway.
To develop a centre of excellence, enhancing the Trust's reputation for training, service delivery and treatment, through the provision of a centralised service in modern accommodation.	Support and consolidate the provision of emergency floor concept at LRI
To ensure that the changing needs and expectations of a growing population are met in line with Trust clinical strategy and national guidance standards	Ensures that the service model of care is delivered in line with National ,Trust and local health economy KPI's
	Patient safety is enhanced, and clinical risk is reduced
To provide an ED that is compliant with NHS building guidance standards	Where possible ensures that the service is developed in line with NHS Guidance in terms of HBN, HTM, national and Trust policy and local health economy policy in terms of capacity provision
To improve the clinical effectiveness and safety of urgent and emergency care service across Leicester	Quality of care is enhanced, in terms of the model of care, and seamless pathways of care and patient flows.
	The built environment enhances clinical practice that support clinical effectiveness, improved patient outcomes and patient safety
To improve the clinical adjacencies of services to optimise clinical safety and reduce clinical risk.	Provides enhanced departmental relationships and clinical adjacencies that support clinical effectiveness and improved patient outcomes
To facilitate the modernisation of services, including streamlining patient pathways and efficient working practices providing an ED that ensures adequate infrastructure and capacity for supporting services that are conducive to the needs of a modern workforce	Ensures facilities are future proofed and adaptable to the changing needs of the health economy
To equip the ED to respond effectively to existing and known commissioning requirements, as well as to respond flexibly to future changes in service direction and demand.	Improved privacy and dignity of provisions for all patients
	Consolidates existing services & provides clinical expertise whilst realising the Emergency Floor concept
To improve the environment and the	Improved patient access through a single

Investment Objective	Benefit Criteria
experience of users (patients, visitors and staff) of Leicester Royal Infirmary Hospital Accident and Emergency Department	front door
	Enhances patient, visitor and staff safety through the built environment
To provide a solution that is aligned to the Trust DCP plan and Trust organisation as a whole.	The design solution minimises the impact of the construction process on the site and therefore delivery of the Trust core services
	Option enables future proofing of the physical ED environment aligned to DCP future expansion needs
The development will be delivered on time with minimal disruption to current service delivery	The enabling moves will facilitate the Emergency Floor programme whilst minimising delay to delivery
	Reduces complexity and sequence dependency of enabling moves
	Maintains blue light access throughout whole build process

2.21 Main Risks

Table 2.11 Main Risks and Counter-Measures

Risk	Mitigation
NTDA, CCG's, OSC's, Better Care Together Board and other key external stakeholders - are not supportive of the project	Engagement progressed from SOC stage onwards, with full involvement and engagement anticipated during the development of the Full Business Case
Potential change in organisational clinical strategy	Medical Director, who is responsible for clinical strategy, chairs the Project Board
NTDA approval and/ or funding not forthcoming	Ongoing discussions with NTDA with approval of key milestones. Do Minimum option would be pursued in the event of a lack of capital funding
Victorian Society/ League of Nurses – concern at Chapel being demolished - potential risk to programme	Once OBC approved, engagement with Victorian Society/ League of Nurses to agree the relocation of historical artefacts
Planning & Highways - do not support design proposals	Initial meetings with Council have been very positive – full engagement planned with highways consultants during design development
Extended project programme - will result If enabling works not progressed prior to FBC approval	Trust Board to agree assurance required to proceed enabling works at risk
Delay - due to unforeseen demolition and construction risks	Surveys carried out for M&E and statutory compliance related areas to identify potential issues

Risk	Mitigation
	in advance
Service Disruption – The project impacts negatively on provision of emergency care services during implementation significantly affecting patient outcomes and surgical services	This risk is mitigated by an assessment of the programme and developing a project plan that limits disruption. Communication with design and project management team is essential

2.22 Constraints and Dependencies

The constraints and dependencies relevant to the project are:

- **Budget** - the Trust has a limited capital budget, and must seek approval from the NTDA for any expenditure of over £5m of Treasury capital (i.e. excluding funds from donations). The Trust currently has access to approximately £8m for any required enabling works and £4m for business case and design development related fees.
- **Physical** - the existing accommodation is heavily occupied, making enabling works an essential component of this project and the potential for disruption to the Trust organisation and infrastructure as a whole
- **Phasing** - difficult, and potentially reducing the ability to comply with national guidance
- **Timeliness** – the hospital will see a year on year increase in demand, both in terms of Urgent care and Emergency reviews The new facility must be operational by August 2016
- **Trust Transformation Programme**- Trust wide schemes for redevelopment of the Trust sites are all interdependent. It is essential that phasing and enabling works are scoped accurately to minimise any disruption
- **Capital** - The project overall is dependent on the Trust securing the majority of capital through support from the NTDA

3 | The Economic Case

3.1 Introduction

In accordance with the Capital Investment Manual and requirements of HM Treasury's Green Book (A Guide to Investment Appraisal in the Public Sector), this section of the OBC documents the wide range of options that have been considered in response to the potential scope identified within the Strategic Case. It identifies the critical success factors, determines the shortlisted options and appraises each to determine the preferred option.

Additionally, this case also provides an overview of the main costs, benefits and risks associated with each of the selected options. Importantly, it indicates how they were identified and the main sources and assumptions.

3.2 Critical Success Factors

The critical success factors for this project are considered to be:

Table 3.1 Critical Success Factors

No.	CSF	Explanation
1	**Quality**	To what extent does the option provide opportunities to deliver "Caring at its Best" by optimising the quality (clinical outcomes, safety and experience) of patient services provided during the transition period and in the future?
2	**Meeting Commissioners' intentions for healthcare services**	Does the option satisfy the existing and future anticipated models of care?
3	**Business Needs**	The preferred option satisfies the existing and future business needs of the Trust as described in the Strategic Case.
4	**Strategic Fit**	The preferred option provides a holistic fit and synergy with other key elements of national, local and Trust strategies
5	**Value for Money (VFM)**	The option provides economies of scale, scope and efficiencies, whilst maintaining quality and standards of effectiveness in the delivery of care.
6	**Benefits Optimisation**	How well does the option optimise the potential return on expenditure – business outcomes and benefits (qualitative and quantitative, direct and indirect to the Trust) – and assist in improving overall VFM (economy, efficiency and effectiveness)?

No.	CSF	Explanation
7	**Potential Affordability**	Does the option satisfy the Trust's ability to innovate, adapt, introduce, support and manage the required level of change, including the management of associated risks and the need for supporting skills (capacity and capability).
8	**Sustainability**	The Trust is confident in its ability to fund the required level of expenditure – namely, the capital and revenue consequences associated with the proposed investment
9	**Achievability**	The preferred option provides the Trust with maximum flexibility to respond to continuously evolving healthcare provision, for example reducing our carbon footprint and modifying site capacity

3.3 Determining the Capacity

The approach used to determine capacity requirements for emergency care is based on activity projection across three scenarios. These scenarios are as follows:

- **Base Scenario: Demographic growth at 10% over ten years**
- **Medium Scenario: 30% growth over ten years to reflect additional impacting issues over and above demographic increase**
- **High Scenario: 50% growth over ten years, reflecting the recent historical growth rate**

The scenarios for assessment activity (driven by LRI medical emergency admissions) are as follows:

- **Base Scenario: Demographic growth at 15% over ten years**
- **Medium Scenario: 25% growth over ten years to reflect additional impacting issues over and above demographic increase**
- **High Scenario: 35% growth over ten years, reflecting the recent historical growth rate**

Percentage adjustments are then applied to each scenario relating to model of care improvements to determine overall capacity requirements across the three scenarios. These models of care adjustments relate to Urgent Care Centre's current share of attendances, Urgent Care Centre future share of growth, shift to Primary Care and Paediatric UCC referrals to ED. Table 3.1 outlines the projected activity for each scenario and the associated ED capacity requirement. The agreed schedule of accommodation can be found at Appendix 3d.The proposed space requirement is 7137.4sqm.

Table 3.2 Scenario Activity Projections and Associated ED Capacity Requirements (current treatment times)

Percentage Growth 2012/13 - 2022/23	Paeds	Eyes	Majors	Minors	Resus	Grand Total	UCC	All inc. UCC
Low Scenario	12%	9%	14%	-32%	16%	12%	75%	11%
Medium Scenario	32%	29%	34%	-20%	36%	32%	108%	31%
High Scenario (inc. shift)	77%	49%	54%	-8%	56%	52%	86%	46%

Rooms Required 2022/23	Paeds	Eyes	Majors	Minors & UCC	Resus	Grand Total
Current (estimated)	10	4	29	17	12	72
Low Scenario	12	4	31	19	13	79
Medium Scenario	14	4	36	22	14	90
High Scenario (inc. shift)	16	4	40	22	16	98

The activity model facilitated an assessment of the impact of varying assumptions about the productivity on the resultant number of ED places required. An efficiency saving of 20% in the average treatment time has been incorporated into the model to reflect the improvement expected to be delivered from the provision of purpose-built ED facilities collocated with assessment, diagnostic imaging, pathology and pharmacy services. Factoring in this reduction in treatment time reduces the capacity requirement for ED and allows the projected number of places to deal with the high scenario rate of growth.

Table 3.3 Scenario Activity Projections and Associated ED Capacity Requirements (20% reduction in treatment times)

Rooms Required 2022/23	Paeds	Eyes	Majors	Minors & UCC	Resus	Grand Total
Reduction in Treatment Time	N/A	N/A	-20%	N/A	-20%	
Low Scenario	12	4	25	19	10	70
Medium Scenario	14	4	29	22	11	80
High Scenario (inc. shift)	16	4	32	22	13	87
Proposal	**15**	**4**	**32**	**22**	**12**	**85**

A similar exercise was undertaken for the assessment unit places, and a target of a 20% reduction in average length of stay (from 20 hours to 16 hours) incorporated. The beds required for current ALOS are detailed for the three growth scenarios below.

Table 3.4 Scenario Activity Projections and Associated Assessment Capacity Requirements (current ALOS)

Growth Scenario	Average arrivals per hour	Beds required (20 hour ALOS)	Activity Growth	Occupancy Rate
Baseline	2.70	81	0%	70%
Demographic (15%)	3.11	91	12%	70%
Intermediate (25%)	3.38	98	21%	71%
High (35%)	3.65	105	29%	72%

The reduction in ALOS allows the high scenario growth to be accommodated in the same bedstock as the model predicts for current workload (and current ALOS), ie, 81 beds. Assuming a generic 16-bed module of accommodation has driven the provision of 80 beds for medical assessment services, which is modelled to be sufficient to deal with the highest growth scenario on the basis of the reduction in ALOS being achieved.

Features of the scheme which support the delivery of a reduced ALOS include:

- Provision of single-floor emergency service obviating the need for lift travel to other floors and the consequential transfer times and inefficiencies;
- Integration of assessment and ED services with satellite imaging, pharmacy & pathology services to facilitate rapid diagnosis and discharge of patients.
- Inclusion of enhanced ambulatory care facilities to avoid treating patients in trolley/bed spaces at all, and to divert them to clinic facilities more suitable to their condition (e.g., DVT, cellulitis, TIA, etc).

Table 3.5 Scenario Activity Projections and Associated Medical Assessment Capacity Requirements (20% reduction in ALOS)

Growth Scenario	Average arrivals per hour	Beds required (16 hour ALOS)	Activity Growth	Occupancy Rate
Baseline	2.70	60	0%	66%
Demographic (15%)	3.11	67	12%	68%
Intermediate (25%)	3.38	72	21%	68%
High (35%)	3.65	77	29%	69%

A similar approach has been taken to the modelling of other functions: understanding the impact of securing efficiencies to deliver more productive clinical capacity rather than building the maximum accommodation to deal with the highest possible annual growth rate.

3.4 Long-list of options

The long list of options is described below in Table 3.3. This list has been reviewed in a number of clinical forums. The long list has also been subjected to a technical appraisal to determine impact relating to site constraints and requirements of the building. Table 3.3 provides the outcome of these reviews, identifying whether the option was shortlisted for detailed appraisal, or discounted. The key criterion for short listing was based on the extent to which each option met the project objectives, for example, Emergency Floor concept, access and timing to deliver.

Table 3.6 Long Listed Options

Option	Description
0	Do Minimum - Ensure critical backlog maintenance is undertaken and review clinical processes & procedures
1A	Balmoral Building – Existing 1st floor refurbishment with some assessment provision elsewhere (inc courtyard infill & extension)
1B	Balmoral Building – Existing 1st floor and ground floor refurbishment hot floor/assessment floor
1C	Balmoral Building – Existing floor refurbishment with displacement of radiology
2A	Jarvis Building – Demolition of Jarvis building and part new build/part refurbishment existing floor
2B	Jarvis Building - Demolition of Jarvis building and new build
2C	Jarvis Building - Demolition of Jarvis building and new build ED and refurbish assessment on single floor
3A	Victoria Building – Demolition of Victoria building and part new build/part refurbish assessment on single floor
3B	Victoria Building - Demolition of Victoria building and new build
4	Sandringham Building – refurbishment of 2 floors Sandringham building and new build extensions
5	Havelock Street Car park – New build 2 storey development on Havelock Street car park
6	Knighton Street Car park - New build 2 storey development on Knighton Street car park
7	Victoria Building Staff Car park - New build 2 storey development on Victoria Street car park

A summary of the review of the long listed options is set out in Table 3.2 below.

Table 3.7 Results of Review of Long Listed Options

Option		Current Discounted/Shortlisted Status
0	**Do Minimum - Ensure critical backlog maintenance is undertaken and review clinical processes & procedures**	**Shortlisted** as a baseline comparator
1A	**Balmoral Building – Existing 1st floor refurbishment with some assessment provision elsewhere (inc courtyard infill & extension)**	**Shortlisted**
1B	Balmoral Building – Existing 1st floor and ground floor refurbishment hot floor/assessment floor	*Discounted – This was discounted on the basis that it does not strategically fit to the Trusts critical success factors requirement for a single floor ED*
1C	Balmoral Building – Existing floor refurbishment with displacement of radiology	*Discounted – This option was discounted on the basis of diagnostics needing to be a key adjacency requirement of the ED. This option could not deliver the Trust strategic requirements*
2A	Jarvis Building – Demolition of Jarvis building and part new build/part refurbishment existing floor	*Discounted – This option does not meet the essential adjacency requirements and ED single floor concept and timing to deliver*
2B	Jarvis Building - Demolition of Jarvis building and new build	*Discounted - - This option does not strategically fit with the Trust's DCP plans and timing to deliver. It also does not strategically fit to the Trusts critical success factor regarding the requirement for a single floor emergency and assessment service*
2C	**Jarvis Building - Demolition of Jarvis building and new build ED and refurbish assessment on single floor**	**Shortlisted**
3A	**Victoria Building – Demolition of Victoria building and part new build/part refurbish assessment on single floor**	**Shortlisted**
3B	Victoria Building - Demolition of Victoria building and new build	*Discounted - This option does not strategically fit with the Trust's DCP plans and timing to deliver. It also does not strategically fit to the Trusts critical success factors requirement for a single floor ED*

Option		Current Discounted/Shortlisted Status
4	Sandringham Building – refurbishment of 2 floors Sandringham building and new build extensions	*Discounted – This was discounted on the basis that it does not strategically fit to the Trusts critical success factor regarding the requirement for a single floor emergency and assessment service*
5	Havelock Street Car park – New build 2 storey development on Havelock Street car park	*Discounted– This was discounted on the basis that it does not strategically fit to the Trusts critical success factors requirement for a single floor ED*
6	Knighton Street Car park - New build 2 storey development on Knighton Street car park	*Discounted– This was discounted on the basis that it does not strategically fit to the Trusts critical success factor regarding the requirement for a single floor emergency and assessment service*
7	Victoria Building Staff Car park - New build 2 storey development on Victoria Street car park	*Discounted– This was discounted on the basis that it does not strategically fit to the Trusts critical success factor regarding the requirement for a single floor emergency and assessment service*

3.5 Short Listed Options

The short listing took place in a project meeting and the non-financial option appraisal agreement in October 2013. The revised options are detailed below:

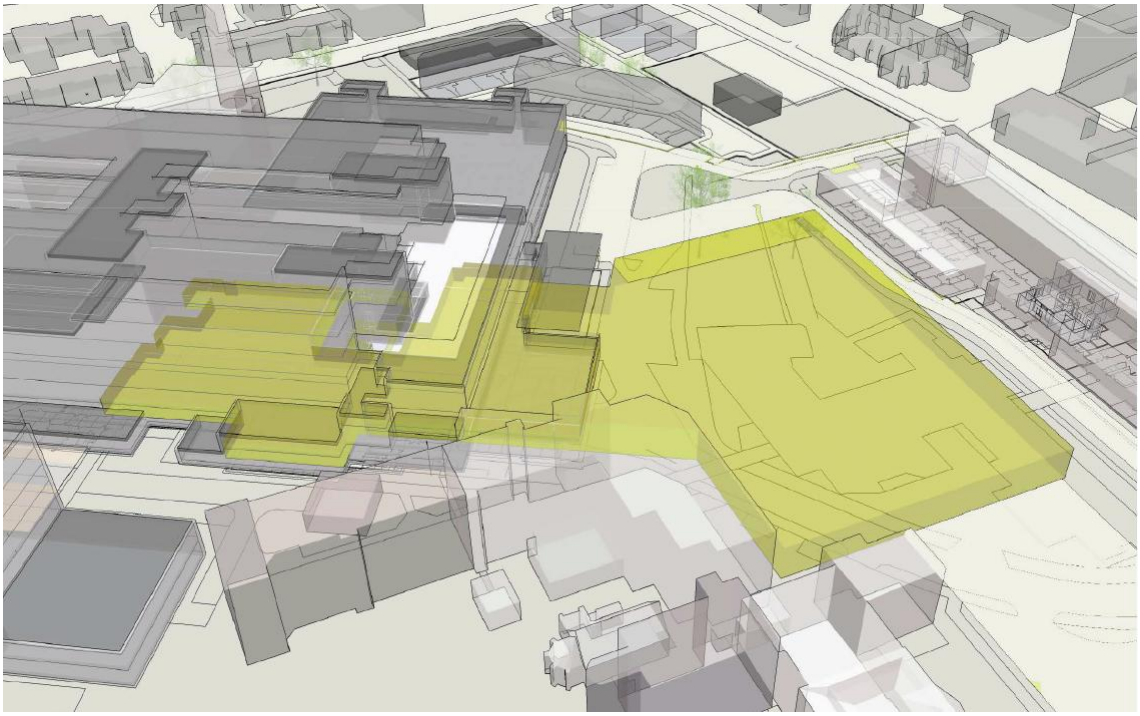
- Option 0: Do Minimum - Ensure critical backlog maintenance is undertaken and review clinical processes & procedures
- Option 1A: Existing 1st floor refurbishment with some assessment provision elsewhere, (inc courtyard infill & extension)
- Option 2C: Demolition of Jarvis building & new build ED & refurbish assessment on single floor
- Option 3A: Demolition of Victoria building and part new build/part refurbish assessment on single floor

Figure 3A details the proposed location of the shortlisted options. Appendix 5a outlines the phasing works required for each option.

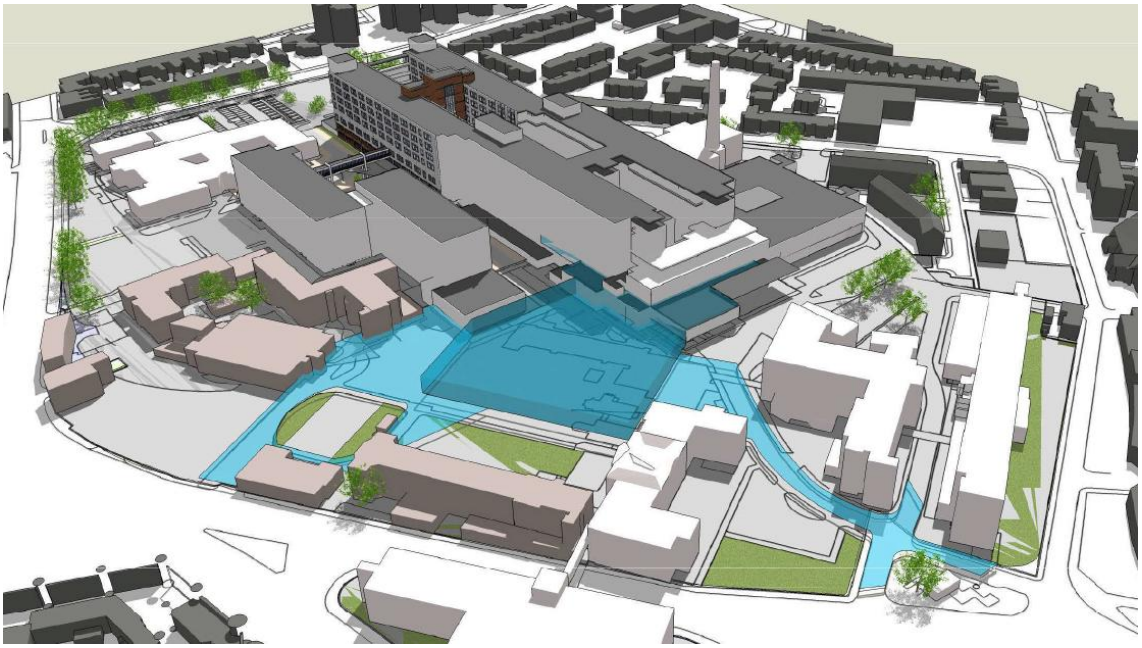
Figure 3A Proposed Location of Options

Option 1A

Option 2C



Option 3A



3.6 Economic Appraisal

3.6.1 Introduction

This section provides a detailed overview of the main costs, benefits and risks associated with each of the selected options. Importantly, it indicates how they were identified and the main sources and assumptions. The economic appraisal is summarised at Appendix 6.

3.6.2 Estimating Benefits

Methodology

The benefits associated with each option were identified by the Project Steering Group and confirmed at 2 workshops held in October 2013 (Appendix 7) with the stakeholders for the ED Floor scheme.

Description, Sources and Assumptions

The benefits identified fell into the following main categories, as shown in Table 3.4 below. Costs and cash-releasing benefits are included in the economic appraisal, together with qualitative and societal benefits. Qualitative benefits have been assessed using a weighting and scoring process.

Table 3.8 Main Qualitative or non-cash releasing Benefits to the Trust

Quality

- Quality of care is enhanced, in terms of the model of care, and seamless pathways of care and patient flows.
- The built environment enhances clinical practice that support clinical effectiveness, improved patient outcomes and patient safety
- Provides enhanced departmental relationships and clinical adjacencies that support clinical effectiveness and improved patient outcomes

Meeting Commissioner Intentions

- Improved Privacy and dignity provisions for all patients
- Consolidates existing services & provides clinical expertise whilst realising the Emergency Floor concept
- Improved patient access through a single front door process
- Consolidates existing services & provides clinical expertise whilst realising the Emergency Floor concept

Business Need

- To implement a design solution that provides a safe emergency care service that ensures capacity and known flexibility for current and known future demands of patients requiring emergency care
- Improve patient pathway management reducing the clinical risk and discomfort through the emergency care pathway.
- Support and consolidate the provision of emergency floor concept at LRI

Strategic Fit

- Ensures that the service model of care is delivered in line with National ,Trust and local health economy KPI's
- To implement a design solution that provides a safe emergency care service that ensures capacity and known flexibility for current and known future demands of patients requiring emergency care

Sustainability/ Value for Money

- Ensures facilities are future proofed and adaptable to the changing needs of the health economy

Achievability/ Affordability

- The design solution minimises the impact of the construction process on the site and therefore delivery of the Trust core services
- Option enables future proofing of the physical ED environment aligned to DCP future expansion needs
- The enabling moves will facilitate the Emergency Floor programme whilst minimising delay to delivery
- Reduces complexity and sequence dependency of enabling moves
- Maintains blue light access throughout whole build process

3.6.3 Estimating Costs

Capital Costs of the shortlisted options

The total capital costs for each of the following options are summarised below full details can be found in the OB forms in Appendix 8a, 8b and 8c.

Table 3.9 Summary of Capital Costs

Capital Costs	Option 1A Balmoral £	Option 2C Jarvis £	Option 3A Victoria £
Construction	22,524,225	23,769,432	23,643,192
Fees	6,221,226	6,719,934	6,344,090
Equipment	1,725,917	1,635,853	1,635,853
Decant	13,550,282	8,644,584	7,840,866
Planning Contingency	1,528,869	1,612,611	1,586,707
Sub Total	**45,550,519**	**42,382,414**	**41,050,708**
Optimism bias	4,250,254	4,483,058	3,411,420
Inflation	3,340,533	3,523,508	3,466,908
Total	**53,141,306**	**50,388,980**	**47,929,036**

Capital costs were compiled by the Trust's cost advisers and the main assumptions are

- Cost for each of the options are at PUBSEC 191
- A provisional location adjustment of -6% has been applied
- VAT has been included at 20% where it is generally applicable although the intention is to work with VAT advisers to identify elements of the costs for which recovery can be made.
- The capital cost for the Do Minimum option have been based on an assessment of backlog maintenance and the current known costs of upgrading the accommodation to condition B16 and is estimated as £3,577K. This includes c£1m of sunk costs which have been excluded from the Generic Economic Model (GEM).

In accordance with the Capital Investment Manual and the Treasury Green Book the capital for each of the shortlisted options have been adjusted for optimism bias

The costs used in the GEM were based on these costs but excluded VAT inflation and sunk costs and these are shown below. Full details of these costs and the cashflows associated with each element are shown in Appendix 9a (GEM feeder files).

[16] The Trust are in the process of reviewing the current costs however these are the latest known estimates

Table 3.10 Summary of Capital Costs Used for GEM

Capital Costs Ex VAT and Inflation	Option 1A Balmoral £	Option 2C Jarvis £	Option 3A Victoria £
Construction	18,770,188	19,807,860	19,702,660
Fees	5,272,669	5,705,778	5,379,243
Equipment	1,438,264	1,363,211	1,363,211
Decant	11,291,902	7,203,820	6,534,055
Planning Contingency	1,274,058	1,343,843	1,322,256
Sub Total	**38,047,080**	**35,424,512**	**34,301,425**
Optimism bias	3,541,878	3,735,882	2,842,850
Sunk Costs	-1,310,201	-1,310,201	-1,310,201
Total for Gem	**40,278,757**	**37,850,192**	**35,834,074**

The capital costs for the Do Minimum option excluding VAT inflation and sunk costs is £2,475,006.

Risks

The risks associated with each option have been captured in the planning contingency which reflects the risks and uncertainty associated with each option. This has then been used in the GEM.

Life-Cycle Costs

Lifecycle costs associated with each option have been provided by the quantity surveyors Capita for a period of 60 years and these have been used in the economic appraisal. With regard to the do nothing an assumption of similar spend every ten years has been made.

Revenue Costs

The impact of the three options is primarily of a capital nature together with savings which the new development will enable.

Revenue costs are based on those shown in the Financial Case. For the Do Minimum option the baseline position has been used (i.e. that with no savings). For the shortlisted options the impact of the savings has been included in line with the assumptions in the financial case but excluding the impact of capital charges as this is taken into account within the economic appraisal.

Table 3.11 Revenue Costs

ED Income and Expenditure	2012 /13	2013 /14	2014 /15	2015 /16	2016 /17	2017 /18	2018 /19	2019 /20	2020 /21	2021 /22	2022/23
	Actual £k	Out-turn £k	Forecast £k	Forecast £k	Forecast £k	Forecast £k	Forecast £k	Forecast £k	Forecast £k	Forecast £k	Forecast £k
Income											
ED Tariff	21,162	21,129	21,129	21,129	21,129	21,129	21,129	21,129	21,129	21,129	21,129
ED Other	4,657	4,402	4,402	4,402	4,402	4,402	4,402	4,402	4,402	4,402	4,402
Medical Assessment Unit		8,263	8,263	8,263	8,263	8,263	8,263	8,263	8,263	8,263	8,263
Impact of single front door			-1,370	-1,370	-1,370	-1,370	-1,370	-1,370	-1,370	-1,370	-1,370
Growth			676	1,374	2,094	2,837	3,604	4,395	5,212	6,055	6,925
Total	**25,820**	**33,794**	**33,100**	**33,798**	**34,518**	**35,261**	**36,028**	**36,820**	**37,637**	**38,479**	**39,349**
Expenditure											
Pay											
Nursing	6,441	6,880	6,880	6,880	6,880	6,880	6,880	6,880	6,880	6,880	6,880
Nursing Agency	1,598	1,445	1,445	1,445	1,445	1,445	1,445	1,445	1,445	1,445	1,445
Medical Staff	6,790	8,008	8,008	8,008	8,008	8,008	8,008	8,008	8,008	8,008	8,008
Medical Locum	2,311	1,630	1,630	1,630	1,630	1,630	1,630	1,630	1,630	1,630	1,630
A&Cs	958	1,210	1,210	1,210	1,210	1,210	1,210	1,210	1,210	1,210	1,210
EDU	673	643	643	643	643	643	643	643	643	643	643
EDU Agency	15	285	285	285	285	285	285	285	285	285	285
Impact of single front door			-536	-536	-536	-536	-536	-536	-536	-536	-536

ED Income and Expenditure	2012 /13	2013 /14	2014 /15	2015 /16	2016 /17	2017 /18	2018 /19	2019 /20	2020 /21	2021 /22	2022/23
	Actual £k	Out-turn £k	Forecast £k	Forecast £k	Forecast £k	Forecast £k	Forecast £k	Forecast £k	Forecast £k	Forecast £k	Forecast £k
Additional staff costs due to activity growth					1,155	1,155	1,155	2,425	2,425	3,124	3,124
Total	**18,785**	**20,099**	**19,562**	**19,562**	**20,717**	**20,717**	**20,717**	**21,988**	**21,988**	**22,686**	**22,686**
Non pay											
Nursing	1,823	1,705	1,705	1,705	1,705	1,705	1,705	1,705	1,705	1,705	1,705
Medical Staff	67	95	95	95	95	95	95	95	95	95	95
A&C	26	119	119	119	119	119	119	119	119	119	119
EDU	202	185	185	185	185	185	185	185	185	185	185
Impact of single front door			-136	-136	-136	-136	-136	-136	-136	-136	-136
Additional non pay costs due to activity growth			67	132	200	269	341	414	491	569	650
Total	**2,119**	**2,104**	**2,035**	**2,100**	**2,167**	**2,236**	**2,308**	**2,382**	**2,458**	**2,537**	**2,618**
Total Direct cost	**20,904**	**22,202**	**21,597**	**21,662**	**22,884**	**22,953**	**23,025**	**24,369**	**24,446**	**25,222**	**25,304**
Medical assessment unit		8,263	8,263	8,263	8,263	8,263	8,263	8,263	8,263	8,263	8,263
Additional MAU beds			0	0	933	1,466	1,999	2,532	3,065	3,598	-8,263
Savings on repatriation to additional MAU beds			0	0	-933	-1,466	-1,999	-2,532	-3,065	-3,598	8,263
FM costs	471	471	471	471	636	636	636	636	636	636	636

ED Income and Expenditure	2012 /13	2013 /14	2014 /15	2015 /16	2016 /17	2017 /18	2018 /19	2019 /20	2020 /21	2021 /22	2022/23
	Actual £k	Out-turn £k	Forecast £k	Forecast £k	Forecast £k	Forecast £k	Forecast £k	Forecast £k	Forecast £k	Forecast £k	Forecast £k
Support service costs	3,897	3,864	3,864	3,864	3,864	3,864	3,864	3,864	3,864	3,987	4,115
Overheads	8,745	11,233	11,233	11,233	11,233	11,233	11,233	11,233	11,233	11,233	11,233
Impact of single front door			-165	-165	-165	-165	-165	-165	-165	-165	-165
Additional support costs due to activity growth			82	164	247	329	411	493	575	658	658
Total Costs (baseline)	**34,017**	**46,033**	**45,344**	**45,492**	**46,960**	**47,112**	**47,266**	**48,692**	**48,851**	**49,834**	**50,043**

Table 3.12 Impact of Scheme

Impact of scheme including capital charges	2014 /15 £k	2015 /16 £k	2016 /17 £k	2017 /18 £k	2018 /19 £k	2019 /20 £k	2020 /21 £k	2021 /22 £k	022/23 £
Reduction in Agency and other costs			-1,693	-1,693	-1,693	-1,693	-1,693	-1,693	-1,693
Reduction in Staff Costs			-416	-416	-416	-874	-874	-1,357	-1,357
Change in depreciation	-170	-170	711	1,005	1,005	1,005	1,005	1,005	1,005
Additional FM costs			127	127	127	127	127	127	127
Change in Rate of return	-89	-89	962	932	897	862	827	792	756
Impact on Trust I and E	**-259**	**-259**	**-309**	**-44**	**-79**	**-572**	**-607**	**-1,127**	**-1,162**

3.6.4 Net Present Cost Findings

The overall Net Present Cost (NPC) summaries of the three options based on the costs and cash flows outlined above are as follows (full details and cashflows are in the GEM provided in Appendix 9a, with the outputs summarised below):

Table 3.13 Key Results of Economic Appraisals

Option	Appraisal period	NPC £ 000	Risk Adjusted £ 000	Risk Adjusted NPC £ 000
Do Minimum	60 years	1,297,886.6	109.0	1,299,093.6
Option 1A Balmoral	60 years	1,276,086.1	1,207.0	1,277,293.1
Option 2C Jarvis	60 years	1,272,779.4	1,268.0	1,274,047.4
Option 3A Victoria	60 years	1,272,084.7	1,253.0	1,273,337.7

3.6.5 Equivalent Annual Cost Findings

The overall Equivalent Annual Cost (EAC) summaries of the three options based on the costs and cash flows outlined above are as follows:

Table 3.14 Overall NPC Summaries Based on Costs & Cash Flows

Option	Appraisal period	EAC £ 000	Risk Adjusted £ 000	Risk Adjusted NPC £ 000
Do Minimum	60 years	49,483.87	4.068643	49,487.94
Option 1A Balmoral	60 years	48,652.69473	45.053689	48,697.74842
Option 2C Jarvis	60 years	48,526.62194	47.330636	48,573.95257
Option 3A Victoria	60 years	48,500.13379	46.770731	48,546.90452

3.6.6 Economic Appraisal Conclusions

Economic Appraisal Conclusion - Cost

The GEM is a discounted cash flow model widely used in public sector business cases. It is used to help assess the relative costs and benefits of the shortlisted options contained in OBCs and FBCs and in particular to assess which option offers best value for money and should therefore be selected as the 'Preferred Option'. It is underpinned by Treasury 'Green Book' and DH guidance.

The GEM calculates NPC and EAC for the options under consideration. The NPC for an option is the present value of the cost of that option over the appraisal period. The discount rate used is 3.5% over the first 30 years and 3% beyond 30 years. The EAC is the NPC converted into an equivalent annual cash flow. The costs used in the GEM agree to, or are reconcilable to, the costs used in the financial appraisal.

The option which offers the best value for money is the one with the lowest NPC and EAC. This is the preferred option from a purely financial perspective.

As can be seen from the above Option 3A has the lowest in both cases and is therefore the preferred option.

3.7 Qualitative Benefits Appraisal

The qualitative benefits appraisal took place in October 2013 (2nd October and 7th October) and summarised the views of project team on the major qualitative beneficial features of the project. A weighting and scoring exercise was carried out as described below[17].

Table 3.7 below identifies those representing the main stakeholders in the project taking part in the benefits appraisal in June 2013.

[17] It is important to note: Objective 11, Benefit 1 was scored by the technical team to assist in the scoring exercise when related to impact of construction on the Trust services as a whole. Refer to Appendix 15 to view this process

Table 3.15 Project Team

Name	Role	Organisation
Nicky Topham	Project Director	UHL
Louise Naylor	Project Manager – Site Reconfiguration	UHL
David Finch	Building Services Manager	UHL
Nigel Bond	Capital Projects Manager	UHL
Jane Edyvean	CMG General Manager	UHL
Ben Teasdale	Lead Consultant ED High Acuity	UHL
Catherine Free	CBU Medical Lead	UHL
Sam Jones	Lead Consultant Paeds ED	UHL
Chris Turner	Project Manager	Capita
Michael Rope	OBC PM	Capita
Marianne Graham	OBC Author	Capita
Ian Morgan	Senior Architect	Capita
Debbie Saunders	Senior Architect	Capita

The project team initially reviewed the Benefit Criteria and Weighting; these are agreed as follows:

Table 3.16 Criteria Weighting Results

Criteria	Weight %
1. To provide the Trust with increased capacity for emergency services to meet the demands of population growth, changing service models and improved efficiency targets	10
2. To increase the productivity of emergency care at LRI	7.5
3. To develop a centre of excellence, enhancing the Trust's reputation for training, service delivery and treatment, through the provision of a centralised service in modern accommodation	7.5
4. To ensure that the changing needs and expectations of a growing population are met in line with Trust clinical strategy and national guidance standards	7.5
5. To provide an ED that is compliant with NHS building guidance standards	2.5
6. To improve the clinical effectiveness and safety of urgent and emergency care service across Leicester	20
7. To improve the clinical adjacencies of services to optimise clinical safety and reduce clinical risk	5
8. To facilitate the modernisation of services, including streamlining patient pathways and efficient working practices providing an ED that ensures adequate infrastructure and capacity for supporting services that are conducive to the needs of a modern workforce	10

Criteria	Weight %
9. To equip the ED to respond effectively to existing and known commissioning requirements, as well as to respond flexibly to future changes in service direction and demand	5
10. To improve the environment and the experience of users (patients, visitors and staff) of Leicester Royal Infirmary Hospital Accident and Emergency Department	5
11. To provide a solution that is aligned to the Trust DCP plan and Trust organisation as a whole.	8
12. The development will be delivered on time with minimal disruption to current service delivery	12
TOTAL	**100**

Table 3.17 Raw Score Results

Criteria	Option			
	0	1A	2C	3A
To implement a design solution that provides a safe emergency care service that ensures capacity and known flexibility for current and known future demands of patients requiring emergency care	1.00	7.00	5.00	7.50
Improve patient pathway management reducing the clinical risk and discomfort through the emergency care pathway.	1.00	7.50	5.00	7.00
Support and consolidate the provision of emergency floor concept at LRI	1.00	7.50	7.00	7.50
Ensures that the service model of care is delivered in line with National ,Trust and local health economy KPIs	1.00	7.50	6.00	7.50
Patient safety is enhanced, and clinical risk is reduced	1.00	6.50	7.50	7.50
Where possible ensures that the service is developed in line with NHS Guidance interms of HBN, HTM, national and Trust policy and local health economy policy in terms of capacity provision	1.00	6.00	8.00	8.00
Quality of care is enhanced, in terms of the model of care, and seamless pathways of care and patient flows.	1.00	8.00	6.00	7.50
The built environment enhances clinical practice that support clinical effectiveness, improved patient outcomes and patient safety	1.00	8.00	6.00	8.00
Provides enhanced departmental relationships and clinical adjacencies that support clinical effectiveness and improved patient outcomes	1.00	8.00	6.00	8.00

Criteria	Option			
	0	1A	2C	3A
Ensures facilities are future proofed and adaptable to the changing needs of the health economy	1.00	6.00	7.00	8.00
Improved Privacy and dignity provisions for all patients	1.00	6.00	8.00	8.00
Consolidates existing services & provides clinical expertise whilst realising the Emergency Floor concept	1.00	8.00	6.00	7.50
Improved patient access through a single front door process	2.00	9.00	9.00	9.00
Enhances patient, visitor and staff safety through the built environment	1.00	7.50	8.00	8.00
The design solution minimises the impact of the construction process on the site and therefore delivery of the Trust core services	7.18	4.64	3.54	4.91
Option enables future proofing of the physical ED environment aligned to DCP future expansion needs	1.00	4.00	6.00	8.00
The enabling moves will facilitate the Emergency Floor programme whilst minimising delay to delivery	10.00	4.00	7.50	7.00
Reduces complexity and sequence dependency of enabling moves	10.00	4.00	7.50	7.00
Maintains blue light access throughout whole build process	8.00	6.00	5.00	7.50
	51.18	**131.74**	**129.64**	**148.71**
Rank	**4**	**2**	**3**	**1**

The reasons for differences in scores between options are discussed below.

Option 0 It was agreed to maintain this option within the shortlist as a baseline comparator. This option scored less well than the other options demonstrating that it does not support the strategic fit for the Trust in providing increased capacity, flexibility in capacity, efficiencies in emergency care pathways, or contribute to benefits relating to patient experience and privacy and dignity.

Option 1A This option scored reasonably in most areas of benefit criteria, however in terms of future proofing capacity requirements and benefit realisation it was viewed that this option could not deliver the maximum benefits that Option 3A could. The existing floor plate would be utilised, however the single floor concept for all services, inclusive of assessment could not be achieved. The following outline additional reasons for this options scoring:

- It was viewed that maintaining access for blue light services throughout the project would provide more complexities than options 2C and 3A potentially impacting on clinical efficiencies and patient safety
- Continuation of service delivery throughout the project could be compromised due to all the enabling works required

- Constraints relating to decanting issues on the 2nd floor and design around existing stair wells and lifts
- Paediatric access is not optimal requiring entry to ED via lift which is not considered best practice and will require street level access.
- The current 1 way traffic system impacts on patient access with this option
- Compliance with HBN standards is constrained since the majority of the proposed development sits in the retained estate, as opposed to 2C and 3A options

It is also clear the enabling moves required to facilitate this option would be more significant in comparison to the other shortlisted options, and as a consequence would prove considerably disruptive to a number of services that would need to relocate. The services have been identified as the following:

- Adult Outpatients 1 to 4
- Childrens Outpatients 1 to 4
- Out of Hours Service
- Fracture Clinic
- Ophthalmology
- ENT
- Max Fax Outpatients
- Physio Gymnasium
- Main Entrance, WH Smiths, WRVS, Pharmacy and Police

Option 2C This option demonstrated similar scoring to 1A, however for different benefit achievement. It was viewed that this option could not deliver the maximum benefits required to achieve the strategic fit for the Trust and improve capacity, efficiencies and reduce impact on Trust DCP operationally. Although this option could provide opportunities for further expansion and maintain emergency services operations throughout the build project it was viewed that it limits itself as a viable non financial option by:

- Ambulance access is across area where ‘walk in’ is required and therefore compromising the ‘walk in’ patient access
- Assessment services are not a key adjacency in this option therefore constraining pathway /process development and compromising efficiencies in service delivery.
- The new build element does not enhance multidisciplinary working with key adjacencies not on the same floor (e.g. surgical separate from assessment clinic). It was viewed that the adjacencies were inferior to what 1A option could provide (diagnostic adjacency to assessment services restricted)
- This option will require a temporary entrance to access the ED department and then transfer to permanent site once completed. In the interim this will require outpatients accessing the area at the same time which is viewed as not appropriate for a ED department
- This option potentially impacts on the Trust’s DCP and strategic redevelopment plans relating to women’s services in the Kensington building

Further to the above, the enabling moves required to implement this option are deemed not to be as significant as option 1A due to the nature of the services and associated areas required for relocation. Identified for relocation under this option is as follows:

- Printing Services
- Medical Records (ED), Stores & Facilities Management space
- Childrens Laundry
- University Space
- Women's & Childrens Management Offices
- Women's & Childrens Clinical Services
- GU Clinic
- Gynaecology
- HR Shared Services
- Link Corridor & Bridge to Kensington

Option 3A This option demonstrated through the non-financial appraisal process that the Trust is able to realise benefits and achieve strategic objectives and critical success factors of providing an appropriate solution to meeting current and future capacity demands for emergency care. This option lends itself to a detailed design process that provides essential departmental adjacencies.

- This option lends itself to a detailed design process that provides essential departmental adjacencies
- Majors and Resuscitation areas can be located close to the front door and the ambulance will have an ambulance only access to the department
- Adjacencies to the minor injuries and minor illness unit are enhanced and assessment services will maintain essential adjacencies within the department
- Paediatric emergency services demonstrated good adjacencies and separate paediatric entrance point is provided
- Ambulance access is provided on the same level as department entry which is essential for blue light access. The provision of an ambulance only access to the hospital department is seen as a better outcome to that which the other options can provide
- The single floor concept can be achieved with provision of diagnostics and assessment within the department and opportunities for flexibility and future proofing the design

In comparison to the other shortlisted options, the enabling moves associated with option 3A are deemed the least disruptive to the wider organisation with regards clinical and non clinical operations, and are more aligned with the overarching vision for the site. Required relocations have been identified as follows:

- Urgent Care Centre
- Out Patient Clinics
- Fielding Johnson Ward
- Medical Physics & IM&T

- Multi Disciplinary Team Office
- Clinical Genetics OP Clinics and Clinical Skills Reception
- Chapel

The option scores were then weighted in the ratios as applied to the original raw scores. The results are shown in Table 3.10 overleaf.

This clearly shows that Option 3A is the preferred non-financial option. It provides an effective solution to the Trust's needs and in particular will be significantly more effective than the other options at providing flexibility, meeting capacity demands, enhancing the patient experience and emergency care pathway efficiencies. It also offers a solution with the least impact on the Trust's clinical and non clinical operations, DCP and strategic plans.

Table 3.18 Scoring Results – Weighted

	Critical Success Factor	Project objective	Benefit Criteria		Weight	Option 0 Do Minimum. Ensure critical backlog maintenance is undertaken and review clinical processes & procedures		Option 1A Existing 1st floor refurb with some adult assessment allowed for elsewhere (inc courtyard infill & extension)		Option 2C Demolition of Jarvis building & new build ED & refurb assessment on single floor		Option 3A Demolition of Victoria building & new build ED & refurb assessment on single floor	
						Score (1-10)	Weighted score	Score (1-10)	Weighted score	Score (1-10)	Weighted score	Score (1-10)	Weighted score
1	Business Need	To provide the Trust with increased capacity for emergency services to meet the demands of population growth, changing service models and improved efficiency targets.	To implement a design solution that provides a safe emergency care service that ensures capacity and known flexibility for current and known future demands of patients requiring emergency care	25%	10.0%	1	0.1	7	0.7	5	0.5	7.5	0.75
2	Business Need	To increase the productivity of emergency care at LRI	Improve patient pathway management reducing the clinical risk and discomfort through the emwrgency care pathway.		7.5%	1	0.075	7.5	0.5625	5	0.375	7	0.525
3	Business Need	To develop a centre of excellence, enhancing the Trust's reputation for training, service delivery and treatment, through the provision of a centralised service in modern accommodation.	Support and consolidate the provision of emergency floor concept at LRI		7.5%	1	0.075	7.5	0.5625	7	0.525	7.5	0.5625
4	Strategic Fit	To ensure that the changing needs and expectations of a growing population are met in line with Trust clinical strategy and national guidiance standards	Ensures that the service model of care is delivered in line with National ,Trust and local health economy KPI's	10%	2.5%	1	0.025	7.5	0.1875	6	0.15	7.5	0.1875
			Patient safety is enhanced, and clinical risk is reduced .		5.0%	1	0.05	6.5	0.325	7.5	0.375	7.5	0.375
5	Strategic Fit	To provide an Emergency Department that is compliant with NHS building guidance standards	Where possible ensures that the service is developed in line with NHS Guidance interms of HBN, HTM, national and Trust policy and local health economy policy in terms of capacity provision		2.5%	1	0.025	6	0.15	8	0.2	8	0.2
6	Quality	To improve the clinical effectiveness and safety of urgent and emergency care service across Leicester:	Quality of care is enhanced, in terms of the model of care, and seamless pathways of care and patient flows.	25%	10.0%	1	0.1	8	0.8	6	0.6	7.5	0.75
			The built environment enhances clinical practice that support clinical effectiveness, improved patient outcomes and patient safety		10.0%	1	0.1	8	0.8	6	0.6	8	0.8
7	Quality	To improve the clinical adjacencies of services to optimise clinical safety and reduce clinical risk.	Provides enhanced departmental relationships and clinical adjacencies that support clinical effectiveness and improved patient outcomes		5.0%	1	0.05	8	0.4	6	0.3	8	0.4
8	Sustainability, Service Modernisation, Value for Money	To facilitate the modernisation of services, including streamlining patient pathways and efficient working practices providing an Emergency Department that ensures adequate infrastructure and capacity for supporting services that are conducive to the needs of a modern workforce	Ensures facilities are future proofed and adaptable to the changing needs of the health economy	10%	10.0%	1	0.1	6	0.6	7	0.7	8	0.8
9	Meeting Commissioners' intentions for healthcare services	To equip the Emergency Department to respond effectively to existing and known commissioning requirements, as well as to respond flexibly to future changes in service direction and demand.	Improved Privacy and dignity provisions for all patients	10%	3.0%	1	0.03	6	0.18	8	0.24	8	0.24
			Consolidates existing services & provides clinical expertise whilst realising the Emergency Floor concept		2.0%	1	0.02	8	0.16	6	0.12	7.5	0.15
10	Meeting Commissioners' intentions for healthcare services	To improve the environment and the experience of users (patients, visitors and staff) of Leicester Royal Infirmary Hospital Emergency Department	Improved patient access through a single front door process		2.0%	2	0.04	9	0.18	9	0.18	9	0.18
			Enhances patient, visitor and staff safety through the built environment		3.0%	1	0.03	7.5	0.225	8	0.24	8	0.24
11	Achievability	To provide a solution that is aligned to the Trust DCP plan and Trust organisation as a whole.	The design solution minimises the impact of the construction process on the site and therefore delivery of the Trust core services	20%	4.0%	7.182	0.28728	4.636	0.18544	3.545	0.1418	4.909	0.19636
			Option enables future proofing of the physical A&E environment aligned to DCP future expansion needs		4.0%	1	0.04	4	0.16	6	0.24	8	0.32
12	Achievability	The development will be delivered on time with minimal disruption to current service delivery	The enabling moves will facilitate the Emergency Floor programme whilst minimising delay to delivery		4.0%	10	0.4	4	0.16	7.5	0.3	7	0.28
			Reduces complexity and sequence dependancy of enabling moves		4.0%	10	0.4	4	0.16	7.5	0.3	7	0.28
			Maintains blue light access throughout whole build process		4.0%	8	0.32	6	0.24	5	0.2	7.5	0.3
				100%	100%		2.26728		6.73794		6.2868		7.53636
					Rank		4		2		3		1

3.8 Risk Appraisal – Unquantifiable

The Trust relevant risks for this business case are outlined in Section 6.

3.9 The Preferred Option

Combined Investment Appraisal – Value for Money

As identified above the preferred option from both a financial and non financial perspective is option 3A Victoria.

This option offers the best value for money as it has the lowest NPC and is the most effective solution based on the non financial review.

As can be seen from the table the second ranked option from the qualitative appraisal is option 1A Balmoral. We have therefore for the switching point assessed the point at which this option becomes the preferred based on the NPC per point.

Analysis shows that the costs of the preferred option would need to increase by 12% before option 1A becomes the preferred option.

Table 3.19 Summary of Economic and Value for Money Appraisal

Criteria	Option			
	0	1A	2C	3A
Raw scores	51.18	131.74	129.64	148.71
Weighted Scores	2.27	6.74	6.27	7.54
Rank (non-financial)	4	2	3	1
Net present cost (NPC) (£k)	1,299,094	1,277,293	1,274,047	1,273,338
NPC per point score (£k)	572,288	189,509	203,197	168,878
Rank (VFM)	4	3	2	1
Rank	**4**	**2**	**3**	**1**

4 | The Commercial Case

4.1 Introduction

This section of the OBC outlines the proposed procurement strategy in relation to the preferred option outlined in the Economic Case.

4.2 Procurement Strategy

The scheme will be procured through UHL's framework partnership with Interserve Facilities Management (IFM). The framework for major projects has been set up to mirror the Procure 21+ (P21+) framework principles for the delivery of construction projects.

The P21+ framework was initiated in July 2012 and is available to NHS organisations in England. It is the Department of Health's preferred method of procurement for new builds and refurbishments on the NHS estate. Procure 21+ and its predecessor Procure 21 have over £5bn worth of schemes registered. The Department of Health has stated that P21+ schemes are providing value for money solutions to over 200 NHS Trusts.

Whilst the LLR FMC partnership is bespoke to UHL, and therefore outside the P21+ framework, it offers the same value for money assurances on construction. This is through adherence to an agreed schedule of professional services rates, and use of overhead and profit recovery percentages that reflect recognised P21+ pricing structures.

Value for money considerations over business case and design development during the early stages of projects have been assured through the procurement of the partnership with IFM, under which professional services rates have been benchmarked against the current OGC framework for such services.

NHS Horizons has been set up as a client function for UHL and will act for them in development of the commercial and contractual arrangements for the scheme.

The benefits of the bespoke framework are that a high quality pre-approved supply chain is available to UHL without having to go through EU OJEU or NHS framework processes. This saves an estimated 6 months in procurement time and significant consequential costs. In addition, it allows UHL and Interserve to work collaboratively in developing the scheme using common principles and tools that are proven to deliver quality schemes on time and within budget.

Under the bespoke framework, IFM is appointed as prime contractor for the delivery of projects; commercial arrangements and contracts are pre-agreed to cover commissioning of the business case through to final delivery of the asset using negotiated, and NEC 3, forms of contract. The risk of cost overrun is transferred to IFM once the GMP has been agreed and construction stage commenced.

Project risk is dealt with openly from the outset of the project and the client, IFM and design are encouraged to take an active role in identifying, mitigating and apportioning risk to the party best suited to deal with it.

IFM's supply chain for professional and construction services is as follows:

Table 4.1 Supply Chain Details

Role	Organisation
Pre-construction	
Business case preparation	Capita
Mechanical and electrical consultants	Capita
Architects	Capita
Structural engineers	Capita
Cost Consultants	Capita
GMP development	Interserve Construction
Construction	
Building contractor	Interserve Construction
Mechanical and electrical contractor	Interserve Construction

Under the framework, IFM has:

- Taken single point responsibility to manage the design and construction process from completion of OBC through to project completion
- Assembled a dedicated team from its supply chain of experienced health planners, designers and specialists, to successfully deliver facilities that will benefit patients and staff alike
- Provided benefits of experience of long term partnering arrangements that will continue throughout the life of the project
- Committed to identifying construction solutions that will assist in the implementation of improved service delivery, best practice and delivering best value.

IFM and UHL will work together through the full business case (FBC) stage in the coming months to develop and agree a guaranteed maximum price for delivery of the scheme. This will reflect:

- Nationally agreed profit and overhead rates (P21+ overhead and profit equivalents)
- Fees for professional advice such as design and cost management
- Market tested packages for construction works on an open book basis

The GMP will be assessed for overall value for money by cost consultants acting for both IFM and NHS Horizons, the client organisation working on behalf of UHL. This will take into account elements such as:

- Prevailing rates for similar works nationally and locally.
- Published cost indices.
- Knowledge of the cost of work in the hospital from other recent schemes
- Prime contractor and client retained risks as identified in the joint risk register

Should the scheme not proceed, the Trust will own the design at point of termination but will be liable for IFM costs up to that point, in line with contractual commitments made during commissioning of the project.

4.3 Key Factors Affecting Outcomes

4.3.1 Design, Build and Construction Management

The preferred option will require planning consent. Appendix 10 highlights the planning related issues and the key planning policies for each shortlisted option. Discussions are now underway with the local planning authority to initiate the planning application process.

It should also be noted that a key aspect of the enabling requirements with regards the preferred option is to move the Trusts chapel/ multi faith provision so the associated building can make way for the proposed development. Due to projects that have been considered in recent years, substantial work has been undertaken with the Trusts Chaplaincy and other key benefactors to identify all that required to undertake such a move.

It is of course considered unfortunate for the chapel to have to make way for the preferred option, but all involved recognise the current accommodation does not align itself with what is considered appropriate for the provision of modern day multi faith requirements, especially for a major acute hospital with diverse multi cultural needs.

Specialist consultants will be involved in this aspect of the planning application to provide the necessary advice when it comes to dealing with such buildings.

Full building control approval will be sought to current standards.

Phasing/enabling of works can be viewed within Appendix 5a.

4.3.2 Implementation Timescales

Section 6 of this business case, (Table 6.3) outlines the implementation programme.

The Project Programme is intended to deliver the project by August 2016, though this timeline is predicated on the enabling works being commenced post NTDA approval of the Outline Business Case and in parallel with commencement of the Full Business Case process.

The Trust Board and NTDA should have assurance with this approach as the majority of enabling and associated demolition works sit comfortably with the the future Development Control Plan for the LRI site.

4.3.3 Building Research Establishment Environmental Assessment Method (BREEAM)

The Trust are committed to achieving no less than a Very Good rating under BREEAM assessment. This will be achieved through the contractual obligation that underpin the P21+ Framework

In addition to BREEAM the AEDET (Achieving Excellence in Design Evaluation Toolkit) evaluation process will take place as the design proposals develop through the FBC process. The detailed design process at FBC stage will also demonstrate building regulation and fire code compliance.

4.3.4 Potential for Risk Transfer

The LLR Framework has a single comprehensive risk management process, which the Trust will be using. The Emergency Floor Project Senior Responsible Officer (SRO) and IFM act as joint owners of the joint project Risk Register for this scheme, responsibility for risks identified in it are then to be allocated and identified on the associated risk register. The risk of cost overrun is transferred to IFM once the GMP has been agreed and construction stage commenced.

4.3.5 Proposed Charging Mechanisms

The Trust intends to make payments in relation to works required in accordance with the LLR Framework Agreement. The NEC Option C Form of Contract will be the agreed form of Building Contract for IFM works. The Building Contract stipulates the payment mechanism, timescales, method of payment calculation etc.

Charging mechanisms approach applied relates to IFM being paid the Defined Cost of the works plus their fee up to the GMP. Under the current contract there is a mechanism for a Gain Share whereby if the final costs are below the GMP then there is the potential for both the Trust and IFM to share the savings, generally on a 50/50 basis if the final cost is up to 5% less than the GMP; if the final cost is more than 5% lower than the GMP then the client generally retains 100% of the savings (if the final cost exceeds the GMP then there is no additional cost to the Client, unless instructed otherwise). This in turn incentivises efficient working and unnecessary cost.

4.3.6 Proposed Contract Lengths

Contract lengths will be set in relation to the LLR Framework Agreement. The basis of the ED Project Contract will be the NEC Option C contract which contains core clauses and Secondary / Z clauses specific to the Framework route and bespoke requirements of the Client.

4.3.7 Proposed Key Contractual Clauses

Key contractual clauses in relation to works associated with this scheme will be in accordance with LLR Framework contract terms, or existing Trust contracts as appropriate.

4.3.8 Personnel Implications (including TUPE)

TUPE Regulations will not apply to this investment as no undertakings will transfer between employing entities.

4.3.9 Procurement Strategy and Implementation Timescales

The procurement strategy is outlined above, and the Implementation timescales are outlined in Section 6.

4.3.10 Equipment Strategy

The Trust intends to implement an equipment strategy that incorporated the following:

- Ownership of the majority of equipment
- Some Equipment leased e.g. beds and trolleys leased under the bed management contract
- Larger imaging equipment within the ED will be included within the Trust's Managed Equipment Service (MES) contract e.g. diagnostics/ imaging.

The equipment work stream will continue to progress the equipment strategy in more detail throughout the FBC process.

4.3.11 Financial Reporting Standard 5 Accountancy Treatment

Assets underpinning delivery of the service will be reflected on the Trust's balance sheet.

5 | The Financial Case

5.1 Introduction

The purpose of this section is to set out the forecast financial implications of the preferred options as set out in the Economic Case and the proposed deal (as described in the Commercial Case). The Trust was formed in April 2000 and has achieved its financial targets over the past 12 years. The financial results for 2011/12 and 2012/13 show that the Trust made a surplus of £88k and £91k respectively - details for future years are set out below.

The short listed options have undergone a rigorous level of scrutiny as far as practicably possible for this stage in business case proceedings, and have proved to be robust in terms of the delivery of significant clinical benefits. It is now important to ensure that these options will be affordable to the Trust and will remain so.

5.2 Capital Costs

The capital costs of the preferred option total £48.7M including forecast out-turn inflation. This figure also includes the decant costs associated with the scheme.Below is an analysis of the total costs.

Table 5.1 Summary of Capital Costs

Capital Costs	Option 3A Victoria (£)
Construction	23,643,192
Fees	6,344,090
Equipment	1,635,853
Decant	7,840,866
Planning Contingency	1,586,707
Sub Total	**41,050,708**
Optimism bias	3,411,420
Inflation	3,466,908
Total	**47,929,036**

5.3 Financing

The table below sets out the cashflow associated with the scheme together with sources of funding. This shows that the Trust has clearly identified its capital requirements and has also identified relevant sources of funding.

As can be seen the Trust is funding both the initial development costs and the decant costs from its own resources.

The Trust will require a total of £47,929,0364 of this, £12m will be funded through Trust capital and £36m through exceptional PDC and/or public loan funding:

Table 5.2 Borrowing Profile

UHL ED Floor	2013/14 £	2014/15 £	2015/16 £	2016/17 £	2017/18 £	TOTAL £
Capital Expenditure	8,323,572	13,848,153	24,480,266	1,106,701	170,344	47,929,036
Funded By:						
PDC/Public Loan		9,927,720	24,480,266	1,106,701	170,344	35,685,031
Trust Resources	8,323,572	3,920,433				12,244,005
Total Funding	8,323,572	13,848,153	24,480,266	1,106,701	170,344	**47,929,036**

5.4 Income and Expenditure

As discussed earlier in the business case the Trust has undertaken a review of future demand within the UHL ED. This work based on a number of factors including demographics and acuity has identified significant increases in the coming years. Additionally the Trust has recently introduced a single front door initiative which has resulted in the diversion of minors activity from ED to the Urgent Care Centre which is currently operated by George Elliott NHS Trust.

The table below shows the impact of these factors on current activity levels and this in turn underpins the assumptions shown in the forecast income and expenditure table below (further details are contained within the finance Appendix 9).

Table 5.3 ED Floor Forecast Activity Analysis (excludes UCC)

	2012 /13	2013 /14	2014 /15	2015 /16	2016 /17	2017 /18	2018 /19	2019 /20	2020 /21	2021 /22
Paeds	33,933	35,002	36,104	37,242	38,415	39,625	40,873	42,161	43,489	44,897
Eyes	15,913	16,374	16,849	17,338	17,841	18,358	18,891	19,438	20,002	20,503
Majors	59,369	61,328	63,352	65,443	67,602	69,833	72,138	74,518	76,977	79,677
Minors	47,475	29,539	30,455	31,399	32,372	33,376	34,410	35,477	36,577	37,787
Resus	13,518	14,018	14,537	15,075	15,632	16,211	16,811	17,433	18,078	18,410
Total	**170,208**	**156,262**	**161,297**	**166,496**	**171,862**	**177,403**	**183,122**	**189,027**	**195,123**	**201,273**

This increase in activity leads to an increase in costs both for staffing and non pay.

With regards to staffing the Trust is developing a detailed workforce plan which will form part of the assumptions at FBC stage.

At OBC stage the Trust has assumed that without investment in this scheme additional staff will be required in line with its current staff to activity ratios for medical and nursing staff but that administration and clerical staff will remain constant.

Support costs such as Imagining Pathology and Therapies are also expected to increase although not in direct proportion to activity.

With regard to staffing increases, these are not expected to be linear and annual, but rather on a stepped basis as activity reaches certain levels.

In addition to addressing practical issues of accommodating this increasing activity, the proposed scheme will enable the Trust to make significant savings and these are shown in the table below.

Key assumptions that underpin the additional savings are the move to upper quartile peer group staffing ratios for additional staff to cover the additional activity and the significant reduction in agency staff.

In identifying these savings the Trust has ensured that there is no double count with current CIP savings. Currently the Trust has an internal CIP target of c6% and for the purposes of the OBC it is assumed that this will address the tariff deflation.

The following table shows the impact on the division's income and operating costs at 2013/14 prices but assuming no investment. As can be seen the additional income associated with the increased activity is offset by increased costs.

Table 5.4 ED – Income & Expenditure

ED Income and Expenditure	2012 /13	2013 /14	2014 /15	2015 /16	2016 /17	2017 /18	2018 /19	2019 /20	2020 /21	2021 /22	2022/23
	Actual £k	Out-turn £k	Forecast £k	Forecast £k	Forecast £k	Forecast £k	Forecast £k	Forecast £k	Forecast £k	Forecast £k	Forecast £k
Income											
ED Tariff	21,162	21,129	21,129	21,129	21,129	21,129	21,129	21,129	21,129	21,129	21,129
ED Other	4,657	4,402	4,402	4,402	4,402	4,402	4,402	4,402	4,402	4,402	4,402
Medical Assessment Unit		8,263	8,263	8,263	8,263	8,263	8,263	8,263	8,263	8,263	8,263
Impact of single front door			-1,370	-1,370	-1,370	-1,370	-1,370	-1,370	-1,370	-1,370	-1,370
Growth			676	1,374	2,094	2,837	3,604	4,395	5,212	6,055	6,925
Total	**25,820**	**33,794**	**33,100**	**33,798**	**34,518**	**35,261**	**36,028**	**36,820**	**37,637**	**38,479**	**39,349**
Expenditure											
Pay											
Nursing	6,441	6,880	6,880	6,880	6,880	6,880	6,880	6,880	6,880	6,880	6,880
Nursing Agency	1,598	1,445	1,445	1,445	1,445	1,445	1,445	1,445	1,445	1,445	1,445
Medical Staff	6,790	8,008	8,008	8,008	8,008	8,008	8,008	8,008	8,008	8,008	8,008
Medical Locum	2,311	1,630	1,630	1,630	1,630	1,630	1,630	1,630	1,630	1,630	1,630
A&Cs	958	1,210	1,210	1,210	1,210	1,210	1,210	1,210	1,210	1,210	1,210
EDU	673	643	643	643	643	643	643	643	643	643	643
EDU Agency	15	285	285	285	285	285	285	285	285	285	285
Impact of single front door			-536	-536	-536	-536	-536	-536	-536	-536	-536

ED Income and Expenditure	2012 /13	2013 /14	2014 /15	2015 /16	2016 /17	2017 /18	2018 /19	2019 /20	2020 /21	2021 /22	2022/23
	Actual £k	Out-turn £k	Forecast £k	Forecast £k	Forecast £k	Forecast £k	Forecast £k	Forecast £k	Forecast £k	Forecast £k	Forecast £k
Additional staff costs due to activity growth					1,155	1,155	1,155	2,425	2,425	3,124	3,124
Total	**18,785**	**20,099**	**19,562**	**19,562**	**20,717**	**20,717**	**20,717**	**21,988**	**21,988**	**22,686**	**22,686**
Non pay											
Nursing	1,823	1,705	1,705	1,705	1,705	1,705	1,705	1,705	1,705	1,705	1,705
Medical Staff	67	95	95	95	95	95	95	95	95	95	95
A&C	26	119	119	119	119	119	119	119	119	119	119
EDU	202	185	185	185	185	185	185	185	185	185	185
Impact of single front door			-136	-136	-136	-136	-136	-136	-136	-136	-136
Additional non pay costs due to activity growth			67	132	200	269	341	414	491	569	650
Total	**2,119**	**2,104**	**2,035**	**2,100**	**2,167**	**2,236**	**2,308**	**2,382**	**2,458**	**2,537**	**2,618**
Total Direct cost	**20,904**	**22,202**	**21,597**	**21,662**	**22,884**	**22,953**	**23,025**	**24,369**	**24,446**	**25,222**	**25,304**
Medical assessment unit		8,263	8,263	8,263	8,263	8,263	8,263	8,263	8,263	8,263	8,263
Additional MAU beds			0	0	933	1,466	1,999	2,532	3,065	3,598	-8,263
Savings on repatriation to additional MAU beds			0	0	-933	-1,466	-1,999	-2,532	-3,065	-3,598	8,263
FM costs	471	471	471	471	636	636	636	636	636	636	636

ED Income and Expenditure	2012 /13	2013 /14	2014 /15	2015 /16	2016 /17	2017 /18	2018 /19	2019 /20	2020 /21	2021 /22	2022/23
	Actual £k	Out-turn £k	Forecast £k	Forecast £k	Forecast £k	Forecast £k	Forecast £k	Forecast £k	Forecast £k	Forecast £k	Forecast £k
Support service costs	3,897	3,864	3,864	3,864	3,864	3,864	3,864	3,864	3,864	3,987	4,115
Overheads	8,745	11,233	11,233	11,233	11,233	11,233	11,233	11,233	11,233	11,233	11,233
Impact of single front door			-165	-165	-165	-165	-165	-165	-165	-165	-165
Additional support costs due to activity growth			82	164	247	329	411	493	575	658	658
Total Costs (baseline)	**34,017**	**46,033**	**45,344**	**45,492**	**46,960**	**47,112**	**47,266**	**48,692**	**48,851**	**49,834**	**50,043**

Below we have modelled the income and expenditure impact of the scheme including capital charges. As can be seen, under a Trust resources and exceptional PDC option, the scheme is affordable.

We have also modelled a Trust resources and loan scenario based on a 25 year loan and the current debt management office public loan rates. This indicates that the Trust would need to find additional savings to ensure affordability throughout the period, however, as discussed above, the Trust is currently developing a detailed Workforce Plan for ED and it is anticipated that this will identify further significant savings. The Trust has prudently not included them at OBC stage.

Table 5.5 Income & Expenditure Impact – Trust Resources & Exceptional PDC

Impact of Scheme	2014 /15 £k	2015 /16 £k	2016 /17 £k	2017 /18 £k	2018 /19 £k	2019 /20 £k	2020 /21 £k	2021 /22 £k	2022 /23 £k
Reduction in Agency costs			-1,693	-1,693	-1,693	-1,693	-1,693	-1,693	-1,693
Reduction in Staff Costs			-416	-416	-416	-874	-874	-1,357	-1,357
Change in depreciation	-170	-170	711	1,005	1,005	1,005	1,005	1,005	1,005
Additional FM costs			127	127	127	127	127	127	127
Change in Rate of return	-89	-89	962	932	897	862	827	792	756
Total impact	-259	-259	-309	-44	-79	-572	-607	-1,127	-1,162

Below is the impact of the loan option:

Table 5.6 Income & Expenditure Impact – Trust Resources & Loan

Impact of loan option	2014 /15 £k	2015 /16 £k	2016 /17 £k	2017 /18 £k	2018 /19 £k	2019 /2 £k	2020 /21 £k	2021 /22 £k	2022 /23 £k
Reduction in Agency costs	0	0	-1,693	-1,693	-1,693	-1,693	-1,693	-1,693	-1,693
Reduction in Staff Costs	0	0	-416	-416	-416	-874	-874	-1,357	-1,357
Change in depreciation	-170	-170	711	1,005	1,005	1,005	1,005	1,005	1,005
Additional FM costs	0	0	127	127	127	127	127	127	127
Repaymet of loan capital	397	1,376	1,427	1,427	1,427	1,427	1,427	1,427	1,427
Interest on loan	397	1360	1356	1299	1242	1185	1128	1071	1014
Total impact	624	2,567	1,513	1,750	1,693	1,178	1,121	580	523

5.5 Impact on Trust Income, Cash Flow & Balance Sheet

The Table below sets out the impact on the Trust's balance sheet. Further details to support these figures are within the finance Appendix (9).

Table 5.7 Impact on Trust Balance Sheet

Balance Sheet	2013 /14	2014 /15	2015 /16	2016 /17	2017 /18	2018 /19	2019 /20	2020 /21	2021 /22	2022/23
Assets Under Construction	8,323,572	13,848,153	24,480,266	1,106,701	170,344					
Impairments on new building coming into use (DV likely revaluation)				-17,024,301						
Impairment on partial demolition of Victoria based m2	-2,472,646									
Depreciation				-711,445	-1,005,283	-1,005,283	-1,005,283	-1,005,283	-1,005,283	-1,005,283
Change to Fixed Assets	-2,472,646			30,022,946	29,188,007	28,182,723	27,177,440	26,172,157	25,166,873	24,161,590
Impact on Balance Sheet	-2,472,646									
Rate of return on assets				1,050,803	1,021,580	986,395	951,210	916,025	880,841	845,656

As can be seen, the demolition of part of the existing Victoria Building will lead to an impairment in the first instance and this has been based on the square meterage demolished as a percentage of the total building area.

The new Emergency Floor project is expected to be available in August 2016 and prior to this it is treated as an asset under construction.

On coming into use, we have assumed that as a result of the DV valuation there will be an impairment of 30%. With regard to the decant, this work is not anticipated to add significant value to the estate and we have assumed an impairment of 70% for this work.

The value of these impairments are shown below:

Table 5.8 Value of Impairments

Impairments	£K
Demolitions	2,473
Decant Schemes	5,489
New asset coming into use	11,536
Total	**19,497**

5.6 Sensitivity

The key sensitivities are the expectations of growth together with the additional revenue and the Trust's ability to realise the savings it has identified.

Below we have modelled the impact on additional income of 1% less growth pa than forecast. As can be seen this has a significant impact on the additional income levels.

However in response to this scenario the Trust would be able to reduce its recruitment of additional staff.

Table 5.9 Impact of 1% less Growth

	2014/15 £k	2015/16 £k	2016/17 £k	2017/18 £k	2018/19 £k	2019/20 £k	2020/21 £k	2021/22 £k
Income Growth Assumption	676	1,374	2,094	2,837	3,604	4,395	5,212	6,055
Income Growth at 1% less pa	465	940	1,425	1,922	2,429	2,947	3,477	4,018

We have also modelled the impact of the Trust not achieving the savings in staff due to moving to the upper quartile in staffing for the ED and not fully achieving its target reduction in agency staff.

As can be seen this will have a major impact on the affordability. However the Trust is currently developing a workforce plan so as to ensure it has a robust strategy to achieve the savings.

Table 5.10 Impact of not Achieving Staff Savings

	2014/15 £k	2015/16 £k	2016/17 £k	2017/18 £k	2018/19 £k	2019/20 £k	2020/21 £k	2021/22 £k
Reduction in Agency Costs	0	0	-1,693	-1,693	-1,693	-1,693	-1,693	-1,693
Reduction in Staff Costs	0	0	-416	-416	-416	-874	-874	-1,357
Impact	0	0	1,055	1,055	1,055	1,283	1,283	1,525

5.7 Affordability

As can be seen the scheme is affordable under an exceptional PDC funding route and with additional savings being reviewed as part of the workforce planning will be affordable under a loan funding option.

5.8 Long Term Financial Model

Set out below is the Trust's current Long Term Financial Model (LTFM) assumptions. The LTFM is currently being updated and will incorporate the impact of the scheme as outlined below.

Table 5.11 LTFM Assumptions

Change in Income	2014 /15 £k	2015 /16 £k	2016 /17 £k	2017 /18 £k	2018 /19 £k	2019 /20 £k	2020 /21 £k	2021 /22 £k	2022 /23 £k
Impact of single front door	-1,370	-1,370	-1,370	-1,370	-1,370	-1,370	-1,370	-1,370	-1,370
Growth	676	1,374	2,094	2,837	3,604	4,395	5,212	6,055	6,055
Total	**-694**	**4**	**724**	**1,467**	**2,234**	**3,025**	**3,842**	**4,685**	**4,685**
Change in Costs									
Impact of single front door	-165	-165	-165	-165	-165	-165	-165	-165	-165
Additional staff costs due to activity growth			1,155	1,155	1,155	2,425	2,425	3,124	3,124
Impact of single front door Non pay	-136	-136	-136	-136	-136	-136	-136	-136	-136
Additional Non Pay costs due to activity growth	67	132	200	269	341	414	491	569	569
Impact of single front door on indirect costs	-165	-165	-165	-165	-165	-165	-165	-165	-165
Additional indirect Support costs due to activity growth	82	164	247	329	411	493	575	658	658
Sub Total	-318	-170	1,134	1,285	1,439	2,866	3,024	3,884	3,884
Reduction in Agency costs			-1,679	-1,847	-1,847	-1,847	-1,847	-1,847	-1,847

Change in Income	2014 /15 £k	2015 /16 £k	2016 /17 £k	2017 /18 £k	2018 /19 £k	2019 /20 £k	2020 /21 £k	2021 /22 £k	2022 /23 £k
Reduction in Staff Costs			-416	-416	-416	-874	-874	-1,357	-1,357
Change in depreciation	-170	-170	735	1,037	1,037	1,037	1,037	1,037	1,037
Additional FM costs			127	127	127	127	127	127	127
Change in Rate of return	-89	-89	968	938	902	866	829	793	793
Total	**-577**	**-430**	**869**	**1,124**	**1,242**	**2,175**	**2,297**	**2,636**	**2,636**

Income figures in this table are consistent with the Trust Integrated Business Plan (IBP) and Long Term Financial Model (LTFM).

Expenditure figures are also consistent with the IBP and LTFM. These include agreed CIPs.

As outlined in the base case table above the increase in activity will lead to an increase in income and in costs.

Table 5.12 Impact on LTFM

Change in Income	2014 /15 £k	2015 /16 £k	2016 /17 £k	2017 /18 £k	2018 /19 £k	2019 /20 £k	2020 /21 £k	2021 /22 £k
Impact of single front door	-1,370	-1,370	-1,370	-1,370	-1,370	-1,370	-1,370	-1,370
Growth	676	1,374	2,094	2,837	3,604	4,395	5,212	6,055
Total	**-694**	**4**	**724**	**1,467**	**2,234**	**3,025**	**3,842**	**4,685**
Change in Costs								
Impact of single front door	-165	-165	-165	-165	-165	-165	-165	-165
Additional staff costs due to activity growth			1,155	1,155	1,155	2,425	2,425	3,124
Impact of single front door Non pay	-136	-136	-136	-136	-136	-136	-136	-136
Additional Non Pay costs due to activity growth	67	132	200	269	341	414	491	569
Impact of single front door on indirect costs	-165	-165	-165	-165	-165	-165	-165	-165
Additional indirect Support costs due to activity growth	82	164	247	329	411	493	575	658
Sub Total	-318	-170	1,134	1,285	1,439	2,866	3,024	3,884
Reduction in Agency costs			-1,679	-1,847	-1,847	-1,847	-1,847	-1,847
Reduction in Staff Costs			-416	-416	-416	-874	-874	-1,357
Change in depreciation	-170	-170	735	1,037	1,037	1,037	1,037	1,037

Change in Income	2014 /15 £k	2015 /16 £k	2016 /17 £k	2017 /18 £k	2018 /19 £k	2019 /20 £k	2020 /21 £k	2021 /22 £k
Additional FM costs			127	127	127	127	127	127
Change in Rate of return	-89	-89	968	938	902	866	829	793
Total	**-577**	**-430**	**869**	**1,124**	**1,242**	**2,175**	**2,297**	**2,636**

It should be noted that a key assumption underpinning the figures is that the overheads (e.g. Instrumentation, Discharge Lounge, HR, Finance etc) within the Trust remain constant despite the increase in activity. This will be further examined in the FBC.

As can be seen from the sub total income will be higher than the additional cost primarily because of the overheads assumption outlined above.

The further savings are a result of the impact of the scheme.

As will be noted Income and Expenditure (table 5.4) above includes the overheads allocated to the department by the PLICS system.

Below we have assessed the impact of excluding these overheads and as can be seen the ED does not make a financial contribution.

We have also outlined below the contribution required at varying levels of overhead charges.

Table 5.13 Impact of Excluding Overheads

ED INCOME AND EXPENDITURE Excluding overheads	2012/ 13 Actual £k	2013/ 14 Out-turn £k	2014/ 15 Forecast £k	2015/ 16 Forecast £k	2016/ 17 Forecast £k	2017/ 18 Forecast £k	2018/ 19 Forecast £k	2019/ 20 Forecast £k	2020/ 21 Forecast £k	2021/ 22 Forecast £k	2022/ 23 Forecast £k
INCOME	21,162	21,129	21,129	21,129	21,129	21,129	21,129	21,129	21,129	21,129	21,129
ED Tariff	4,657	4,402	4,402	4,402	4,402	4,402	4,402	4,402	4,402	4,402	4,402
ED Other		8,263	8,263	8,263	8,263	8,263	8,263	8,263	8,263	8,263	8,263
Medical Assessment Unit			-1,370	-1,370	-1,370	-1,370	-1,370	-1,370	-1,370	-1,370	-1,370
Impact of single front door			676	1,374	2,094	2,837	3,604	4,395	5,212	6,055	6,925
Total	**25,820**	**33,794**	**33,100**	**33,798**	**34,518**	**35,261**	**36,028**	**36,820**	**37,637**	**38,479**	**39,349**
EXPENDITURE: Pay											
Nursing	6,441	6,880	6,880	6,880	6,880	6,880	6,880	6,880	6,880	6,880	6,880
Nursing Agency	1,598	1,445	1,445	1,445	1,445	1,445	1,445	1,445	1,445	1,445	1,445
Medical Staff	6,790	8,008	8,008	8,008	8,008	8,008	8,008	8,008	8,008	8,008	8,008
Medical Locums	2,311	1,630	1,630	1,630	1,630	1,630	1,630	1,630	1,630	1,630	1,630
A&C	958	1,210	1,210	1,210	1,210	1,210	1,210	1,210	1,210	1,210	1,210
EDU	673	643	643	643	643	643	643	643	643	643	643
EDU Agency	15	285	285	285	285	285	285	285	285	285	285
Impact of single front door			-536	-536	-536	-536	-536	-536	-536	-536	-536

ED INCOME AND EXPENDITURE Excluding overheads	2012/ 13 Actual £k	2013/ 14 Out-turn £k	2014/ 15 Forecast £k	2015/ 16 Forecast £k	2016/ 17 Forecast £k	2017/ 18 Forecast £k	2018/ 19 Forecast £k	2019/ 20 Forecast £k	2020/ 21 Forecast £k	2021/ 22 Forecast £k	2022/ 23 Forecast £k
Additional staff costs due to activity growth					1,155	1,155	1,155	2,425	2,425	3,124	3,124
Total	**18,785**	**20,099**	**19,562**	**19,562**	**20,717**	**20,717**	**20,717**	**21,988**	**21,988**	**22,686**	**22,686**
EXPENDITURE: Non Pay											
Nursing	1,823	1,705	1,705	1,705	1,705	1,705	1,705	1,705	1,705	1,705	1,705
Medical Staff	67	95	95	95	95	95	95	95	95	95	95
A&C	26	119	119	119	119	119	119	119	119	119	119
EDU	202	185	185	185	185	185	185	185	185	185	185
Impact of single front door			-136	-136	-136	-136	-136	-136	-136	-136	-136
Additional Non Pay costs due to activity growth			67	132	200	269	341	414	491	569	650
Total	**2,119**	**2,104**	**2,035**	**2,100**	**2,167**	**2,236**	**2,308**	**2,382**	**2,458**	**2,537**	**2,618**
TOTAL DIRECT COSTS	**20,904**	**22,202**	**21,597**	**21,662**	**22,884**	**22,953**	**23,025**	**24,369**	**24,446**	**25,222**	**25,304**
Medical Assessment Unit		8,263	8,263	8,263	8,263	8,263	8,263	8,263	8,263	8,263	8,263
Additional MAU beds			0	0	933	1,466	1,999	2,532	3,065	3,598	-8,263

ED INCOME AND EXPENDITURE Excluding overheads	2012/ 13 Actual £k	2013/ 14 Out-turn £k	2014/ 15 Forecast £k	2015/ 16 Forecast £k	2016/ 17 Forecast £k	2017/ 18 Forecast £k	2018/ 19 Forecast £k	2019/ 20 Forecast £k	2020/ 21 Forecast £k	2021/ 22 Forecast £k	2022/ 23 Forecast £k
Savings on repatriation to additional MAU beds			0	0	-933	-1,466	-1,999	-2,532	-3,065	-3,598	8,263
FM Costs	471	471	471	471	636	636	636	636	636	636	636
Support Service Costs	3,897	3,864	3,864	3,864	3,864	3,864	3,864	3,864	3,864	3,987	4,115
Overheads	8,745	11,233	0	0	0	0	0	0	0	0	0
Impact of single front door			-165	-165	-165	-165	-165	-165	-165	-165	-165
Additional Support costs due to activity growth			82	164	247	329	411	493	575	658	658
TOTAL COSTS (BASELINE)	**34,017**	**46,033**	**34,112**	**34,259**	**35,728**	**35,879**	**36,033**	**37,460**	**37,618**	**38,602**	**38,810**
Deficit	8,197	12,239	1,011	461	1,209	618	5	640	-18	122	-539
Overhead contribution											
At 5%			1,706	1,713	1,786	1,794	1,802	1,873	1,881	1,930	1,941
At 10%			3,411	3,426	3,573	3,588	3,603	3,746	3,762	3,860	3,881
At 20%			6,822	6,852	7,146	7,176	7,207	7,492	7,524	7,720	7,762

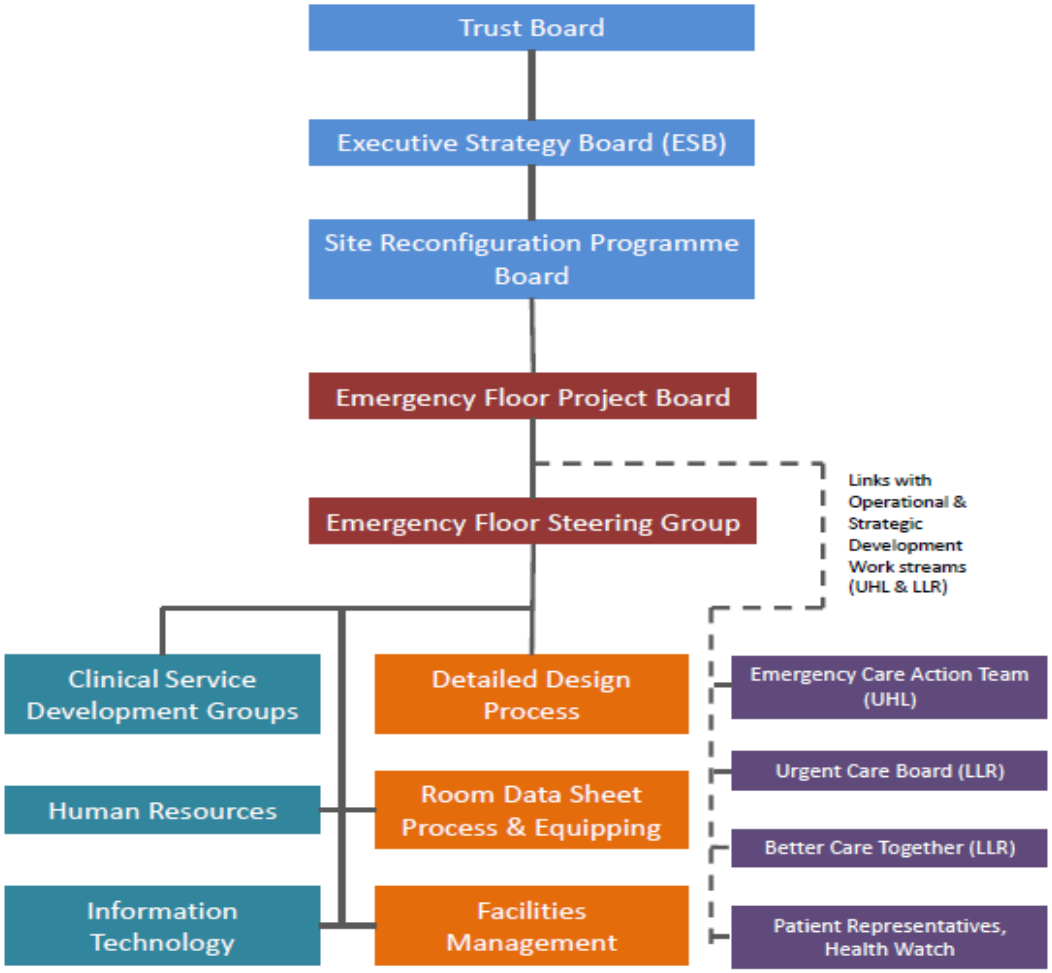
6 | The Management Case

6.1 Introduction

The Management Case provides a summary of the arrangements which have been put into place for the successful delivery of the proposed reconfiguration of the Emergency Floor, the associated other service relocations required as a result of the decanting moves, service operational changes, and to secure the benefits sought through the investment.

6.2 Project Governance Arrangements

Project Governance arrangements have been established to reflect national guidance18 and the Trust's own Capital Governance Framework, as shown in the diagram below:



[18] Capital Investment Manual 'Managing Capital Projects' (Department of Health); PRINCE2 (Office of Government Commerce); Managing Successful Programmes (Office of Government Commerce/ Efficiency & Reform Group)

6.3 Outline Project Roles and Responsibilities

Key Project delivery roles are described below:

- **Senior Responsible Owner (SRO):** This role is being performed by the Medical Director, with responsibility to the Executive Trust Board for delivery of the project to meet their terms of reference

- **Senior User:** This role is being performed by the Clinical Director for the Emergency & Specialist Medicine CMG, with responsibility for ensuring that the project maintains alignment with the service and business targets described in the Business Case and working within the terms of reference set by the Project Board.

- **Project Director:** This role is being performed by the Site Reconfiguration Project Director with overall responsibility for directing the Trust's capital development schemes and reporting to the Site Reconfiguration Programme Board.

- **Development Project Manager:** This role is being performed by the Regional Operations Director for Capita Property & Infrastructure (Health Division). The person will have day to day responsibility for administration of the development of the project (within the delegated role permitted by Project Board).

- **Service Project Managers:** Senior managers from the ED and associated departments that are proposed to make up the Emergency Floor solution will undertake this role, having day to day responsibility for providing advice on the service brief to the development team and for planning and delivery of service and workforce change under the direction of the Senior User.

Regular Progress Reports will be submitted to the Site Reconfiguration Programme Board and Executive Strategy Board for onward reporting and management within the established Trust management structure.

6.3.1 Core Group Responsibilities:

The roles and responsibilities for the main project groups are summarised as follows:

Executive Strategy Board (ESB)

This group is a designated committee appointed by the Trust Board, with responsibilities which in summary, include:

- To advise the Trust Board on formulating strategy for the organisation.
- To ensure accountability by holding each other to account for the delivery of the strategy and through seeking assurance that all systems of control are robust and reliable.

To lead the Trust executively, in accordance with our shared values, to deliver our vision and, in doing so, help shape a positive culture for the organisation

Site Reconfiguration Programme Board

This group is a designated committee appointed by the Trust Board, with responsibilities which in summary, include:

- Monthly review of scheme progress and status
- Provision of interim direction to maintain progress
- Decision on matters for escalation for ESB and Trust Board direction/ information

Emergency Floor Project Board

The membership of the Project Board is:

Table 6.1 Trust Transformation Project Board

Member	Title
Dr Kevin Harris	Chair/ Medical Director
Nicky Topham	Project Director/ Programme Director of Reconfiguration, UHL
Chris Turner	Project Manager/ Associate Director, Capita
Stephen Samuels	Senior Supplier/ Director of Interserve, UHL Facilities Management
Andrew Seddon	Director of Finance
Phil Walmsley	Head of Operations
Catherine Free	Senior User/ Acute CMG
Andrew Furlong	Senior User/ Deputy Medical Director
Ian Scudamore	Senior User/ Woman's & Children's Divisional Director or Representative
Kim Wilding	Senior User/ UCC Divisional Manager or Representative
Nigel Bond	LLR Faculties Management Company

Key roles and responsibilities will include:

- Responsibility for delivering the project within the parameters set within the business case
- Providing high level direction on stakeholder involvement and monitoring project level management of stakeholders
- Providing the strategic direction for the project
- Ensure continuing commitment of stakeholder support
- Key stage decisions
- Progress monitoring

Monthly progress reports, including projections of forthcoming key activities and decisions, will be submitted to the Project Board by the Project Director
The standing agenda will be as follows:

- Apologies:
- Minutes of Previous Meeting
- Matters Arising
- Development Progress Report
- Clinical Service update
- Service model refinement
- Recruitment and training
- Stakeholders and Communications
- Any other business
- Date of Next Meeting

Emergency Floor Steering Group

The membership of the Steering Group is:

Table 6.2 Emergency Floor Steering Group

Member	Title
Nicky Topham	Project Director
Chris Turner	Project Manager
Andrew Seddon	Director of Finance
Louise Naylor	Trust Site Reconfiguration Project Manager
David Finch	Building Services Manager
Nigel Bond	Trust Capital Projects Manager
Jane Edyvean	CBU Manager
Sam Jones	Lead Consultant – Paediatrics
Catherine Free	Lead Consultant – Medical
Ben Teasdale	Lead Consultant – Emergency care
Jaydip Banerjee	Lead Consultant - ED Low Acuity
Mark Williams	Lead Consultant - EDU/MH
Nigel Langford	Lead Consultant – Triage & Treatment
Keith Blanshard	Lead Consultant – Clinical Support
Lee Walker	Lead Consultant – Adult Assessment
Kim Wilding	Senior User Urgent Care Centre
Lisa Lane	ED High Acuity Lead Nurse
Kerry Morgan	ED High Acuity Lead Nurse
Andrew Coser	ED Low Acuity
Kate Hardiment	ED Low Acuity

Steve Peck	ED Low Acuity
Vijay Savant	ED Low Acuity
Sanjay Varma	ED Low Acuity
Gaby Harris	ED Low Acuity
Chandra Brown	ED Low Acuity Service Manager
Marianne Elloy	ED Low Acuity Paediatric ENT
Fay Gordon	CBU Manager
Geraldine Burdett	EDU/Mental Health Nurse
Paul Knowles	EDU/Mental Health
Julie Burdett	Triage and Treatment
John Jameson	Triage and Treatment
Gillian Wardle	Adult Assessment Lead Nurse
Shaheen Steers	Adult Assessment Lead Nurse
Esther Hyde	Adult Assessment
Emily Laithwaite	Adult Assessment
Daniel Barnes	Clinical Support
Ruth Denton-Beaumont	Clinical Support
Judy Gilmore	Clinical Support
Cathy Lea	Clinical Support
Andrew Rickett	Clinical Support
Stephen Samuels	Director – Interserve FM
Ian Morgan	Architect - Capita
Jonathan Hughes	Health Planner - Capita
Mark Wightman	Director Communications and External Relations

This group will be chaired by the Project Manager. Key roles and responsibilities will include:

- Day to day responsibility for the delivery of the project to meet the parameters described within the business case
- Provision of appropriate reports on status to the Project Director
- Management of risks and issues and escalation of appropriate matters for executive direction/ approval
- Providing working groups with detailed briefs
- Monitoring, co-ordinating and controlling the work of the Working Groups
- Drawing together the outputs of the Working Groups
- Ensure continuing commitment of stakeholders, both internal and external

The group will meet monthly or more frequently as required in accordance with the phase of the project. The Standing Agenda will be as follows:

- Apologies:
- Minutes of Previous Meeting
- Matters Arising
- Progress Report
- Shared BREEAM / Planning Issues

Other groups are likely to be established by the Project Steering Group as the project develops.

A Project Initiation Document (PID) has been prepared to provide detailed information on proposed project management arrangements, including:

- Aims and objectives
- Benefits and constraints
- Organisation
- Roles and responsibilities
- Detailed programme for stage activities
- Risk management arrangements
- Statutory Approvals and Quality Standards
- Project Communications

Working Groups

Working Groups will be convened to provide advice and direction to the detailed design process in developing this development. Their role can be summarised as follows:

- Architect Led Design Team: This group will be led by the Trusts appointed lead Architect and will be responsible for:
- Managing design progress and coordination issues
- Identifying key matters for Trust assistance/ decision making
- Identifying design risks and issues for management and if appropriate escalation to the project team
- Service Development: Representing clinical services, responsibilities will include:
- Provide comment to the Project Manager on Reviewable Design Information
- Liaise with Infection Control to gain advice on final product/ detail selection issues
- Refinement of Operational Policy(s)
- Support the work of the Equipping process in preparation of key stage documents

Equipping Group

This group will be responsible for confirmation and procurement of equipment required for the operational needs of the Emergency Floor solution. This will include:

- Producing equipment schedules

- Planning the procuring of equipment in accordance with the Trusts SFIs and SOs and to ensure compliance with BREEAM obligations
- Planning the commissioning of equipment
- Understanding the transfer requirements of existing equipment/ furniture (as appropriate)

Hard and Soft Facilities Management:

Representing the needs of hard and soft FM, provide the following support:

- Providing comments to the Project Manager on reviewable design Information
- Advising on FM related fittings, fixtures and equipping selection as part of the detailed design process
- Updating whole hospital policies and service agreements to reflect the departmental operation of the proposed Emergency Floor
- Advising on risks or issues which may threaten the success of the scheme
- Managing delivery of client related BREEAM obligations

Information & Communications Technology

This group will be responsible for ensuring that voice and data requirements are delivered for the scheme, along with advice on equipment which is linked with communications (eg. CCTV, entry systems, BMS etc). This will cover

- Addressing any queries from the Design Team in relation to the design of cabling and associated works
- Reviewing any design information in relation to ICT
- Planning the transfer and commissioning of voice and data provision from the existing operating locations to the new development

The end stage of the project will result in the completion, handover and commissioning of the new facility. The Emergency Floor Project Board is responsible for providing assurance that the project has been delivered in terms of product and quality in line with the business case.

6.3.2 Project Plan

The Project Programme is intended to deliver the project by August 2016, though this timeline is predicated on the enabling works being commenced post NTDA approval of the Outline Business Case and in parallel with commencement of the Full Business Case process. The milestones for this project are set out below.

Table 6.3 Project Milestones

Milestone	Date
Preparation of Outline Business Case	October/ November 2013
Outline Business Case circulated to Executive Team for review	18th November 2013
Outline Business Case presented to Executive Team	19th November 2013
Outline Business Case circulated to Trust Board for review	21st November 2013
Outline Business Case presented to Trust Board Development	21st November 2013
Outline Business Case presented for Trust Board approval	28th November 2013
Outline Business Case sent to the NTDA	December 2013
Outline Business Case presented to CCGs & UCB	December 2013
NTDA approval of the Outline Business Case	February 2014
Commence Full Business Case	February 2014
Commence enabling works	March 2014
Full Business Case presented for Trust Board approval	June 2014
Full Business Case sent to the NTDA	July 2014
NTDA approval of the Full Business Case	September 2014
Enabling works completed/ commence construction phase	December 2014
Handover	July 2016
Trust Commissioning Period	July/ August 2016
Trust Operational	August 2016

A project budget has been agreed and set up as shown in Table 6.4 below.

Table 6.4 Project Capital Budget Requirement:

Capital Costs	Option 3A Victoria (£)
Construction	23,643,192
Fees	6,344,090
Equipment	1,635,853
Decant	7,840,866
Planning Contingency	1,586,707
Sub Total	**41,050,708**
Optimism bias	3,411,420
Inflation	3,466,908
Total	**47,929,036**

6.4 Use of Special Advisors

Special advisers have been used in a timely and cost-effective manner in accordance with the Treasury Guidance.

Table 6.5 External Advisors

Emergency Floor Development		
1	Capita	Architects
2	Capita	Cost Consultants
3	Capita	Business case / Finance analysis
4	Capita	Structural Engineers
5	Capita	Mechanical and Electrical Engineers
6	Capita	PMO
7	Interserve	Building/Construction Supervisors
8	Capita	CDM

6.5 Stakeholder Engagement Plan

Table 6.6 Key Stakeholders

Internal stakeholders	External stakeholders
▶ Trust Board ▶ Clinical staff ▶ Non clinical staff ▶ Patient Rep ▶ IT ▶ Estates & Facilities ▶ Finance ▶ HR ▶ PCTs ▶ Unions	▶ NHS Trust Development Authority (NTDA) ▶ Education provider – ▶ Local acute Trusts – ▶ CCG's ▶ General Public ▶ Special interests groups

6.6 Outline Arrangements for Change and Contract Management

Change management associated with the project will be managed through the Project Board and executive forums that preside over it, under the chairmanship of the Senior Responsible Owner (SRO) and Trust Board respectively. Day to day change management issues will be discussed at the Project Steering Group level and any resultant contract and/ or cost changes will need to be approved by the Project Board.

6.7 Outline Arrangements for Benefits Realisation

The delivery of benefits will be managed through the Emergency Floor Project Board. An outline copy of the benefits realisation plan is attached at Appendix 11 and will be expanded for the FBC submission. This sets out who is responsible for the delivery of specific benefits, when they will be delivered, and how achievement of them will be measured. The key opportunity is presented by the new design for facilities, which will ensure capacity meeting demand, efficiencies in service delivery, compliance to standards and minimised disruption to overall Trust operations.

Key benefits of the project are:

- To implement a design solution that provides a safe emergency care service that ensures capacity and known flexibility for current and known future demands of patients requiring emergency care
- Improve patient pathway management reducing the clinical risk and discomfort through the emergency care pathway
- Support and consolidate the provision of emergency floor concept at LRI
- Ensures that the service model of care is delivered in line with National, Trust and local health economy KPI's
- Patient safety is enhanced, and clinical risk is reduced

- Where possible ensures that the service is developed in line with NHS Guidance in terms of HBN, HTM, national and Trust policy and local health economy policy in terms of capacity provision
- Quality of care is enhanced, in terms of the model of care, and seamless pathways of care and patient flows
- The built environment enhances clinical practice that support clinical effectiveness, improved patient outcomes and patient safety
- Provides enhanced departmental relationships and clinical adjacencies that support clinical effectiveness and improved patient outcomes
- Ensures facilities are future proofed and adaptable to the changing needs of the health economy
- Improved Privacy and dignity provisions for all patients
- Consolidates existing services & provides clinical expertise whilst realising the Emergency Floor concept
- Improved patient access through a single front door process
- Enhances patient, visitor and staff safety through the built environment
- The design solution minimises the impact of the construction process on the site and therefore delivery of the Trust core services
- Option enables future proofing of the physical ED environment aligned to DCP future expansion needs
- The enabling moves will facilitate the Emergency Floor programme whilst minimising delay to delivery
- Reduces complexity and sequence dependency of enabling moves
- Maintains blue light access throughout whole build process

6.8 Outline Arrangements for Risk Management

The Trust ensures through the involvement of its employees, that risk management serves as a mechanism for risk reduction. Also, by taking a proactive approach to managing risk exposure, the Trust ensures protection of its patients, staff, visitors, assets and reputation. This project will be managed in that context.

6.8.1 Risk Management Policy

The risk management system is described in the Trusts Risk Management Policy which is accessible to all staff via the Trust Intranet. It is based on an iterative process of:

- Identifying and prioritising the risks to the achievement of the organisation's policies, aims and objectives
- Evaluating the likelihood of those risks being realised and the impact should they be realised
- Managing the risks efficiently, effectively and economically

This is achieved through a sound organisational framework, underpinned by a robust policy framework, which promotes early identification of risk, the co-ordination of risk

management activity, the provision of a safe environment for staff and patients, and the effective use of financial resources.

The Trust Risk Register details, in order of relative importance, all the significant risks facing the Trust which are most likely to affect (positively or otherwise) achievement of the Trust's objectives. Appendix 12a highlights the relevant current ED risks on the Trust Risk Register

All new Trust employees attend the corporate induction course, which includes elements of risk management, before they commence their duties in the workplace. This corporate induction is followed by a local induction, delivered by the service line manager, during which time staff receive information on risks specific to that service.

Risks are identified through feedback from many sources such as proactive risk assessments, adverse incident reporting and trends, clinical benchmarking and audit data, complaints, legal claims, patient and public feedback, stakeholder/partnership feedback and internal/external assurance assessments. Appendix 12c provides an overview of the robust system of risk management across the Trust.

6.8.2 Assurance Framework

The Trust's Assurance Framework provides it with a simple but comprehensive method for the effective and focused management of the principal risks to meeting the Trust's corporate objectives. In this way it provides a structure and describes the controls and assurance mechanisms in place to manage the identified risks. This simplifies Board reporting and the prioritisation of action plans, which, in turn, allows for more effective performance management.

The key elements of the Assurance Framework are:

- Establishment of the Trust's principal objectives (strategic & directorate)
- Identification of the principal risks that might threaten the achievement of these objectives
- Identification and evaluation of the key controls intended to manage these principal risks
- Setting out of the arrangements for obtaining assurance on the effectiveness of the key controls across all areas of principal risk
- Evaluation of the assurance across all areas of principal risk
- Identification of the positive assurances and areas where there are gaps in controls and or assurances
- Putting in place of plans to take corrective action where gaps have been identified in relation to principal risks
- Maintenance of dynamic risk management arrangements including, crucially, a well-informed risk register

Therefore, the Assurance Framework provides a simple framework for reporting key information to Boards. It identifies which of the organisation's objectives are at risk because of inadequacies in the operation of controls or where the organisation has insufficient assurance about them. At the same time it provides structured assurances about where risks are being managed effectively and objectives are being delivered.

The primary focus is confidence that effective processes are in place to deliver the strategic objectives of the Trust. This allows Boards to determine where to make efficient use of their resources and address the issues identified in order to improve the quality and safety of care.

Where any significant gaps in assurance are identified they are transferred to the risk register and an action plan is developed.

6.8.3 Project Risk Register

A risk management framework will be formulated to provide a comprehensive risk assessment and control framework for the project. This will focus on:

- The risks appertaining to developing the OBC for submission.
- The risks associated with the delivery of the options for schemes being developed – this will need to be used in the evaluation of the various design options and tested against the benefits defined for the Scheme
- Risk that is highlighted from the individual work stream committees and presented at the Project Board meeting

The reporting will follow the PRINCE2 process of checkpoint, highlight and exception reports. The condition will be indicated by using red, amber or green (RAG) colour code as outlined below.

Table 6.7 Risk Register Colour Code

Score	Probability	Impact
5	Almost certain	Severe
4	Likely	Major
3	Possible	Moderate
2	Unlikely	Minor
1	Rare	None

Score	RAG Status	Definition
15-20	R	Corrective action urgently required
7-14	A	Condition requires corrective action which has been implemented
6 or less	G	Condition is on programme or within budget no special action is required

The comprehensive risk register for the project will be monitored by the project manager, and reported monthly to the Project Board. The detailed risk register for this project, for each short listed option, is outlined in Appendix 12b. Additional Risks are also highlighted within Appendix 13 and 14. The focus of risk management will address broadly:

- Non-delivery of project outcomes as defined in stages of the project plan (the Board will manage business risks)
- Threats to the completion of the project within cost and time (managed on a day-to-day basis by the Programme Manager)

The initial key risks to the delivery of the project are shown in Table 6.8 below:

Table 6.8 Key Delivery Risks

Risk		Mitigation	
Approval Risk The proposals do not receive the approval of the board, the planning authority and/or NTDA resulting in abortive costs	5x2	The risk is mitigated by fixed consultancy fees up to planning approval stage that are already budgeted for in the current Capital Programme	5x1
Affordability Risk The Trust cannot afford the proposed proposals, resulting in abortive cost	5x3	This risk is mitigated by an assessment of affordability as part of the business case process and costs in the business case that will be competitively tendered through the P21+ framework	5x1
Programme Risk The proposals delay the redevelopment plans, resulting in abortive cost and failure to meet strategic objectives	4x4	This risk is mitigated by the delivery of the emergency care project being programmed as part of the redevelopment governance structure. P21+ framework will be utilised	4x1
Design Risk Design does not deliver the required specification resulting in failure to meet the project objectives and delayed changes impacts on phasing of work and abortive costs relating to planning and implementation	4x2	The risk is mitigated by design flexibility and early involvement of external expert design and technical consultants. P21+ provides contractual responsibilities by supply chain partners	4x1
Clinical Risk Interruption to service provision within clinical areas during phase implementation and set up of new capacity requirements	4x5	Early involvement and consultation with clinical users and detailed programme planning at all phases	4x2

Risk		Mitigation	
Procurement Risk Contractor complications and escalating costs	4x2	This risk is mitigated by a detailed commercial case, detailed and specific contract arrangements in place	3x2

6.9 Outline Arrangements for Post Project Evaluation

The outline arrangements for post Project Evaluation (PPE) have been established in accordance with best practice. The trust will ensure that a thorough post-project evaluation is undertaken at key stages in the process to ensure that positive lessons can be learnt from the project. These will be of benefit to:

- The Trust – in using this knowledge for future capital schemes
- Other key local stakeholders – to inform their approaches to future projects
- The NHS more widely – to test whether the policies and procedures used in this procurement have been used effectively
- Contractors – to understand the healthcare environment better

The evaluation will examine the following elements, where applicable at each stage:

- The effectiveness of the project management of the scheme – viewed internally and externally
- The quality of the documentation prepared by the Trust for the contractors and suppliers
- Communications and involvement during procurement
- The effectiveness of advisers utilised on the scheme
- The efficacy of NHS guidance in delivery the scheme
- Perceptions of advice, guidance and support from the strategic health authority and NHS Estates in progressing the scheme

Formal post project evaluation reports will be compiled by project staff, and reported to the Board to ensure compliance to stated objectives.

6.9.1 Post Implementation Review (PIR)

These reviews ascertain whether the anticipated benefits have been delivered and are timed to take place immediately after the new emergency care unit opens and then 2 years later to consider the benefits planned.

6.10 Gateway Review Arrangements

A Gateway 1 / 2 Review will be booked when the Trust Board has approved this OBC.

6.11 Contingency Plans

The Trust has a framework for Business/Service Continuity. In this instance, the Emergency Care Directorate ensures that the Trust's emergency care service contingency plans are in place for the event of any disruption.

The Trust's framework ensures the Trust can comply with the business continuity provisions of the Civil Contingencies Act 2004. Contingency plans have been developed to ensure the Trust can continue to deliver an acceptable level of service of its critical activities in the event of any disruption.

In the event that this project fails and the ED is not re-developed, the Trust will continue to implement and realise the benefits of its current Emergency Care action plan. The Trust will implement the Do Minimum albeit limiting in achieving capacity requirements and efficiencies, however it will enable a continuation of Emergency services within its existing facility.

In terms of financial contingency, Section 5 highlights a planning Contingency of 5% of the total costs, including fees and equipment, for short listed options.

Signed: .....

Senior Responsible Owner

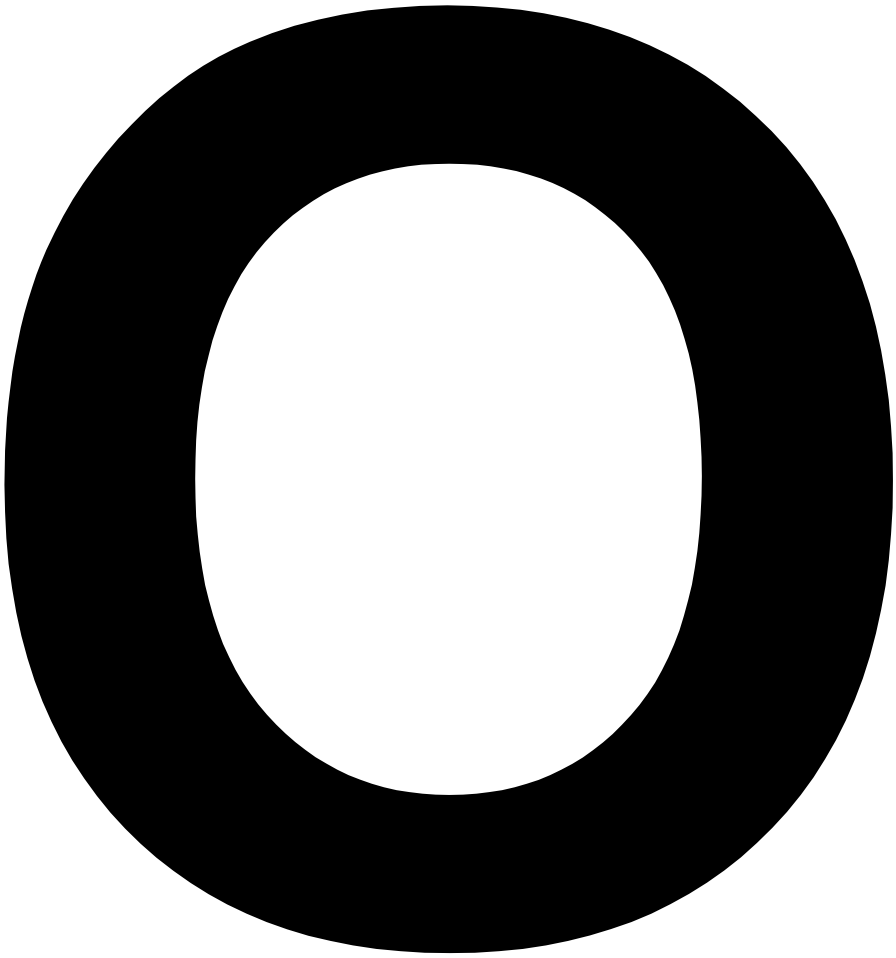
Date: .....

Appendices

Appendices are attached as separate documents and consist of the following:

Appendix 1a	Letter re ECIST review- Visit 25 March 2013
Appendix 1b	Emergency Care Action Plan
Appendix 1c	Detailed Strategic Case Guiding strategies
Appendix 2	CQC Intelligence Monitoring Report October 2013
Appendix 3a	Model of care
Appendix 3b	Activity and Capacity Workings
Appendix 3c	LRI ED Design Operational Policy v0 1131014
Appendix 3d	Schedule of Accommodation
Appendix 3e 2013	UHL NHS Trust Emergency Care 4hr performance trajectory
Appendix 4	Development Control Plan
Appendix 5a	Phasing of Options
Appendix 5b	1.500 drawing 1A Balmoral
Appendix 5c	1.500 drawing 2C Jarvis
Appendix 5d	1.500 drawing 3A Victoria
Appendix	Economic Appraisal
Appendix 7	Non financial Appraisal Workshops
Appendix 8a	OBC Form Option 1A Balmoral (Including Decant)
Appendix 8b	OBC Form Option 2C Jarvis (Including Decant)
Appendix 8c	OBC Option 3A Victoria (Including Decant)
Appendix 8d	Assumptions & Exclusions Option 1A Balmoral - Nov 2013
Appendix 8e	Assumptions & Exclusions Option 2C Jarvis - Nov 2013
Appendix 8f	Assumptions & Exclusions Option 3A Victoria - Nov 2013
Appendix 9a	GEM Modelling
Appendix 9b	Optimism Bias Calculations Option 1A
Appendix 9c	Optimism Bias Calculations Option 2C
Appendix 9d	Optimism Bias Calculations Option 3A
Appendix 10	LRI Planning Input to OBC
Appendix 11	Benefits Realisation Plan
Appendix 12a	ED Risks on Trust Risk Register
Appendix 12b	Short Listed Options Risk register
Appendix 12c	Risk Management Policy

Appendix 13	LRI ED Short List Options MEP Appraisal Report
Appendix 14	LRI ED Structural Options Appraisal
Appendix 15	Technical Team non financial appraisal October 2013
Appendix 16	Decant Works LRI ED programme
Appendix 17	CCG supporting Documentation
Appendix 18	Opt 1A, 2C, 3A - Sidecast for Fees, NW & Other
Appendix 19	Project Initiation Document



Trust Board Paper O

To:	**Trust Board**
From:	Rachel Overfield – Chief Nurse
Date:	**28 November 2013**
CQC regulation:	Outcome 1, 5, 7 and 13

Title:	Better Care for Frail Older Patients Following a Hip Fracture

Author/Responsible Director:
Nicolette Morgan, Consultant Geriatrician
Rachel Overfield, Chief Nurse

Purpose of the Report:
To provide the Trust Board with an insight into work streams in place to improve the quality of care for patients admitted to the hip fracture ward (Ward 32 LRI Site).

The Report is provided to the Board for:

Decision		Discussion	
Assurance		Endorsement	

Summary / Key Points:
The trauma unit at the Royal site admits over 850 older patients with hip fracture each year. Most are frail, very elderly >85 with comorbidities and high rates of delirium and dementia.

Ward 32 became a dedicated hip fracture ward in July 2012, jointly led by geriatrics and orthopaedics. The ward also became a pioneer LIA team (June 2013) and has completed stage 1 of the Elder Friendly Quality Mark (August 2013).

Work streams to improve the experience of care for patients from these projects include:

- Creating a dementia friendly ward environment
- Improving communication regarding patient care & discharge
- Obtaining and responding to patient and carer feedback
- Better provision of information about rehabilitation process & options
- Reducing falls through medication review (Fallsafe)
- Displaying a ward family tree & Welcome to the ward pack
- Focus on bereavement care and use of the amber pathway

Recommendations:
To role out good practice to all areas within UHL caring for frail older people.

Previously considered at another corporate UHL Committee? No

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

Resource Implications (eg Financial, HR): A number of these work streams have financial implications specifically Estates and Facilities.

Assurance Implications: N/A

Patient and Public Involvement (PPI) Implications: Yes

Stakeholder Engagement Implications: N/A

Equality Impact: Yes

Information exempt from Disclosure: N/A

Requirement for further review? No

P

To:	**Trust Board**
From:	**Chief Nurse/Medical Director**
Date:	**28/11/13**
CQC regulation:	All

Trust Board Paper P

Title:	Gap analysis of the key recommendations from Robert Francis QC, Professor Bruce Keogh and Professor Don Berwick, with the Trust's quality and safety priorities

Author/Responsible Director:
Chief Nurse/Medical Director

Purpose of the Report:

- The purpose of this report is to provide the Board (via the Quality Assurance Committee) with assurance that the three reports have been reviewed and key actions identified to address any gaps.

The Report is provided to the Board for:

Decision		Discussion	X
Assurance	X	Endorsement	

Summary / Key Points:

- This report draws together a number of the themes around quality, culture, patient experience, openness and transparency, accountability and education and training, and provides a gap analysis against these themes.

- This report focuses on those recommendations that apply to Trust activity rather than regulation or wider healthcare issues.

- Although the reports have some common themes, in particular relating to the need for cultural change, there are however, some differences in approach. Where Francis emphasises individual and corporate accountability and recommends the use of criminal sanctions, Berwick places his emphasis on blame-free learning culture with criminal sanction as a last resort. The Keogh methodology is now being implemented nationally by Sir Mike Richards, Chief Inspector of Hospitals as part of the new inspection regime.

- Appendix 2 of this report highlights some of the key themes from the reports, together with existing assurance and potential gaps.

- These gaps include the:
    - Need to review the leadership capacity and capability across the Trust (Lead- Director of Human Resources);
    - Review of workforce to take place to ensure sufficient suitable trained/competent staff (Lead- Chief Nurse/Medical Director)
    - Need to endure there are good governance processes with the establishment of the new Clinical Management structure and introduction of the Performance, Assurance, Escalation and Response framework (Lead- Chief Nurse)

Recommendations:

- Review the gap analysis including the proposed leads and timescales.

• Note that further reports will be presented to the Executive Quality Board via the Executive Leads.	
Previously considered at another corporate UHL Committee ? QAC 28/08/13 Trust Board 25/07/13 Trust Board 26/09/13	
Strategic Risk Register **n/a**	**Performance KPIs year to date** **n/a**
Resource Implications (eg Financial, HR) **n/a**	
Assurance Implications	
Patient and Public Involvement (PPI) Implications In public domain	
Equality Impact **n/a**	
Information exempt from Disclosure **no**	
Requirement for further review ?	

REPORT TO: **Trust Board**

DATE: **28th November 2013**

REPORT BY: **Chief Nurse/ Medical Director**

SUBJECT: **Gap analysis of the key recommendations from Robert Francis QC, Professor Bruce Keogh and Professor Don Berwick, with the Trust's quality and safety priorities**

1.0 Introduction

1.1 The reports published by Robert Francis QC, Professor Bruce Keogh and Professor Don Berwick in 2013 each contain a number of key recommendations and ambitions directly pertinent to acute providers. These are summarised in Appendix I.

1.2 Reports on each have previously been presented at the Trust Board and Quality Assurance Committee.

1.3 This report draws together a number of the themes around quality, culture, patient experience, openness and transparency, accountability, education and training, and provides a gap analysis against these themes (Appendix 1).

1.4 This report focuses on those recommendations that apply to Trust activity rather than regulation or wider healthcare issues.

1.5 Although the reports have some common themes, in particular relating to the need for cultural change, there are however, some differences in approach. Where Francis emphasises individual and corporate accountability and recommends the use of criminal sanctions, Berwick places his emphasis on blame-free learning culture with criminal sanction as a last resort. The Keogh methodology is now being implemented nationally by Sir Mike Richards, Chief Inspector of Hospitals as part of the new inspection regime.

1.6 The purpose of this report is to provide the Board (via the Quality Assurance Committee) with assurance that the three reports have been thoroughly reviewed and key actions identified to address any gaps.

2.0 The Francis report

2.1 The Mid-Staffordshire NHS Foundation Trust Public Inquiry (Chair – Robert Francis QC) published on 6 February 2013 makes 290 recommendations, of which around 88 require direct or indirect action by provider organisations.

2.2 The inquiry examined the commissioning, supervisory and regulatory bodies in the monitoring of Mid Staffordshire hospital between January 2005 and March 2009. It considered why serious problems at the Trust were not identified sooner and highlighted import lessons to be learnt for the future of patient care in the NHS.

2.3 The government also indicated that all NHS hospitals should set out how they intend to respond to the inquiry's conclusion before the end of 2013.

2.4 Francis sets out his aspirations:

- No tolerance of non-compliance with fundamental standards
- Openness and transparency, duty of candour to patients
- Strong and patient centred healthcare leadership
- Stronger regulation
- Compassionate, caring and committed nursing service
- Accurate, useful and relevant information about services

Throughout the report Francis refers to culture and listening to patients and acting on what they are telling us.

3.0 Government Response to the Francis Report

3.1 The government published its initial response to the report in March 2013 entitled 'Patients First and Foremost', and highlighted a 5 point plan for improvement:

- Preventing Problems
- Detecting Problems Quickly
- Taking Action Promptly
- Ensuring Robust Accountability
- Ensuring staff are trained and motivated

4.0 Keogh Report

4.1 The Keogh Report was published on 16 July 2013 after the review of quality of care and treatment provided by 14 hospital Trusts.

4.2 Keogh had already identified 5 key themes in the design of the review process, these are seen as the core foundations of high quality care:

- Patient experience
- Safety
- Workforce
- Clinical and operational effectiveness
- Governance and leadership.

4.3 Key quality findings from the reviews were:

- Poor engagement of patients and staff;

- Poor implementation of early warning scoring, particularly with reference to hospital acquired pneumonia;
- Weak workforce data that did not reflect the reality of the situation in clinical areas with over reliance on temporary staff;
- Lack of clear approaches to quality improvement;
- A disconnect between the leaderships view of the clinical risks and the frontline reality.

4.4 Having completed the reviews, Keogh sets eight ambitions for the NHS. The methodology used by Keogh has now been adopted by Mike Richardson for the new style Care Quality Commission inspections which the Trust will be participating in the first quarter of 2014.

5.0 Berwick report

5.1 The Berwick Report, commissioned by the Government in response to the Francis report was published on 6 August 2013. It focuses on creating an effective safety culture within the NHS. The risk management culture Berwick advocates is one of transparency, learning and improvement. Like Keogh he emphasises the importance of safe staffing levels for all clinical areas and the real-time monitoring of actual staffing against this standard. Berwick's report centres on patient safety. He argues that quality and safety cannot be separated. Berwick states that "the most important single change in the NHS: to become a system devoted to continual learning and improvement in patient care – top to bottom, end to end". To achieve this he highlights the following as fundamental to understanding and achieving the necessary cultural changes:

- Patient safety problems exist in all health systems
- Staff are not to blame
- Central focus must always be on patients
- Clear warning signals are missed
- Clarity of ownership and leadership needed
- A culture of fear is toxic to safety and improvement
- There should be a driven and resourced agenda to build the capability for improvement

6.0 Assurance and Gap Analysis

6.1 Appendix 2 highlights some of the key themes from the reports, together with existing assurance and potential gaps.

6.2 These gaps include the:

- Need to review the leadership capacity and capability across the Trust (Lead- Director of Human Resources);
- Review of workforce to take place to ensure sufficient suitable trained/competent staff (Lead- Chief Nurse/Medical Director)
- Need to endure there are good governance processes with the establishment of the new Clinical Management structure and

introduction of the Performance, Assurance, Escalation and Response framework (Lead- Chief Nurse).

7.0 Recommendation

7.1 The Trust Board are asked to:

- Review the gap analysis including the proposed leads and timescales.
- Note that further reports will be presented to the Executive Quality Board via the Executive Leads.

The reports of Robert Francis QC, Professor Sir Bruce Keogh and Professor Don Berwick - Main findings

Francis
The overarching conclusion is that 'a fundamental culture change is needed' to put patients first, 'which can largely be implemented within the system that has now been created by the new reforms'.

The recommendations with the Francis report are wide ranging, but taken together the aims are to:

- Foster a common culture shared by all in the service of putting the patient first
- Develop a set of fundamental standards the breach of which should not be tolerated
- Ensure openness, transparency and candour throughout the system about matters of concern
- Make individuals and organisations properly accountable for what they do and ensure protection of the public
- Provide a proper degree of accountability for senior managers and leaders
- Enhance recruitment education and training
- Develop and share ever improving means of measuring and understanding the performance of individual professionals and teams.

Keogh.

The following were identified as being core foundations of high quality care:

Patient experience – understanding how the views of patients and related patient experience data is used and acted upon (such as how effectively complaints are dealt with and the visibility of feedback themes reviewed at board level).

Safety – understanding issues around the trust's safety record and ability to manage these (such as compliance with safety procedures or trust policies that enhance trust, training to improve safety performance, the effectiveness of reporting issues of safety compliance or use of equipment that enhances safety);

Workforce – understanding issues around the trust's workforce and its strategy to deal with issues within the workforce (for instance staffing ratios, sickness rates, use of agency staff, appraisal rates and current vacancies) as well as listening to the views of staff;

Clinical and operational effectiveness – understanding issues around the trust's clinical and operational performance (such as the management of capacity and the quality – or presence - of trust wide policies, how the trust addresses clinical and operational performance) and in particular how trusts use mortality data to analyse and improve quality of care;

Governance and leadership – understanding the trust's leadership and governance of quality (such as how the board is assured of the performance of the trust to ensure that it is safe and how it uses information to drive quality improvements).

Berwick recommendations:

1. The NHS should continually and forever reduce patient harm by embracing Whole heartedly an ethic of learning

2. All leaders concerned with NHS healthcare – political, regulatory, governance, executive, clinical and advocacy – should place quality of care in general, and patient safety in particular, at the top of their priorities for investment, inquiry, improvement, regular reporting, encouragement and support

3. Patients and their carers should be present, powerful and involved at all levels of healthcare organisations from wards to the boards of Trusts

4. Government, Health Education England and NHS England should assure that sufficient staff are available to meet the NHS's needs now and in the future. Healthcare organisations should ensure that staff are present in appropriate numbers to provide safe care at all times and are well-supported

5. Mastery of quality and patient safety sciences and practices should be part of initial preparation and lifelong education of all health care professionals, including managers and executives

6. The NHS should become a learning organisation. Its leaders should create and support the capability for learning, and therefore change, at scale, within the NHS

7. Transparency should be complete, timely and unequivocal. All non-personal data on quality and safety, whether assembled by government, organisations, or professional societies, should be shared in a timely fashion with all parties who want it, including, in accessible form, with the public

8. All organisations should seek out the patient and carer voice as an essential asset in monitoring the safety and quality of care

9. Supervisory and regulatory systems should be simple and clear. They should avoid diffusion of responsibility. They should be respectful of the goodwill and sound intention of the vast majority of staff. All incentives should point in the same direction

10. We support responsive regulation of organisations, with a hierarchy of responses. Recourse to criminal sanctions should be extremely rare, and should function primarily as a deterrent to wilful or reckless neglect or mistreatment

Integrated action plan for themes from Keogh, Berwick and Francis reports **Appendix II**

Themes from Keogh Review Ambitions, Berwick Report Recommendations and Francis Report	Assurance/Existing Workstreams	Any gaps or Further Actions Required?	Lead	By When
Keogh Ambition 1 We will have made demonstrable progress towards reducing avoidable deaths in our hospitals, rather than debating what mortality statistics can and can't tell us about the quality of care hospitals are providing. **Berwick Report Recommendation 5** Mastery of quality and patient safety sciences and practices should be part of initial preparation and lifelong education of all health care professionals including managers and executives. **Patients First and Foremost** - Theme of preventing problems **Francis Report** - Themes around information and quality of data and openness, transparency and candour	• The Trust monitors mortality rates and reports in the public domain. The Medical Director meets regularly with the Head of Outcomes and Effectiveness to look at our performance. • The Trust takes data from Dr. Foster, HED and other, national sources so that we can compare how well we are doing. • Integrated dashboard presented to the Trust Board each month. • Particular areas of interest which impact on mortality rates are used to inform the priorities (respiratory pathway is a workstream for the Quality Commitment Programme in 2013- 2014). • Trust has participated in LLR mortality review (initial response to QPMG 13/11/13). • All services have Mortality and Morbidity meetings.	• Need to strengthen governance arrangements within the newly formed CMGs and agree assurance and escalation response framework. • Need to establish overarching Mortality Review Group • Action request that view Innovation Improvement Science Unit. Request the new IISU to consider QI methodology and report back to EQB. • Audit quality of M&M meetings.	Chief Nurse Medical Director Medical Director/ Associate Director of Quality Improvement Medical Director	November 2013 November 2013 December 2013

Themes from Keogh Review Ambitions, Berwick Report Recommendations and Francis Report	Assurance/Existing Workstreams	Any gaps or Further Actions Required?	Lead	By When
Keogh Ambition 2 The boards and leadership of provider and commissioning organisations will be confidently and competently using data and other intelligence for the forensic pursuit of quality improvement. They, along with patients and the public, will have rapid access to accurate, insightful and easy to use data about quality at service line level. **Berwick Report Recommendation 2** All leaders concerned with NHS Healthcare should place quality of care and patient safety at the top of their priorities **Berwick Report Recommendation 7** Transparency should be complete, timely and unequivocal. All nonpersonal data on quality and safety should be shared in a timely fashion with all parties who want it, including, in accessible form, with the public. **Patients First and Foremost** – Theme of detecting problems early **Francis Report** – Theme of openness, transparency and	• The Quality and Performance report details mortality information (monthly update) at Trust Board, Quality Assurance Committee and Quality and Performance Management Group. • The Trust Board has received a Board development session in relation to mortality and a detailed report at October Trust Board. • Staff are encouraged to report incidents. • 3636 anonymous staff concern reporting line. • Staff are encouraged to record incidents onto the Datix system. • Ward boards display information about quality and safety for the public using safety crosses to make the information clear and accessible. • Full and routine disclosure of all	• There is a national and local requirement to present data in a meaningful way to the public. Further consideration required. • Review of the Quality and Performance report. • There is a shortfall in skills of data analysis and interpretation (particularly statistical analysis). Establishment of the Business Strategy Support Team will concentrate the skills available to support the Board and management teams (scoping required). • Ward quality dashboards need to be implemented to make ward level data accessible to support ward sisters, matrons and clinical leads to understand their data and to take appropriate actions. The dashboards will also enable Trust to be aware of any areas of underperformance	Director of Strategy Director of Strategy Chief Nurse	TBC TBC November 2013

Themes from Keogh Review Ambitions, Berwick Report Recommendations and Francis Report	Assurance/Existing Workstreams	Any gaps or Further Actions Required?	Lead	By When
candour	RCA and complaint responses to patients and/or relatives. • Monitoring of quarterly safety metric internally and with Commissioners. • Strong quality, safety and experience component at Annual Public Meeting.	in a timely way and where necessary take remedial action. • Further work to be undertaken to provide quality data for the public • Review of complaints process and policy required following publication of Report of handling of complaints by NHS hospitals in England by Ann Clwyd MP. • Strengthen quarterly Patient Safety report to include rates of incidents by CMG's.	Lead Director TBC Director of Safety and Risk Director of Safety and Risk	December 2013 December 2013
Keogh Ambition 3 Patients, carers and members of the public will increasingly feel like they are being treated as vital and equal partners in the design and assessment of their local NHS. They should also be confident that their feedback is being listened to and see how this is impacting on their own care and the care of others.	• The Quality Commitment Programme identified need to improve patient experience and work stream identified for elderly and dementia patients. • Regular events with prospective governors.	• There needs to be closer links between all aspects of patient experience to include complaints, patient surveys and social media. • Increase story telling at CMGs and corporately.	Chief Nurse	December 2013

Integrated action plan for themes from Keogh, Berwick and Francis reports **Appendix II**

Themes from Keogh Review Ambitions, Berwick Report Recommendations and Francis Report	Assurance/Existing Workstreams	Any gaps or Further Actions Required?	Lead	By When
Berwick Report Recommendation 3 Patients and their carers should be present, powerful and involved at all levels of healthcare organisations from wards to the boards of trusts. **Berwick Report Recommendation 8** All organisations should seek out the patient and carer voice as an essential asset in monitoring the safety and quality of care. **Patient First and Foremost** – Theme of preventing problems **Francis Report** – Theme of fostering a common culture shared by all and developing a set of fundamental standards.	• Regular patient stories at Trust Board meetings. • Friends and Family Test – substantial patient feedback now available to be used to make service improvement. • Patient advisors sit on Trust Committees and undertake quality walkabouts. • Overview and Scrutiny Committee conduct quality visits and formally report so they can seek the views of member and the public. • Daily reviews of patients by the duty Matrons/Site team are being undertaken to ensure that the patients care needs to continue to be met and if this is not possible that they are moved to an appropriate area. This is monitored at the daily site meetings. • Patients/Carers involved in new build solutions e.g. NNU	• Establish complaints review panel and invite membership from Healthwatch and Pt Advisors. • Patient Experience Group to be established. • Need to invite the patients and relative or carer to join RCA investigation teams. • Need to share outcomes and learning of complaints and SUIs more widely with patients and the public via forums, newsletters and website. • Need for greater analysis and triangulation of patient feedback • Further development of matrons and senior sisters about standards and responding to concerns required. • Large scale public Listening	Director of Safety and Risk Director of Nursing Director of Safety and Risk Director of Communications Chief Nurse Chief Nurse Director of Communications	January 2014 December 2013 February 2014 TBC TBC TBC December 2013

Themes from Keogh Review Ambitions, Berwick Report Recommendations and Francis Report	Assurance/Existing Workstreams	Any gaps or Further Actions Required?	Lead	By When
		events planned.		
Keogh Ambition 4 Patients and clinicians will have confidence in the quality assessments made by the Care Quality Commission, not least because they will have been active participants in inspections. **Berwick Report Recommendation 10** We support responsive regulation of organisations. **Patient First and Foremost** – Theme of ensuring robust accountability **Francis Report** – Theme of ensuring that relentless focus of the healthcare regulator is on policing compliance with the fundamental standards of care.	• The Chief Operating Officer and the Associate Medical Director were part of the Keogh Review Inspection Team and are part of the first wave of CQC inspections. • The Trust has offered the CQC the services of its relevant staff to be part of the new CQC regime.	• Work needs to be undertaken to ensure that the Trust learns from the CQC's inspection process which will help when undertaking its own robust assessments and in formulating action plans to address areas requiring improvement. • Need to introduce a programme of internal 'mock' inspections to provide assurance about the standards of care being delivered.	Director of Clinical Quality/ Chief Nurse Director of Clinical Quality/ Chief Nurse	December 2013 TBC
Keogh Ambition 5 No hospital, however big, small or remote, will be an island unto itself. Professional, academic and managerial isolation will be a thing of the past. **Berwick Report Recommendation 1** The NHS should continually and forever reduce patient harm by embracing	• The Learning from Experience Group promotes organisational learning. • Patient safety now featuring in undergraduate medical training.	• Strengthen governance arrangements within the clinical specialities and the CMGs through agreeing Performance Assurance, Escalation and Response framework. • Gap: Increase the use of quality improvement	Chief Nurse/ Chief Operating Officer Head of Service Improvement	December 2013 February 2014

Themes from Keogh Review Ambitions, Berwick Report Recommendations and Francis Report	Assurance/Existing Workstreams	Any gaps or Further Actions Required?	Lead	By When
wholeheartedly an ethic of learning. **Berwick Report Recommendation 6** NHS should become a learning organisation. Its leaders should create and support the capability for learning and therefore change within the NHS. **Patients First and Foremost** – Theme of preventing problems **Francis Report** – Theme of fostering a common culture	• The Trust hosts the Academic Science Health Network. • Members of the Trust participate in a number of regional and national fora to share and disseminate good practice and to learn from others. • Patient safety report monthly (QPMG and QAC) • Integrated Board performance dashboard (Quality and Performance Report).	methodologies at UHL; within specialities, the CMGs and Corporately. The Innovation Improvement Science Unit. Request the new IISU to consider QI methodology and report back to EQB. • Need to develop RCA competence and expertise amongst the Executive Team. • Develop RCA and complaints training and incident investigation master classes internally. • Improvement and Innovation framework scope organisational improvement skills and training requirements. • Need to strengthen the patient's voice in RCA and complaint responses.	Director of Safety and Risk Director of Safety and Risk Director of Safety and Risk	March 2014 March 2014 March 2014
Keogh Ambition 6 Nurse staffing levels and skill mix	• Nurse staffing review completed and presented to Executive	• Need further work to link compassion into the	Chief Nurse/ Director of Human Resources	TBC

Themes from Keogh Review Ambitions, Berwick Report Recommendations and Francis Report	Assurance/Existing Workstreams	Any gaps or Further Actions Required?	Lead	By When
will appropriately reflect the caseload and the severity of illness of the patients they are caring for and be transparently reported by trust boards. **Berwick Report Recommendation 4** Healthcare organisations should ensure that staff are present in appropriate numbers to provide safe care at all times and are well supported. **Patients First and Foremost** – Theme of ensuring staff are trained and motivated **Francis Report** – Theme of compassion linked to reward	Team 27/08/13. Priority areas identified for investment including supervisory time for ward sisters. Sickness absence monitored in Q+P report. • Temporary staff (bank and in some cases locum) used in some areas but carefully monitored and skill mix considered. Expectation is that temporary staff are appropriately inducted. • There are a few recruitment hot spots areas/areas for medical staff of high vacancies reflecting national shortages, for example E.D. This is closely monitored and locums are inducted appropriately. • Detailed nursing workforce report developed with monthly reporting at QPMG and QAC. • Twice daily process overseen by senior nurses to ensure safe staffing on a shift by shift basis, with an escalation process if safety issues arise.	appraisal process • Need to implement plans for twice daily review of staffing • Difficulties with national recruitment. Recruitment plan to be implemented. • Need to have greater transparency re: nurses available each shift and display at ward level for public. • Need to implement the national nursing strategy and 6Cs • Need to review clinical skills training and monitoring of competence.	Chief Nurse Chief Nurse/ Director of Human Resources Chief Nurse Chief Nurse Chief Nurse	TBC Commenced Commenced 25/11/13 TBC TBC

Themes from Keogh Review Ambitions, Berwick Report Recommendations and Francis Report	Assurance/Existing Workstreams	Any gaps or Further Actions Required?	Lead	By When
Keogh Ambition 7 Junior doctors in specialist training will not just be seen as the clinical leaders of tomorrow, but clinical leaders of today. The NHS will join the best organisations in the world by harnessing the energy and creativity of its 50,000 young doctors. **Patients First and Foremost** – Theme of ensuring staff are trained and motivated **Francis Report** – Theme of leadership	• All F1 and F2 doctors receive quality and safety training as part of a structured training programme. • Doctors in Training forum chaired by Dipti Samani (Specialist Registrar).	• Need to ensure ideas and projects developed by junior doctors are supported and incorporated into working patterns across the Trust.	Medical Director	TBC
Keogh Ambition 8 All NHS organisations will understand the positive impact that happy and engaged staff have on patient outcomes, including mortality rates, and will be making this a key part of their quality improvement strategy. **Patients First and Foremost** – ensuring staff are trained and motivated **Francis Report** – Themes of developing fundamental standards of care and compassion.	• Listening in Action staff engagement programme. • Explicit behaviours and core values identified by the Trust. • Values and behaviours incorporated into appraisals and application forms. • Reward strategy recognises required behaviours.	• Leadership and OD strategies to be reviewed in the context of Francis, Keogh and Berwick reports.	Director of Human Resources	December 2013

Trust Board Paper Q

To:	**Trust Board**
From:	**Chief Nurse**
Date:	**28th November 2013**
CQC regulation:	**Outcome C16 and C4**

Title	**A REVIEW OF NHS HOSPITALS COMPLAINTS SYSTEM – PUTTING PATIENTS BACK IN THE PICTURE – CLWYD/HART REPORT**

Author/Responsible Director: Director of Safety and Risk

Purpose of the Report:

Publication of the Clwyd-Hart review into the NHS hospitals complaint process was released on 28th October 2013 and sets out a number of recommendations to improve the complaints system. The government-commissioned inquiry, led by Labour MP Ann Clwyd and Professor Trish Hart, was a response to the Francis Report which detailed 13 specific recommendations that relate directly to complaints and their handling. This report outlines UHL's strategy for dealing with the recommendations contained in the report.

The Report is provided to the Board for:

Decision		Discussion	X
Assurance		Endorsement	X

Summary / Key Points:

The report focuses on key points raised by patients and what patients want in regard to complaints:-

- More than 2,500 testimonials were received by the Review Panel from patients, their relatives, friends or carers who described problems with the quality of treatment or care in NHS hospitals
- Further to the testimonials, 400 people talked in detail about their experience of complaining and how it felt in practice. Patients and relatives clearly stated what they wanted:-
- A number of stakeholders and organisations were consulted as part of the review and their views were also captured:-
- Since the review, many health organisations have signed up to a range of pledges to promote the patient's voice and improve complaints handling across the NHS.

Recommendations:

The report makes a large number of recommendations aimed at a variety of stakeholders including Trusts, the Department of Health, professional bodies and the CQC. The authors state that they are putting the health service on a year's notice to improve the hospital complaints system and improve accountability and transparency.

The main proposal for this trust, which were considered and approved by the Executive Quality Board are:

- Further, early collaboration with HealthWatch to consider this report and improving our complaints handling including reporting to the Board;
- Consider the establishment of an internal Complaints Review Panel with lay representation;
- Hold a 'Putting Patients Back in the Picture' LiA event with internal staff and external stakeholders;
- Consider UHL making pledges to our patients and public on complaint handling;
- Review the training needs re complaints handling within the Trust;
- Improved triangulation of complaints, patient experience and NHS Choices information;
- Consider a mechanism for independent advocacy of complaints / concerns.

Previously considered at another corporate UHL Committee?

QPMG and QAC.

Strategic Risk Register:	**Performance KPIs year to date:** CQC outcomes Quality Schedule requirements CQUIN Framework

Resource Implications (eg Financial, HR):

Assurance Implications:
CQC, NHSLA compliance

Patient and Public Involvement (PPI) Implications:
Engagement with Patient Advisers, Healthwatch and interested groups. Disclosure on data through annual report, Quality Account and Trust Board papers.

Stakeholder Engagement Implications:

Equality Impact: Under review.

Information exempt from Disclosure: None

Requirement for further review?

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST

REPORT TO: **TRUST BOARD**

DATE: **28TH NOVEMBER 2013**

REPORT BY: **CHIEF NURSE**

SUBJECT: **A REVIEW OF NHS HOSPITALS COMPLAINTS SYSTEM – PUTTING PATIENTS BACK IN THE PICTURE – CLWYD-HART REPORT**

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1. INTRODUCTION

1.1 The long-awaited publication of the Clwyd-Hart review into the NHS hospitals complaint process was released on 28th October 2013 and sets out a number of recommendations to improve the complaints system. The government-commissioned inquiry, led by Labour MP Ann Clwyd and Professor Trish Hart, was a response to the Francis Report which detailed 13 specific recommendations that relate directly to complaints and their handling.

1.2 'Putting Patients Back in the Picture' sets out the reasons people complain, picks up on staff attitudes and concerns about resources and goes on to set out what patients want from a complaint system. The full report is provided at Appendix **1**.

1.3 Although separate, the review took place concurrently with a similar review undertaken by the office of the Parliamentary and Health Services Ombudsman. The PHSO, Dame Julie Mellor, has called for a 24/7 complaints service that is more easily accessible to patients, arguing that the 'toxic cocktail' of difficulties in complaining on the public side and reluctance to respond on the NHS side creates major problems.

1.4 The Clwyd-Hart review focused on acute hospitals but states that many of the reflections and comments are as relevant to other health and care settings. In summary this report echoes Francis' opinion that, for complainants, "the days of delay, deny and defend must end". A government response to the report and its recommendations is expected in due course.

2. SUMMARY OF FINDINGS

WHAT PATIENTS SAID

2.1 More than 2,500 testimonials were received by the Review Panel from patients, their relatives, friends or carers who described problems with the quality of treatment or care in NHS hospitals. A summary of their views is captured below:-

Key points raised:

- Lack of information – patients said they felt uninformed about their care and treatment.
- Compassion – patients said they felt they had not been treated with the compassion they deserve.
- Dignity and care – patients said they felt neglected and not listened to.
- Staff attitudes – patients said they felt no one was in charge on the ward and the staff were too busy to care for them.
- Resources – patients said there was a lack of basic supplies like extra blankets and pillows.

WHAT PATIENTS WANT

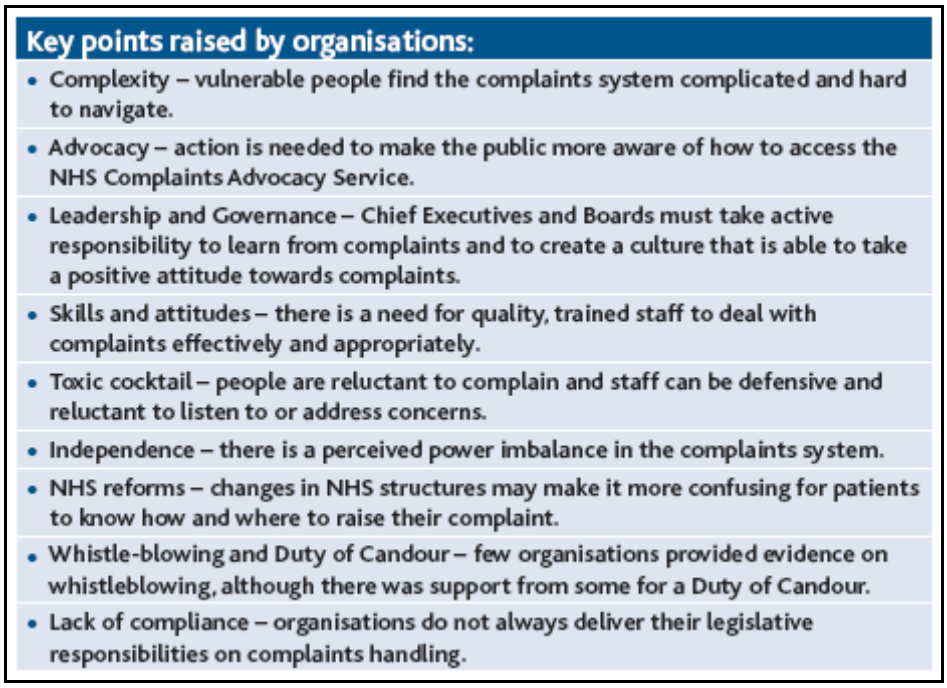
Further to the testimonials, 400 people talked in detail about their experience of complaining and how it felt in practice. Patients and relatives clearly stated what they wanted:-

Key points raised:

- Information and accessibility – patients want clear and simple information about how to complain and the process should be easy to navigate.
- Freedom from fear – patients do not want to feel that if they complain their care will be worse in future.
- Sensitivity – patients want their complaint dealt with sensitively.
- Responsiveness – patients want a response that is properly tailored to the issue they are complaining about.
- Prompt and clear process – patients want their complaint handled as quickly as possible.
- Seamless service – patients do not want to have to complain to multiple organisations in order to get answers.
- Support – patients want someone on their side to help them through the process of complaining.
- Effectiveness – patients want their complaints to make a difference to help prevent others suffering in the future.
- Independence – patients want to know the complaints process is independent, particularly when they are complaining about a serious failing in care.

KEY POINTS RAISED BY ORGANISATIONS

A number of stakeholders and organisations were consulted as part of the review and their views were also captured:-



3. RECOMMENDATIONS

3.1 The report makes a large number of recommendations aimed at a variety of stakeholders including Trusts, the Department of Health, professional bodies and the CQC. The authors state that they are putting the health service on a year's notice to improve the hospital complaints system and improve accountability and transparency.

3.2 To achieve this, the review has got 12 key organisations to sign up to a series of pledges. These include:

- The Nursing and Midwifery Council to include new duties over complaints handling in its code of conduct.
- A pledge from Health Education England to develop an e-learning course to improve training.
- NHS England promising to work with local managers to hold hospitals and other providers to account.
- The Care Quality Commission to place a strong focus on complaints in its new hospital inspection regime.
- Hospitals will also be expected to publish annual reports in "plain English" on complaints.

3.3 Although there are many recommendations, we will focus on those most relevant to UHL and our patients.

i Trusts should provide patients with a way of feeding back comments and concerns about their care on the ward.

ii Attention needs to be given to the development of appropriate professional behavior in handling complaints. This includes honesty, openness and a willingness to listen to the complainant, and to understand and work with the patient to rectify the problem.

iii Staff need to record complaints and the action that has been taken and check with the patient that it meets their expectation.

iv There should be NHS accredited training for people who investigate and respond to complaints.

v Trusts should actively encourage both positive and negative feedback about their services. Complaints should be seen as essential and helpful information and welcomed as necessary for continuous service improvement.

vi Every Chief Executive should take personal responsibility for the complaints procedure, including signing off letters responding to complaints, particularly when they relate to serious care failings.

vii There should be Board-led scrutiny of complaints. All Boards and Chief Executives should receive monthly reports on complaints and the action taken, including an evaluation of the effectiveness of the action.

viii Every Trust has a legislative duty to offer complainants the option of a conversation at the start of the complaints process. This conversation is to agree on the way in which the complaint is to be handled and the timescales involved.

ix Hospitals should offer a truly independent investigation where serious incidents have occurred.

x When Trusts have a conversation with patients at the start of the complaints process they must ensure the true independence of the clinical and lay advice and advocacy support offered to the complainant.

xi Board level scrutiny of complaints should regularly involve lay representatives.

4. PROPOSALS

4.1 Following consideration of all the recommendations and noting the on-going work of external organisations, we propose that there are a number of recommendations which we can action without delay. These include:-

- Increase the signage around the Trust for patients and relatives who wish to raise concerns;
- Improve feedback mechanisms at ward level;
- Deal with patient concerns early – 'real-time';
- Strengthen the sign-off arrangements for complaint responses;
- Early engagement with patient groups on complaints;
- Update complaints handling guidance for new CMGs.

4.2 However, other recommendations will require further consideration so the following is proposed:-

- Further, early collaboration with HealthWatch to consider this report and improving our complaints handling including reporting to the Board;
- Consider the establishment of an internal Complaints Review Panel with lay representation;
- Hold a 'Putting Patients Back in the Picture' LiA event with internal staff and external stakeholders;
- Consider UHL making pledges to our patients and public on complaint handling;
- Review the training needs re complaints handling within the Trust;
- Improved triangulation of complaints, patient experience and NHS Choices information;
- Consider a mechanism for independent advocacy of complaints / concerns.

5. SUMMARY

5.1 The Clwyd-Hart report details on-going dissatisfaction of patients and relatives accessing and using the complaints process in NHS hospitals. The findings of this review are no surprise as they largely come to the same conclusions as many previous reviews on complaints which highlight the need to empower and support that patient voice.

5.2 The report found that people think there is a lack of independence in the current system and it creates specific expectations for various bodies in the NHS as well as for Trusts.

5.3 In consideration of the findings of the report, the Rt. Hon. Oliver Letwin MP has announced that he will be undertaking two separate reviews looking at how to make it easier for the public to make a complaint and how complaints are treated by the NHS. These will be reported on once published.

5.4 It is likely that the number of UHL concerns / complaints will increase further but increasingly, provided they are handled appropriately and lessons learned, patient groups and external organisations view this as a good thing.

5.5 Trust Board is invited to discuss and consider the proposals listed under 4.2 and 4.3, above.

Moira Durbridge
Director of Safety and Risk
November 2013

A Review of the NHS Hospitals Complaints System Putting Patients Back in the Picture

Final report

Right Honourable Ann Clwyd MP and Professor Tricia Hart

October 2013

Contents

This report is dedicated to the memory of Owen Dryhurst Roberts

Chapter One:
Introduction

The successes and failures of the National Health Service (NHS) have been debated vigorously in Parliament and elsewhere since its foundation. Aneurin Bevan, the Minister of Health who founded the NHS in 1948, was aware of the need for ways of correcting mistakes. He said, *'The sound of a dropped bedpan in the hospital at Tredegar (in his Ebbw Vale constituency) would reverberate around the Palace of Westminster'*. In today's language it could be translated as a call for transparency; for learning lessons from mistakes; and for continuous improvements in quality.

Sixty five years later the NHS still enjoys wide support as an institution, one of whose basic principles is to treat all patients with compassion and commitment. The rights and responsibilities of NHS staff and patients are listed in the NHS Constitution[1], but unfortunately these are not always evident in practice. Public confidence has been eroded by evidence of poor care and treatment and subsequent failures of the complaints system to acknowledge or rectify shortcomings. Such incidents have had serious and even devastating consequences for patients, their relatives, carers, and friends.

One of the most shocking failures in NHS care was documented on 6th February 2013 when Robert Francis QC published his Public Inquiry into Mid Staffordshire NHS Foundation Trust. He found "*a story of appalling and unnecessary suffering of hundreds of people*" and added: "*They were failed by a system which ignored the warning signs and put corporate self-interest and cost control ahead of patients and their safety*."[2]

He wrote: "*A health service that does not listen to complaints is unlikely to reflect its patients' needs. One that does will be more likely to detect the early warning signs that something requires correction, to address such issues and to protect others from harmful treatment*."[3]

"A complaints system that does not respond flexibly, promptly and effectively to the justifiable concerns of complainants not only allows unacceptable practice to persist, it aggravates the grievance and suffering of the patient and those associated with the complaint, and undermines the public's trust in the service."

1 NHS Constitution
2 Francis Press Statement
3 Public Inquiry into the Mid Staffordshire NHS Foundation Trust, Volume 1, Chapter 3 pp 245-287 Mid Staffordshire Inquiry Report

It was Robert Francis' report that prompted the Prime Minister and the Secretary of State for Health to commission this review of NHS hospital complaints handling. What follows is a report of the findings and recommendations of the review.

The co-Chairs

This review was co-chaired by the Rt. Hon Ann Clwyd MP for the Cynon Valley and Professor Tricia Hart, Chief Executive, South Tees Hospitals NHS Foundation Trust.

In a radio interview on BBC Radio 4's World at One in December 2012, Ann Clwyd described the way in which her husband, Owen Roberts, had died in the University Hospital of Wales. Ann Clwyd spoke of the "coldness, resentment, indifference and contempt" of some of the nurses who were supposed to be caring for him. She broke down in tears as she recalled his last hours, shivering under flimsy sheets, with an ill-fitting oxygen mask cutting into his face, wedged up against the bars of the hospital bed. She said her husband, a former head of News and Current Affairs for BBC Wales, died "like a battery hen."[4]

Following this programme and others she received letters and emails from hundreds of people who were appalled at such a lapse in standards of basic decency and compassion. Many included accounts of other shocking examples of poor care and of the difficulty people encountered when trying to complain.

Ann Clwyd has long experience as an MP. She was a member of the Royal Commission on the NHS from 1977-1979 during which she became known as, 'The patient's friend'. She was a member of the Welsh Hospital Board from 1970-1974. She also campaigned for many years for justice for pneumoconiosis sufferers.

Co-chair, Professor Tricia Hart has experience of 39 years as a nurse, midwife, community nurse, health visitor and senior executive member of NHS Trust boards. She also has experience as a member of Robert Francis' inquiry team. She spent 18 months as nurse adviser to the first Francis inquiry into the Mid-Staffordshire Trust, which reported in February 2010. She was then asked her to perform a similar role on the full public inquiry.

All the members of the External Review Team are listed at the back of the report.

Terms of reference

This Review was instigated by the Prime Minister to consider the handling of concerns and complaints in NHS hospital care in England and, in doing so:

- consider how to align more closely the handling of concerns and complaints about patient care;
- identify where good practice exists, and how good practice for delivering to those standards is shared and what helps or hinders its adoption;

[4] BBC News Wales

- consider what standards might best be applied to the handling of complaints;
- consider how intelligence from concerns and complaints can be used to improve service delivery, and how this information might best be made more widely available to service users and commissioners;
- consider the role of the Trust Board and senior managers in developing a culture that takes the concerns of individuals seriously and acts on them;
- identify the skills and behaviours that staff, including clinical staff, need to ensure that the concerns of individuals are at the heart of their work;
- consider how complainants might more appropriately be supported during the complaints process through, for example, advice, mediation and advocacy; and
- include the handling of concerns raised by staff, including the support of whistle-blowers.

The co-Chairs were encouraged to make recommendations about:

- any aspect of the NHS complaints arrangements and other means by which patients make concerns known;
- the way that organisations receive and act on concerns and complaints;
- how Boards and managers carry out their functions; and
- the process by which individual organisations are held to account for the way that they handle concerns and complaints."

The co-chairs focused on acute hospitals, although they have taken evidence from and about other care providers. Many of the reflections and comments that follow could be as relevant to primary care, community services and social care as they are for acute hospitals.

Evidence collection

A dedicated postal and email address enabled people to send accounts of their experiences with the complaints system and make suggestions for improvements.

Letters from patients, relatives, friends and carers received before the start of the review were also included in the evidence.

In all over 2500 letters and emails were received. The Department of Health Review Team took responsibility for the analysis of this data.

Seven public engagement events were held in which oral evidence was taken from patients, relatives, friends and carers. These allowed the Review Team to understand how the complaints process is perceived and why people may be discouraged from complaining.

Eight individual meetings were held with people the co-chairs considered to have particular expertise with the complaints process. The names of these participants are listed at the back of the report.

Helped by advisers with experience of patient representation, the review team visited nine NHS hospitals and one hospice, meeting complaints managers, frontline staff and board members.

Meetings were held with 20 leading organisations in the health and social care sector. These organisations are listed at the end of the report.

Discussions were held with leaders of key organisations in the sector to secure pledges of support for the recommendations of the Review. These organisations are listed at the end of the report.

In all the meetings, notes and minutes were analysed by the Department of Health Review Team and discussed by the team.

Chapter Two:
Setting the scene

Annual figures from the Health and Social Care Information Centre show that there were over 162,000 complaints about NHS care in 2012/13. This amounts to 3000 per week. Over a number of years, there have been many official reports which explored what was wrong with the complaints system and made recommendations for change. Unfortunately many of these recommendations have not been fully implemented.

Previous inquiries

Dame Janet Smith reviewed complaints procedures in the Fifth Report of the Shipman Inquiry, published in 2004.[5] She took account of a series of previous investigations and reports including: the Wilson Report 'Being Heard' in May 1994; the Public Law Project's report 'Cause for Complaint?' in September 1999; and the York Health Economics Consortium's report (the York Report) in March 2001. Dame Janet's review identified:

- A lack of fair procedures;
- Failure to investigate complaints properly;
- Failure to give adequate explanations;
- Failure to take account of the inherent imbalance of power between healthcare professionals and patients, including the patient's fear of retribution;
- Lack of impartiality in organisations investigating their own conduct;
- Absence of accountability to an external body;
- Complaints handlers lack of necessary skills;
- High levels of dissatisfaction among complainants with all levels of the system.[6]

The Government made similar points in April 2003, when it published NHS Complaints Reform: Making Things Right.[7] The report recorded that patients and staff feel that:

- It is unclear how, and difficult to raise complaints and concerns;
- There is often a delay in responding to complaints and concerns;

[5] Dame Janet's Report – section on complaints

[6] This summary of Dame Janet's concerns was given by Robert Francis in the Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry, Volume 1, para 3.6 Reference to Dame Janet's Report – see page 246

[7] NHS Complaints Reform: Making Things Right See para 2.8

- Too often complainants receive a negative response
- Complainants do not seem to get a fair hearing;
- Patients do not get the support they need when they want to complain;
- The Independent Review stage does not have the credibility it needs;
- The process does not provide the redress patients want;
- There does not seem to be any effective way of learning from complaints in order to bring about improvements.

The Health Select Committee

In July 2011, the Health Select Committee published its report on Complaints and Litigation. On complaints, the Committee:

- Supported the current two tier system but noted that it had not been fully implemented across the NHS;
- Noted the importance of PALS for many complainants;
- Recommended that there should be a single local point of access for the entire local resolution of a complaint and that this could be provided by integrated complaints and advice teams;
- Expressed its concerns about the visibility of advocacy services to complainants and recommended more work to improve patient awareness and access; and
- Recommended that a single one organisation should be responsible for maintaining an overview of complaints handling in the NHS, setting and monitoring standards, supporting change, and analysis of complaints data.

The Government rejected the last recommendation but accepted many of the Select Committee's findings.

The Francis report

Despite the implementation of the two tier complaints system, Robert Francis did not feel that it was fit for purpose. He made 14 recommendations on the handling of complaints in his report on Mid Staffordshire. He said the key themes were:

- The reluctance of patients and those close to them to complain, in part because of fear of the consequences. This, and other barriers which prevent organisations receiving complaints need to be addressed;
- Support for complainants, whether or not they are specifically vulnerable, with advice and advocacy still requires development; in particular, it should be clear that advocates can offer advice on the substance of the complaint that is required, and information should be provided on available support organisations;

- The feedback, learning and warning signals available from complaints have not been given a high enough priority;
- Information about the content of complaints should, where permissible, be made available to and used by commissioners and local scrutiny bodies; the Care Quality Commission (CQC) should use material from complaints more widely; and
- There is a case for independent investigation of a wider range of complaints.

Other Reviews

Robert Francis endorsed the Patients' Association's standards for good complaints handling. These standards were developed as part of the Health Foundation funded 'Speaking Up' project. They were aimed at improving the quality of complaints handling at Mid Staffordshire NHS Foundation Trust and elsewhere. These standards were refined over a two year period by a group including clinicians, lay people and complaint managers.

The Ombudsman has also set out principles which are intended to promote a shared understanding of what is meant by good complaint handling, and to help public bodies in the Parliamentary and Health Service Ombudsman's jurisdiction deliver first-class complaint handling to all their customers.

We welcome these principles.

A series of other reviews on aspects of NHS care and treatment followed the Francis report and are relevant to this Review. They include:

- Professor Sir Bruce Keogh's, review on the quality of care and treatment provided by 14 NHS hospital Trusts with persistently high mortality rates. The Keogh Review reported on 16th July 2013.[8]
- Professor Don Berwick's review of patient safety in the NHS. Professor Berwick reported on 6th August 2013.[9]
- Camilla Cavendish's review of how the training and support of healthcare and care assistants could be improved so that patients receive compassionate care in both NHS and social settings. Camilla Cavendish published her report on 10th July 2013.[10]
- The review of how the Liverpool Care Pathway was being used in practice for people at the end of their lives. The Review, chaired by the crossbench peer Baroness Julia Neuberger, reported on 15th July 2013.[11]

When someone has a concern the first step should be to discuss the matter with the practitioners concerned, such as doctors, allied health professionals, nurses,or paramedics. At this level problems can be resolved quickly and immediate appropriate action can help avoid

[8] Professor Sir Bruce Keogh Report
[9] Professor Don Berwick Report
[10] Camilla Cavendish Report
[11] Liverpool Care Pathway Report

an issue escalating into a more serious problem. Reported concerns or complaints need to be noted in writing by the staff concerned along with any action taken and the outcome.

'Customer service complaints often can and should be resolved immediately by the person receiving the complaint apologising and rectifying the issue, be they a clinician, a PALs officer or any other employee of the NHS. Due to the nature of these types of complaints, admitting there was a problem, dealing with it and apologising will save time and resources that can be diverted to prompt and effective investigation and resolution of more serious and complex cases.' [12]

If it is felt that the concern has not been resolved or if a patient feels unable to discuss the problem with the practitioners, there are two options. Either the complaint can be raised, verbally or in writing, with the Hospital Trust or it can be made to the body responsible for purchasing the hospital's services on behalf of the public, the local Clinical Commissioning Group (CCG). The CCG may refer to problem to the Hospital Trust or deal with it themselves in according to regulations.

Complaints made to Hospital Trusts may come through a variety of routes, for example, directly to the Chief Executive, through to a clinical colleague or made through the Complaints' Manager. An investigation then takes place, usually by the Trust itself, although some Trusts use external investigators. This process is described as "local resolution".

The complaint should be acknowledged within three working days, and the hospital trust should offer to discuss with the person making the complaint the manner in which the complaint is to be handled, the period within which the complaint is likely to be to be investigated and when the response is likely to be sent. Even if the complainant declines a discussion, they should be notified of the timescales above.

The person making the complaint should be kept informed of progress and told the outcome of the investigation into the complaint, including an explanation of the conclusions and confirmation of any action taken or proposed as a result of the complaint.

Many complaints are successfully resolved at this level, by this "local resolution" process.

If the complainant is unhappy with the outcome of their complaint at a local level, their next step is to refer the matter to the Health Service Ombudsman. The Ombudsman is independent of the NHS and government, accountable directly to Parliament.

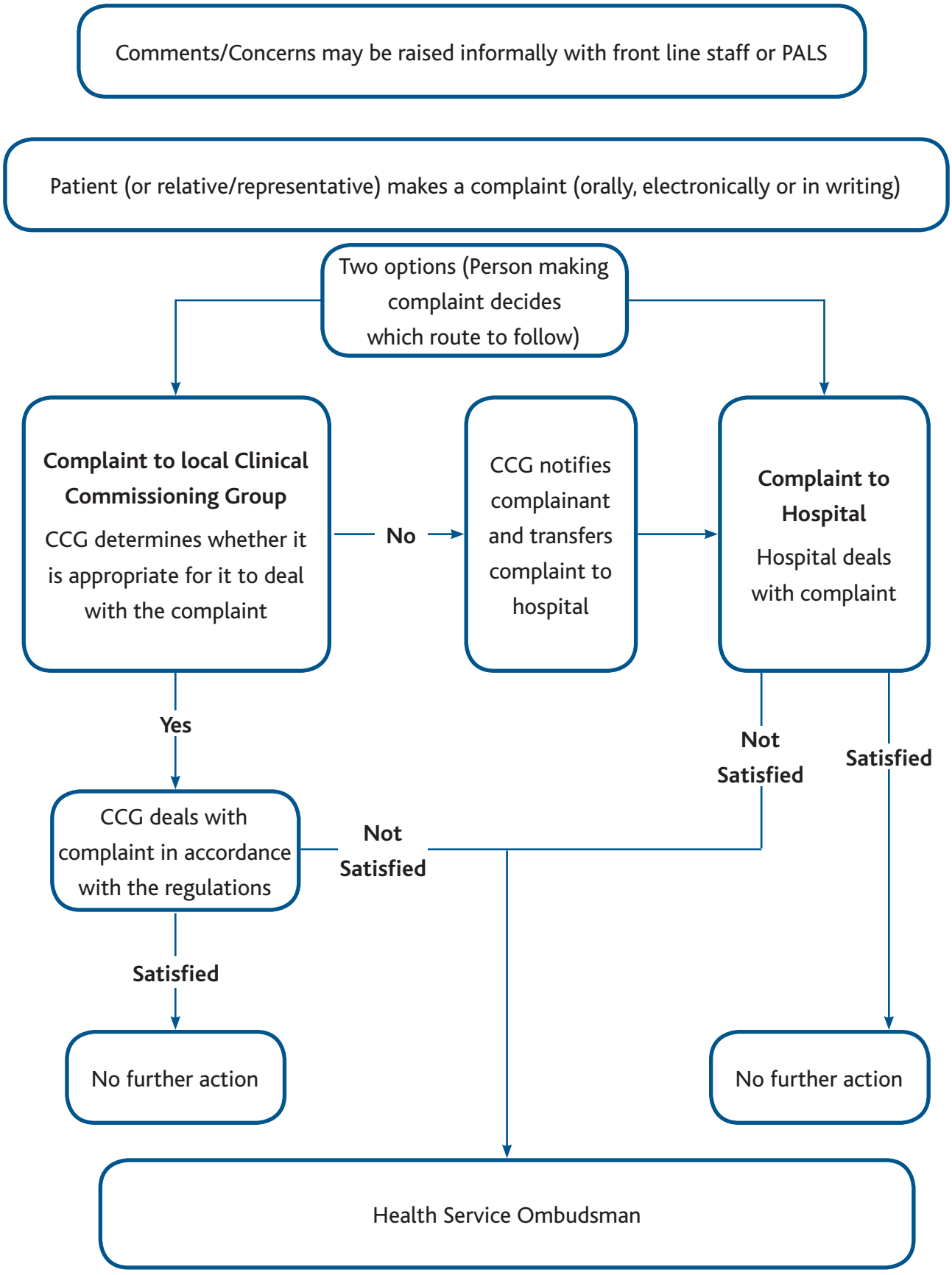
In 2011-12, the Ombudsman received **16,333** complaints. Of these, the Ombudsman took a closer look at **4,399** complaints and agreed to investigate **400** cases.

Assistance for Complainants

Most hospitals currently provide a Patient Advice and Liaison Service (PALS), which provide general help, support and information to patients. Since some hospitals combine this function with that of complaints management there is clearly a potential conflict of interest. Many respondents to our review said that they found this situation confusing and perceived a

[12] Select Committee Report on Complaints and Litigation

The Complaints Process



conflict of interest, where the people responsible, for supporting and advising them, were employed by the very organisation against which they were making their complaint.

Independent assistance can also be provided by the Independent Advocacy Services. This service operates outside the NHS, and supports people making a complaint, or thinking of making a complaint, about their NHS care or treatment.

The way in which NHS complaints advocacy services are commissioned was changed from 1 April 2013[13]. These services are now arranged directly by each English local authority, which determines how this advocacy is to be delivered in their areas. Each local authority is obliged to commission a provider of advocacy services for their area.

[13] Health and Social Care Act 2012

Chapter Three:
Why people complain

More than 2500 testimonials were received from patients, their relatives, friends or carers. The majority describe problems with the quality of treatment or care in NHS hospitals.

Key points raised:

- **Lack of information – patients said they felt uninformed about their care and treatment.**
- **Compassion – patients said they felt they had not been treated with the compassion they deserve.**
- **Dignity and care – patients said they felt neglected and not listened to.**
- **Staff attitudes – patients said they felt no one was in charge on the ward and the staff were too busy to care for them.**
- **Resources – patients said there was a lack of basic supplies like extra blankets and pillows.**

1. Lack of information

Lack of information was one of the main reasons for dissatisfaction. Patients, their family, carers and friends often felt inadequately informed about the patient's condition, prognosis and expected treatment. Doctors were seen infrequently and nurses were evasive about matters they considered the province of the doctor.

> *'The process is too complicated, there is a lack of information, it's designed to put people off.' (Patient comment at meeting)*

Patients did not know who to ask for information, and often only saw the same member of staff once or twice. There was insufficient communication between staff, so that questions or concerns were not passed on and dealt with, and patients had to repeat the same things several times. Members of staff to whom they did speak were often ill informed about their situation. There were instances where staff did not consult medical notes and others when medical notes were inadequate or missing.

We formed the impression that this sense of confusion caused by lack of information made people fear that they or their relative had not received the right care. As a result, they were more likely to question the treatment or make a formal complaint.

2. Compassion

Many of the people who contacted the Review felt they had not been treated with the level of respect, compassion and sympathy that they expected or deserved. Terms used about staff attitudes and behaviour included "offhand", "rude", "impatient" and "callous." The choice of such words was the consequence of patients feeling they were a problem or a burden, rather than being cared for.

> *"Care was slapdash, treatment was not given; communication was non-existent." (Friend of patient who died)*

People frequently reported that they had witnessed a lack of compassion from staff towards patients.

> *"At some of the most important events of the day, meal times, when it should be all hands on deck, the staff are nowhere to be seen. What on earth can they be doing that takes precedence?" (Former nurse)*

> *"The attitude of the consultant varied between pompous, arrogant and condescending. This was a man with a trail of young doctors in tow, moulding them (as I later found) in the same uncaring way." (Daughter of patient)*

3. Dignity and care

We read many accounts of patients not being treated with dignity or respect.

This included neglect of basic comfort, problems with the quality and choice of food and lack of help at meal times. Other problems described to us included: patients not being listened to or being left alone for too long; lack of privacy; lack of respect in the way they are spoken to or handled and lack of compassion.

> *'The main complaint from patients of all ages is of poor basic nursing care. No bathing, toileting, ensuring patients are hydrated and nourished, and little sympathy and empathy.' (Patient)*

> *First time in hospital, mother had two broken wrists. No one would feed her when meals were delivered, despite the fact that she had two arms strapped up in the air! My aunt had to travel over two hours every day just to ensure that she was fed.' (Son of patient)*

We did not form the impression that patients were generally making unreasonable demands or exaggerating minor inconveniences. People were, by and large, describing significant lapses in the standards of care they were entitled to and that hospital managers, clinicians and carers should feel proud to provide.

Many people said that staff frequently did not (or could not) make time to speak to patients in a friendly or concerned way. This was not what they expected from staff providing their care. As a result, minor needs or concerns that could have been resolved promptly or courteously, might be neglected until they turned into major problems or formal complaints.

A common theme was that those who could not speak up for themselves were most likely to suffer from a lack of dignity and care. However, there were also examples of articulate and assertive patients being neglected or treated badly.

> *"I have long thought those patients in hospital, particularly people without known relatives and friends, the elderly and the confused, need someone to represent their interests – a Champion." (Patient)*

There was a particularly powerful concern expressed by the families and friends of patients. They said they could provide care and speak up for a patient when they were on the ward – such as helping a patient to the toilet or demanding more information from a doctor – but, when they went home, the patient was left alone and vulnerable.

Several respondents linked the problem of neglect and advocacy to nurses not having the time, or perhaps the inclination, to perform their role of listening to patients and ensuring their needs were met.

> *"The nurse is supposed to be the patient's advocate, doing all for the patient that he would do for himself if he were able." (Former nurse)*

4. Staff attitudes

Some people shared their positive experiences of treatment and care. However, a significant number (including many former nurses) believed that the quality of nursing care is in decline, because of changes in the role of nurses and in their training and professional ethos. The observations or criticisms included: a belief that nurses are not as disciplined as in the past; are not properly supervised; are not sufficiently compassionate; are too focused on the 'technical' side of nursing; lack a sense of responsibility towards their patients; and are seen not to be prepared to do everything necessary to ensure the right level of care, whatever the lack of resources or competing demands on their time.

One specific perception relating to care was a sense that no-one was 'in charge', particularly on wards, and that as a result, there was no-one to talk to, or raise concerns with, and problems were left to fester.

> *'I went to the nursing station on one occasion to see the entire team bidding at the end of an eBay auction. I was kept waiting, ignored, until it was ended.' (Relative of patient)*

> *'When visiting my wife... after an operation to mend her broken hip, I asked a nurse for help as she was being very, very sick. She announced, 'I am a graduate. I don't do sick' and left me to deal with the situation.' (Husband of patient)*

> *'If you can't understand that a patient needs a drink, is cold, or needs to go to the toilet, then you shouldn't be in nursing.' (Patient comment at meeting)*

Although many of the comments that we received were about nurses, we believe that the issues apply to all professionals, both clinical and non-clinical. Patients, their carers and relatives reflected on nurses because they are the most visible profession in hospitals.

5. Resources

Many people raised concerns over lack of equipment and even of basic supplies, such as incontinence pads, extra blankets or pillows. This echoes concerns noted in the Francis report. However, the main concern about resources concerned the availability of staff. The Review heard that there were not enough staff, or they had too much else to do that took them away from patient care, or that staff were not sufficiently trained or experienced, or that they were under too much pressure.

> *'The most common term that I heard from nurses in particular was that, 'I am too busy, I will do it later', and later never came.' (Daughter who complained on behalf of her mother)*

Chapter Four:
What it feels like to complain

Around 400 people who contacted the Review talked in detail about their experience of complaining, how it felt in practice, and what they went through.

This Chapter explores the themes that emerged and what patients, relatives, friends and carers want to see improved.

Key points raised:

- **Information and accessibility – patients want clear and simple information about how to complain and the process should be easy to navigate.**
- **Freedom from fear – patients do not want to feel that if they complain their care will be worse in future.**
- **Sensitivity – patients want their complaint dealt with sensitively.**
- **Responsiveness – patients want a response that is properly tailored to the issue they are complaining about.**
- **Prompt and clear process – patients want their complaint handled as quickly as possible.**
- **Seamless service – patients do not want to have to complain to multiple organisations in order to get answers.**
- **Support – patients want someone on their side to help them through the process of complaining.**
- **Effectiveness – patients want their complaints to make a difference to help prevent others suffering in the future.**
- **Independence – patients want to know the complaints process is independent, particularly when they are complaining about a serious failing in care.**

1. Information and accessibility

Some people told us that they were unaware how to raise concerns or make complaints, either for themselves or on behalf of friends or relatives. It was clear that many had wanted to complain but did not. They did not know what to expect if they did complain, what would happen, or what rights they might have if they were unhappy with the process.

The lack of information about deadlines contributed to dissatisfaction with the operation of the complaints system. For example, some people had inaccurate information about the process and wrongly believed that they had missed a deadline.

'I had not complained before, as I was well aware that complaints have to be made within six weeks of being in hospital.' (Comment from a patient)

People also said they were frustrated by the way in which their ability to complain successfully was hampered because they had not known what information to record, for example, the names of clinical staff.

Patients, and in particular their relatives, friends and carers, said that when they were in the midst of a traumatic event making a complaint was the last thing on their mind.

"At the time I was too exhausted and traumatised by the experience to do anything about it." (Daughter of father who died)

"I followed all the correct procedures but found the experience very difficult despite my understanding of how the NHS works." (Retired nurse)

'[I] found a confused system where the NHS was judge and jury and where the strategic intent seemed to be to destroy the complaint.' (Family member)

What patients want: Patients want a complaints system that is easy to understand and to use; that is easily accessible and does not require any particular expertise to navigate; and that takes account of the difficulties many people face in expressing themselves or giving evidence, particularly at times of stress, ill health or in bereavement.

2. Freedom from fear

People expressed their, fear that their, or their relative's, care might get worse if they were to complain. They also felt intimidated by the power of professionals or institutions; the complexity of the system and the feeling that nothing will happen – that all their effort will prove to be worth nothing. There is also a strong sense that people who are less able (or feel less able) do not complain.

Some people were left with an overwhelming sense of guilt that they had not complained, feeling that had they done so they might have protected a loved one. This had sometimes haunted people for years afterwards.

"I was frightened to complain and be left with no medical care." (Former patient)

"I did not complain much because I was afraid that my mother would suffer reprisals." (Daughter of patient)

What patients want: people who wanted to complain – particularly those worried about the quality of care being provided for a friend or relative – need a guarantee that the complaint will never lead to poorer care or treatment for the patient. Complaining should be penalty free. Patients want staff to be professional and non-judgmental about the way in which they

deal with complaints. They do not want to be blamed if they complain but rather, for staff to see complaints as an opportunity to improve the care given to others in future.

3. Sensitivity

People recalled how hurt they felt when they were trying to make a complaint because they felt that their feelings were ignored during a time of crisis in their lives. For many, this pain and distress had been life changing.

> *"Complaints procedure attitude is knee-jerk: deny, defend and delay. We don't need money to change attitudes. What we need is a compassionate, proactive approach." (Patient comment at meeting)*

> *"I personally feel destroyed by the whole episode." (Father of son who died)*

> *"The complaints process is a defensive operation, not an enquiry. No independent forum. No advocate. No investigation. The complaint harmed me. [I am] unable to grieve for my father." (Family member)*

What patients want: Patients want the complaints system to acknowledge the emotional trauma suffered from poor care, illness and bereavement. The way complaints are handled should be sympathetic and sensitive and not seek to reduce, deny or marginalise people's feelings. Patients want to be included in the process and clear about how a complaint will be investigated. They want their feelings respected and not to feel left on the side lines.

4. Responsiveness

People were often unhappy that their concerns were not addressed on the spot by staff. Had they been resolved then, people would not have had to make a formal complaint. People also complained that insufficient attempts had been made to understand their complaint or to assess how serious it was.

> *"Complaints departments should make early personal telephone contact with a complainant rather than an impersonal letter, and if necessary arrange an early meeting, to ensure a complaint is fully understood. Many complaints would probably be quickly diffused, and those of substance could be quickly structured." (Friend of patient who died)*

> *"I just wanted to make sure no one else suffered in the same way again. Sadly I don't believe anything at all was done... In the end I simply gave up." (Family member)*

What patients want: Patients want a complaints system that is flexible and proportionate to the cause of the complaint and provides appropriate remedy. A 'light touch' approach may be more satisfactory than a full, formal investigation in some cases, and as far as possible, the hospital should try and resolve issues and concerns without the need to trigger a formal complaint in the first place. Where an issue becomes a complaint the approach to the investigation should match the seriousness of the issues involved.

5. A prompt and clear process

Delays in processing and resolving complaints were a huge source of frustration. There was often no explanation for the reasons for delay and patients were not kept informed about where their complaint had reached in the system. Explanations that were given – such as staff being on leave – were not adequate. Delays were one of the main causes of dissatisfaction. People felt that only their unremitting efforts would keep a complaint from lapsing; and that, whatever the rhetoric the hospital did not welcome the complaint and would prefer it went away.

> *"I am becoming more and more distressed that this matter has not been resolved almost seven months later." (Daughter of father who died)*

> *"I have struggled for six years to find out what happened and who is accountable, even to get a proper apology. It has been awful and I have discovered so many others in exactly the same position. There seems to be a culture of concealment and shoulder shrugging.' (Friend of patient who died)*

What patients want: most patients want their complaints dealt with promptly and may suffer if the process is drawn out. Others want the system to recognise that people who are recuperating or bereaved may not be able to bring a complaint immediately or respond to questions within set deadlines.

6. A seamless service

One specific concern people raised was the way the complaints system did not deal adequately with issues that were the responsibility of more than one organisation. These involved cases where the substance of the complaint related to different parts of the health and care system, often requiring answers from more than one department or organisation. The problems of managing care across such boundaries (for example, arranging adequate home care for people discharged from hospital) were a source of dissatisfaction.

> *"We battled for months to get answers as to how and why K died, and after following all of the official enquiry and complaints procedures, being blocked and stalled at every turn by the two NHS Trusts involved, we were left with no choice but to engage solicitors to help us find out what happened to her." (Parents of daughter who died)*

What patients want: Patients want a complaints system to cover all aspects of a patient's care, even if this crosses boundaries within the NHS or between the NHS and social care. They want to be able to make only one complaint about their whole experience within the system.

7. Support

People said they felt isolated or 'out-gunned' by a powerful and monolithic organisation. Many patients, and some friends and relatives, were so affected by their time in hospital that

they were unable to pursue complaints effectively. People said they wanted help to find their way through the process, and have someone with expertise on their side. Many had not heard of the NHS Complaints Advocacy Service and some felt that it did not offer all the help they needed.

"I no longer had the strength to carry on complaining to [the Trust]." (Former patient)

"For such serious complaints as questionable deaths, at what is a very distressing time, complainants need help to obtain medical records and to access an independent clinician to help interpret them and trace what happened." (Friend of patient who died)

"People hadn't heard of the advocacy service. This should be better publicised." (Patient comment at meeting)

What patients want: Patients would like to see a service that provides advocacy, representation and support to those who need and want it. They want to know there is someone to speak for them if necessary, and help them to make sense of a complicated system.

8. Effectiveness

Many people who complain felt that nothing had been learnt or achieved as a result of their complaint. They were disappointed about this because this had been one of their reasons for complaining in the first place. Many people said that an early acknowledgement of fault and a genuine apology would have satisfied them; but that having suffered through a lengthy and taxing complaints system, they wanted the hospital to acknowledge their responsibility and for staff to face appropriate sanctions where necessary.

"I don't and never have wanted compensation, but I do want the fact they let me sister die unnecessarily and the appalling treatment acknowledged." (Sister of relative who died)

"We want a sincere and heartfelt 'sorry' not just a grudging apology forced upon the person." (Wife of patient)

"All I want is answers as to why my husband died, answers to the poor care he received or should I say lack of care." (Wife of patient who died)

"I just wanted to make sure this didn't happen to somebody else." (Patient at meeting"

What patients want: Patients want to know that their complaints make a difference. The prime desired outcomes are usually the admission of responsibility, an apology, the reassurance that lessons will be learned and – where appropriate and where individuals are clearly at fault – some form of sanction. This is particularly important if staff have attempted to cover up their failings. Patients want openness and to know that where staff have done something wrong they will not be allowed to remain anonymous.

9. Greater independence when there are serious care failings

People said they were disturbed that the NHS is "marking its own homework" and feel scared or upset if they think their complaint has gone directly to the person they are complaining about. Some people said there should be an independent complaints authority, not run by the NHS. Others thought that an independent body would be better able to deal with complaints that crossed over several departments or providers. Some were unhappy with their experience of the Ombudsman.

"The system is biased in favour of the hospital." (Wife of patient)

"My own thought on what is required is a new agency mirroring the Independent Police Complaints Commission. To ask the hospitals to "police" their own work is just as unacceptable as with the police." (Former patient)

"The investigation was inadequate and not independent. The person I complained about conducted the investigation." (Patient comment at meeting)

"My case was proved when I got medical opinion from abroad after the Ombudsman turned down my case." (Wife of deceased patient)

What patients want: Patients want to know that even if the complaint is handled internally, there is scope for an external review or a further level of scrutiny if their complaint fails or stalls. Some did not feel that the Ombudsman provided the level of independence required in the system, either because cases had to pass too high a hurdle to be considered, or because of the low number of cases upheld.

Chapter Five:
What organisations told us

During this Review we received submissions from organisations working in, and with, the NHS on complaints handling, and supporting patients, their carers and relatives. We received survey data and other evidence about people's attitudes to complaints, and heard views from many organisations on what needs to change to improve the way the NHS handles complaints.

This chapter summarises some of the key pieces of evidence we received, and the main themes that emerged. This augmented what patients told us and helped us build a more complete picture and inform our recommendations.

Key points raised by organisations:

- **Complexity – vulnerable people find the complaints system complicated and hard to navigate.**
- **Advocacy – action is needed to make the public more aware of how to access the NHS Complaints Advocacy Service.**
- **Leadership and Governance – Chief Executives and Boards must take active responsibility to learn from complaints and to create a culture that is able to take a positive attitude towards complaints.**
- **Skills and attitudes – there is a need for quality, trained staff to deal with complaints effectively and appropriately.**
- **Toxic cocktail – people are reluctant to complain and staff can be defensive and reluctant to listen to or address concerns.**
- **Independence – there is a perceived power imbalance in the complaints system.**
- **NHS reforms – changes in NHS structures may make it more confusing for patients to know how and where to raise their complaint.**
- **Whistle-blowing and Duty of Candour – few organisations provided evidence on whistleblowing, although there was support from some for a Duty of Candour.**
- **Lack of compliance – organisations do not always deliver their legislative responsibilities on complaints handling.**

Complexity

Vulnerable people find the complaints system complicated and hard to navigate. The charity Mencap, for example, referred to the findings of its two reports 'Death by Indifference' (2007 and 2012) on unnecessary deaths of people with learning disabilities. It said:

"*Both reports stated that the complaints process was slow, bureaucratic and defensive. This not only means that families, who have often been bereaved in traumatic circumstances, may wait years to reach some form of justice for their loved one, but that crucially the NHS fails to learn the lessons and take the steps to prevent further avoidable deaths and serious incidents*."

Mencap added: "*On average, it takes between 18 months and two years to complete the local stage ... It is simply not right that some families have been forced to wait years for an apology or an explanation for the death of their loved one*."

The charity Mind reported "*poor record keeping, with correspondence going astray, complaints not being properly registered, long delays in responding or no response at all*." It wrote: "*People told us that it was hard to find out who to complain to, what help they could get and what their legal rights were ... We were also told that people found complaints forms very inaccessible*."

HealthWatch England, the independent consumer champion for health and social care in England, summed up the experience by saying: "*The complaints system can be off-putting, complex and slow... There is limited confidence that making a complaint will lead to learning and change*."

Advocacy

Several organisations called for action to make the public more aware of how to access the NHS Complaints Advocacy (NHSCA), and were unhappy about the recent reforms of April 2013. Others pointed out that it is now operating under different names, in different areas, with different access points. The loss of a "national brand" was causing confusion among the public.

"*Patients should have the right to access advocacy services where they receive treatment in their home county. There need to be common approaches among all local authority commissioners*." SEAP Complaints Advocacy provider.

"*It is important that NHSCA providers, NHS providers, HealthWatch and others, work together to establish a clear identity and brand for the NHSCA service. This has been made more difficult, but far from impossible by the arrangements for the NHSCA to be provided by a large number of locally commissioned organisations*." VoiceAbility – complaints advocacy provider.

"*The current model of NHS Complaints Advocacy should be reviewed. Locally NHSCA should be available through a local 'one stop shop' (local Healthwatch) which local people can easily identify, and which will also use complaints information to inform its representation of patients and seek improvements*." Action Against Medical Accidents (AvMA).

Leadership and Governance

Many organisations referred to the role of leadership and governing bodies in their evidence. There was a strong view that Chief Executives and Boards must take active responsibility for looking at complaints, which should involve examining the narrative, not just the numbers, and ensuring this gets the right level of attention in the organisation. There was also a view that Chief Executives should take personal responsibility for the complaints' process, including signing off letters responding to complaints.

Chief Executives and Boards have a crucial role in ensuring there is the right attitude and approach in the organisation. This should focus on 'learning', to welcome complaints and concerns. The insights they bring should be used to improve patient care.

"To be successful, the drive for change must be owned and led by those who run the service, with the right balance being struck between external pressures and internal ownership." (NHS Confederation)

"The most effective method of using complaints to improve care is to create and support the expectation that providers and their boards take responsibility for monitoring and learning from complaints." (Monitor)

"Supporting Directors of Nursing to take an active role in complaints management can help ensure that a 'ward to board' approach is adopted across an organisation, and as visible members of senior management they can help to model good practice at the organisational level to frontline staff." (RCN).

"NHS hospital boards [to] receive reports on complaints that include: an analysis which enables boards to consider trends and themes as well as responses to individual complaints; assessments on whether real organisational learning and service improvements have taken place as a result of complaints; feedback on patient experience of complaining in order to plan improvements to hospital complaints procedures; and consistent measures to test the effectiveness of complaints handling overall." The Parliamentary and Health Service Ombudsman (PHSO)

"Hospital boards should see complaints as treasure – and get better at handling them" (Prof. Patterson New Zealand Ombudsman)

Staff skills and attitudes

The complaints process relies on the skill of the staff who run it, and the leaders who oversee it. Several organisations mentioned the importance of having good quality, trained complaints managers. AvMA said complaints managers are far too often junior, not sufficiently trained and need proper accreditation. SEAP believe complaints staff should be senior managers who report to a director.

Several organisations agreed that real transformational change depends on improving the attitude and skill of staff who deal with dissatisfied patients. The General Medical Council acknowledged that doctors need better social skills and pledges to address this in training.

However, the organisations responsible for delivering care made little mention of how and when the NHS should say sorry, which is an issue that people care about as described in Chapter Four.

"An apology for a failure must be accompanied with a service improvement outcome. To quote a client: there's no point in apologising if you're not going to do anything about it." (SEAP)

Toxic cocktail

The PHSO told the Review: *"At its worst there is a toxic cocktail that prevents concerns and complaints being heard and addressed. This is a combination of reluctance on the part of patients, families and carers to express their concerns or complaints and a defensiveness on the part of hospitals and their staff to hear and address concerns. As a result opportunities to learn and improve care are lost."*

PHSO provided information from research conducted in 2012. It showed 18% of patients wanted to complain, but just over half of them did not actually put in a complaint.[14] The reasons for not complaining include:

- People don't know where or how to complain and fear they won't be listened to or taken seriously;
- Some people fear that they will get a worse service if they complain;
- Patients may lack an advocate or need specialised support – 1 in 4 of those in hospital is cognitively impaired.

This analysis of the public's reluctance to complain was reinforced by research this year for the Care Quality Commission, which found that one in nine people would be reluctant to speak out about poor care.[15] The main reasons people gave for not speaking up were:

- Not wanting to be thought of as a troublemaker (26%);
- Believing that complaining wouldn't make a difference (25%);
- Thinking that members of staff were so stretched that complaining wouldn't help (15%);
- Fearing that their care would get worse if they spoke up (11%).

The CQC said that more than half of those who had voiced a concern about poor health or social care felt that their feedback wasn't welcomed (55%). A similar proportion felt they hadn't received a satisfactory response (57%). Just over a third (34%) said they didn't feel they had been treated with respect while their concern was being looked into.

When people were asked what would persuade them to speak out, the CQC said there was overwhelming support for:

- knowing what standard of care they have a legal right to expect (76%);

[14] Health Service Ombudsman's submission to the Complaints Review
[15] CQC research – Full ICM report at: April 2013 research report for CQC

- being encouraged by people who are providing the care to speak up (75%);
- expecting the service to routinely know what action was taken in response to feedback (70%).

Research for HealthWatch England, found:

- 48% of people do not have the confidence that formal complaints are actually dealt with (rising to 60% among the 55+ age group);
- 54% of people who had a problem with health or social care in the past three years did nothing to report it;
- 49% of consumers surveyed have no trust in the system.[16]

Independence

Organisations representing patients told the Review about a perceived power imbalance in the complaints system. Mencap for instance made a series of points on this theme. It reported:

"When complaints are pursued locally with the hospital or GP practice, it is our experience that it is often impossible to find out what really went wrong ... Among the families that Mencap has supported, very few feel that justice had been achieved through the local complaints procedure. A much-cited complaint is the power inequity inherent in the local complaints procedure.

"After a death (or serious untoward incident), most local complaints are investigated by members of NHS staff working within the same Trust. Occasionally, investigators may be drawn from even the same unit (or specialty). Both pose possible conflict of interests. Very rarely, a Trust will bring in an external expert to adjudicate on a complaint, and pay for this to happen. This again calls into question the investigation's impartiality."

Consequences of NHS Reforms

Some organisations noted that changes in NHS structures introduced by the Health and Social Care Act 2012 have had consequences for people making complaints. The NHS Confederation noted:

"*We have serious concerns that following the NHS reforms the complaints system has become more difficult to navigate and risks leaving patients confused about who to complain to*."

During a face to face meeting with the Review Team, the NHS Confederation suggested that Clinical Commissioning Groups should play a vital role. They should use their leverage to ensure that providers have good complaints systems in place, but there is currently no systematic way for CCGs to look at complaints.

[16] Healthwatch England research

Although primary care is not the focus of this Review, complaints about acute care may well come through at primary level. People may complain to a GP about poor arrangements for discharge from hospital or relatives may complain after a death in hospital.

Whistle-blowing and duty of candour

Few organisations made references to whistleblowing in their responses to this Review. Some mentioned the proposed Duty of Candour and the LGA made the following points:

"*There is a fundamental need for a more open and honest approach to investigating and responding to complaints. This will require a shift in current culture and behaviour which tends to be defensive or not treat complaints seriously enough.*

"The implementation of a statutory Duty of Candour will greatly assist in bringing about this change if it is robust enough to ensure that every organisation and every staff member in it has to take it seriously and is held to account if they do not."

Julie Bailey of Cure the NHS comments that;

"We must make it safe for doctors and others to speak out when they speak the truth about wrong doing in their Trust."

Lack of Compliance with legislative duties

As we carried out our review, we were repeatedly told many organisations are not complying with their existing legislative duties with regard to complaint handling.

As an example, there is a legislative requirement on organisations to make information available to the public as to their arrangements for dealing with complaints, and how further information about those arrangements may be obtained[17]. Yet, Mind said:

> *"People told us that it was hard to find out how to complain, who to complain to, what help they could get and what their legal rights were."*

and in their evidence to us, the NHS Confederation wrote:

> *"...we are calling for CCGs and NHS England to provide clear information to patients and the public about their complaints process."*

We have also been made aware of instances where organisations have not offered to discuss with the person making a complaint the manner in which the complaint is to be handled[18]. There is also a legislative requirement, during the investigation, to keep the person making the complaint informed, as far as reasonably practical, as to progress of the investigation[19].

[17] The Local Authority Social Services and National Health Services Complaints (England) Regulations 2009 [SI 2009 No.309]; regulation 16

[18] The Local Authority Social Services and National Health Services Complaints (England) Regulations 2009 [SI 2009 No.309]; regulation 13

[19] The Local Authority Social Services and National Health Services Complaints (England) Regulations 2009 [SI 2009 No.309]; regulation 14

The Health Select Committee, in its 2011 report on *Complaints and Litigation* made the point that "there is still a considerable amount of work to do in order to fully implement the system throughout England". The Committee further recommended that "...commissioning authorities...should be the engines that drive improvement in complaints handling". We consider that, whilst individual hospital Boards have an important role to play, so too have commissioning bodies, particularly in respect of NHS hospitals complying with their legislative duties.

Chapter Six:
Recommendations

Although words may inspire change they are not enough to hardwire it into the NHS and this is what our recommendations are designed to achieve. Our proposals reflect the principles in the NHS Constitution and build on those of previous reports. Our recommendations must therefore be read in conjunction with our proposals on implementation in Chapter Seven.

We focus on four areas for change: improving the quality of care; improving the way complaints are handled ensuring independence in the complaints procedures; and whistle-blowing.

1. Improving the quality of care

If standards of care were better and patients felt they could raise concerns on the ward and see them dealt with at the time, many would not feel they have to complain at all.

Recommendations

- Staff providing basic care should be adequately trained, supported and supervised. **Action: Trusts, professional bodies and representative organisations, HEE, clinical leaders and managers**
- There should be annual appraisals linked to the process of medical revalidation which focus on communication skills for clinical staff and dealing with patient concerns positively. This goes hand in hand with ensuring that communication skills are a core part of the curriculum for trainee clinical staff. **Action: HEE, professional bodies and representative organisations, clinical leaders and managers**
- Trusts should ensure that there is a range of basic information and support available on the ward for patients, such as a description of who is who on the ward and what they do; meal times and visiting times; and who is in charge of care for the patient. Care should be taken to ensure that differences in language, culture and vulnerability are taken account of in this. **Action: Trusts, clinical leaders and managers, clinicians and practitioners**
- Patients should be helped to understand their care and treatment. While written information is helpful, it is always important to discuss diagnoses, treatments and care with a patient. Patients frequently need to revisit topics already addressed. Where appropriate, their relatives, friends or carers may be included in discussions. **Action: Trusts,**

professional bodies and representative organisations, HEE, clinical leaders and managers, clinicians and practitioners, patients

- Trusts should provide patients with a way of feeding back comments and concerns about their care on the ward including simple steps such as putting pen and paper by the bedside and making sure patients know who to speak to if they have a concern – it could be a nurse or a doctor, or a volunteer on the ward to help people. **Action: Trusts, education and training organisations, clinical leaders and managers, clinicians and practitioners, patients**
- Hospitals should actively encourage volunteers. Volunteers can help support patients who wish to express concerns or complaints. This is particularly important where patients are vulnerable or alone, when they might find it difficult to raise a concern. Volunteers should be trained. **Action: Trusts, volunteer organisers**

Recommendations for Trusts and Boards

- Trust Chief Executives and Board members should be supported so they have the necessary skills in effective communication, seeking and using patient feedback, routinely throughout their organisation and are equipped to ensure their organisation learns from that feedback. **Action: NHS Leadership Academy and NHS Confederation**
- PALS should be re-branded and reviewed so it is clearer what the service offers to patients and it should be adequately resourced in every hospital. **Action: DH**
- Every Trust should ensure any rebranded patient service is sufficiently well sign-posted and promoted in their hospital so patients know where to get support if they want to raise a concern or issue. **Action: Trusts**
- The CQC should include complaints in their hospital inspection process and analyse evidence about what the Trust has done to learn from their mistakes. **Action: CQC**

2. Improvements in the way complaints are handled

Too often patients feel uncertain or confused when they feel they have a problem. Some never complain because they feel it may be unjustified or because they think staff are too busy. Others may lack confidence or feel intimidated or find the complaints procedure hard to understand, too complex or tiring. It should not be painful or difficult to complain, and when patients do complain it should not be up to them or their relatives to continually chase progress.

There needs to be a change in the way hospital staff approach dealing with complaints. All feedback, including complaints, offer valuable information which can lead to improvements, but there has to be the right organisational ethos to enable this to happen, so that both patients and their friends or relatives and the staff involved feel supported.

Complaints vary in their seriousness and frequency. Many complaints involve staff who deliver basic patient care and where these are listened to empathetically, immediate appropriate action can be taken to rectify a problem. When action is delayed or mishandled it can cause great distress and a breakdown in the trust between the patient, their family or friends and the hospital.

Recommendations

- Attention needs to be given to the development of appropriate professional behaviour in the handling of complaints. This includes honesty and openness and a willingness to listen to the complainant, and to understand and work with the patient to rectify the problem. **Action: Trusts, professional bodies and representative organisations, clinical leaders and managers, clinicians and practitioners**
- Staff need to record complaints and the action that has been taken and check with the patient that it meets with their expectation. **Action: Trusts, professional bodies and representative organisations, education and training organisations and clinical leaders and managers, clinicians and practitioners**
- Complaints are sometimes dealt with by junior staff or those with less training. Staff need to be adequately trained, supervised and supported to deal with complaints effectively. **Actions: Trusts, education and training organisations, clinical leaders and managers**
- There should be NHS accredited training for people who investigate and respond to complaints. **Action: Trusts, HEE**
- Trusts should actively encourage both positive and negative feedback about their services. Complaints should be seen as essential and helpful information and welcomed as necessary for continuous service improvement. **Action: Trusts, HEE, clinicians and practitioners**
- It needs to be clearly stated how whistle-blowers are to be protected and gagging clauses should not be allowed in staff contracts. **Action: DH**
- The development of the 'cultural barometer' should continue. This will determine if a workplace is suffering from a problem with staff attitudes or organisational approach. **Action: NHS England and DH**
- The independent NHS Complaints Advocacy Service should be re-branded, better resourced and publicised. It should also be developed to embrace greater independence and support to those who complain. Funding should be protected and the service attached to local HealthWatch organisations. **Action: Local Authorities**
- HealthWatch England should continue to bring together patients and representative groups, and lead the Healthwatch network in the public campaign to improve complaints' systems in health and social care. Some funding should be made available to help organisations to fully participate in this important work. **Action: Healthwatch England, DH.**

Recommendations for Trusts and Boards

- Every Chief Executive should take personal responsibility for the complaints procedure, including signing off letters responding to complaints, particularly when they relate to serious care failings. **Action: Trusts**
- There should be Board-led scrutiny of complaints. All Boards and Chief Executives should receive monthly reports on complaints and the action taken, including an evaluation of the effectiveness of the action. These reports should be available to the Chief Inspector of Hospitals. **Action: Trust Chief Executives and Boards**
- There should be a new duty on all Trusts to publicise an annual complaints' report, in plain English, which should state what complaints have been made and what changes have taken place. **Action: DH**
- Every Trust has a legislative duty to offer complainants the option of a conversation at the start of the complaints process. This conversation is to agree on the way in which the complaint is to be handled and the timescales involved. **Action: Trusts**
- Where complaints span organisational boundaries, the Trusts involved should adhere to their statutory duty to cooperate so they can handle the complaint effectively. **Action: Trusts**
- Further work should be done to explore how we look for the right skills in the recruitment of Chief Executives and Board members. They need to be capable of ensuring that their Trust is a learning organisation. **Action: NHS Leadership Academy**
- Commissioners and regulators should establish clear standards for hospitals for complaints handling. These should rank highly in the audit and assessment of the performance of all hospitals. **Action: CCGs, CQC**
- There should be proper arrangements for sharing good practice on complaints handling between hospitals, including examples of service improvements which result from action taken in response to complaints. **Action: DH, Trusts**
- Regulators and the PHSO should work more closely to co-ordinate access for patients to the complaints system, and to detect failings in clinical or other professionals or Trusts. **Action: PHSO**
- We welcome the ongoing discussions on making a Duty of Candour a statutory requirement and recommend that a Duty of Candour is introduced. **Action: DH**

3. Greater perceived and actual independence in the complaints process.

Patients must have confidence in the complaints process. When there have been serious failings, it is particularly important that patients feel the process is independent. Too often hospitals are seen to be 'marking their own homework' and this undermines public

confidence. Much more needs to be done to ensure that there is a level of independence at the local stage which is acceptable to those who complain. Trust Boards should have a duty to offer this and should ensure that this is implemented.

We agree with the Francis Report, which recommended that hospitals should always use an independent investigator in circumstances, where:

- A complaint amounts to an allegation of a serious untoward incident;
- Subject matter involving clinically related issues is not capable of resolution without an expert clinical opinion;
- A complaint raises substantive issues of professional misconduct or the performance of senior managers.
- A complaint involves issues about the nature and extent of the services commissioned.

We believe that the gap between a local Trust dealing with a complaint by, 'Local Resolution' and a patient taking their unresolved complaint to the Health Service Ombudsman is too great. In our view, the PHSO is too far removed from where the actions complained of took place and lacks accountability to local people. We are especially concerned that the PHSO did not act on complaints arriving from the scandal at Mid-Staffordshire Hospital, and we are not reassured by current plans simply to increase the number of complaints the PHSO takes up at a national level. We find the idea of local offices of the Ombudsman service an attractive one.

Our recommendations therefore focus on ways to bring more independence into complaints handling, and complaints advocacy at the local level where there are serious failings in care, how to bring more external patient scrutiny into Trusts, and on ensuring the true interests of patients are represented in several wider reforms which are now needed.

We are not alone in our concern about the independence of the complaints system from the NHS and its organisations.

- the Health Select Committee's recommendation in 2011, that "*one organisation should be responsible for maintaining an overview of complaints handling in the NHS, setting and monitoring standards, supporting change, and analysis of complaints data*.
- Professor Don Berwick's suggestion of "*further consideration of an independent national complaints management system that is easy to access and use, and that would also highlight and promote better practice and improvements in the NHS*.

However, the experience and the evidence that we have received tells us that the creation of a new organisation is unlikely to be the solution to the problems that we have identified. Neither will simply leaving things as they are and hoping that change will lead to the improvements needed. Many of the recommendations of previous reports and enquiries have not been acted upon, hence our proposals on implementation in Chapter Seven.

Recommendations

- Hospitals should offer a truly independent investigation where serious incidents have occurred.
  Action: Trusts
- When Trusts have a conversation with patients at the start of the complaints process they must ensure the true independence of the clinical and lay advice and advocacy support offered to the complainant.
  Action: Trusts
- Patient services and patient complaints support should remain separate so patients do not feel they have to go through PALS first before they make a complaint. **Action: Trusts**
- Patients, patient representatives and local communities and local HealthWatch organisations should be fully involved in the development and monitoring of complaints systems in all hospitals. **Action: Trusts**
- Board level scrutiny of complaints should regularly involve lay representatives. **Action: Trusts**

4. Whistle-blowing

The question of whistle-blowing was raised occasionally by both staff and patients during the course of the review. During our work, the Secretary of State announced change in this area. We were pleased to hear of his decision to ban the practice of so called "gagging" clauses, used where hospitals reach an agreement with disaffected staff to terminate employment in return for a financial payment. Such clauses have in the past obliged clinical and other staff to be silent about practices which endanger patient safety. We support their removal.

However, we have heard in the course of our work repeated concerns about a number of unresolved questions surrounding this issue. These concerns relate firstly to securing justice for past whistle-blowers whose careers have been seriously jeopardised and who have suffered financially as a result of drawing attention to malpractice.

We urge the Department of Health to undertake the review of such cases with a view to both learning lessons for the future and undertaking restorative justice for those individuals affected.

Secondly, there remains disquiet about the opportunities available for staff to be heard, when they believe there is bad practice both within hospitals, and in the wider regulatory system. There is uncertainty too about what employment protection is genuinely to be offered to future whistle-blowers who reveal their concerns externally to regulators, or the press and media, for example.

Future arrangements

We believe that much more needs to be done to avoid the need for whistle-blowing in the future, and to protect those who with justification speak out, where there is no other means of drawing attention to situations where patient safety is threatened.

Recommendations:

- Clear guidance for staff on how they should report concerns, including access to the Chief Executive on request. **Action: DH**
- A board member with responsibility for whistle-blowing should be accessible to staff on a regular basis. **Action: Trusts**
- A legal obligation to consider concerns raised by staff, and to act on them if confirmed to be true.
  Action: Trusts
- In assessing the complaints systems of hospitals the CQC should investigate the ease with which staff can express concerns and how whistleblowing is responded to where it has taken place. **Action: CQC**
- The CQC itself should designate a board-member with specific responsibility for whistle-blowing, and ensure that it acts on intelligence received from whistle-blowers. **Action: CQC**

Chapter Seven:
Implementation and pledges to act

The ambition for this review was always that it would lead to real change that is hard-wired into the system. This is not the first report on complaints handling, and as outlined in Chapter 2, a great deal is known about what needs to be done. The challenge however is to ensure the implementation of our recommendations so that they lead to real improvements for patients.

Now, following Robert Francis's investigation, it is clear that the complaints system must be improved if public confidence in the NHS is to be maintained.

We envisage that the drivers for change should be threefold:

1. **Consumer Power.** Much more needs to be done to encourage patients and the wider public to insist on a better complaints system for the NHS. We are pleased to have been able to meet several consumer and patient bodies in the course of this review. They include HealthWatch England, Citizens Advice, Patients Association, Action for Victims of Medical Accidents, the Consumers Association, National Voices, and others. Between them they are powerful, with impressive contacts and skills, and already doing good work to improve complaints systems for patients. We are delighted they have agreed to work together locally and nationally, to monitor and press for the implementation of many of our recommendations and the pledges below.

   We urge however that resources be provided to this grouping to enable them to develop this joint work to the best effect, both nationally and locally,and that the funding for local Healthwatch organisations is protected by ringfencing it in the future.

2. **A Champion for Complaints Reform.** It is clear from all the evidence that we have heard that the patient who wishes to complain needs a champion, in a health care system which has, over many years, failed to demonstrate that it takes complaints seriously or welcome them as an opportunity to make improvements to the care that it provides.

We considered carefully whether to recommend the creation of a new, time-limited role, to drive the reform of complaints that is so desperately needed. However for the time being we think that the creation of this new role – a Commissioner for Complaints Reform – should be deferred. In discussion with the newly appointed Chief Inspector of Hospitals, Professor Mike Richards, we understand that he sees both the substance of complaints and the manner in

which they are handled by staff and boards, as central to his work and he can help to make progress in the immediate future.

We therefore set out below the key tasks that we believe should fall to CQC, through the Chief Inspector of Hospitals to deliver in the coming year: He should prioritise in his work the examination of the handling of complaints by NHS organisations.

- In doing so, the CQC through the Chief Inspector should:
  - produce and publish a thematic report on complaints, based on the findings of all the hospital inspections that he carries out in the year following the publication of this report;
  - consider the issues set out in our review as part of the thematic report on complaints – the prevention and handling of complaints, independent support for the complainant and the way that hospital boards lead the handling of complaints, and learn from them;
  - consider the sharing of good practice in complaints handling, perhaps through the development of a national resource.
- In the course of his hospital inspections, and as part of a thematic report on complaints, working with others in the health and care system, particularly HealthWatch England, CQC through the Chief Inspector of Hospitals should have due regard to the issues below that we believe remain unresolved, namely the need for:
  - a more localised and accountable second tier complaints review system, capable of analysing and detecting local trends;
  - more, and more effective, independent support for complainants at the local resolution stage;
  - enforceable standards in complaints handling, which can be used by the CQC and the Chief Inspector as well as providing a means of comparing the performance of hospitals; this should include standards governing the ease with which staff themselves can bring forward concerns.
  - commissioners (CCGs and NHS England) to improve their service specification for complaints handling and having access to intelligence about complaints.
- CQC, through the Chief Inspectors of Hospitals, General Practice and Adult Social Care should work in partnership so that lessons from different sectors can be learned and shared, issues relating to complaints along the whole care pathway can be identified and a collective view taken on the issues set out above.
- CQC, through the Chief Inspector of Hospitals should work closely with Healthwatch England, PHSO and patient and consumer groups, to ensure that his report takes account of the views and experiences of those using the NHS and that they help him in his consideration of the four issues set out above.

- These additional functions of the Chief Inspectors need to be properly resourced. The Department of Health should ensure that CQC and, where appropriate, Healthwatch England, is provided with the additional staff and funding necessary to carry out the thematic work and prepare and publish a report. **Action: DH, CQC**
- We will consider the findings of the Chief Inspectors and whether sufficient progress has been made in tackling the issues and problems set out in this report. We recommend that, once the Chief Inspectors' report is published, the Secretary of State for Health seeks our views on the progress made and any further recommendations that we might have to accelerate improvement. **Action: DH**
- We also urge that the Health Select Committee should continue its work on this subject and revisit the question of complaints handling within the same time scale.

With the knowledge that the Chief Inspectors will report on progress within a year, we hope that all involved will wish to be seen to be playing their part in developing a complaints system we can be proud of for the future.

3. Pledges to Act:

The third driver for change is pledges to act. We are grateful to the many organisations who have pledged to take action. We commend them for doing so and look to others to follow suit. The pledges in the following pages largely complement our recommendations, set out in Chapter 6, and focus on the importance of keeping reform of the complaints handling system in the spotlight and sustaining the pressure that will lead to change.

Nursing and Midwifery Council (NMC)

The NMC's Code and education standards include clear duties on nurses and midwives in relation to complaints handling, communication with patients and raising concerns. The NMC will be undertaking a planned review of the Code and other practice standards in the next year as part of the preparation work for revalidation. The NMC will ensure that these duties are highlighted in the revised Code which will form the benchmark for appraisals and revalidation. The NMC plans to publish its new Code and standards by December 2014. The NMC will also take more immediate steps to raise awareness of these duties and their guidance on raising concerns amongst nurses, midwives and the public.

The NMC will improve the experience of patients and other complainants who become involved in their fitness to practise proceedings by providing more information and support throughout the process. The NMC plans to have their new arrangements in place by April 2014.

The NMC will work more closely with other regulators and healthcare organisations to share data and intelligence including, where appropriate, complaints information and patient feedback, in order to enable them to better protect the public. The NMC plans to have a new operational protocol and data sharing agreement in place with the Care Quality Commission

by December 2013 and to develop similar arrangements with other regulators during 2014/15.

Royal College of Nursing (RCN)

The RCN will host a workshop with nurses to consider the report after its publication, and will produce a short guide/advice sheet for nurses by spring 2014.

NHS Trust Development Authority (NHS TDA)

The NHS TDA's Accountability Framework for NHS Trust Boards highlights the centrality of patient experience, with a clear focus on complaints. The NHS TDA will take into account the message and recommendations of the Clwyd/Hart complaints review, as it further develops its approach to holding Trusts to account for providing patient-centred care. The NHS TDA will align its approach with that of Monitor, CQC and NHS England to ensure Trusts are being given consistent messages.' NHS TDA will consider any changes needed to the Accountability Framework and will reissue it by the end of April 2014.

Health Education England (HEE)

HEE will develop an e-Learning resource for complaints handling, with modules specific to complaints staff, and also modules to raise awareness of the importance of, and process for dealing with patient feedback and complaints. Work to create the specification for the e-learning resource for complaints handling will be completed by December 2013 (subject to agreement by all parties). A procurement process for the resource will then take place with the intention that it will be widely available in 2014.

HEE will work with regulators and other key partners to review training, education and CPD programmes to include and give greater emphasis to developing student and staff awareness of a positive attitude to hearing, accepting and responding to patient concerns, complaints and compliments. A review of the provision of training, education and CPD programmes will take place by LETB education commissioning leads (in partnership with regulators such as the NMC etc and HEIs) to include and give greater emphasis to developing student and staff awareness of a positive attitude to hearing, accepting and responding to patient concerns, complaints and compliments. This review will be completed by May 2014 and include a clear action plan for delivering recommendations.

Local Government Association (LGA)

The LGA will support councils by focusing on the role of councillors as advocates for their communities.

Working with the Centre for Public Scrutiny, by April 2014, the LGA will provide information and learning about public feedback, complaints and insight about NHS services to lead councillors for adults and children's services; health and wellbeing boards; local HealthWatch commissioners; and council scrutiny.

NHS Confederation

The NHS Confederation pledges to hold discussions with its members about the review's recommendations at two regional events by spring 2014. These discussions will be used to identify and share good practice about complaints handling in hospitals and to inform the NHS Confederation's response to the review.

NHS Employers

NHS Employers will promote the outcomes from the National Complaints review through engaging and working in partnership with NHS employers and staff-side through a 12 month work programme through existing networks and forums of HR Directors, Workforce Leaders/ partners and Regional Social Partnership Forums and will provide feedback to the DH.

General Medical Council (GMC)

The GMC's core guidance for all doctors, *Good medical practice*, sets out what is expected of doctors, including in communication and partnership working with patients. Its guidance emphasises the need to listen to patients, provide the information they need, be polite and considerate as well as treat patients fairly and with respect. The GMC is examining how these skills can be better reflected in postgraduate training and also promoted as part of continuing professional development for all doctors. The GMC plans to consult patients and others on this work early in 2014. Guided by the work of an independent review of post graduate medical education, jointly sponsored with the Academy of Medical Royal Colleges, by September 2014, the GMC will be working with the medical Royal Colleges and other key interest groups to embed the generic professional competences outlined in *Good Medical Practise* in postgraduate training.

The GMC will also look at how well prepared medical graduates feel to deal with patient concerns and complaints in a positive way. They will do so as part of their review of the impact of Tomorrow's Doctors 2009, which sets out the outcomes and standards for undergraduate medical education. This research will be received in the second half of 2014 and work will have begun to identify any changes that may need to be made.

The GMC believes there will be increasing use of instant patient feedback and welcomes the greater transparency and patient involvement this brings. The GMC also believes patient feedback in general is vital for professional development and it has produced guidance for best practise for patient feedback as part of the revalidation process, which requires doctors to go through a series of annual checks. As part of the evaluation of revalidation, the GMC will look at the role of patient feedback and how it can be further developed. By September 2014, a research partner will have been commissioned to undertake this work.

The GMC will act to support patients through fitness to practice cases, undertaking to take tailored face to face opportunities to explain the process and outcomes. Interim findings from the pilot programme have been positive and the GMC will receive the final evaluation at the end of 2013. Subject to favourable findings and agreement of the Council, the GMC expect to have established the essentials of this programme in all four countries by mid-2015.

Monitor

Working with partners, Monitor will make sure foundation trusts understand what best practice in complaints handling looks like and what Monitor expects of them. For example, as part of their quarterly monitoring process during the summer Monitor have asked foundation trusts to explain how their Boards use complaints in their assessment of quality performance and how they assure themselves that they comply with Monitor's *Quality Governance Framework* in relation to complaints and whistleblowing. During the autumn, Monitor will analyse their responses to identify any issues that might require us to take further action.

Monitor will continue to work closely with the CQC during the autumn as it develops its new inspection and assessment regime relating to leadership, governance and culture to ensure that we are clear how CQC concerns relating to complaints could trigger further investigation or regulatory action in foundation trusts by Monitor.

Monitor will share information about complaints quickly and effectively with our partners, and already does so with the CQC.

Care Quality Commission (CQC)

CQC is committed to putting people who use services at the centre of their work, and including people's experiences as a core focus of their inspections. CQC has recently announced their intention to gather and use a much wider range of information from patients and the public, and CQC will use the outcome of this review to inform their regulatory assessment of the NHS and other health and social care services where relevant. In particular over the next year CQC will improve how they are looking at leadership, governance and culture, and will:

- develop the way they use CQC complaints information as well as other views and feedback from people who use services in their surveillance model to ensure they are embedded consistently and given significant weighting (winter 2013/14);
- analyse the number and themes of complaints and feedback they receive directly;
- work closely with and share information with their regulatory partners about complaints;
- strengthen how they consider complaints as they develop their approach to assessing quality and safety of hospitals and other services (Autumn/Winter 2013).

NHS England

NHS England will review the role of commissioners, including their own, in holding providers to account for a positive attitude towards patient feedback, concerns, complaints and compliments, with specific reference to using the standard contract and quality accounts as relevant existing tools. NHS England will undertake this work by March 2014.

NHS England is supporting the piloting of the cultural barometer, and in the evaluation, revisions and potential rollout of the barometer, will consider the content and

recommendations of the Complaints review. NHS England will undertake this work by March 2014.

The Parliamentary and Health Service Ombudsman

The Ombudsman is independent of the NHS but has committed to do the following:

- The HSO wants to participate actively in discussions on whether an NHS vision for excellence in complaint handling can be developed along with ways of measuring individual hospital level performance against that vision.
- The HSO will regularly share insights from the complaints that they see with Parliament, the Department of Health, regulators and the NHS itself. Reflecting one of their core strategic aims, they will collate and provide this information in the way which it can be most useful in showing key learning (both of good practice, and learning from things that have gone wrong) and so support improvement in the complaints system.
- The HSO will support organisations such as NHS England and the Foundation Trust Network in the development and embedding of good board practice.
- The HSO will contribute to work by the NHS to define the competencies for complaint handlers and develop a suitable accreditation framework.
- The HSO will also contribute to the definition of competencies required on the ward to handle expressions of dissatisfaction before they turn into complaints.
- The HSO will work with others to develop and promote good practice from ward to board using our experience and the findings from our research.

Even if recommendations for improvements are implemented, there will still be occasions when something will go wrong. In the most serious of those cases, HSO hopes that NHS Trusts will use the option of self-referral to the Health Service Ombudsman for independent investigation; and so allow HSO to play their part in delivering justice, finding out what went wrong and ultimately helping the NHS to restore public trust in what is such a key public service.

Chapter Eight:
Good Work

During the Review we found good work in the NHS.

In this Chapter we highlight some examples from around the country showing how patients are being encouraged to provide feedback about their care, how some organisations provide additional support when they complain, and what organisations do with the insight they get from patients who raise concerns and complain.

Case study one: The critical friend

Central Manchester University Hospitals NHS Foundation Trust

Patients or relatives complaining about services at Central Manchester University Hospitals NHS Foundation Trust may be pleasantly surprised by the tone of the response. In the most serious cases, they are offered direct personal support from a senior executive. Cheryl Lenney, Director of Nursing (Adult), said a director or deputy director is assigned as a "critical friend", acting as an independent advocate on behalf of the complainant. That might involve helping people to navigate a way through the organisation to find out whether mistakes were made, why things went wrong and what will be done to provide better care in future.

Ms Lenney said:

> *"We tell them: I am your one point of contact in the organisation. They value the fact that we are very senior. We will see them through to the end result of an investigation. That may mean helping a family to get further information that they hadn't asked for at the start. And sometimes a bereaved family may want this help to continue through to an inquest.*
>
> *"The family may be satisfied with the result of an investigation, when they have an explanation of what happened. Or they may not. If a member of staff has been investigated in a disciplinary procedure, we share the outcome. We can't make right what went wrong, but we can signpost complainants to legal services or the NHS Litigation Authority. We are not defensive. We are supportive."*

'Critical friends' are assigned only for complex cases when there has been a suspected serious untoward incident and a patient has been harmed or has died. But the Trust has been putting a lot of effort into answering all complaints fully, openly and in plain English. The letter responding to a complaint is regarded as a 'final product' that has to meet certain quality standards. Ms Lenney said it should demonstrate:

- robust investigation;
- clear awareness of the issues;
- knowledge of what the individual has experienced;
- a strong feeling of empathy in the apology; and
- saying what the Trust will do to prevent that happening again.

The Trust tries to pre-empt people's need to complain by facilitating meetings with the clinical teams who were involved in any case that has caused concern. It also collects data about complaints that have arisen in a particular clinical setting or ward, feeding the information back to the teams involved and requiring a response.

Other initiatives include a complaint review group, chaired by one of the trust's non-executive directors and 'Feedback Fridays' when middle managers spend time on the wards listening to patients to gather information about how services could improve.

Case study two: Customer focus

Birmingham Heartlands Hospital

Patients and relatives arriving at Birmingham Heartlands hospital are left in no doubt that senior NHS managers treat their opinions seriously. On the front door of the main entrance is a "Tell us what you think" poster. Inside in the foyer there is a Patient Services desk, giving the organisation a customer-focussed feel. It displays colourful, eye-catching booklets seeking opinions about how the hospital is doing. One is "*Tell us what you think about our services – a guide to giving feedback or reporting a concern.*" Another is: "*How are we doing? Compliments, comments, concerns.*"

The booklets, which are also displayed in outpatients, on the wards and in the discharge lounge, explain in user-friendly language what is involved in raising a concern or complaint, and give advice on independent advocacy. There are forms for completion by a complainant, or for comment. The hospital website has a direct link to Patient Opinion feedback on its home page.

The hospital standard is for complaints to be acknowledged within a maximum of three days, when the complainant is given a named case manager who becomes responsible for overseeing resolution. The standard is for every complaint to be answered within 25 days, except in the most complex cases.

Recent examples of changes in clinical practice as a direct result of complaints/feedback include the redesign of the patients' care pathway in A&E and new procedures in the Gynaecology department for women suffering miscarriages.

Board members take part in a sub-group that reviews stories of individual patient experiences. It provides a monthly report to the Board and to the meeting of Executive Directors, giving patient feedback, including signed or anonymous comments on the Patient Opinion and NHS Choices websites. The Trust takes a monthly snapshot of performance by

asking 15 patients' on each ward to complete a questionnaire about their experience. It compares this information with results from the Friends and Family Test, staff sickness returns, complaints data and reports from unannounced visits by members of the consultative Healthcare Council. On the wards in Heartlands, each patient has a folder beside the bed with information about visiting hours, who's who among the staff and how to give feedback or make a complaint. A recent audit identified missing folders from various areas and a new replacement order has been organised with updated information. The policies are being extended to the Trust's other hospitals at Solihull and Good Hope.

Case study three: Using patients' experiences to build better services.

Royal United Hospital, Bath.

Staff and management at the Royal United Hospital (RUH), Bath, know that by listening to feedback and being open to making changes, they can improve their patient services. Both during and after their time in the hospital, patients and relatives have many options for commenting on their experiences besides using the traditional PALS and Complaints routes. For instance, patients and relatives who want to give more immediate feedback are invited to meet for a cup of tea with the ward sister on a weekly basis on the wards. Other methods of feedback include the "Friends and Family Test" at the point of discharge. Patients and carers can also use the in-house real-time patient feedback system, which can also be accessed on line from the patient/carer's own computer.

Another way that RUH ensures they focus their services around the patient is through the Patient Experience Group (PEG). This group comprises administrative and clinical staff together with representatives from community organisations including previous patients, senior citizen organisations, Carer Support Wiltshire and other carer groups. The PEG is invited to give feedback on changes to the patient services within the hospital or to suggest how these services could be improved. The composition of this group is regularly reviewed to ensure it reflects the broadest possible cross section of service users with its aim to focus on any Trust-wide strategic issues for service users and to drive and support a Trust wide approach to improve the experience of patients and carers.

One of the ways that the RUH works with patients, families, carers and staff is by presenting their stories at '*See it my way'* events. Patient focused events such as these allow staff to reflect on the hospital experience from the patients perspective and staff agree from the feedback collected after these events, that it provides real value in terms of their overall understanding of how patients and their families lives are affected due to specific conditions and also how they can adapt their own working practises to benefit patients in future. "*See it my way*" has broached a number of topics ranging from "living with learning difficulties" to "being deaf.

These many and varied approaches to receiving and using information from patients, relatives and staff helps to create a responsive flexible culture of learning and therapy within RUH. As

Medical Director Tim Craft says "*the patients' experience is inseparable from the staff and family experience*".

Case study four: Easy and practical steps to put confidence in your complaints system.

St. Christopher's Hospice, London.

St. Christopher's Hospice in South London have a number of sensible practices in place which gives confidence to the patient and relative who may wish to make a complaint or give feedback. Upon first booking an appointment, the hospice issue an information book which explains services and includes information on how to make a complaint. This encourages the patient, who may otherwise feel daunted at complaining, to do so. It also makes the complaints process easy to understand and more accessible.

Front line workers, from porters to clinical staff, are given induction training in which they are encouraged to respond openly to patients' and relatives' questions and concerns. Staff are encouraged to deal with the situation immediately if this seems appropriate, and to alert their manager to situations that may develop into a complaint. The aim here is to pre-empt complaints, perhaps by giving people the opportunity to talk to a manager and resolve potential misunderstandings and issues.

The senior management team (SMT) at St. Christopher's manage the complaints process and deal with most complaints. Written responses to complaints are scrutinised by at least 2 members of the SMT. They avoid jargon wherever possible and apologies are readily given when warranted. When complaints are upheld, complainants are advised how practice will change as a result.

An internal review of responses to complainants by clinical managers, the senior management team and the Board takes place every 6 months. This ensures that any learning points are disseminated and required actions have been taken.

Case study five: Training the NHS staff of the future

University of Southampton

The Faculty of Health Sciences at the University of Southampton has a very impressive approach to training their students to be receptive of patient feedback, and in handling complaints effectively.

For example, pre-registration nursing students and those undertaking physiotherapy, occupational therapy and podiatry programmes are explicitly taught about the handling of complaints and the raising of concerns in their practice placement briefing sessions, and they are further developed within subsequent placements in the NHS.

Nursing and midwifery students have opportunities to practice their skills through scenarios simulated with patient actors, and through an innovative and award winning teaching

method called Forum theatre, in which staff actors and student audiences review a range of strategies, and communication skills required to manage challenging situations as they escalate.

Within the Faculty, an enhanced specialist support service was established for students who either wished to raise concerns about suboptimal care (whistleblowing), or who were involved in adverse events. With regard to supporting patients and raising concerns, the support service includes preparing students for, and accompanying them through, the experience of giving evidence to investigating officers or disciplinary panels.

All students reporting significant concerns are assisted in the construction of a detailed and robust witness statement which aids the investigation process.

The service achieved national recognition by the Nursing and Midwifery Council (NMC), and in 2011 was cited as an 'outstanding' provision, and 'unique within Higher Education Institutions within the UK'. It was recommended by the NMC reviewer to be rolled out as a national model, and is featured on the NMC website as an example of best practice.

Annex A:
Thank you and acknowledgements

We would like to thank everyone who contributed to this Review. It would not have been possible without the openness, commitment, engagement, and support of many individuals and organisations. Nor would it have been possible without the input from patients, members of the public, NHS bodies, organisations and voluntary groups who provided written evidence or attended regional events.

Thanks to over 2500 people who cared enough to share their concerns

External review team members

Professor Elizabeth Anionwu
Ms Stella Colwell
Ms Gill Corney
Rosie Glazebrook
Alison Lowton
Dominic Makuvachuma-Walker
Sonia Mangan
Dr Kieran Mullan
Stephen Snart

NHS and hospice staff

Barts Health NHS Trust
Cambridge University Hospitals NHS Foundation Trust
Central Manchester Universities Hospitals NHS Foundation Trust
Heart of England NHS Foundation Trust
Nottinghamshire Healthcare NHS Trust
Royal United Hospital Bath NHS Trust
Salford Royal NHS Foundation Trust
South Tees Hospitals NHS Foundation Trust
St Christopher's Hospice

Universities

Brunel
Southampton
Teesside

Expert input outside the Key Partners Group

Julie Bailey
Professor Don Berwick
Catherine Dickson
Paul Hodgkin
Professor Sir Brian Jarman
Dr Ray Johannsen-Chapman
Professor Ron Paterson
Dr Tony Wright
John Carvel
Professor Sir Mike Richards
Sharon Grant

Key Partners Group in the health and care system

Action against Medical Accidents
Care Quality Commission
Foundation Trust Network
General Medical Council
Health Education England
Healthwatch England
Local Government Association
Monitor
National Voices
NHS Confederation
NHS Employers
NHS England
NHS Trust Development Authority
Nursing and Midwifery Council
Patients Association
Parliamentary and Health Service Ombudsman
Professional Standards Authority
Royal College Nursing
Royal College Physicians
Royal College Surgeons

Patient Groups

Action against Medical Accidents
Citizens Advice Bureau
Consumers' Association
National Voices
Patients Association
Patient Opinion

Department of Health Review Team

Annex B:
the evidence

The Review received over 2,500 individual submissions or comments from members of the public, including patients, their families and friends, and former members of staff. Some were hand-written letters, others sent in detailed dossiers on their own experiences, and there were also many hundreds of emails and telephone calls. All were reviewed and assessed and helped to build a picture of people's experiences when things went wrong in hospitals and when they used the complaints system to try to put it right.

The majority of submissions were about people's experiences in hospital: nearly 2,000 in total. This evidence has been invaluable in exploring the underlying reasons why people were unsatisfied and why some of them went on to complain.

A smaller number – around 400 – went on to comment specifically about the complaints system, and of these around 150 made suggestions about how the system itself could be improved. Again, all were reviewed and all those that made substantial comments or suggestions were coded to indicate their areas of interest and concern, to help with our analysis. Further, we selected representative comments from a range of contributions and a number of these are included word-for-word in this report to illustrate and support the analysis and conclusions.

Finally, it is worth noting the significant number of former nurses, doctors and other health professionals who took the trouble to write in to the Review. These contributions were particularly valuable, as there were very few submissions from current members of staff.

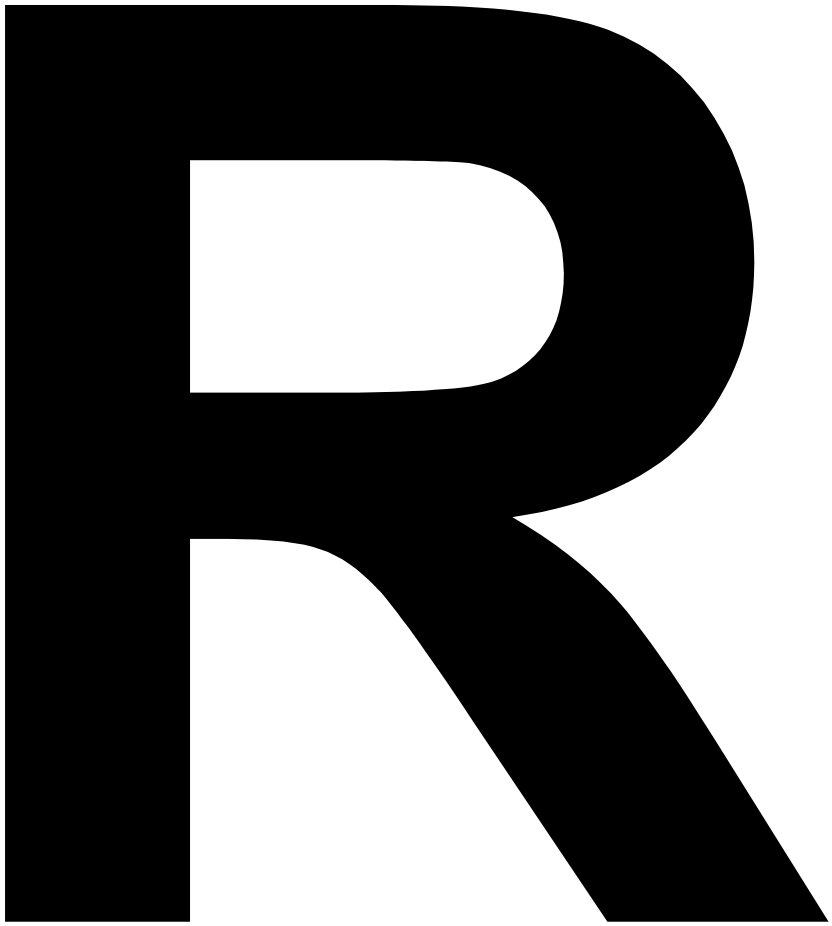
The co-Chairs of the review were supported by a team of eight external members. The members were from a range of backgrounds in the health, private and voluntary sector – all of whom had an interest in improving complaints handling for the benefit of patients and the NHS.

The Review team:

- visited nine hospital trusts across the country and a non NHS organisation in order to meet with staff and discuss their current approach to handling complaints.
- held three regional events in London, Birmingham and Newcastle. During these events, the team heard the views and experiences of voluntary organisations who represented patient groups, with a particular focus on access and support issues.
- held four patient events, during which individual patients who had had personal experiences of using the complaints procedure were invited to provide their views.

- had face to face meetings with eight prominent UK and international individuals all of whom had expertise in complaints handling, use of information or representing patient views.
- Held two workshops, one in May and one in June, with around twenty key partners in the health and care system.

2901299
October 2013
Produced by Williams Lea



University Hospitals of Leicester NHS
NHS Trust

To:	**Trust Board**
From:	**Chief Nurse**
Date:	**28 November 2013**
CQC regulation:	Outcome 16 – Assessing and Monitoring the Quality of Service Provision

Trust Board Paper R

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 31 October 2013.
b) An action tracker to monitor progress of BAF actions
c) A summary diagram of risk movements from the previous month.
d) Suggested parameters for scrutiny of the BAF.
e) 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 no changes to BAF risk scores during the reporting period
- Risk numbers four, five, six and 10 will come under the ownership of the Director of Strategy with immediate effect.
- Actions 12.8, 13.7 and 13.8 are now RAG rated red reflecting significant delays in completion.
- The recent favourable Deanery visit in relation to training of Junior Doctors in ED has been added to the BAF (risk number 13) as evidence of external positive assurance.
- Gaps in controls for risk three in relation to the current nursing vacancies and difficulties in recruitment have been identified along with actions to improve controls.
- Board members are invited to review the following BAF risks.
  Failure to transform the emergency care system (risk owner – COO).
  Inability to recruit, retain, develop and motivate staff (risk owner DHR).
  Ineffective organisational transformation (risk owner DS).
- There have been seven high risks have opened on the UHL risk register during October 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;

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: **28 NOVEMBER 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 Board Assurance Framework (BAF) as of 31 October 2013.
b) An action tracker to monitor progress of BAF actions.
c) A summary diagram of BAF risk score to show any changes in BAF risk scores from the previous month.
d) Parameters for Board scrutiny of the BAF.
e) Notification of any new extreme or high risks opened during the reporting period.

2. BAF POSITION AS OF 31 OCTOBER 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.

2.3 During this reporting period there have been no changes to BAF risk scores as evidenced in appendix three.

2.4 Board members are asked to note that, at the request of the CEO, risk numbers four, five, six and 10 will come under the ownership of the Director of Strategy with immediate effect.

2.5 Actions 12.8, 13.7 and 13.8 are now RAG rated red reflecting significant delays in completion.

2.6 With the agreement of the UHL Executive Team (ET) the recent favourable Deanery visit in relation to training of Junior Doctors in ED has been added to the BAF (risk number 13) as evidence of external positive assurance.

2.7 In relation to risk three, the ET has identified additional gaps in controls and has provided actions to improve the controls relating to the difficulties in recruiting to current nursing vacancies.

2.8 At time of writing the report updates to actions due for completion/review in October 2013 have not been received in respect of action 1.11 The Director of Finance and Business Services is asked to provide the Board with a verbal update of progress for this action.

2.9 To provide an opportunity for more detailed review three BAF risks are presented on a monthly basis for Board members to review against the areas listed in appendix four. These risks will be presented in their numerical sequence and the risks below are presented for review against the parameters outlined in appendix four:

- Failure to transform the emergency care system (risk owner – COO).
- Inability to recruit, retain, develop and motivate staff (risk owner DHR).
- Ineffective organisational transformation (risk owner DS).

3 EXTREME AND HIGH RISK REPORT.

3.1 As described in the UHL Risk Management Policy the Board will receive notification of any extreme/ high risks that have opened during the reporting period. The Board are therefore asked to note that seven new high risks have opened during October 2013 and are listed below. The details of these risks can be found at appendix five.

Risk ID	Risk Title	Risk Score	CMG/Corporate Directorate
2234	There is a medical staffing shortfall resulting in a risk of an understaffed Emergency Department	20	Emergency and Specialist Medicine
2244	Medium-term staffing shortages/ lack of equipment/poor processes in Ophthalmology causing deterioration in service	20	Musculoskeletal and Specialist Surgery
2094	Delayed roll out of outsourced Transcription process , unavailability of skilled workforce and flexible workers	20	Musculoskeletal and Specialist Surgery
2240	The impact of vacancies in Physiotherapy and Occupational Therapy on service delivery	16	Clinical Support and Imaging
2237	Risk of results of outpatient diagnostic tests not being reviewed or acted upon resulting in patient harm	16	Corporate Medical
2247	There are 500 Registered Nurse vacancies across UHL leading to a deterioration in service and adverse effect on financial position	16	Nursing
2239	Impact of closure of the hydrotherapy pool facility at LGH.	15	Clinical Support and 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.

Peter Cleaver,
Risk and Assurance Manager,
20 November 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: OCTOBER 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.	16	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	12	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	12	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	12	12
Risk 10 – Inadequate reconfiguration of buildings and services	a - To provide safe, high quality patient-centred health care	12	9
Risk 11– Loss of business continuity	g - To be a sustainable, high performing NHS Foundation Trust	9	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 OCTOBER 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 (£1m adverse to plan M6)			

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 217wte 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.				
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.		Monthly /weekly financial reporting to Finance and Performance (F&P) Committee and Board.	(c) Failing to manage marginal activity efficiently and effectively.	Ongoing discussions with commissioners about planned re-investment of the MRET deductions. (1.11)		Review Oct 2013 DFBS

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.		

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST – BOARD ASSURANCE FRAMEWORK OCTOBER 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 Nov 2013 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 Nov 2013 CO O

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST – BOARD ASSURANCE FRAMEWORK OCTOBER 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.	4x4=16	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 M6	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 = 91.9% -**	No gaps identified.	No actions required.		
	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).			(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) Consult and implement pay progression policy (3.6) Implementation of Recruitment and Retention Premia for ED staff (3.4)		Jan 2014 DHR Nov 2013 DHR **Nov 2014** **DHR** **Nov 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 55% at M6)	(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 OCTOBER 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	4x3=12	Monthly progress reports to Exec Strategy Board and F&P Committee. Approval of framework and operational arrangements due at Trust Board June 2013. Thereafter 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 Ctte.	None identified	Not applicable	4x3=12	N/A

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST – BOARD ASSURANCE FRAMEWORK OCTOBER 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	4x3=12	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 Business Strategy Support Team 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		Regular reports to TB reflecting progress of 12 month programme	None identified	Not applicable		

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST – BOARD ASSURANCE FRAMEWORK OCTOBER 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		Economic modelling incorporated into the Trust Reconfiguration Strategic Outline Case (SOC) structure and process.	No gaps identified	Not applicable		
			Regular reports to Exec Strategy Board and Trust Board Various inputs from Exec Team to BCT work.	No gaps identified	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)		Nov 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 OCTOBER 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. Anecdotal feedback from partners and soft intelligence indicates that relations with key organisations and individuals are improving under new UHL leadership.			5X2=10	

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST – BOARD ASSURANCE FRAMEWORK OCTOBER 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. Corporate oversight via QPMG, 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. 105).	(a) UHL risk adjusted perinatal mortality rate below regional and national average.	Women's CBU to work with Dr Foster and other trusts to better understand risk adjustment model (8.2).		Jan 2014 MD
	Robust implementation of actions to achieve Quality Commitment (save 1000 extra lives in 3 years).		SHMI remains "within expected" (i.e. 105). Independent analysis of mortality review performed by Public Health. Report of results to go to 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 (67.6% at M6).				
	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 total number of harms recorded in UHL is 122 (i.e. 92.84% harm free) for M6	(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 OCTOBER 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.	4x3=12	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) 81.8% admitted RTT performance (M6). Backlog plans require further development in line with review of demand and capacity in key specialties. (a) No external assurance of recovery plans (c) Capacity issues created by emergency demand causes cancellations of operations.	Further development of backlog plans. RTT revised plans submitted to commissioners 11/9/13 awaiting formal acceptance. (9.8) Outputs from initial capacity and demand review to inform recovery plan development (9.10) Re-configuration of surgical beds to create a 'protected area' for surgical patients or by use of independent sector. (9.2)	4x3=12	Nov 2013 COO Nov 2013 COO Nov 2013 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 OCTOBER 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.	3x4=12		(a) Key measures to demonstrate success of strategy and reporting lines not yet identified.	Key measures for gauging success of strategy to be developed by specialties as part of their 'mini-IBPs' and will be monitored via divisional and directorate boards. (10.1)	3X3=9	Dec 2013 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.		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 FT application.	Ensure success of FT Application (see risk 6 for further detail). (10.2) Secure capital funding. (10.3)		Apr 2015 CEO 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 OCTOBER 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.	3x3=9	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 Nov 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 Nov 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 OCTOBER 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 OCTOBER 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 outocome fromDeanery 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	**October 2013**
Frequency of review:	Monthly
Date of last review:	September 2013

REF	ACTION	SENIOR LEAD	OPS LEAD	COMPLETION DATE	PROGRESS UPDATE	STATUS
1	**Failure to achieve financial sustainability**					
1.6	Re-establishing clinical coding improvement team under John Roberts. Initial action plan in place.	DS	ADI	Review ~~August~~ October 2013	**Complete.** Restructure of coding team completed - site leads and audit role in place.	5
1.11	Ongoing discussions with commissioners about planned re-investment of the MRET deductions.	DFBS		Review October 2013	The previous timescale for completion was optimistic and a revised timescale for completion of discussions and resolution of the issue has been provided.	3
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	On track.	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	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 Nov 2013. Additional 19 IP beds for LPT also in process of being put in place	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 next stage is consultation on the final draft before approval by Executive colleagues. The launch of the strategy is anticipated launch date for the strategy is 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	There has been a programme of Trust wide recruitment campaigns for Registered nurses and HCA's during 2013 which have proved successful, 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 for the first time. 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 and the success will be evaluated. A comprehensive rolling programme of advertising has been proposed for 2014 which will further support the progress already made	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 2013	Presentation of proposal to Executive Strategy Board on 1st October. Comments received and work to finalise a Policy for consultation with staff side underway. Initial staff side comments will be acquired at the JSCNC of 11.11.13. A further progress update will be presented to the ET Strategy Board in December.	3
3.4	Implementation of Recruitment and Retention Premia for ED staff.	DHR	DDHR	~~September~~ ~~October~~ November 2013	**Partial completion**. R and R premia approved by Remuneration Committee and in place for band 5 Nurses. ED Consultants have received communication and further work progressing in terms of job planning. Deadline for completion extended until end of November 13.	3
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 57% (at end of October 2013) First three e-learning packages have been completed:- • Information Governance • Manual Handling (non-patient) Equality and Diversity.	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	4
3.7	Update e-UHL records to ensure accuracy of reporting on a real time basis	DHR		March 2014	Working progress with designing new system and completion of Project Documentation for review by IMT Project Board on 4 November 2013	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
3.8	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**					
5	**Ineffective strategic planning and response to external influences**					
6	**Failure to achieve FT status**					
6.10	Director of Strategy to be Exec lead for BCT. Ad hoc cover to continue until appointment in place.	CEO		October 2013	**Complete.** Director of Strategy appointed.	5

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
6.11	Action plans to be developed to address recommendations from independent reviews.	CEO	DCLA	~~Review July September~~ November 2013	Document sourced from Sandwell and West Birmingham NHS Trust that will serve to complement our existing policy for responding to external recommendations and requirements. The Director of Clinical Quality will now work to merge these two documents and provide a revised UHL policy. Deadline extended to reflect the timeline for this work. Completion date has slipped as policy now needs to take account of organisational restructuring. Deadline extended to November 2013	3
7	**Failure to maintain productive and effective relationships**					
7.2	Extend stakeholder surveys into wider group of stakeholders (e.g.CCGs, LAT, Universities, etc) to complement the 'soft intel'.	DMC		~~September~~ October 2013	**Complete**	5
8	**Failure to achieve and sustain quality standards**					
8.2	Women's CBU to work with Dr Foster and other trusts to better understand risk adjustment model related to the national quality dashboard.	MD		January 2014		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
8.9	Analysis of mortality review by Public Health.	MD		~~September~~ November 2013	**Complete**. Analysis of mortality review by Public Health performed and report outlining results to go to TB in November	5

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
8.10	Implementation of Electronic Patient Record (EPR)	CIO		2015	We are 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
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	On track.	4
9.7	Action plan to resolve Imaging issues to be developed.	COO		~~July~~ ~~August~~ October 2013	**Complete.**. Additional funding secured from commissioners to reduce imaging backlog. Recovery implementation underway and 62 day performance currently on track with trajectory.	5
9.8	Further development of backlog plans. RTT revised plans submitted to commissioners 11/9/13 awaiting formal acceptance.	COO		~~August~~ ~~September~~ End of ~~October~~ November 2013	Formal recovery plan now intended for submission by end November	3
9.9	NHS Intensive Support team will be invited into UHL to review capacity and demand assumptions and provide assurance to recovery plans.	COO		~~September~~ End of October 2013	**Complete.** Initial capacity and demand review completed by IST.	5
9.10	Outputs from IST initial capacity and demand review to inform recovery plan development	COO		~~November 2013~~		4
10	**Inadequate reconfiguration of buildings and services**					

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
10.1	Key measures for gauging success of clinical strategy to be developed by specialties as part of their 'mini-IBPs' and will be monitored via divisional and directorate boards.	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.	3
10.3	Secure capital funding to implement Estates Strategy.	DFBS		~~May 2013~~ December 2013	Work underway on capital planning around reconfiguration – SOC due for completion in Dec '13 / Jan '14 which will be the key vehicle to agree availability of capital funding.	4
11	**Loss of business continuity**					
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	Work with IM&T has been completed. All projects in IM&T that require downtime have to be signed off by the Change Advisory Board. Part of the process is consulting with EPO and HOO. This process will continue as normal through the managed business partnership. Delays are being encountered developing agreed processes with Interserve. Progress will be reviewed during October 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
11.10	Training and Exercising events to involve multiple CBUs/Divisions 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.	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	Draft plan due w/c 4th November	3
11.13	Training and Exercising events to involve multiple CBUs/Divisions to validate plans to ensure consistency and coordination	COO	EPO	August 2014		4
12	**Failure to exploit the potential of IM&T**					
12.8	TDA approvals documentation to be completed	CIO		~~October 2013~~ Review Jan 2014	The current discussion around 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 CBU engagement facilitate meetings to discuss Medical Education Strategy and Action Plans with CBUs.	MD	AMD	December 2013	On track.	4
13.2	Relevance of the UHL Education Committee to be discussed at CBU Meetings in an effort to improve attendance.	MD	AMD	December 2013	On track.	4
13.3	Doctors in Training Committee needs to be established along with terms of reference to ensure more effective communication to Juniors.	MD	AMD	November 2013	**Complete.** Group now established	5

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
13.4	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	On track.	4
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 CBU management meetings and liaise with CBUs in an effort to improve engagement of CBUs.	MD	AMD	December 2013	On track.	4
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	The Odames Ward has been identified and a project groups 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 CBUs to help them understand the implication of SIFT and their funding streams.	MD	AMD	December 2013	On track.	4

Key

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

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
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 four

BAF RISK SCORE MAP – OCTOBER 2013

Likelihood ↓	Consequence				
	1	2	3	4	5
	Insignificant	Minor	Moderate	Major	Extreme
5 Almost Certain					1. Financial sustainability ● 2. Emergency care system ●
4 Likely			10. Reconfiguration of buildings and services ●	3. Recruit, retain, develop and motivate staff ● 6. FT status ● 8. Achieve and sustain quality standards ●	
3 Possible			11. Business continuity ● 12. IM&T ●	4. Organisational transformation ● 13. Education and training culture ● 9. Operational performance ● 5. Strategic planning and response to external influences ●	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 OPERATIONAL RISKS SCORING 15 OR ABOVE FOR THE PERIOD 01/10/13 - 31/10/13

REPORT PRODUCED BY: UHL RISK AND ASSURANCE MANAGER

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 score increased from initial risk score
⮟	Risk score decreased from initial risk score
★	New risk since previous reporting period
⇔	No Change in risk score since previous reporting period

Ref Text Risk with elapsed risk review date and/or elapsed action due date

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
2234	Emergency and Specialist Medicine	ED	There is a medical staffing shortfall resulting in a risk of an understaffed Emergency Department	04/10/2013	04/11/2013	Consultant vacancies, Poor quality care, continued lack of retention. Stress and burnout. Increased incidents and complaints. Inability to do the general work of the department. 4 hour target. Increased sickness. Middle grade vacancies, Poor quality care, reputation. Risk of losing trainees due to incorrect service/training balance. Trainee attrition. Stress, poor morale. Trainees not wanting to apply for consultant positions. Reduced cohesiveness as a trainee group. Risk to four hour target. Increased sickeness Junior grade vacancies, Poorer quality care. 4 hour target. Stress. Juniors defecting to other specialities. Increased sickness. Poorer quality of training resulting in poor deanery reports. Non ED medical consultants, Increased incidents. Serious incidents. Stress. Locums□Financial. Poor quality care. Increased complaints, incidents, claims, serious incidents. Increased consultant workload. Lack of uniformity. Risk to 4 hour target. Paediatric medical staffing□Poorer quality care for paediatric population. Increased number of incidents, complaints and claims. Reduced ability to maintain CPD com	Patients	The chief executive and medical director have met with senior trainees in Leicester ED to invite them to apply for consultant positions. The East Midlands Local Education and training board has recognised middle grade shortages as a workforce issues and has set up several projects aiming to attract and retain emergency medicine trainees and consultants. Advanced nurse practitioners and non-training CT1 grades have been employed in order to backfill the shortage of SHO grade junior doctors. There has been shared teaching sessions in which non ED consultants and ED consultants have shared skills, (i.e. ED consultants learning about collapse in the elderly and elderly medicine consultants doing ALS). The non ED consultants have been set up on a specific mailing list so that new developments and departmental 'mini-teaches' (= learning cases from incidents) can be shared. Only approved locum agencies are used for ED internal locums and their CVs are checked for suitability prior to appointing them. Locums receive a brief shop floor induction on arrival and also must sign Locum doctors are only placed in paeds ED in except The grid paediatric trainees shift pattern has changed ED employs medical registrars to work night shifts in E ED consultants have extended their shop-floor hours t	Extreme	Likely	20	To engage with active recruitment at all levels (Consultant, non-training grades, oversees doctors, advanced nurse practitioners) - No due date listed.	6	BTD

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
2244	Musculoskeletal and Specialist Surgery	Ophthalmology	Medium-term staffing shortages/ lack of equipment/poor processes in Ophthalmology causing deterioration in service	29/10/2013	29/11/2013	**Causes** Admin staffing shortages following a previous MoC exercise. This is exacerbated by a slow recruitment process following successful interview and unavailability of temporary workforce with necessary skill set and access to hospital systems. Poor management processes and inadequate assurance mechanisms. Staffing vacancies in Medical records. Lack of assurance mechanisms. Use of ICE for outpatient letters (taking existing staff approximately 30% longer to type and process). Lack of computers and printers. A-Scanner (biometry) is broken and replacement not yet delivered. Lack of clinical space in OPD. **Consequences** Transcription: There is a considerable typing backlog in the department which is not maintaining a steady state in relation to patient letters. Currently there is a backlog of 14,500 patient letters. These include letters to GPs and interdepartmental referrals. This leads to ineffective communication with GPs and other eye centres and may impact adversely on the patient's underlying condition e.g. GPs may not prescribe new treatments if patients fail to attend or may commence ne Filing: There is a significant backlog in relation to filing of typed lette Referrals Management: Delays to registering and booking of referrals. Potential for patients newly referred not to be seen by clinica Missing referrals. Files of referrals found in drawers. Clinic Management: New patients booked to inappropriate clinics as referrals are Notes not prepared for clinic. Clinic outcomes not entered onto clinic management system Evening clinics not efficient due to inadequate staffing for tes	Quality	Executive Director leadership/ engagement with current issues. Letter to referrers indicating current situation. ICE no longer used and all letters typed using Microsoft 'word'. Additional audio typists recruited supported by agency staffing. Clinic process in place to ensure all clinics are cashed up on the day and outcomes dealt with All referrals to go to consultants for triage before booking. Route for urgent cases made explicit. Clinicians asked to keep outcome sheet on discharged patients for subsequent handover to clerk at the end of a clinic. Continual monitoring and reporting of the backlog of typed letters and filing of typed letters. Transfer of some cataract (x67) / oculoplastics (x87) cases to independent sector. Weekly monitoring of waiting list and RTT position. Two new Fellows recruited for diabetic oedema retinal injections (backlog expected to be cleared by end of October 2013. Nursing staff and A&C staff available until 8pm (however no technicians available) Use of WHO surgical safety checklist in theatres Ongoing monitoring of incidents and complaints data Weekly senior team meeting to ensure controls are ef Agency staff supporting clinic and notes preparation Skilled staff moved to appropriate areas e.g. waiting li	Major	Almost certain	20	Begin monitoring the backlog and ensure real progress in achieving a steady state (9 - 12 weeks to catch-up with backlog and 20 weeks to achieve steady state (i.e. backlog at a maximum of 1000) - 31/3/14. Identify suitable workstations for additional staff and install computers and printers. - 22/10/13. Monitor the progress in reducing the number of typed letters waiting to be filed and agree a point at which the previous process can be reinstated. - 31/3/14. Improve theatre utilisation by the effective management of operating lists and Implement processes to enable theatre list booking up to 6 weeks in advance. - (4 weeks in advance by) 31/10/14 Organise 'clean room' sessions for Mon, Tues and Thurs am. - 15/10/13. Contact Procurement to expedite delivery of A-Scanner and review progress - 22/10/13. Develop clinical pathways (referral to follow-up). 31/12/13. Facilities to provide quotes for enabling works to alleviate lack of clinical space. - 22/10/13. Training of clinic clerks to be reinforced and data quality checking initiated. - 22/10/13. Close liaison with HR team to expedite the recruitmer Development and 'sign-off' of new protocols for indep	9	DTR

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
2094	Musculoskeletal and Specialist Surgery	Ophthalmology	Delayed roll out of outsourced Transcription process , unavailability of skilled workforce and flexible workers	12/10/2012	31/10/2013	**Causes:** -Reduction in secretarial skilled staffing due to previous MoC process -Delays in recruitment process preventing appointment to posts in a timely manner. -Use of DICT8 not delivering anticipated efficiencies. -High turnover of staff on fixed-term contracts that leave when substantive posts become available. -Bank and agencies cannot supply adequate numbers of staff to fill vacancies **Consequences:** -Outcomes missing from system. -Outcome slips filed in incorrect locations. -Patient notes may not contain relevant documentation. -Extensive delays in referral letter process (current backlog of approximately 11000 letters in -Ophthalmology, 3000 letters in ENT, 2000 letters in Breast Care) may lead to: Longer waiting times for treatment. -Increased number of complaints. -Adverse impact on reputation of specialty/Trust. -Insufficient staff to cope in cases of IT system failures. -H&S risk to staff due to numbers of patient notes stored inappropriately increasing the risk of slips, trips, and falls hazards. -Existing staff under increased stress due to increased workl -Additional costs for overtime/ agency staff.	Patients	Stress audits performed Regular team meetings to provide support for A&C staff Staff training Temporary agency staff recruited 2 ops managers Weekly team meetings New Head of Service Outsourcing activity to private sector Significant number of vacancies filled in supporting A+C ENT typing outsourced to DICT8. Ophthalmology using ICE and template letters for referrals. Overtime and additional hours worked by existing staff. Trajectories developed and monitored in relation to addressing backlog. Urgent cases given priority for typing. Time allowed for 'protected typing' whenever possible. Involvement of UHL Health and safety team to help address staff safety issues. Additional racking for notes sourced and installed. ENT commenced using DICTATE IT	Major	Almost certain	20	recruit to vacant service manager post - 31/10/2013 recruit addition medical staffing - 31/10/2013	8	DTR

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
2240	Clinical Support and Imaging	Physiotherapy & Occupational Therapy	The impact of vacancies in Physiotherapy and Occupational Therapy on service delivery	09/10/2013	31/10/2013	**Causes** (hazard) The increase in vacancies has been caused by delays to recruitment via a management of change process, maternity leave, turnover and a protracted Trust recruitment process. **Consequence** (harm / loss event) Impact on patient journey time through the emergency process: deterioration in response time for new patient assessment, increased time for 'therapy complete', potential increase in unsafe discharge (patients not therapy complete), increased LoS, inadequate support to admission avoidance schemes, reduced participation in board / ward rounds / MDTs. Increase in outpatient waiting list numbers and breach of targets. Breach of operational targets due to reduced therapy participation e.g. stroke Quality Indicators. Increase in staff stress and sickness absence. Potential loss of income due to reduction in outpatient staffing and redirection of staff from outpatients to inpatients. Increase in complaints (internal service users and external patients, relatives and carers).	HR	Use of bank staff where possible (but limited numbers). Use of overtime (though staff not keen to take up due to work pressures and annual leave). On going discussions with HR to quicken the recruitment / selection process. Therapy management team chasing references and completing CRB risk assessments where possible. Generic adverts out for Band 5 OT / PT; discussions on going regarding over recruitment plan. On going exploration of more efficient ways of working and workload measurement as part of the therapy pathway review. Specific plans in place in service areas where there are critical staffing issues. 5 locum's agreed for August and September to cover critical vacancies; 4 currently sourced.	Major	Likely	16	On going review of services and concentration of staffing in areas of greatest demand - 31/10/2013 Continuation of existing staff working additional hours / overtime; continued use of bank staff - 30/10/2013 Employ further locum staff; on-going needs assessment - 31/10/2013 Continue to work with HR Shared Services to expedite the recruitment process and get staff in to post - 31/10/2013	6	LCOO

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
2237	Medical Directorate	Medical Directorate	Risk of results of outpatient diagnostic tests not being reviewed or acted upon resulting in patient harm.	07/10/2013	07/11/2013	**Causes** Outpatients use paper based requesting system and results come back on paper and electronically. Results not being reviewed acknowledged on IT results systems due to; Volume of tests Lack of consistent agreed process IT systems too slow and 'lock up' Results reviewed not being acted upon due to; No consistent agreed processes for management of diagnostic test results Actions taken not being documented in medical notes due to; Volume of work and lack of capacity in relation to medical staff Lack of agreed consistent process Referrals for some tests still being made on paper with no method of tracking for receipt of referral, test booked or results. Poor communication process for communicating abnormal results back to referring clinician; Abnormal pathology results- cannot always contact clinician that requested test and paper copies of results not being sent to correct clinicians or being turned off to some areas. Suspicious imaging findings- referred to MDT but not always also communicated back to clinician that referred for test. Lack of standards or meeting standards for diagnostic tests i **Consequences** Potential for mismanagement of patients to include: Severe harm or death to patient Suboptimal treatment Delayed diagnosis Increased potential for incidents, complaints, inquests and cl Risk of adverse publicity to UHL leading to loss of good repu Financial consequences to include: Potential increase in NHSLA contributions Potential increased LOS.	Patients	Abnormal pathology results escalation process Suspicious imaging findings escalated to MDTs	Major	Likely	16	Implementation of Diagnostic testing policy across Trust - to ensure agreed speciality processes for outpatient management of diagnostic tests results. March 14 Development IT work with IBM to improve results system for clinicians and Trust to develop EPR with fit for purpose results management system. - Jan 16	8	BCOL

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
2247	Nursing	Nursing	There are 500 Registered Nurse vacancies across UHL leading to a deterioration in service and adverse effect on financial position	30/10/2013	30/11/2013	**Causes** Shortage of available Registered Nurses in Leicestershire. Nursing establishment review undertaken resulting in significant vacancies due to investment. Insufficient HRSS Capacity leading to delays in recruitment. **Consequences** Potential increased clinical risk in areas Increase in occurrence of pressure damage and patient falls Increase in patient complaints Reduced morale of staff, affecting retention of new starters Risk to Trust reputation Impact on Trust financial position due to premium rate staffing being utilised to maintain safety. Increased vacancies across UHL Increased paybill in terms of cover for establishment rotas prior to permanent appointments HRSS capacity has not increased to coincide and support the increase in vacancies across the Trust Delays in processing of pre employment checks due to increased recruitment activity Delayed start dates for business critical posts Benefits of bulk and other recruitment campaigns not being realised as effectively as anticipated and expected Service areas outside of nursing being impacted upon due to emphasis on nursing roles.	Patients	HRSS structure review. A temporary Band 5 HRSS Team Leader appointed. A Nursing lead identified. Recruitment plan developed with fortnightly meetings to review progress. Vacancy monitoring. Bank/agency utilisation. Shift moves of staff. Ward Manager/Matron return to wards full time.	Major	Likely	16	A team will be formed to manage the complete end to end recruitment processes for all Registered Band 5 Nurses and Midwives and HCA's for all CMG's and specialties - 15/11/13 Shift by shift monitoring of gaps - 30/11/13 Ward Manager/Matron return to wards full time. - TBA Ward dashboards - 30/12/13 Ward performance process - 30/12/13 Over recruit HCAs. - Ongoing Utilise other roles to liberate nursing time - 30/12/13	12	CRIB

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
2239	Clinical Support and Imaging	Physiotherapy	Impact of closure of the hydrotherapy pool facility at LGH.	09/10/2013	31/10/2013	**Causes** (hazard) The LGH hydrotherapy pool was closed on 17th May 2013 by Interserve due to problems with the plant room equipment, drainage and the fabric of the pool and that it did not meet current specifications / standards for use. **Consequence** (harm / loss event) Patients cannot access hydrotherapy treatment whilst the pool is out of action, with the potential for some patients to experience deterioration in their condition. Patients may not also be able to commence treatment when clinically indicated. The therapy service will receive no income from pool hire to external NHS users, self-help groups or private businesses during the pool downtime, resulting in under recovery against plan and financial pressure in the short-term. Prolonged closure may encourage users to source alternate facilities, threatening income long-term. A significant increase in complaints, inquiries etc is anticipated from service users, the media, public representatives etc, particularly in light of the emotive closure of the LRI pool facility previously and the attention attracted by this.	Economic	Where appropriate patients are being asked to attend for land based exercises / treatment until such time as the pool re-opens. All current NHS patients using the facility have been contacted and needs assessed. To note, there is no alternate UHL facility since the closure of the LRI pool three years ago and further, there is no access to an alternate facility within the City or County. All external users have been notified of the closure and advised of the estimated downtime. Two of the self-help groups also run land based exercise sessions for their members and will continue with these until the pool re-opens. The service / CBU management team are working intensively with Horizons FM / Interserve to confirm the required capital works, secure the capital funding and undertake the upgrade to the facility as quickly as possible.	Moderate	Almost certain	15	Work commencement and completion - 3/11/2013 Document weekend policy & meet with private users to discuss and agree - 31/10/2013	4	CSH

Risk ID	CMG	Specialty	Risk Title	Opened	Review Date	Description of Risk	Risk subtype	Controls in place	Likelihood	Impact	Current Risk Score	Action summary	Target Risk Score	Risk Owner

Clinical Management Groups

CMG	Datix Code
Cancer, Haematology, Urology, Gastroenterology and Surgery (CHUGS)	CMG1
Renal, Respiratory and Cardiac (RRC)	CMG2
Emergency and Specialist Medicine	CMG3
Intensive Care, Theatres, Anaesthesia, Pain Management, Sleep (ITAPS)	CMG4
Musculoskeletal and Specialist Surgery	CMG5
Clinical Support and Imaging	CMG6
Women's and Children's	CMG7

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

Old CBUs: GI Med, Surgery, Urology & Cancer, Haematology, Oncology
PLAN2 and PLAN03

Specialty	Datix Code
Clinical Haematology	HAEMC
Gastroenterology	GASTRO
Gastroenterology (Inpatients)	GASIP
General Surgery	GENSUR
Oncology	ONCO
Palliative Care	PALLIA
Radiotherapy	RADT
Urology	UROL
Bowel Cancer Screening	BOWEL

IG1

Renal, Respiratory and Cardiac (RRC) - CMG2

Old CBU: Cardiac, Renal, Respiratory - ACUT03

Specialty	Datix Code
Allergy	ALLERG
Biomedical Research Unit	BIOMED
Cardiac Investigations	CINVST
Cardiac Rehabilitation	CREHAB
Cardiac Surgical Wards	CARSGW
Cardiology	CARDIO
Cardiovascular	CAVASC
Clinical Decisions Unit	CDU
Clinical Immunology	CLIMMU
Coronary Care Unit	CORCAR
Discharge Lounge (GH)	DISCGH
Nephrology	NEPHRO
Renal Transplant	RENTRA
Respiratory Medicine	RM
Satellite Units	SATEL
Thoracic Surgery	TSURG

Emergency and Specialist Medicine - CMG3

Old CBUs: Emergency Care & Specialty Medicine - ACUT01 and ACUT02

Specialty	Datix Code
Dermatology	DERMAT
Discharge lounge (LRI)	DISCHL
Emergency Department	ED
Infectious Diseases	INFECT
Medicine for the Elderly	ELDER
Metabolic Medicine	METBOL
Neurology	NEUROL
Rapid Assessment Unit (Ward 15, LRI)	RAU
Rheumatology	RHEUM
Short Stay Unit (Ward 16, LRI)	SSU
Stroke Services	STRKSV

Intensive Care, Theatres, Anaesthesia, Pain Management, Sleep (ITAPS) - CMG4

Old CBU: ITAPS - PLAN05

Specialty	Datix Code
Anaesthesia	ANAE
Critical Care	CRITCR
Daycase Surgery	DCSURG
ECMO - Adult	ECMO
Pain Management - Acute	PAINAC
Pain Management - Chronic	PAINCH
Recovery	RECOV
Sleep Disorders	SLEEP
Sterile Services	STSERV
Theatres	THETRS

Musculoskeletal and Specialist Surgery - CMG5

Old CBUs: Specialist Surgery & Musculoskeletal - PLAN01 AND PLAN04

Specialty	Datix Code
Breast Surgery	BRESUR
Elective Orthopaedics	ELORTH
Maxillofacial	MAXFAX
Ophthalmology	OPHTHA
Orthodontics & Restorative Denistry	ODONT
Otorhinolaryngology/ENT	ENT
Plastic Surgery	PLAS
Retinal Screening	RETINA
Sports Medicine	SPORT
Trauma Orthopaedics	TRORTH
Vascular Services	VASC

Clinical Support and Imaging - CMG6

Old CBUs: Imaging and Med Physics & Professional Services & Pathology
ACUT05, ACUT06 and PATH (from Corporate Div.)

Specialty	Datix Code
Breast	BREAST
Cardiovascular Procedures	CARVAS
Cross Sectional Imaging (CT/MRI)	CTMRI
Medical Physics	MEDPHY
Plain Films	PLAIN
Radioisotopes	RADIO
Screening Procedures	SCREEN
Ultrasound	ULTRA
Booking Centre	BOOK
Dietetics	DIET
LL Pharmacy	LLPHAR
Medical Records	MEDREC
Nutrition Nurses	NUTRIT
Occupational Therapy	OCCT
Orthotics	ORTHOT
Outpatients	OUTPAT
Pharmacy Home Care	PHARHO
Pharmacy	PHARM
Pharmacy - Anaesthetics	PHARM01
Pharmacy - Lloyds	PHARLL
Pharmacy - Cancer Services	PHARM02
Pharmacy - Cardiorespiratory	PHARM03
Pharmacy - Children's	PHARM04
Pharmacy - Medicine & ED	PHARM05
Pharmacy - Musculoskeletal	PHARM06
Pharmacy - Renal	PHARM07
Pharmacy - Surgical Services	PHARM08
Pharmacy - Women's	PHARM09
Phlebotomy	PHLEB
Physiotherapy	PHYS
Podiatry	POD
Psychology	PSCH
Speech and Language Therapy	SPEE
Old Pathology CBU. Was in Corporate Division	
Blood Transfusion	BLOOD
Clinical Microbiology	CLMICR
Cytogenetics	CYTOGE
Blood Sciences	FAST
General Pathology	GPATH
Cellular Pathology	HIST
Immunology	IMMUNO
IT Services	IT
Logistics and Stores	LOGIST
Special Biochemistry	SPBIO
Special Haematology	SPHAEM
Stem Cell	STEM

Women's and Children's - CMG7

Old CBUs: Women's & Children's - WOCH01 and WOCH02

Specialty	Datix Code
Clinical Genetics	CLIGEN
Family Planning	FAMILY
GU Medicine	GUMED
Gynaecology	GY
Maternity	MATERN
Neonatology	NEONAT
Paediatrics	PAED
Paediatrics (Cardiorespiratory)	CARPAE