UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST

TRUST BOARD

MEETING TO BE HELD ON THURSDAY 31 JULY 2014 FROM 9.45AM IN GLOUCESTER HOUSE. AGE UK, MELTON MOWBRAY, LE13 1JE

Public meeting commences at 12.15pm

AGENDA

Please take papers as read and note the venue for this meeting

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 1-14).			-
2.	**APOLOGIES AND WELCOME** To receive apologies for absence, including Ms J Wilson, Non-Executive Director. To welcome Mr S Sheppard, Acting Director of Finance.	-	**Acting Chairman**	-
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**	
5.	**CONFIDENTIAL MINUTES** Confidential Minutes of the 26 June 2014 Trust Board meetings. *For approval*	**A**	**Acting Chairman**	9.45 – 9.46am
6.	**MATTERS ARISING** Confidential action log from the 26 June 2014 Trust Board. *For approval*	**B**	**Acting Chairman**	9.46 – 9.55am
7.	**REPORT BY THE DIRECTOR OF STRATEGY**	**presentation**	**Director of Strategy**	9.55 – 10.20am
8.	**REPORT BY THE ACTING DIRECTOR OF FINANCE** *Commercial interests*	**C**	**Acting Director of Finance**	10.20 – 10.35am
9.	**REPORTS BY THE CHIEF NURSE** *commercial interests, personal data and prejudicial to the conduct of public affairs*	**D & E**	**Chief Nurse**	10.35 – 10.50am
10.	**JOINT REPORT BY THE ACTING CHAIRMAN & THE DIRECTOR OF CORPORATE AND LEGAL AFFAIRS**	**F**	**Acting Chairman/ Director of Corporate and**	10.50 – 11am

	Prejudicial to the conduct of public affairs		**Legal Affairs**	
11.	**REPORT BY THE DIRECTOR OF CORPORATE AND LEGAL AFFAIRS** *personal data*	**G**	**Director of Corporate and Legal Affairs**	11 – 11.05am
12.	**REPORTS FROM BOARD COMMITTEES**			11.05 – 11.10am
12.1	**FINANCE AND PERFORMANCE COMMITTEE** Confidential Minutes of the 25 June 2014 meeting for noting and endorsement of any recommendations. *Prejudicial to the conduct of public affairs*	**H**	**Finance and Performance Committee Chair**	
12.2	**QUALITY ASSURANCE COMMITTEE** Confidential Minutes of the 25 June 2014 meeting for noting and endorsement of any recommendations. *Prejudicial to the conduct of public affairs*	**I**	**QAC Non-Executive Director**	
12.3	**REMUNERATION COMMITTEE** Confidential Minutes of the 26 June 2014 meeting for noting and endorsement of any recommendations. *Prejudicial to the conduct of public affairs*	**J**	**Acting Chairman**	
13.	**CORPORATE TRUSTEE BUSINESS**			
13.1	**CHARITABLE FUNDS COMMITTEE** Confidential Minutes of the inquorate 9 June 2014 meeting for endorsement of any recommendations. *Prejudicial to the conduct of public affairs*	**K**	**Charitable Funds Committee Chair**	11.10 – 11.12am
14.	**ANY OTHER BUSINESS**	**-**	**Acting Chairman**	11.12 – 11.15am
11.15am – 12.15pm break for meeting with Age UK representatives				
15.	**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.			
16.	**ACTING CHAIRMAN'S OPENING COMMENTS**	**-**	**Acting Chairman**	
17.	**MINUTES**			
	Minutes of the 26 June 2014 Trust Board meeting. *For approval*	**L**	**Acting Chairman**	12.15 – 12.16pm
18.	**MATTERS ARISING**			12.16 – 12.25pm
	Action log from the 26 June 2014 meeting. *For approval*	**M**	**Acting Chairman**	
19.	**REPORT BY THE CHIEF EXECUTIVE**			
19.1	**MONTHLY UPDATE REPORT – JULY 2014** *For discussion and assurance*	**N**	**Chief Executive**	12.25 – 12.30pm

20.	**CLINICAL QUALITY AND SAFETY**			
20.1	**"LEARNING LESSONS TO IMPROVE CARE" REPORT** *For assurance*	**O (to follow)**	**Medical Director**	12.30 – 1pm
20.2	**MEDICAL REVALIDATION/APPRAISAL ANNUAL REPORT** *for assurance*	**P**	**Medical Director**	1 – 1.10pm
20.3	**HEALTH AND SAFETY ANNUAL REPORT** *for approval*	**Q**	**Chief Nurse**	1.10 – 1.15pm
20.4	**"SIGN UP TO SAFETY"** *for assurance*	**Additional paper 1**	**Chief Nurse**	1.15 – 1.25pm
21.	**STRATEGY, FORWARD PLANNING AND RISK**			
21.1	**VASCULAR SERVICES OUTLINE BUSINESS CASE** *For approval*	**R**	**Director of Strategy**	1.25 – 1.40pm
21.2	**CAPITAL FUNDING FOR REPROVISION OF CLINICAL SPACE** *For approval*	**S**	**Director of Strategy**	1.40 - 1.50pm
21.3	**MANAGED PRINT – LRI BUSINESS CASE** *For approval*	**T**	**Chief Executive**	1.50 – 2pm
21.4	**ORTHOPAEDIC TRAUMA CMF IMPLANTS AND ASSOCIATED PRODUCTS FRAMEWORK** *for approval*	**U**	**Acting Director of Finance**	2 – 2.10pm
21.5	**(DRAFT) STRATEGIC FORWARD BUSINESS PLANNING PROGRAMME FOR TRUST BOARD** *for discussion*	**V**	**Director of Strategy**	2.10 – 2.20pm
21.6	**MEDICAL WORKFORCE STRATEGY** *for approval*	**W**	**Director of Human Resources**	2.20 – 2.30pm
21.7	**RISK MANAGEMENT POLICY** *for approval*	**X**	**Chief Nurse**	2.30 – 2.35pm
21.8	**BOARD ASSURANCE FRAMEWORK** *For discussion and assurance*	**Y**	**Chief Nurse**	2.35 – 2.45pm
22.	**QUALITY AND PERFORMANCE** *For assurance*			
22.1	**MONTH 3 QUALITY, FINANCE AND PERFORMANCE REPORT** *For assurance* ***The Trust Board is invited to identify key issues for discussion at the meeting, noting the overall structure of this item as follows:-*** **Quality** (a) The **Non-Executive Director Chair** of the **Quality Assurance Committee** will be invited to comment verbally on the month 3 position, as considered at the meeting held on 30 July 2014 (the Minutes of which will be presented to the 28 August 2014 Trust Board); (b) **Lead Executive Directors** will then be invited to comment **by exception** on their respective sections of the month 3 report, specifically:- • **Chief Nurse** – patient safety and quality, quality commitment, patient experience;	**Z**	**QAC Non-Executive Director** **Chief Nurse**	2.45 – 3.05pm

	• **Medical Director** – mortality rates; **<u>Finance and Performance</u>** (c) **Acting Trust Chairman** to comment verbally on the month 3 position, as considered at the **Finance and Performance Committee** meeting held on 30 July 2014 (the Minutes of which will be presented to the 28 August 2014 Trust Board). (d) **Lead Executive Directors** will then be invited to comment **by exception** on their respective sections of the month 3 report, specifically:- • **Chief Operating Officer** – operational performance and exception reports; • **Director of Human Resources** – staff appraisal, sickness absence and statutory and mandatory training compliance; • **Chief Executive** – information management and technology performance, and • **Chief Nurse** – facilities management.		**Medical Director** **Acting Trust Chairman** **Chief Operating Officer** **Director of Human Resources** **Chief Executive** **Chief Nurse**	
22.2	**2014-15 MONTH 3 FINANCIAL POSITION** *For assurance*	**AA**	**Acting Director of Finance**	3.05 – 3.15pm
22.3	**EMERGENCY CARE PERFORMANCE AND RECOVERY PLAN** *For discussion and assurance*	**BB**	**Chief Operating Officer**	3.15 – 3.25pm
23.	**GOVERNANCE**			
23.1	**NHS TRUST OVER-SIGHT SELF CERTIFICATION** *For discussion and approval*	**CC**	**Director of Corporate and Legal Affairs**	3.25 – 3.30pm
23.2	**BOARD EFFECTIVENESS REVIEW – PROPOSED CHANGES** *for discussion and approval*	**DD**	**Acting Trust Chairman and Director of Corporate and Legal Affairs**	3.30 – 3.45pm
23.3	**UHL ANNUAL REPORT 2013-14** *For discussion and approval*	**EE**	**Director of Marketing and Communications**	3.45 – 3.50pm
24.	**REPORTS FROM BOARD COMMITTEES**			3.50 – 3.55pm
24.1	**FINANCE AND PERFORMANCE COMMITTEE** Minutes of the 28 May 2014 meeting for noting and endorsement of any recommendations.	**FF**	**Acting Chairman**	
24.2	**QUALITY ASSURANCE COMMITTEE** Minutes of the 28 May 2014 meeting for noting and endorsement of any recommendations.	**GG**	**QAC Non-Executive Director**	
25.	**TRUST BOARD BULLETIN – JULY 2014**	**HH**	**-**	-
26.	**CORPORATE TRUSTEE BUSINESS**			
26.1	**CHARITABLE FUNDS COMMITTEE** Minutes of the 9 June 2014 inquorate meeting for noting and endorsement of any recommendations.	**II**	**Charitable Funds Committee Chair**	3.55 – 3.57pm

27.	**QUESTIONS FROM THE PUBLIC RELATING TO BUSINESS TRANSACTED AT THIS MEETING**		**Acting Chairman**	3.57 – 4.12pm
28.	**ANY OTHER BUSINESS**		**Acting Chairman**	4.12 – 4.15pm
29.	**CHAIR'S BULLETIN** *for discussion and agreement* Trust Board to be invited to identify and agree the key messages for onward communication to UHL staff after this Board meeting.	**verbal**	**Acting Chairman**	4.15 – 4.25pm
30.	**DATE OF NEXT MEETING**			
	The next Trust Board meeting will be held on **Thursday 28 August 2014** from **10am** in **seminar rooms A & B, Clinical Education Centre, Leicester General Hospital.**	**-**		

Helen Stokes
Senior Trust Administrator

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST

MINUTES OF A MEETING OF THE TRUST BOARD, HELD ON THURSDAY 26 JUNE 2014 AT 10AM IN THE C J BOND ROOM, CLINICAL EDUCATION CENTRE, LEICESTER ROYAL INFIRMARY

Present:
Mr R Kilner – Acting Trust Chairman
Mr J Adler – Chief Executive (excluding Minutes 180/14/3 – 182/14/2)
Col. (Ret'd) I Crowe – Non-Executive Director
Dr S Dauncey – Non-Executive Director
Dr K Harris – Medical Director
Ms K Jenkins – Non-Executive Director
Mr R Mitchell – Chief Operating Officer
Ms R Overfield – Chief Nurse
Mr P Panchal – Non-Executive Director (from Minute 182/14/2)
Professor D Wynford-Thomas – Non-Executive Director

In attendance:
Dr T Bentley – Leicester City CCG (from Minute 175/14)
Ms K Bradley – Director of Human Resources
Miss A Chapman – Student Nurse (for Minute 181/14/1)
Ms K Dickens – Learning Disability Acute Liaison Lead Nurse Practitioner (for Minute 181/14/1)
Mr D Henson – LLR Healthwatch Representative (designate) (from Minute 175/14)
Mr P Hollinshead – Interim Director of Financial Strategy
Ms H Leatham – Head of Nursing, Patient Experience Sister (for Minute 181/141/)
Mr S Sheppard – Deputy Director of Finance
Ms K Shields – Director of Strategy
Ms H Stokes – Senior Trust Administrator
Dr I Sturgess – Interim Consultant (for Minute 183/14/3)
Mr S Ward – Director of Corporate and Legal Affairs
Mr M Wightman – Director of Marketing and Communications (from Minute 172/14)

ACTION

163/14 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 164/14 – 174/14), having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest.

164/14 APOLOGIES

Apologies for absence were received from Ms J Wilson, Non-Executive Director.

165/14 DECLARATIONS OF INTERESTS IN THE CONFIDENTIAL BUSINESS

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

166/14 ACTING CHAIRMAN'S AND CHIEF EXECUTIVE'S OPENING COMMENTS

There were no confidential opening comments from either the Acting Trust Chairman or the Chief Executive.

Resolved – that the position be noted.

167/14 CONFIDENTIAL MINUTES

Resolved – that the confidential Minutes of 29 May and 16 June 2014 be confirmed as a correct record and signed accordingly by the Acting Trust Chairman. **CHAIR**

168/14 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.

169/14 REPORTS BY THE DIRECTOR OF HUMAN RESOURCES

Resolved – that this Minute be classed as confidential and taken in private accordingly, on the grounds of commercial interests.

170/14 REPORT BY THE CHIEF NURSE

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.

171/14 REPORTS BY THE INTERIM DIRECTOR OF FINANCIAL STRATEGY

Resolved – that this Minute be classed as confidential and taken in private accordingly, on the grounds of commercial interests.

172/14 REPORT BY THE ACTING CHAIRMAN

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.

173/14 REPORTS FROM BOARD COMMITTEES

173/14/1 Audit Committee

The Audit Committee Chair (Ms K Jenkins Non-Executive Director) advised that all appropriate issues from the 27 May 2014 Audit Committee had been raised at the 28 May 2014 Trust Board. In response to a query from the Acting Trust Chairman, she considered that a further Audit Committee meeting was required before September 2014, noting that the original date of 5 July 2014 was not now suitable. **STA**

Resolved – that (A) the confidential Minutes of the 27 May 2014 Audit Committee be received and the recommendations and decisions therein be endorsed and noted respectively, and

(B) the inquorate July 2014 Audit Committee date be rescheduled before the Committee's next formal meeting in September 2014. **STA**

173/14/2 Quality Assurance Committee

Resolved – that this Minute be classed as confidential and taken in private accordingly, on the grounds of personal information.

174/14 CORPORATE TRUSTEE BUSINESS

174/14/1 Charitable Funds Committee

Resolved – that this item 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.

175/14 DECLARATIONS OF INTERESTS IN THE PUBLIC BUSINESS

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

176/14 ACTING CHAIRMAN'S OPENING COMMENTS

The Acting Chairman drew members' attention to the following issues:-

(a) his thanks to Mr E Charlesworth for his previous work as the Healthwatch representative on the Trust Board. Members noted the significant contribution made by Mr Charlesworth, particularly to the paediatric congenital heart review. Mr D Henson was the new LLR Healthwatch representative on the UHL Trust Board and would attend formally from July 2014 (attending today in an observer capacity);
(b) the appointment of Mr P Traynor as the new UHL Director of Finance from Autumn 2014. Mr P Hollinshead, Interim Director of Financial Strategy would continue in post until mid-July 2014 supported by Mr S Sheppard, Deputy Director of Finance. This was therefore the last UHL Trust Board for Mr Hollinshead, and the Acting Trust Chairman thanked him for his contribution since January 2014, and
(c) that this was also the final Trust Board meeting for Ms K Jenkins Non-Executive Director. The Acting Trust Chairman thanked Ms Jenkins for her significant contribution to UHL since her 2010 appointment and wished her well for the future.

Resolved – that the position be noted.

177/14 MINUTES

Resolved – that the Minutes of the 29 May 2014 Trust Board be confirmed as a correct record.

178/14 MATTERS ARISING FROM THE MINUTES

Paper L 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 1** (Minute 141/14 of 29 May 2014) – following an enquiry by UHL, no change was planned to the Birmingham venue for the UHL Chairman interviews;
(b) **items 3 and 3a** (Minute 145/14/3 of 29 May 2014) – issues relating to the Oldest Old Strategy were now being actioned through the Frail Older People's Strategy Board, and could therefore be removed from the action log; **STA**
(c) **item 6** (Minute 145/14/5 of 29 May 2014) – discussion of the new format Board Assurance Framework would now take place at the 17 July 2014 Trust Board development session;
(d) **item 14** (Minute 117/14/1(b) of 24 April 2014 – members were reminded of the agreement to move the issue of 'providing further information to the Audit Committee Chair re: the Quality Schedule and CQUIN indicators' to the Audit Committee matters arising log and delete it from this Trust Board report, and **STA**
(e) **item 16** (Minute 90/14/1 of 27 March 2014) – the timetable of Trust Board-required approvals for individual capital schemes would be part of the overall development of a plan on strategic timescales, with a draft accordingly to the July 2014 Finance and Performance Committee. **IDFS**

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

179/14 REPORT BY THE CHIEF EXECUTIVE – MONTHLY UPDATE REPORT (JUNE 2014)

The Chief Executive advised that most of the key issues within his monthly report at paper M were covered on the Trust Board agenda, particularly the Trust's financial position and emergency care performance. Many patients had been present at the congenital heart disease review visit of 30 May 2014, and the Chief Executive noted that UHL's vision for the future on this issue included working collaboratively with Birmingham on a heart of England network. The finalisation of national standards had now been delayed until September 2014, however. Paper M also noted the national requirement for all healthcare economies to develop system operational resilience plans by July 2014.

Resolved – that the Chief Executive's June 2014 monthly update be noted.

180/14 STRATEGY, FORWARD PLANNING AND RISK

180/14/1 LLR Health and Social Care 5-Year Strategy Directional Plan for the Better Care Together Programme

The Director of Strategy tabled the (draft) LLR 5-year health and social care strategy directional plan (Better Care Together – paper N, together with a 'frequently asked questions' [FAQ] document), which progressed (and enhanced) existing partnership working between LLR organisations and set out both the rationale for change and the intended direction of travel. The strategy outlined the organisational inputs for each of the key models of care, noting a focus both on frail and older people and also on planned care (particularly involving patients in their care decisions). Noting the key decisions needed on where care was delivered, the strategy also looked at estates plans.

The UHL and the LLR 5-year plans were now aligned, and the plans presented the best use of public money to obtain the best possible health and social care outcomes. A summary of UHL's 5-year plan would be discussed in Minute 180/14/2 below. In discussion on the LLR 5-year health and social care plan, the Trust Board:-

(a) noted comments from Dr A Bentley, CCG representative, on primary care's keenness to be involved, and on the crucial need for appropriate IT to underpin the strategy;
(b) recognised that implementation of the strategy was key, and would require some very detailed work. Although noting that external support might be continued in the short-term, the Chief Executive emphasised the role of the people running the service on the ground in delivering the strategy. He also noted the crucial need for continued strong clinical engagement;
(c) queried how the LLR financial challenge compared to that of other similarly positioned healthcare economies, and sought assurance on whether the actions within the strategy would deliver that financial requirement;
(d) commented on the need to develop healthcare economy wide KPIs, rather than on an organisational level;
(e) queried whether any Non-Executive Director involvement was planned for the Better Care Together Programme Board. The Chief Executive advised that governance structures were currently being reviewed, and
(f) noted that the plan presented today was in draft form, with the finalised version due by the end of September 2014 when it would be re-presented to all organisations' Boards.

Resolved – that (A) the draft LLR 5-year health and social care strategy (Better Care Together) be received and noted, and

(B) the finalised version of the LLR 5-year health and social care plan be presented to the Sept 2014 Trust Board. **DS**

180/14/2 (Draft) UHL 5-Year Plan

The Director of Strategy then also tabled an executive summary of UHL's own draft 5-year plan (paper O), which had itself been drafted in the context of the wider LLR 5-year plan above. UHL's plan was strongly shaped by its clinical strategy, which had itself been developed through intensive clinical engagement on the required clinical adjacencies and co-dependencies. The Director of Strategy noted the likelihood that services would become smaller and more specialised, with an accompanying reduction in infrastructure costs. The Director of Strategy also outlined the 2-stage approach to UHL's 5-year plan, involving an initial continued focus on internal efficiency and productivity and certain key developments such as the new emergency floor, the transfer of vascular services to the Glenfield Hospital and cardiovascular co-location to consolidate specialised services. This would then be followed in years 3-5 by more detailed implementation of the clinical strategy, recognising both the significant capital required and the ambitious timescales.

In discussion on UHL's 5-year plan, the Trust Board:-

(a) noted that (as with the LLR 5-year plan) it was currently in draft, with the finalised version to be presented to the September 2014 Trust Board for approval; **DS**
(b) noted comments from Dr A Bentley, CCG representative, welcoming UHL's restated commitment to partnership working and clinical engagement. He considered that UHL's plan looked both sensible and sustainable, and would enhance patient care;
(c) queried the (eg top 3) risks to delivery of the plan. In response, the Director of Strategy noted risks arising from the both the plan's ambitious aims and its draft nature (eg potential to change). The Chief Executive also noted the key need to identify ways to resource both the transitional and transformational change required by the UHL and LLR plans, which were likely to be significant given the scale of the programme;
(d) sought assurance that the evidence base supported a move to smaller and more specialised services, in terms of the business share available to UHL. The ability to contain service costs was also queried. The Director of Strategy considered that market opportunities did exist and she noted UHL's almost unique position of specialising in virtually the full range of services. She was confident that UHL could attract further work, and she noted existing partnership arrangements with other hospitals;
(e) received assurance that R&D featured appropriately in the plans, including its ability to drive new markets, and
(f) noted that the detailed Delivering Caring at its Best update being provided to the October 2014 Trust Board would also cover the monitoring of progress against the UHL 5-year plan. **DS/CE**

<u>Resolved</u> – that (A) the draft UHL 5-year plan (executive summary) be endorsed;

(B) the finalised UHL 5-year plan be presented to the September 2014 Trust Board for approval, and **DS**

(C) monitoring of progress against UHL's 5-year plan be included in the detailed Caring at its Best update to the October 2014 Trust Board. **CE/DS**

180/14/3 LRI Theatres Recovery Area Business Case

Additional paper 1 from the Director of Strategy sought Trust Board approval for a capital spend of £3,675,300 (phased over 2 years) to proceed with the second phase of the LRI theatres improvement programme, as described in the Full Business Case. In discussion, the Trust Board:-

(a) queried whether the preferred option as per additional paper 1 would provide a single staff rest area, or continue with separate rest areas for different professional groups – the Director of Strategy agreed to confirm this outside the meeting, and
(b) sought (and received) assurance that the spend was included within the Trust's 2014-15 capital plan.

Resolved – that (A) Trust Board approval be given to the capital spend of £3,675,300 (phased over 2 years), to proceed with the second stage of the LRI theatres improvement programme, and

(B) confirmation be provided to Trust Board members outside the meeting on whether the preferred option would result in a single staff rest area. **DS**

180/14/4 Board Assurance Framework (BAF) – Update

The Chief Nurse presented the latest iteration of UHL's BAF (paper P), noting continuing work to develop a new format for the report. With regard to **risk 9** (*failure to achieve and maintain high standards of operational performance*), members noted the need to amend the bed numbers to match those in paper V1 (Minute 183/14/1 below refers). In respect of the 3 risks selected for detailed consideration, the Trust Board noted the following information:- **COO**

- **risk 1** (*failure to achieve financial sustainability)* – it was agreed to include a date for producing the UHL service and financial strategy, and to review the risk score further in July 2014 (retaining the current 5x5 risk rating in the meantime). The Interim Director of Financial Strategy advised that the contract element of this risk should now be green, as UHL expected to sign the 2014-15 contract by the end of the week; **DS IDFS**
- **risk 12** *(failure to exploit the potential of IM&T)* – the EDRM pilots in clinical genetics and musculo-skeletal services were progressing well, and
- **risk 13** *(failure to enhance medical education and training culture)* – this issue was covered further in Minute 182/14/1 below. The main risk remained the quality of the education facilities across UHL (particularly at the LRI). Professor D Wynford-Thomas, Non-Executive Director noted the need to separate out post-graduate from under-graduate issues within this risk entry. **MD**

In further discussion on the narrative report accompanying the BAF itself, the Trust Board considered the 3 new high risks opened during May 2014. It was agreed to review the renal transplant risk score following the review team's return visit, and to retain the current risk score attributed to the homecare medicines issue. **MD**

Resolved – that (A) the bed numbers within risk 9 be amended to match those within the additional capacity report at Trust Board paper V1; **COO**

(B) risk 1:-

- **be amended to included a date for producing the UHL service and financial strategy;** **DS**
- **have its risk rating reviewed further in July 2014 (retaining the 5x5 rating in the meantime).** **IDFS**

(C) risk 13 be reviewed to differentiate between 'postgraduate' and 'undergraduate' education and training issues (where necessary), and **MD**

(D) the risk rating for the new high risk re: renal transplant be reviewed following the review team's return visit to UHL. **MD**

181/14 CLINICAL QUALITY AND SAFETY

181/14/1 Patient Experience – Carer Story Relating to Learning Disabilities

Ms K Dickens, Learning Disability Acute Liaison Lead Nurse Practitioner, presented a carer story relating to the impact of transition from paediatric to adult care for a patient with a learning disability (paper Q). She briefly outlined the patient's history (which included both profound learning and physical disabilities) and explained how a lack of integrated transition from paediatric to adult care had left the patient's mother feeling isolated and anxious. Ms Dickens also outlined the various training and awareness-raising aids available within the Trust for staff when treating patients with learning disabilities (links to which were included in paper Q). The Chief Nurse added that the experience of transferring from children's to adult services outlined in paper Q was not unique to patients with learning disabilities – improving this process was a recognised priority within the Trust and was being led clinically by Dr H Gleeson, Consultant Physician and Endocrinologist. In discussion on the carer story at paper Q, the Trust Board:-

(a) agreed that it would be helpful for the Executive Quality Board and the Quality Assurance Committee to receive further updates on the work of the learning disability service as part of their annual work programme; **CN**

(b) noted that learning disability was one of the key models of care within the LLR and UHL 5-year plans. The Director of Human Resources outlined the background to the creation of UHL's learning disability service, whose work would also be featured in the Trust Equalities Report coming to the August 2014 Trust Board;

(c) welcomed the flexible way of working adopted by the ward in question to accommodate the patient's and carer's needs;

(d) noted (in response to a Non-Executive Director query) the learning disability service's desire to raise its profile and thus improve awareness of learning disability issues across UHL. A crucial priority was also to be able to provide appropriate facilities for patients with a learning disability, including removing current obstacles to the patients bringing in their own personal equipment – this particular issue would be progressed outside the meeting; **CN**

(e) agreed that the burden of negotiating the clinical care system should not be on the patient/carer;

(f) noted a query from Dr A Bentley, CCG representative, on how relationships between UHL's learning disability service and GP practice nurses could be strengthened. He suggested that the UHL service should attend the monthly practice nursing forum in Leicester City and agreed to provide contact details accordingly, and **ABCCG rep**

(g) queried whether learning disabilities were flagged on patients' medical records. The Learning Disability Acute Liaison Lead Nurse Practitioner outlined the various ways in which her team was made aware of learning disabilities patients within UHL so that they could offer assistance where required.

<u>Resolved</u> – that (A) EQB/QAC receive further updates on the work of the learning disability service as part of their annual work programme; **CN**

(B) the current barriers to learning disability patients bringing in their own personal equipment to hospital, be explored outside the meeting with a view to overcoming them, and **CN**

(C) Dr A Bentley, CCG representative, contact Ms H Leatham, Head of Nursing, to discuss strengthening relationships with GP practice nurses (including attendance at the monthly Leicester City nursing practice forum). **AB CCG rep**

181/14/2 UHL Quality Account 2013-14 and Statement of Directors' Responsibilities

Paper R presented the 2013-14 UHL Quality Account (and statement of Directors' responsibilities) for approval by the Trust Board. As the Quality Account had been developed in line with the Department of Health toolkit, its content and manner of publication were therefore mandatory. The Quality Account had been endorsed at the 26 June 2014 QAC meeting, and the external auditors' opinion was appended to paper R. The Chief Nurse advised that the external audit opinion had been unable to confirm full assurance on VTE data and the Friends and Family Test scores – this was due to UHL having included some patients in the VTE data who did not need to be included (thus reporting a worse position than was actually the case), and (ii) not all FFT surveys being available. The Chief Nurse did not consider that either issue was a cause for significant concern. The Trust Board approved the 2013-14 Quality Account (and statement of Directors' responsibilities) as presented, and congratulated UHL's quality team on its production. The Quality Account would now be uploaded on the NHS Choices website by 30 June 2014 as required. **CN**

Resolved – that (A) the 2013-14 Quality Account and statement of Directors' responsibilities be approved as presented and loaded on to the NHS Choices website by 30 June 2014, and **CN**

(B) the Trust Board's congratulations be passed to the Quality Team. **CN**

182/14 STAFFING, EDUCATION AND TRAINING

182/14/1 Medical Education Quarterly Report

Paper S from Professor S Carr, Director of Medical Education and Associate Medical Director (Clinical Education) presented the quarterly update on medical education issues within UHL. The standard of education and training facilities at the LRI site remained the major issue. In discussion on the report, the Acting Trust Chairman voiced concern that medical education leads were not yet in place for all CMGs – in response, the Medical Director clarified that all leads had been identified however some were proving easier to engage with than others. It was agreed to list the CMG leads in the next quarterly report. **MD**
The Acting Trust Chairman also asked for a timescale by when the funding received for medical education and training would be fully reconciled with expenditure on those issues. In response, the Medical Director agreed to cover this in the next quarterly report, noting his discussions on funding streams with the Interim Director of Financial Strategy, the Director of Human Resources, and the Director of Medical Education and Associate Medical Director (Clinical Education). He also noted the distinct funding streams for post- and under-graduate education. **MD**

Resolved – that the next quarterly report on medical education include:- **MD**
(A) a list of all CMG medical education leads, and
(B) a timescale for resolving medical education/training income and expenditure.

182/14/2 Workforce and Organisational Development Quarterly Update

Paper T detailed progress in refreshing UHL's Organisational Development (OD) Plan 2014-16, noting the need to be able to deliver the workforce elements of UHL's 5-year strategy. The plan had been discussed at the June 2014 Executive Workforce Board, also involving Clinical Management Groups. The OD Plan contained 5 key objectives, namely (i) live our values; (ii) improve 2-way engagement and empower our people; (iii) strengthen leadership; (iv) enhance workplace learning, and (v) quality improvement and innovation. It was intended to develop a dashboard accordingly to provide clear and regular feedback to CMGs and Corporate Directorates in the form of an 'OD healthcheck' for their teams. In discussion on the OD Plan refresh, the Trust Board:-

(a) welcomed the dashboard – in response to a Non-Executive Director query, the Director of Human Resources advised that although the dashboard would focus specifically on OD issues rather than wider quality indicators, it would nonetheless also feed in to the wider performance picture;

(b) queried the scope to be more innovative in terms of training, and the scope to influence external education curricula;

(c) received confirmation from the Director of Human Resources that the OD Plan mapped appropriately to the project initiation documents for Delivering Caring at its Best;

(d) noted the intention to explore potential 'earned autonomy' scenarios (where appropriate) in respect of objective (ii) above;

(e) noted that the desired leadership behaviours could be found in UHL's leadership strategy on the Trust's internal website. Although the leadership competencies had previously been shared with the Trust Board, the Director of Human Resources agreed that it was legitimate to review them again in light of the 5-year plan; **DHR**

(f) welcomed progress on statutory and mandatory training compliance;

(g) queried whether existing HR capacity was sufficient for the demands on the service, recognising the increasing size of the operational HR workload. The Director of Human Resources noted the need to focus on OD deliverables, work more innovatively and maximise input/output ratios, and

(h) queried what horizon-scanning was being done in terms of the future representativeness of UHL's workforce, particularly at higher levels. The Director of Human Resources advised that an annual workforce assessment was undertaken, and she noted the current focus on women in medicine and understanding what barriers might be in place to prevent women progressing to more senior levels. Mr P Panchal, Non-Executive Director requested that the Trust Board be kept appropriately informed of these discussions, including (eg) Athena Swan aspects. **DHR**

<u>Resolved</u> – that (A) consideration be given to reviewing UHL's leadership competencies, in light of UHL's draft 5-year plan, and **DHR**

(B) the Trust Board be advised in due course of discussions about ensuring the future representativeness of UHL's workforce, particularly at senior levels. **DHR**

182/14/3 <u>"Hard Truths" Nurse Staffing Update</u>

Paper U updated the Trust Board on UHL nurse staffing, as required by the national 'Hard Truths' commitments. The Trust Board was required to review UHL's nursing establishment twice annually, and the Chief Nurse confirmed that a full acuity-based review would therefore be undertaken in September 2014. The shift by shift fill rate would also be published. No RAG ratings or thresholds had yet been put in place by NHS England, but UHL was likely to be broadly in an amber-green band. UHL was also developing information to help the public navigate the data within the nurse staffing report. With regard to vacancies, the Chief Nurse advised that UHL had recruited to approximately 400 nursing and HCA posts since October 2013. The international nurses recruited by UHL were very well received and would shortly be the subject of a BBC programme. However, the Chief Nurse advised that there was still a risk of approximately 35% of unfilled shifts, and she noted that UHL was not filling to funded establishment. Appendix 2 of paper U contained safety statements and the Chief Nurse was content that appropriate systems were in place to monitor staffing safety. In discussion on the nurse staffing report, the Trust Board:-

(a) noted that a monthly nurse staffing report would be provided to EQB and QAC on behalf of the Trust Board (and to the LLR Clinical Quality Review Group). Nurse staffing headlines would also be included in the quality and performance report; **CN**

(b) queried the impact of the LLR and UHL 5-year plans on nursing figures – in response the Chief Nurse advised that although nurse recruitment was not being reduced, the focus was on a more agile workforce and new roles across the community as a whole;

(c) noted concerns expressed by Dr A Bentley CCG representative, regarding the red column within appendix 2 and the escalation process followed. The Chief Nurse confirmed that any staffing safety issues were escalated to her for resolution – where they could not be resolved a risk assessment was undertaken potentially leading to bed closures or reprioritisation of activity. She also noted that it was common practice to flex beds in paediatrics, and

(d) noted (in response to a query) the trend for bank and agency usage to be higher out of hours. UHL's e-roster system identified gaps in planned rotas 6 weeks in advance.

Resolved – that a monthly nurse staffing report be presented to the Executive Quality Board, Quality Assurance Committee, and the Clinical Quality Review Group (nursing workforce headlines also to be included in the monthly quality and performance report for Trust Board). **CN**

183/14 QUALITY AND PERFORMANCE

183/14/1 Month 2 Quality and Performance Report

The month 2 quality and performance report (paper V - month ending 31 May 2014) advised of red/amber/green (RAG) performance ratings for the Trust, and set out performance exception reports in the accompanying appendices. The June 2014 Quality Assurance Committee had identified no specific issues to highlight to the Trust Board. The Medical Director drew members' attention to the SHMI rate – although this remained at 106 an in-month decline had taken the 12-month rolling average to 100. The Medical Director also advised that the HSMR (hospital standardised mortality ratio) was now broadly the same for weekday and weekend admissions.

The Acting Trust Chairman and Finance and Performance Committee Chair then outlined key operational issues discussed by the 25 June 2014 Finance and Performance Committee, namely:-

MD

(i) e-prescribing and ICE issues, including some TTO prescribing errors which the Committee wished to refer to the QAC;
(ii) progress on the emergency floor enabling works, which would need to be partly aborted in the event that full funding for the scheme was not received;
(iii) concern over the DTOCs rate being consistently above 5% for the year;
(iv) good progress on teamworking and performance within the Cancer, Haematology, Urology, Gastroenterology and General Surgery CMG, as evidenced by their presentation to the Committee;
(v) good progress on nursing e-rostering, although medical e-rostering appeared to be less well advanced, and
(vi) good progress on the Alliance elective care contract.

With regard to operational issues in the month 2 report, the Chief Operational Officer commented particularly on:-

(a) UHL's achievement of the 0.8% target in respect of cancelled operations;

(b) improvements to performance on the Referral to Treatment target for non-admitted patients, which was now close to the 95% target. The aim remained compliance by August 2014. RTT performance for admitted patients was slightly behind plan but the Chief Operating Officer remained confident of meeting the November 2014 timescale;
(c) continued poor performance on choose and book slot availability, although he was confident of getting back on track in respect of this indicator;
(d) disappointing cancer performance for the 2014-15 year to date. Month 1 had seen a significant rise in referrals, with the service unable to meet the increased demand. A recovery plan was now in place but the volume of patients involved was likely to have a negative impact on other performance targets. Dr S Dauncey, Non-Executive Director advised that the June 2014 QAC had discussed the specific rise in breast cancer referrals, commenting on the role of primary care in referring (noting the impact of recent soap opera storylines) – the GP representative on QAC had agreed to feed this back to primary care colleagues. Dr A Bentley, CCG representative, acknowledged that a refresh of referral processes had been delayed and needed progressing. Following discussion, the Trust Board agreed that contact would be made with NHS England re: monitoring of national media stories (eg soap opera storylines), in terms of early warning of any likely rise in demand for the service(s) involved, and **DMC/ COO**
(e) his confidence that TIA performance would return to plan in month 3.

In terms of HR indicators, the Director of Human Resources commented on UHL's sickness absence rate of 3.4% compared to the national NHS average of 4.4%. The Acting Trust Chairman queried whether UHL's appraisal target of 95% was achievable, and if so, what the timescale for achieving it was. The Director of Human Resources reiterated her commitment to the 95% target and agreed to confirm the timescale outside the meeting (thought to be September 2014). **DHR** There were no significant IM&T issues to report in respect of month 2, although the Chief Executive noted plans to increase the key performance indicators in place on the IBM contract. He also advised that UHL had gone out to procurement for an electronic patient record, and hoped to select a supplier in Autumn 2014. A transparent process for prioritising smaller IM&T projects was also being developed through the IBM governance board.

As part of the month 2 quality and performance update, the Trust Board also discussed an update on modelling the right-sizing of UHL capacity for 2014-15 (paper V1), noting the intention to use the 2 wards in the new modular block as acute medical wards, and to close ward 2 at the LGH. Additional nursing staff were being recruited to staff the new wards, which would increase bed capacity on a short-term basis (against the backdrop of the 5-year plan intention to reduce acute beds). In response to a query from the CCG representative, the Chief Operating Officer acknowledged that further work was needed to reconcile the numbers in paper V1. The Chief Executive emphasised that the proposed short-term bed capacity solution relied on whole system working across LLR, particularly in respect of the closure of LGH ward 2. The Acting Trust Chairman queried the rationale for increased WTE investment in the Glenfield Hospital CDU, and the Chief Executive also queried the formal approval process for that decision. The Chief Nurse supported the proposed staffing, however. Following discussion, paper V1 was approved as presented. **COO**

<u>Resolved</u> – that (A) TTO prescription error rates be referred to QAC for consideration; **MD**

(B) contact be made with NHS England re: monitoring of national media stories (eg soap opera storylines), in terms of early warning of any likely rise in demand for the service(s) involved; **COO/ DMC**

(C) the anticipated date for delivering the 95% appraisal target be confirmed outside the meeting, and **DHR**

(D) the short-term bed capacity proposals be approved and progressed accordingly, as per paper V1. **COO**

183/14/2 Month 2 Financial Position

Paper W advised members of UHL's financial position as at month 2 (month ending 31 May 2014). The Interim Director of Financial Strategy noted that at the time of writing the report, the 2014-15 acute contract had constituted a significant risk; this was no longer the case as he was now confident of signing the contract in the near future. However, UHL's £45m cost improvement programme remained challenging. The Interim Director of Financial Strategy also noted that recent data warehouse technical issues had hopefully now been resolved, and he drew the Trust Board's attention to positive developments in respect of continued reduced month 2 pay expenditure, illustrating improved financial control within the organisation. Paper W identified a number of other risks to the financial position (and their proposed mitigating actions) including capacity, RTT delivery, cash flow, and the risk of outsourced claims.

In discussion, Mr I Crowe Non-Executive Director reiterated June 2014 Finance and Performance Committee comments on whether UHL was being sufficiently ambitious in terms of its pay cost savings. The Interim Director of Financial Strategy advised that the Executive Team was reviewing how to ensure (in the longer term) that cost improvement programme schemes were appropriately paycost focused. For future reports, the Acting Trust Chairman requested that the CIP shortfall be shown separately, rather than included in the non-pay budget line as currently. The Acting Trust Chairman also noted the potential upside scenario, as now outlined by the Interim Director of Financial Strategy. **IDFS**

Resolved – that future financial reports show any CIP shortfall separately rather than being included on the non-pay budget line. **IDFS**

183/14/3 Emergency Care Performance and Recovery Plan

Paper X provided an overview of ED performance, noting continued poor performance in month 2 against the 95% target, and continued high levels of both ED attendances and admissions. UHL had submitted a new trajectory to the NTDA and NHS England for delivery of the ED target by August 2014, which would be discussed further with those organisations on 1 July 2014.

Work continued internally to improve emergency care performance and flow, and Dr I Sturgess, Interim Consultant, reiterated the crucial importance of clinical engagement and leadership. He outlined a number of initiatives being tested in ED with the objective of reducing waiting times for patients, reducing length of stay, improving the information given to patients about their care, and standardising ward rounds. In discussion on the update from Dr Sturgess, Dr A Bentley CCG representative supported the need for Bed Bureau referrals to go straight to the admitting specialty rather than ED (unless unstable in the ambulance). Also appended to paper X was a proposed ED Charter – in response to a query Dr Sturgess confirmed that he would be happy to include further details on how to monitor the Charter's KPIs in the July 2014 Trust Board update. In response to further queries, Dr Sturgess considered that the stretch timescales being tested within ED were achievable, but he emphasised the need for them to be used to measure improvement rather than judge performance. **COO**

Resolved – that further detail on measuring progress against the ED charter key performance indicators be provided to the July 2014 Trust Board. **COO**

184/14 GOVERNANCE

184/14/1 NHS Trust Over-Sight Self Certifications

The Director of Corporate and Legal Affairs introduced UHL's self certification returns for

May 2014 (paper Y). Following due consideration, and taking appropriate account of any further information needing to be included from today's discussions, the self certification against Monitor Licensing Requirements (appendix A), and Trust Board Statements (appendix B) were endorsed for signature accordingly by the Chief Executive and submission to the NTDA. **DCLA/ CE**

Resolved – that the NHS Trust Over-Sight Self Certification returns for May 2014 be approved for signature by the Chief Executive, and submitted to the NTDA as required. **DCLA/ CE**

185/14 REPORTS FROM BOARD COMMITTEES

185/14/1 Audit Committee

Resolved – that the 27 May 2014 Audit Committee Minutes be received, and the recommendations and decisions therein be endorsed and noted respectively.

185/14/2 Finance and Performance Committee

Resolved – that the 28 May 2014 Finance and Performance Committee Minutes be received, and the recommendations and decisions therein be endorsed and noted.

185/14/3 Quality Assurance Committee (QAC)

Resolved – that the 27 May 2014 QAC Minutes be received, and the recommendations and decisions therein be endorsed and noted respectively.

186/14 TRUST BOARD BULLETIN

Resolved – that the updated declaration of interests from Mr R Kilner, Acting Trust Chairman (inclusion of "Director of Glebe Meadow Developments Ltd") be noted.

187/14 CORPORATE TRUSTEE BUSINESS

187/14/1 Charitable Funds Committee

In its capacity as Corporate Trustee and due to the inquorate nature of the 9 June 2014 Charitable Funds Committee, the Trust Board approved 2 applications for charitable funding which had been endorsed by the Charitable Funds Committee meeting – application 5006 (£500 for 4 wheelchairs) and 5044 (£11,160 for a colposcope for use within gynaecology).

Resolved – that (A) charitable funds applications 5006 and 5044 be approved by the Trust Board as Corporate Trustee and progressed as appropriate, and **IDFS**

(B) the Minutes of the 9 June 2014 Charitable Funds Committee be submitted to the July 2014 Trust Board. **STA**

188/14 QUESTIONS AND COMMENTS FROM THE PUBLIC RELATING TO BUSINESS TRANSACTED AT THIS MEETING

The following comments and questions were received regarding items of business on the Trust Board meeting agenda:-
(1) a comment on welcomed improvements to the running of the eye clinic, as expressed by a patient now attending the Trust Board meeting.

Resolved – that the questions above and any related actions be noted and progressed by the responsible Executive Director.

189/14 ANY OTHER BUSINESS

189/14/1 Query from the Acting Trust Chairman

Resolved – that this item be classed as confidential and taken in private accordingly on the grounds of personal data.

189/14/2 Jimmy Savile Investigation – Report into Roecliffe Manor Allegations

Reporting verbally, the Director of Corporate and Legal Affairs advised that although an investigation had concluded that abuse had taken place at Roecliffe Manor, no proven link had been identified with Jimmy Savile as an alleged perpetrator. All information on the investigation had been passed to the Police. The report was available on UHL's website. The Director of Corporate and Legal Affairs also noted that the Care Quality Commission's recent inspection of UHL had judged the Trust's safeguarding procedures to be satisfactory.

Resolved – that the position be noted.

190/14 DATE OF NEXT MEETING

The Acting Trust Chairman advised that further to discussions that morning on UHL's Board effectiveness review, it was likely that Trust Board meeting dates would change from October 2014 onwards. Revised dates would be issued as soon as possible. In response to a query from Mr P Panchal Non-Executive Director, the Acting Trust Chairman outlined the proposed handling of the self-certification submissions to the NTDA, which were required by the end of each month, which had also been discussed earlier today.

Resolved – that the next Trust Board meeting be held on Thursday 31 July 2014 at Gloucester House, Age UK, Melton Mowbray, as part of the programme of holding UHL Trust Board meetings in the community.

The meeting closed at 3.35pm

Helen Stokes - **Senior Trust Administrator**

Cumulative Record of Members' Attendance (2014-15 to date):

Name	Possible	Actual	% attendance	Name	Possible	Actual	% attendance
R Kilner (Acting Chair from 26.9.13)	3	3	100	R Overfield	3	2	66
J Adler	3	3	100	P Panchal	3	3	100
T Bentley*	3	3	100	K Shields*	3	3	100
K Bradley*	3	3	100	S Ward*	3	3	100
I Crowe	3	2	66	M Wightman*	3	3	100
S Dauncey	3	3	100	J Wilson	3	2	66
K Harris	3	3	100	D Wynford-Thomas	3	2	66
K Jenkins	3	3	100				
R Mitchell	3	3	100				

* non-voting members

University Hospitals of Leicester NHS Trust

Progress of actions arising from the Trust Board meeting held on Thursday 26 June 2014

Item No	Minute Ref:	Action	Lead	By When	Progress Update	RAG status*
1.	173/14/1	July 2014 Audit Committee meeting to be rescheduled before September 2014 (current date inquorate).	STA	Immediate	Subsequently agreed by Acting Chair that a meeting was not required before the already-scheduled September 2014 Audit Committee.	5
2.	178/14	***Matters arising*** In addition to any actions currently classed as a '5', the following actions to be removed from the log, as either complete or being pursued through other avenues:- • Minute 145/14/1 of 29 May 2014 (updates to be pursued through the Older People's Strategy Board and Delivering Caring at its Best).	STA	Immediate	Actioned.	5
2a	178/14	Discussion on the revised Board Assurance Framework to be held at the July 2014 Trust Board development session.	CN	TBDS 17.7.14	Scheduled on TBDS agenda for 17 July 2014.	5
2b	178/14	Action re: providing additional information on the meaning and impact of the Quality Schedule and CQUIN indicators, to be moved to the Audit Committee matters arising log.	STA	Immediate	Chief Nurse to report accordingly to next Audit Committee meeting on 9 September 2014.	5
2c	178/14	Draft timetable of Trust Board-required approvals for individual capital schemes to be discussed at the July 2014 Finance and Performance Committee.	IDFS	FPC 30.7.14.	Included accordingly on the 30 July 2014 Finance and Performance Committee agenda.	5
3.	180/14/1	Finalised LLR 5-year health and social care plan to be presented to the September 2014 Trust Board.	DS	TB 25.9.14	Scheduled accordingly.	4
4.	180/14/2	***Draft UHL 5-year plan – executive summary*** Final versions of the UHL (and LLR) 5-year plan to be presented to the Trust Board for formal approval in September 2014.	DS/CE	TB Sept/Oct 2014	Being worked through and on track to be presented to the Trust Board in September 2014.	4
4a	180/14/2	Monitoring of progress against the 5-year plan to be included in the detailed Delivering Caring at its Best update being provided to the October 2014 Trust Board.	CE	TB Oct 2014	Scheduled accordingly for report to 30 October 2014 Board meeting.	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***

5.	180/14/3	***LRI theatres recovery area – full business case*** Approval be given to proceed with the capital spend of £3.6752m (phased over 2 years) as per additional Trust Board paper 1.	DS	Immediate	Complete.	5
5a	180/14/3	Confirmation to be provided outside the meeting of whether the scheme would provide a single staff rest area for all staff groups, or maintain the current separate areas for different staff groups.	DS	By 31.7.14	Confirmed as already being included in the business case.	5
6.	180/14/4	***Board Assurance Framework*** Bed numbers within risk 9 to be amended to match those within the additional capacity report at Trust Board paper V1.	COO	Immediate	Actioned.	5
6a	180/14/4	Risk 1 to:- • reflect a date for producing the UHL service and financial strategy, including reconfiguration/SOC, and • have its risk rating reviewed further in July 2014 (retaining the 5x5 rating in the meantime).	DS	By 31.7.14	Completed.	5
6b	180/14/4	Risk 13 to be reviewed to differentiate between 'postgraduate' and 'undergraduate' education and training issues (where necessary).	MD	By 31.7.14	This risk will be reviewed in future updates of the BAF and the distinction made as appropriate.	5
6c	180/14/4	Risk rating for the new high risk re: renal transplant to be reviewed following the review team's return visit to UHL.	MD	Following the visit	Reviewed - current risk rating to remain unaltered for the present time	5
7.	181/14/1	***Patient experience story*** EQB/QAC to receive further updates on the work of the learning disability service as part of their annual work programme.	CN	Ongoing	To be scheduled as appropriate.	5
7a	181/14/1	Current barriers to learning disability patients bringing in their own personal equipment to hospital, to be explored outside the meeting.	CN	Ongoing	Being pursued outside the meeting.	4
7b	181/14/1	Dr A Bentley, CCG representative, to contact Ms H Leatham, Head of Nursing, to discuss strengthening relationships with GP practice nurses.	AB CCG	By 31.7.14	Actioned.	5
8.	181/14/2	***Quality Account 2013-14*** Trust Board congratulations to be passed to the quality team, for the standard of the 2013-14 quality account.	CN	Immediate	Completed.	5

** 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***

9.	182/14/1	***Update on medical education and training issues in UHL NHS Trust*** Next quarterly update to identify (i) medical education and training leads for all CMGs and (ii) to include a timescale for reconciling the funding received and that spent.	MD	TB Sept 2014	Will be included accordingly.	5
10.	182/14/2	***UHL Organisational Development (OD) Plan Refresh 2014-16*** Consideration to be given to reviewing leadership competencies, in light of UHL's draft 5-year plan.	DHR	By 31/08/14	On-going.	4
10a	182/14/2	Trust Board to be advised in due course of discussions about ensuring the future representativeness of UHL's workforce, particularly at senior levels.	DHR	By 31/08/14	To be incorporated into the equality governance update report to be submitted to the 28 August 2014 Trust Board.	5
11.	182/14/3	***Nurse staffing update*** Monthly nurse staffing report to be presented to the Executive Quality Board, Quality Assurance Committee, and the Clinical Quality Review Group (nursing workforce headlines also to be included in the monthly quality and performance report for Trust Board).	CN	Monthly EQB/QAC/ CQRG	Completed/In Place.	5
12.	183/14/1	***Month 2 quality and performance report*** Contact to be made with NHS England re: monitoring of national media stories (eg soap opera storylines), in terms of early warning of any likely rise in demand for the service(s) involved.	COO/ DMC	By 31.7.14	**Verbal update to be provided on 31 July 2014.**	
12a	183/14/1	Issue of TTO prescription error rates to be referred to QAC for consideration.	CN	QAC 30.7.14	Timing of QAC discussion currently under consideration.	4
12b	183/14/1	Anticipated date for delivering the 95% appraisal target to be confirmed outside the meeting.	DHR	By 31.7.14	Under consideration.	4
12c	183/14/1	***(bed capacity)*** Proposals in Trust Board paper V1 to be approved and progressed accordingly (use of the LRI modular block as 2 acute medical wards and closure of LGH ward 2).	COO	Immediate	Actioned.	5
13.	183/14/2	***Month 2 financial position*** For clarity, future updates to separate the CIP shortfall rather than show it on the non-pay budget line.	IDFS	Future finance reports	Actioned.	5

** 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***

14.	183/14/3	***ED performance report*** Further detail on measuring progress against the ED charter key performance indicators, to be provided to the July 2014 Trust Board.	COO	TB 31.7.14	Actioned.	5
15.	184/14/1	***NHS Trust oversight self-certifications*** Authority to be delegated to the Director of Corporate and Legal Affairs to submit the NHS Trust oversight self certification returns to the NTDA by 30 June 2014 as required (last working day).	DCLA	30.6.14	Actioned.	5
16.	187/14/1	***Charitable Funds Committee meeting – 9 June 2014*** Charitable funds applications 5006 and 5044 to be approved by the Trust Board as Corporate Trustee and progressed accordingly.	IDFS	Immediate	Actioned.	5
17.	190/14	***Date of next meeting*** Revised Trust Board meeting dates to be circulated as soon as possible.	DCLA	Once available	Dates to change from January 2015..	5

Matters arising from previous Trust Board meetings

None outstanding.

** 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 N

To:	**Trust Board**
From:	**CHIEF EXECUTIVE**
Date:	**31 JULY 2014**
CQC regulation:	N/A

Title:	**MONTHLY UPDATE REPORT – JULY 2014**

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: **31 JULY 2014**

REPORT BY: **CHIEF EXECUTIVE**

SUBJECT: **MONTHLY UPDATE REPORT – JULY 2014**

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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) 'Learning lessons to improve care' : a report on this subject features elsewhere on the agenda for this meeting of the Board;

(b) emergency care performance;

(c) the Trust's financial position as at month 3 2014/15;

(d) ongoing work to develop a Leicester, Leicestershire and Rutland 'System Resilience Group' Plan 2014/15.

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

24th July 2014

Trust Board paper P

To:	**Trust Board**
From:	Dr Kevin Harris, Medical Director and Responsible Officer
Date:	**31 July 2014**
CQC regulation:	Outcome 14

Title:	**Medical appraisal and revalidation at UHL: report for Trust Board on the appraisal year April 2013-March 2014.**

Author/Responsible Director:
Prof Peter Furness/Dr Kevin Harris

Purpose of the Report:
To inform the Trust Board about work in relation to the duties of the University Hospitals of Leicester (UHL) in its role as a Designated Body for the majority of its medical employees.
To satisfy members of the Board that the Trust is appropriately discharging its statutory duties in this area, and that it can continue to do so in the coming year.

The Report is provided to the Board for:

Decision		Discussion	
Assurance		Endorsement	

Summary / Key Points:
The current system of medical appraisal, with its link to medical revalidation, was established at UHL by the time medical revalidation was introduced by the GMC in 2012 and a detailed description was provided to Trust Board in 2013. The system has continued to function largely as previously described.
UHL has an adequate number of appropriately trained medical appraisers.
Doctors have gained familiarity with the system; the number of delayed appraisals has fallen since last year, as has the number of doctors reported to the GMC for failure to engage with the revalidation process (6 doctors in 2013-14, 14 in 2012-13).
Audit has revealed some minor problems in the documentation of some appraisals. These issues are being addressed by ongoing appraiser training and by the removal of a small number of appraisers.
External oversight of our appraisal and revalidation processes has been taken over by NHS England. This has resulted in increased demands for quality assurance information which may require investment of additional resources in the future.
Independent external review is also being strongly recommended. This has resource implications.

Recommendations:

- To accept this report (noting that it will be shared, along with the annual audit, with the higher level Responsible Officer)
- To alter the Trust's Medical Appraisal and Revalidation Policy and guidance, to clarify the process to be taken in the case of missed appraisals
- To approve the 'statement of compliance' confirming that UHL, as a designated

body, is in compliance with the regulations.

- To provide support for additional funding as reasonably justified and agreed by the Executive to allow UHL to discharge its responsibilities as a designated body.

Previously considered at another corporate UHL Committee?
No

Board Assurance Framework:	**Performance KPIs year to date:**
N/A	As described in the report

Resource Implications (eg Financial, HR):
Provision of adequate resources is a statutory requirement on UHL as a Designated Body. Maintenance of current funding is essential to the discharge of these duties. The report identifies two areas (support staff and IT contract renewal) where additional funding will be needed.

Assurance Implications:
UHL is a Designated Body in law, and as such has a statutory duty to appoint an appropriate Responsible Officer and to provide support to that Responsible Officer to allow him/her to discharge his/her statutory responsibilities.

Patient and Public Involvement (PPI) Implications:
The GMC has repeatedly stated in public that having a good system for medical appraisal and revalidation provides reassurance that a healthcare organisation is employing doctors who can fulfil their roles safely. Having a robust appraisal system is an essential part of maintaining public confidence.

Stakeholder Engagement Implications:
If UHL did not discharge its duties as a Designated Body then its doctors could face difficulty in maintaining a GMC Licence to Practise. Without such a licence a doctor cannot practice medicine in the UK.

Equality Impact:
Doctors arriving from overseas may be unfamiliar with the UK's system of medical revalidation unfamiliar. We work to assist such doctors to comply with the national requirements.
Equality issues have been considered and apart from this there is no impact.

Information exempt from Disclosure:
No

Requirement for further review?
Annual

Medical Appraisal and Revalidation at UHL

Report for Trust Board on the appraisal year April 2013- March 2014

1. Purpose of the Paper

Provider organisations have a statutory duty to support their Responsible Officers in discharging their duties under the Responsible Officer Regulations[1] . NHS England has now taken over the role of the Revalidation Support Team and has reaffirmed the expectation that provider boards will oversee compliance by:

- monitoring the frequency and quality of medical appraisals in their organisations
- checking there are effective systems in place for monitoring the conduct and performance of their doctors
- confirming that feedback from patients is sought periodically so that their views can inform the appraisal and revalidation process for their doctors
- Ensuring that appropriate pre-employment background checks (including pre-engagement for Locums) are carried out to ensure that medical practitioners have qualifications and experience appropriate to the work performed.

The purpose of this document is to inform the Trust Board about work in relation to the duties of the University Hospitals of Leicester (UHL) in its role as a Designated Body for the majority of its medical employees. It covers the appraisal year from 1st April 2013 to 31st March 2014, including steps taken after the end of the appraisal year in respect of doctors who did not complete an appraisal within that year. The information contained is needed to satisfy members of the Board that the Trust is appropriately discharging its statutory duties in this area, and that it can continue to do so in the coming year.

2. Background

Medical Revalidation was launched in 2012 to strengthen the way that doctors are regulated, with the aim of improving the quality of care provided to patients, improving patient safety and increasing public trust and confidence in the medical system. UHL was in a strong position to implement the reforms, because the Trust had been one of a small number of pilot sites prior to the introduction of revalidation. The Trust's revalidation lead, Professor Furness, had experience of leading on revalidation for the Academy of Medical Royal Colleges during the development of

[1] The Medical Profession (Responsible Officers) Regulations, 2010 as amended in 2013' and 'The General Medical Council (Licence to Practise and Revalidation) Regulations Order of Council 2012'

the new processes and was therefore already familiar with what would be required.

In 2013 Trust Board was provided with a report on the appraisal year 2012-13. That report documented in some detail the implementation in UHL of a system of medical appraisal in a form that complies with GMC requirements for revalidation, and our early experience of running such a scheme. That experience was in most respects successful, so to a large extent the appraisal year 2013-14 followed the model previously set. Consequently this report (which is now based on a template provided by NHS England) will only summarise existing appraisal and revalidation mechanisms and document events and results in 2013-14. A copy of last year's report is available on request.

3. Governance Arrangements

Policy and Guidance

UHL's Medical Appraisal and Revalidation Policy, and its associated Guidance document, were approved in 2012. Minor changes were made in 2013-14, merely to adapt the number of Senior Appraisers to UHL's modified management structure. A further change is planned in 2014-15, as discussed below, to clarify the processes to be followed in respect of doctors who fail to deliver an annual appraisal. This change has been approved by the Local Negotiating Committee but has yet to be approved by the Policy and Guidance Committee.

Process for maintaining accurate list of prescribed connections

At the level of the GMC, if a doctor modifies the GMC's record of his/her Designated Body, UHL's Medical Appraisal and revalidation manager is automatically informed. She then contacts the doctor to confirm the connection and to obtain the necessary information to set up the doctor with an account on our online medical revalidation system (PReP).

At the level of the Trust, Trust's HR department informs UHL's Medical Appraisal and revalidation manager of any new medical employees who are not in formal training posts (trainees are monitored by and revalidate through the Deanery). She follows the same procedure and also ensures that the GMC's records correctly reflect the doctor's new Designated Body.

All new medical employees receive a short summary of UHL's medical appraisal and revalidation processes, including how to find more detailed information online and how to contact UHL's Medical Appraisal and revalidation manager .

We have had a small number of doctors where this three- level process did not work; usually in respect of non-consultant doctors who are in posts where there is close supervision and in practice some training is given, but the post is not recognised by the Deanery as a training post. These have come to light by various means, usually as a result of the doctor receiving some communication that reminds them about

revalidation, such as messages from the GMC. We have had to ask the GMC for deferral of the revalidation date in two such cases but no doctor's revalidation has been jeopardised.

4. Medical Appraisal

Appraisal and Revalidation Performance Data

The system for reminding doctors about the need to organise an appraisal is set out in Trust policy and guidance. In brief, each doctor is allocated an 'appraisal due' date. Email reminders are sent two months, one month and one week before an appraisal is due. If a completed appraisal is not recorded using the online medical appraisal software ('PReP'), a further reminder is sent 2 weeks after the appraisal due date.

At the end of the appraisal year (31st March 2014) UHL was the Designated Body for 678 doctors. Of these, 62 did not complete an appraisal within the 2013-14 appraisal year. 57 of these did not have previous agreement (e.g. on grounds of ill-health or maternity leave) to miss an appraisal. All of these missed appraisals have been analysed. All have been contacted with a warning and an invitation to provide any mitigating circumstances.

Dr Harris and Professor Furness met the GMC's local Employment Liaison Officer on 29th April and all the doctors who still had not delivered an appraisal on that date were discussed. On the advice of the GMC's local Employment Liaison Officer, 34 doctors were sent a further communication warning them that if they had not completed an appraisal by a specified date (determined on the basis of individual circumstances, but in most cases 1st July 2014) then the GMC would be asked to initiate its processes for failure to engage with the process of revalidation. As of mid-July 2014, most of the doctors concerned have now completed an appraisal, but the GMC has been formally notified of non-compliance in respect of six doctors. This is fewer than last year (14 doctors, none of whom is included in the list referred this year).

NHS England has recently issued guidance including a definition of a late or missed appraisal which is not identical to that used within UHL, because it included appraisals conducted more than 2 months before or more than 2 months after the appraisal due date. The 'PReP' medical appraisal software we use currently does not allow us to use this new definition. We have discussed this with Premier IT, the supplier of PReP, and we have received assurances that they are working on an update that will implement the new definition.

Reasons for missed appraisals

The circumstances which led doctors to miss appraisals display enormous variety. At one extreme, some doctors have an excellent justification such as prolonged sickness or maternity leave. One doctor is the subject of an investigation by the

GMC, and consequently had been told that this meant that his revalidation would be suspended until the investigation is complete; he had erroneously assumed that this meant that he did not need to complete an appraisal. At the other extreme there are doctors who do not respond to communications about appraisals, even if sent by email and conventional post, until the last minute; some doctors seem to be willing to undertake the process but are disorganised and have not given the process sufficient priority. Some only recently started work at UHL and had taken the view that an appraisal would be pointless until they had worked here for several months. A few, mostly doctors not trained in the UK, deny understanding of the system. Some have been let down by an appraiser who agreed a date then cancelled the meeting. This problem is exacerbated by the disproportionate number of doctors attempting to undertake an appraisal at the end of the appraisal year, in March, when there is no time for rescheduling.

A number of doctors have taken the position that an appraisal cannot be demanded more frequently than once every 12 months. Unfortunately, this group includes many who had a delayed appraisal in 2012-13; typically in April or May of 2013. As a result they ignore the reminders and plan their next appraisal in April or May 2014; thus guaranteeing another 'late' appraisal.

Proposed clarification of penalties for missed appraisals

It is currently UHL policy that doctors who do not deliver a timely appraisal (a) may be reported to the GMC (b) may have annual pay progression blocked and (c) may have disciplinary processes imposed. However, the spectrum of mitigating circumstances described above means that a process is needed to decide what action is justified in each individual case.

The process for (a) is described above. To date (b) and (c) have never been applied, although in the future HR will require a positive recommendation of eligibility for pay progression – including the completion of an annual appraisal – before pay progression is implemented.

The decision to apply a penalty will require judgement on a case-by-case basis and any decision may result in an appeal. Consequently we have proposed that the decisions will be made by the Medical Performance Committee. This will require amendment of the Trust's revalidation policy, as mentioned above.

It is anticipated that missed appraisals will result in blockage of pay progression by default, unless the Medical Performance Committee is convinced that there are exceptional circumstances; whereas further disciplinary processes will be applied only where the Medical Performance Committee is persuaded that there is a wilful determination not to deliver a timely appraisal.

Appraisers

At the end of March 2014 UHL had 159 approved appraisers, all of whom have completed the prescribed training. This meets the acceptable appraiser:appraisee

ratios recommended by NHS England, which is from 1:5 to 1:20. There is a reasonable spread of appraisers across the medical specialties; when appraisal training is offered, CBU leads are invited to consider how many new appraisers their specialty needs and to encourage appropriate doctors to undertake the training.

The in-house full appraiser training course, developed in 2012-13, was run again in January 2014, training 14 new appraisers. It will be run again in early 2015. Those who have completed the course are required to undertake and document a 'mock' appraisal of another trainee appraiser before their names are added to the list of UHL appraisers. The documentation of this appraisal is reviewed by Professor Furness before approval is granted.

In addition, six short 'top-up training' sessions for approved appraisers were run in 2013-14 at each of UHL's hospitals. Further half-day sessions are planned for 2014-15. Attendance registers have been kept; it is anticipated that attendance at at least one top-up session will be made mandatory by the end of 2015-16.

Quality Assurance of Appraisals

For the appraisal portfolio:

The quality of individual appraisal portfolios is audited by two separate but similar processes.

1. Individual appraisal portfolios are audited by an experienced office manager who has received specific training for the purpose, using an audit template provided by NHS England. We do not audit every appraisal in this way, but NHS England's expectation is that a sample (of unspecified size) will be examined. The selection of cases for this audit is designed to include at least one appraisal by each of UHL's approved appraisers.
   In practice, many of the supposedly objective questions are difficult to answer with a simple 'Yes' or 'No'; for example '*Is there evidence that the appraisee was challenged?*'. Consequently, in practice the audit results in any portfolios where there are grounds for concern about the quality of the process or the documentation to be flagged to Professor Furness.
2. When a doctor's revalidation date approaches (i.e. every 5 years) the doctor's appraisal portfolio is checked by UHL's Medical Appraisal and Revalidation Manager. This is primarily to identify any problems with the documentation of which the Responsible Officer should be aware before considering a revalidation recommendation, ideally with time for the doctor to correct those problems. But she also considers the quality of each portfolio in a similar way to that taken in the audit described above.

These processes have identified a number of common problems, mainly around the level of detail of documentation and the appropriate use of the PReP software. The latter has informed the subsequent content of top-up training for appraisers.

In the case of four appraisers it has been necessary to discuss the quality of their work and in three of those cases there was an immediate decision for them to cease undertaking appraisals. Remedial training is offered but in practice this has not been taken up. It remains a concern (discussed in the 2012-13 report), that in the absence of incentives for UHL's doctors to train as appraisers, any expression of concern about appraisal quality is likely to result in the loss of an appraiser, with little motivation for remediation or for others to step forward. However this is not an immediate issue, as UHL currently has the required number of medical appraisers;

After each appraisal, the appraisee is automatically asked to complete a short questionnaire on the quality of the process. This questionnaire has proved very disappointing as a tool to assess the quality of appraisals, because for each appraiser the number of respondents is too small to allow the 'Likert scale' approach of the questionnaire to generate valid numeric results. We have used the information generated to target appraisers who appear to be 'outliers' for review in the audit, as described above, but it is not appropriate to use the results for feedback to individual appraisers.

Audit of individual portfolios feeds into the audit of individual appraisers as described above.

Appraisers are offered support in relation to general issues or individual cases from a group of Senior Appraisers (one per CMG) and the Revalidation Lead. Update training is offered as explained above.

For the organisation:

Progress and problems in the delivery of medical appraisal and revalidation are discussed at quarterly meetings of the Medical Revalidation Support Network; minutes are available on request. The major issues discussed are considered in other parts of this report.

Access, security and confidentiality

This is provided by the mandatory use of the secure 'PReP' online medical appraisal software, which is provided by Premier IT and is designed for the purpose. We have continued to enjoy a good service from Premier IT in relation to technical support, problem solving and further product development.

Outline of data for appraisal.

All appraisers and appraisees should be aware of the GMC's requirements on supporting information for appraisal. The provision of appropriate information is primarily the appraisee doctors' responsibility; it should be checked by the appraiser and it is subject to audit as set out above.

To deliver the required colleague feedback and patient feedback informs that comply with GMC requirements, UHL offers the system provided for that purpose by

Edgecumbe. Its use is not mandatory, but a GMC-compliant system is required and UHL will not fund any other system.

The provision of information on quality improvement, clinical audit, clinical incidents and outcome measures is the responsibility of the appraisee doctor. Availability will vary between different specialties and appraisers are encouraged to demand compliance with the guidance of the relevant medical Royal College.

We have investigated the automated provision of information on clinical incidents using the Datix system, but that system was not designed for this purpose. Therefore appraisers have been informed that they are entitled to ask about clinical incidents on Datix that are associated with their appraisee's name.

The relevance of outcome data in appraisal varies between specialties. In those specialties where outcome data is recommended by the relevant Royal College we would expect it to be provided; it is the responsibility of the individual appraisee to ensure that this information is delivered and discussed with their appraiser. We have investigated providing such information automatically using the Trust's data collection and clinical governance systems, but we have not yet identified a solution that is not excessively complicated. However exploration of this area will continue.

Doctors are told that their record of statutory and mandatory training must be discussed at appraisal. Appraisers have been told that any deficiencies should at minimum become items on the Personal Development Plan, for urgent attention, and may if critical be reported to the relevant UHL manager. The Trust's online system for managing such training does not interface directly with the PReP system for appraisal, but a summary of training can readily be downloaded or printed and provided as an item of supporting information for review.

5. Revalidation Recommendations

Number of recommendations falling due in 2013-14	164
Number of positive recommendations	145
Number of deferral requests	19
Number of non-engagement notifications made at revalidation date	0
Number of non-engagement reports made before revalidation date	6

6. Recruitment and engagement background checks

The UHL Recruitment Services is a centralised recruitment function and conducts the recruitment of all posts into the organisation to ensure full compliance with all of the NHS Employers 'Employment Check Standards'. A dedicated team for doctors

conducts the recruitment of all non-trainee (and trainee) Doctors in line with these standards which consist of the following checks:

Verification of Identity Check
Right to Work in the UK Check
Professional Registration and Qualifications Check e.g. GMC Registration
Employment History and References Check
Criminal Record and Barring Check
Workplace Health Assessment Check

Robust audit and monitoring processes are in place for these checks including the NHSLA and Home Office immigration controls to give assurance that these checks are carried out in accordance with legislation and best practice.

For further information follow the link http://www.nhsemployers.org/your-workforce/recruit/employment-checks/nhs-employment-check-standardshttp://www.nhsemployers.org/your-workforce/recruit/employment-checks/nhs-employment-check-standards

7. Monitoring Performance

Approaches include:

- Medical appraisal, as discussed above
- Analysis of outcome data, as provided by Dr Foster / HED / CHKS
- Action on clinical incidents, reported through DATIX
- Action on complaints received
- Reports from CMG leads
- Reports from other doctors following the GMC requirement to act to protect patient safety

8. Responding to Concerns and Remediation

UHL manages all medical cases relating to conduct, capability and health in line with the national Maintaining High Professional Standards (MHPS) document. The Trust has agreed a process through the Medical Local Negotiating Committee, by which MHPS is implemented. All cases where concern about a doctor has been raised are discussed monthly with the Medical Director and Director of Human Resources to ensure that a supportive and proactive approach is being taken.
In addition, the Medical Director meets regularly with the GMC's employment liaison officer to discusses cases as appropriate with the GMC, and review those cases relevant to the Trust which are currently subject to a GMC process.

9. Risk and Issues

Appraisal quality. Our ongoing audit of appraisals has demonstrated some variable quality, with some showing inadequate documentation. This risk is managed by the ongoing process of checks prior to any revalidation recommendation. Appraisers are continually reminded that their role is to make a meaningful and constructive assessment. This issue is being addressed gradually, as explained above, by a combination of training and removal of any appraisers not meeting the required standard.

We have so far followed the original national guidance to allow doctors to choose their own appraiser. This approach may not be justified, but to date we have not changed this approach without appropriate national guidance.

Inadequate numbers of appraisers. We cannot force doctors to act as appraisers so there is a risk of having insufficient numbers to be able to discharge the statutory duties of the Responsible Officer. To date this has not been an issue.

Funding. UHL, as a Designated Body, has a statutory duty to provide sufficient resources to allow the Responsible Officer to deliver his/her responsibilities. This duty has so far been delivered, but there are foreseeable cost pressures on the horizon, notably:

a) The contract for appraisal support software (PReP) is due for renegotiation in April 2015. The current 3-year contract was won on very favourable terms as Premier IT recognised the need to have UHL: as an 'early adopter' of its new product. Premier IT will also be aware that changing to a different supplier would generate considerable disruption so we anticipate a significant increase in cost.
b) NHS England has strongly recommended that organisations undertake external review of the quality of their medical appraisal and revalidation processes. This is not yet mandatory but may become so. We have not yet commissioned such a review and the medical appraisal budget currently does not include funds to support such a review.

Appraisal support staff. Our Medical Revalidation manager is single handed. She understands the role well and has delivered an excellent service, but there are times of year (notably around the end of the appraisal year) when demands of the role are high. If she was to resign or become unavailable it would be extremely difficult to train a replacement in an acceptable time. Other organisations the size of UHL employ more than one person in this role. The provision of support staff therefore needs to be reviewed but provision of additional staff is currently constrained by funding. Training an existing member of staff in the role to provide backup and cover is a priority.

10. Corrective Actions, Improvement Plan and Next Steps

- Continue the programme of training for new appraisers and updates for existing appraisers, making it mandatory that appraisers attend an update session either this year or next year
- Continue to challenge appraisers whose performance, identified through ongoing audit, raises cause for concern, while anticipating that any such challenge will probably result in the appraiser ceasing to act as an appraiser rather than re-training
- Implement the modified policy for dealing with delayed and missed appraisals, including appropriate publicity to ensure that all doctors are aware of the policy
- Attempt to improve the delivery of outcome data and information about clinical incidents to the appraisal process
- Implement NHS England's new definition of missed or late appraisals (dependent on software updates promised by Premier IT).
- Negotiate renewal or replacement of the contract for medical appraisal support software

11. Recommendations

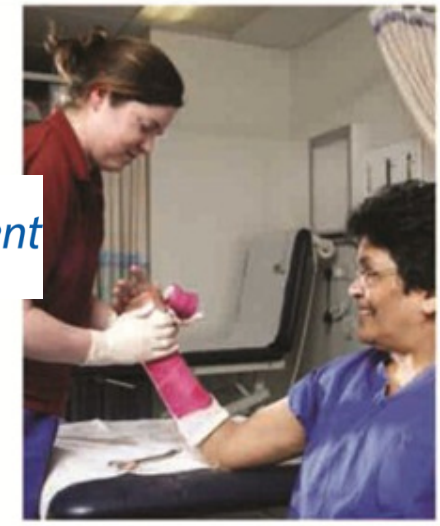
- To accept this report (noting that it will be shared, along with the annual audit, with the higher level Responsible Officer)
- To alter the Trust's Medical Appraisal and revalidation Policy and guidance, to clarify the process to be taken in the case of missed appraisals
- To approve the 'statement of compliance' confirming that UHL, as a designated body, is in compliance with the regulations.
- To provide support for additional funding as reasonably justified and agreed by the Executive to allow UHL to discharge its responsibilities as a designated body.

NHS England

A Framework of Quality Assurance for Responsible Officers and Revalidation

Annex E - Statement of Compliance

Version 4, April 2014



DH Department of Health

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Publications Gateway Reference:	**01142**
Document Purpose	Guidance
Document Name	A Framework of Quality Assurance for Responsible Officers and Revalidation, **Annex E - Statement of Compliance**
Author	NHS England, Medical Revalidation Programme
Publication Date	4 April 2014
Target Audience	All Responsible Officers in England
Additional Circulation List	Foundation Trust CEs , NHS England Regional Directors, Medical Appraisal Leads, CEs of Designated Bodies in England, NHS England Area Directors, NHS Trust Board Chairs, Directors of HR, NHS Trust CEs, All NHS England Employees
Description	The Framework of Quality Assurance (FQA) provides an overview of the elements defined in the Responsible Officer Regulations, along with a series of processes to support Responsible Officers and their Designated Bodies in providing the required assurance that they are discharging their respective statutory responsibilities.
Cross Reference	The Medical Profession (Responsible Officers) Regulations, 2010 (as amended 2013) and the GMC (Licence to Practise and Revalidation) Regulations 2012
Superseded Docs (if applicable)	Replaces the Revalidation Support Team (RST) Organisational Readiness Self-Assessment (ORSA) process
Action Required	Designated Bodies to receive annual board reports on the implementation of revalidation and submit an annual statement of compliance to their higher level responsible officers (ROCR approval applied for).
Timings / Deadline	**From April 2014**
Contact Details for further information	england.revalidation-pmo@nhs.net http://www.england.nhs.net/revalidation/

Document Status

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Annex E – Statement of Compliance

Designated Body Statement of Compliance

The board of the University Hospitals of Leicester has carried out and submitted an annual organisational audit (AOA) of its compliance with The Medical Profession (Responsible Officers) Regulations 2010 (as amended in 2013) and can confirm that:

1. A licensed medical practitioner with appropriate training and suitable capacity has been nominated or appointed as a responsible officer;

   Comments:

2. An accurate record of all licensed medical practitioners with a prescribed connection to the designated body is maintained;

   Comments:

3. There are sufficient numbers of trained appraisers to carry out annual medical appraisals for all licensed medical practitioners;

   Comments:

4. Medical appraisers participate in ongoing performance review and training / development activities, to include peer review and calibration of professional judgements (Quality Assurance of Medical Appraisers or equivalent);

   Comments:

5. All licensed medical practitioners[1] either have an annual appraisal in keeping with GMC requirements (MAG or equivalent) or, where this does not occur, there is full understanding of the reasons why and suitable action taken;

   Comments:

6. There are effective systems in place for monitoring the conduct and performance of all licensed medical practitioners[1], which includes [but is not limited to] monitoring: in-house training, clinical outcomes data, significant events, complaints, and feedback from patients and colleagues, ensuring that information about these is provided for doctors to include at their appraisal;

   Comments:

7. There is a process established for responding to concerns about any licensed medical practitioners[1] fitness to practise;

[1]Doctors with a prescribed connection to the designated body on the date of reporting.

Comments:

8. There is a process for obtaining and sharing information of note about any licensed medical practitioners' fitness to practise between this organisation's responsible officer and other responsible officers (or persons with appropriate governance responsibility) in other places where licensed medical practitioners work;

Comments:

9. The appropriate pre-employment background checks (including pre-engagement for Locums) are carried out to ensure that all licensed medical practitioners[2] have qualifications and experience appropriate to the work performed; and

Comments:

10. A development plan is in place that addresses any identified weaknesses or gaps in compliance to the regulations.

Comments:

Signed on behalf of the designated body

Name: _ _ _ _ _ _ _ _ _ _ _ Signed: _ _ _ _ _ _ _ _ _ _ _

[chief executive or chairman a board member]

Date: _ _ _ _ _ _ _ _ _ _

[2]Doctors with a prescribed connection to the designated body on the date of reporting.

To:	**Trust Board**
From:	**Chief Nurse**
Date:	**31 July 2014**
CQC regulation:	

Trust Board paper Q

Title:	**Annual Health and Safety services Report – 1st April 2014 to 31st March 2014**

Author/Responsible Director: Director of Safety and Risk

Purpose of the Report:

Annual performance for Health and Safety services that details Health and Safety, Local Security Management and Manual Handling for 2013/14

The Report is provided to the Board for:

Decision		Discussion	
Assurance	X	Endorsement	X

Summary / Key Points:
A summary of the performance, challenges and targets for 2013/14.

Recommendations:
To approve the Health and Safety Annual Report

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

Resource Implications (eg Financial, HR)
Y

Assurance Implications
Y

Patient and Public Involvement (PPI) Implications
N/A

Equality Impact
Considered and no impact

Information exempt from Disclosure
No

Requirement for further review?
Annually

University Hospitals of Leicester NHS
NHS Trust
Caring at its best

ANNUAL HEALTH & SAFETY SERVICES REPORT

1st April 2013 to 31st March 2014

Nick Howlett

Health and Safety Services Manager

University Hospitals of Leicester NHS Trust
May 2014

CONTENTS

Section 1 – Executive Summary

Health and Safety

1.1 The Trust set a target of reducing the total number of RIDDOR incidents by 10% per year. This figure has been missed although overall we have had a reduction in injuries by 2.

1.2 During the year there were 49 incidents reported under RIDDOR. 24 of these reportable incidents were not reported within the time limits required by RIDDOR legislation. This is a compliance rate of 48%.

1.3 Reporting of RIDDOR notifiable incidents within 10 -15 days of the incident is a legal requirement and the we will be working to ensure that timely reporting improves in 2014/15.

1.4 Presently we are reporting that only **3.3%** of staff have received any form of Health and Safety training in 2013/14.

1.5 The HSS Team will develop and promote bespoke training programmes targeted at senior and departmental managers throughout the year. This will be informed by a training risk assessment that will be part of the overall approach to Health and Safety risk assessment throughout 2014/15

1.6 We will continue to offer courses on specific aspects of Health and Safety as informed by Local Risk assessment where there is an identified need.

1.7 The HSS team will actively promote the Health and Safety e-learning programme for all staff

1.8 It is our aim that in line with other required training elements, overall compliance will achieve **80%**

1.9 The HSE Improvement Notice 304661440 served against UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST on 25/03/2013 has now been complied with and officially closed on 21/06/2013.

1.10 This year the Health and safety quarterly report will be expanded to include additional items for performance measurement or benchmarking for onward measurement. These will be, RIDDOR reportable injuries, Number of need stick injuries reported, Numbers of staff who have completed some form of approved UHL Health and Safety training, Number of IRMER reportable incidents, Number of settled Employee/Public Liability Claims against the Trust.

1.11 A number of actions have been taken to update the Health and Safety and Manual Handling Webpages. This year with the incorporation of Security Management, there will be one Health and Safety Services webpage to cover all three

Manual Handling

1.12 There were 2 fewer RIDDOR reportable incidents in 2013/14, compared to the previous year and a 20% decrease in RIDDOR reportable days lost .This represents a dramatic turnaround compared to the increase we saw in both sets of figures 2 years ago. A concentration on practical assistance and particularly practical risk reduction methods has been particularly helpful in this regard.

1.13 We aim to reduce reportable days lost by 10% and maintain the low amount of incidents in 2014/15.

1.14 The servicing and maintenance of Manual Handling equipment and Clinical Weighing Scales continues to be of a high standard and certainly meets the minimum legal standards.

1.15 The cost of erroneous call-outs and repairs caused by negligent damage to NH equipment remains unnecessarily high and will continue to be recharged back to the Wards/depts.

1.16 It is anticipated that Health and Safety Services will retain the management of these contracts at least until April 2015.

1.17 This year, the Induction programme has seen greater numbers of course participants but the course continues to be highly rated although the formal feedback on MH 2 has ceased.

1.18 Overall training attendance for Manual Handling was just over 75% for 2013/14

1.19 We will be aiming for training compliance to hit 80% for 2014/15; an improvement of 5% on last years figures.

1.20 The International Nurse Induction will now be conducted separately from the General Induction programme

1.21 Additional, bespoke clinical training facilities at UHL are critical to the future of all practical based training.

1.22 There has been a marked increase in the Bariatric figures we report this year. It is representative of the National and international trends on Obesity and has meant that our Bariatric activity has never been busier.

1.23 The rate has remained the same in that we continue to see a rise of 10 extra admissions compared to the previous year.

1.24 Last year we saw a 15% increase in the total amount of in-patient days and this year that figure has increased by **25.3%.** Consequently, the average length of stay has increased by **2.5** days this year.

1.25 The average patient weight of the Bariatric referrals this year has increased by **20** kgs

1.26 Our information on recorded weight indicates that there are **22**% of patients referred to the service who have no recorded weight. This is an improvement on last years position where **40**% of patient's has no recorded weight and is definitely a step in the right direction.

1.27 The Trusts has had its biggest outlay for rented equipment since we started keeping records 7 years ago. It should also be noted that these figures are based on actual usage aligned to In–patients days. There have been an increasing number of occasions where Wards have failed to inform rental companies when the equipment is no longer needed and incurred costs for days rented that haven't been actually used.

1.28 Overall, the increase in Bariatric Length of Stay has lead to the increase in rented equipment. It is our view that this will continue to increase in 2014/15.

1.29 We will be looking to replace some of our Bariatric equipment as part of the Phase 3 programme for 2015/16 for Patient Surfaces Management. This recognizes that we have about 12 months of life left in the older Bariatric beds and there will be severe challenges to appropriate storage of these beds at the LRI due to the new ED plans and reconfiguration of services/storage.

Local Security Management

1.30 In 2013 the role of the LSMS was transferred to the portfolio of the Director of Safety and Risk (DSR) under the transfer of facilities management services to Interserve. In the interim period, the LSMS brief was supported temporarily by the Risk and Assurance management team.

1.31 To ensure resilience to this position the LSMS role has been combined with that of the Health and Safety Managers. This sits together with Manual Handling in the newly formed Health and Safety Services (HSS) team

1.32 To support the LSMS brief the most important aspect of our taking this forward is the resilience we create behind the overall responsibility. Therefore the HSS manager will undertake he NHS protect LSMS training in September to further support the current officers

1.33 The Annual Organisational crime profile indicates our overall score profile will not differ from last year which will be the following

Category 1 - Violence, Counter-Terrorism, Violence and Theft.

Category 1- Economic crime

This is typical of a large acute trust with a significant annual operating budget and extensive procurement activities.

1.34 As a result of consultation amongst NHS organisations the Work plan profile for 2014/15 is still under consideration and the latest information suggests that NHS protect will not issue the 2014/15 security standards until September 2014 with a submission date in November 2014.

1.35 Trust has trained 7,248 (1573 total in 2012/13) staff in various forms of conflict resolution training (split 2,286 face-to-face and 4,962 e-learning). This tremendous increase is a 400 % improvement on the previous year's figures

1.36 Together with the appointment of the Conflict Management Trainer post we will undertake a Trust-wide Risk Analysis of the training needs of our staff in relation to security issues

1.37 The last 2 years figures for reported assaults via DATIX have remained static in that 526 incidents were reported in both 2012/13 and 2013/14.

1.38 The Security management and Police Liaison committee has been re-established this year.

1.39 With the establishment of the new security management structure aided by the Security Management and Police liaison committee it is anticipated that accurate security incident figures from all 3 UHL sites will be forthcoming on a quarterly basis and form a benchmark for onward progress.

1.40 There is evidence that NIS Security Agency service costs the Trust £370K last year alone at the LRI. Many of the CMGs have a stated aim of reducing this commitment as part of their cost improvement plans and we will be working with clinical colleagues to progress this.

1.41 We are working with Interserve to resolve issues of vicarious liability for security staff to intervene at the request of clinical colleagues to assist in the medical treatment for patients deemed to lack mental capacity.

1.42 There were 2 freedom of Information request this year concerning" Attacks on Spiritual Rooms" and "Patient on Patient Attacks".

Section 2 - Introduction

2.1 This is the first combined report that reflects the services that now come under the Health and Safety Services Umbrella. This report provides information on the performance of the organisation for the period 1st April 2013 to 31st March 2014.

2.2 The report is presented in sections for ease of reference and includes indications of assurance levels in each area and recommendations for actions.

2.3 The Health and Safety Services team aim to develop a safety culture based on realistic assessment of risk and introduction of control measures that are practical and achievable as well as compliant.

2.4 In September 2013, the Health and Safety team, Manual Handling Service and the Security Management brief were amalgamated under one team now known collectively as Health and Safety Services

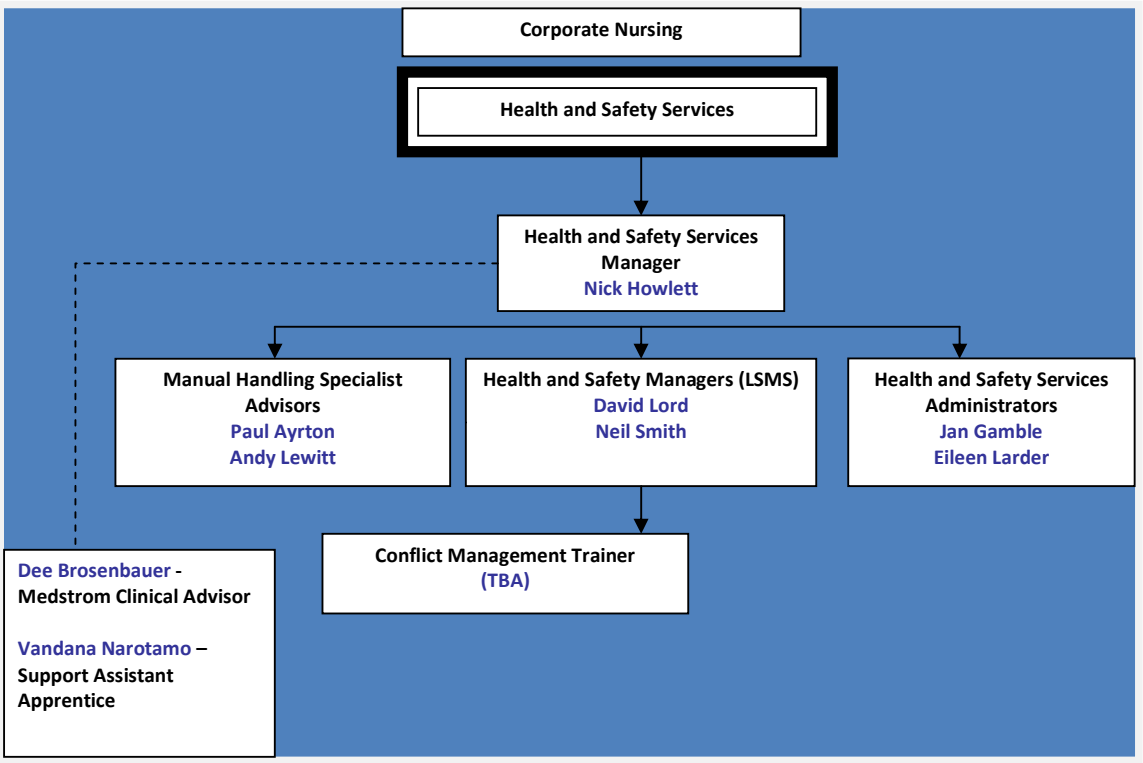
2.5 The reorganization recognized the need to amalgamate the existing team so best utilize existing resource whilst supporting the Introduction of Security Management into the Safety and Risk portfolio.

2.6 This was partly due to the management of change but also a design to give greater support and resilience to all three agendas. The current structure (see below) is still not complete. At the time of writing we are looking to actively recruit to the Conflict Management Trainer post and are also actively looking at a support role for the newly created H&S/LSMS roles.

2.7 Within this structure it was crucial that security management be invested with a longer term commitment then previously managed. NHS Protect is the national body responsible for work on that identifies and tackles crime across the Health Service. They are specific that in that to support the Local Security Management Director, NHS organizations must have a qualified Local Security Management Specialist (LSMS). The previous post-holder has moved to another NHS organization and this inadvertently left the Trust without the support it required.

2.8 To support the ongoing management of this role the current Health and Safety remit was expanded to include that of the LSMS. The pursuance of this aim is described in detail in the Security Management report.

2.9 The Health and Safety Services (HSS) Manager has an active role in the Patient Surfaces Management Contract (PSMC). Part of the support for the day-to-day running of the contract is administered by two Medstrom Support personnel They are both line managed by the Medstrom Area manager but have some line management responsibility to the HSS. This dual role line management has worked well to date and will continue this year.


Corporate Nursing
Health and Safety Services
Health and Safety Services Manager
Nick Howlett
Manual Handling Specialist Advisors
Paul Ayrton
Andy Lewitt
Health and Safety Managers (LSMS)
David Lord
Neil Smith
Health and Safety Services Administrators
Jan Gamble
Eileen Larder
Conflict Management Trainer
(TBA)
Dee Brosenbauer - Medstrom Clinical Advisor
Vandana Narotamo – Support Assistant Apprentice

Section 3 - Health and Safety Annual report

1.1 Annual Health and Safety Audit

The Health and Safety Audit is a systematic review of the health and safety systems and processes in place. It is designed to assess the performance, effectiveness and reliability of health and safety measures in place, report on areas of vulnerability or concern and assist management in the development and planning of corrective actions and an improving safety culture.

1.2 Process

The Annual Health and Safety audit is administered on our behalf by the CASE team. The audit for 2013 was cancelled and this years audit will take place in September 2014.

1.3 Critical review

Through the process of the management of change and the reorganisation of the Divisional/CBU structure in to clinical management groups a tremendous amount of upheaval occurred. This lead to a realignment of roles, change in management and responsibilities not only within the team but throughout the organization.

1.4 The audit needs a clear commitment to be fully applied so that it represents the true picture of Health and Safety practice at a local level. At the time this change occurred the audit was due to be launched and it was felt that that in the climate at the time, the audit was not feasible

1.5 The current audit tool has remained unchanged since its inception in 2002. With the pace of change in healthcare and the changes in prevailing legislation, this year we have decided to review, amend and update the audit tool so that we get a much better reflection of the issues, challenges and areas of good practice in UHL.

1.6 The audit this year will be refocused to give a better understanding of the Health and Safety requirements of each area so that as team we can target deficiencies as well as highlighting areas of good practice.

1.7 The new look audit will focus on evidence based questions that ensure that positive responses can source the required level of information and/or demonstrate the rationale. The emphasis will be on an open and honest response that allows help those areas that most need our assistance

1.8 It is crucial that we get a “warts and all” picture of Health and Safety at a local level. It will only be then that we can truly assure ourselves concerning levels of compliance

1.9 As in previous Audits, we will undertake a comprehensive analysis of the data so that CMGs can be appraised of their performance and deficiencies. Health and Safety managers will then visit each CMG to advise and assist managers to identify and prioritise risk factors and develop plans for corrective actions.

1.10 The audits will be subject to verification by a series of planned “spot” audits by the HSS team to compare the returned findings with the available evidence. This will enable us to comment on our level of confidence with the audit findings.

1.11 This year saw the incorporation of a number of new services and personnel into UHL managed under the banner of the “Alliance”. I anticipate that the Alliance will be

incorporated into the Audit pending some ratification on roles and responsibilities concerning Health and Safety management arrangements with our Community based colleagues.

2.0 Accidents and Incidents reported via Datix

2.1 Accidents to staff within UHL across all sites have resulted in a total of 1028 staff incidents reported on Datix in the twelve months to March 2014. A comparison of accident categories trust wide can be found below

2.2 The top categories of accident which have resulted in the greatest number of reports are: Needle-sticks and Slips, Trips, Falls. This is the same as the previous year and shows that these remain the highest risks to staff at UHL. This year, Violence to staff is reported separately within the Security Management Report

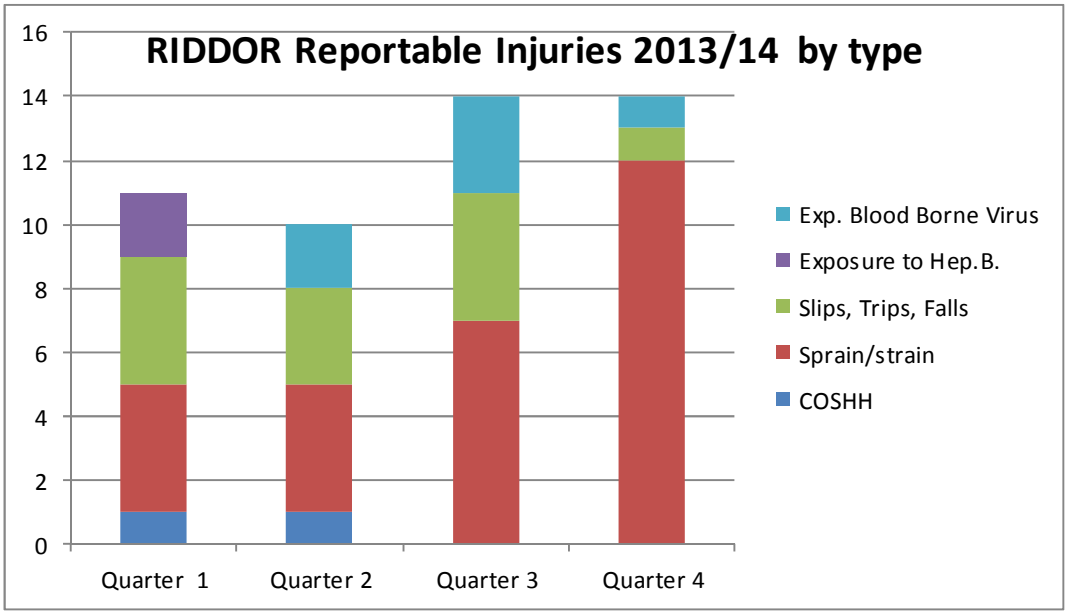
2.3 The heading 'Accident caused by some other means' is the highest reported category with 390 reports. However it is difficult to analyse the accident causation without significant time investment. A similar situation exists with the categories 'Injury by physical or mental strain' and 'Exposure to electricity, hazardous substance etc', The category 'Lifting Accidents' infers manual handling accident rates, yet with only 54 reported is clearly not representative of the real manual handling accident rate.

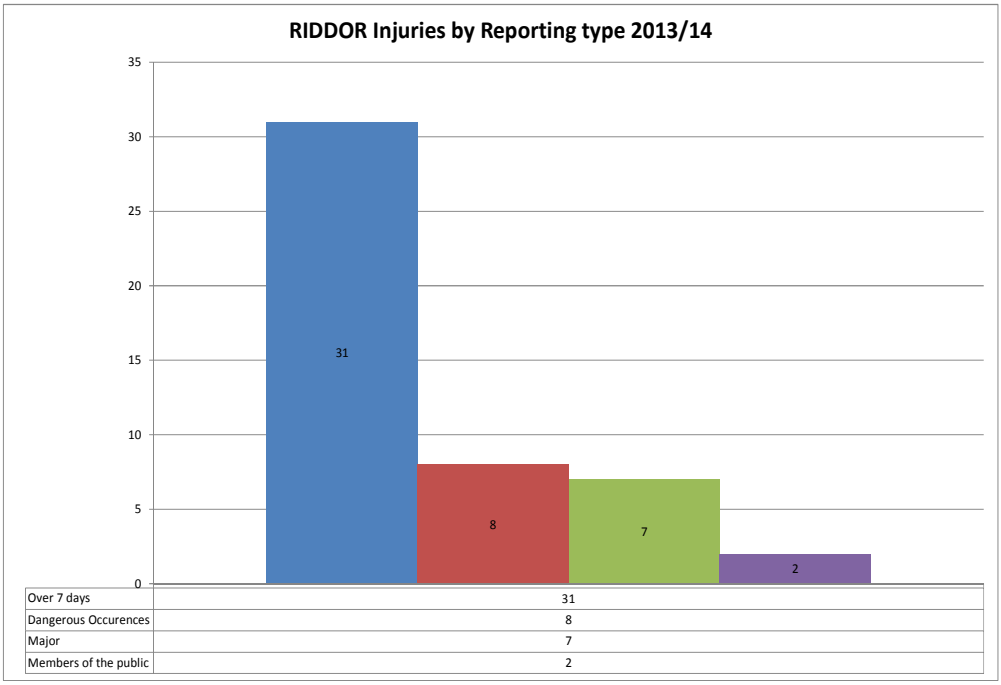
2.4 Needle-stick injuries are categorised in greater detail quarterly by the Occupational Health department and classified as either avoidable or non-avoidable. ***Over 90% of all needlestick accidents are avoidable.***

ACCIDENT TYPE (Datix Categories)	TOTAL 2011/12	TOTAL 2012/13	TOTAL 2013/14
Slips, trips, falls and collisions	**212**	**193**	**211**
Needlestick injury or other Sharps incident	**251**	**257**	**225**
Lifting accidents	**86**	**57**	**54**
Injury caused by physical or mental strain	**102**	**77**	**80**
Exposure to electricity, hazardous substance, etc	**65**	**71**	**60**
Accident caused by some other means	**244**	**420**	**398**
TOTAL:	**960**	**1075**	**1028**

3.0 RIDDOR Incidents Reportable to the Health and Safety Executive

As required under current legislation, **48** workplace accidents were notified to the Health and Safety Executive (HSE) by the Trust's Health and Safety team.





Comparison of RIDDOR Incidents Over 6 Years

Financial Year	Major Injuries	Over 3 day Injuries	Industrial Diseases	Dangerous Occurrences	Public	TOTAL
2008 - 2009	7	85	0	6	-	**98**
2009 - 2010	3	56	1	0	-	**60**
2010 - 2011	2	44	5	9	-	**60**
2011 - 2012	11	39	0	5	2	**57**
		Over 7 day Injuries				
2012 - 2013	6	23	14	7	0	**50**
2013 - 2014	7	31	0	8	2	**48**

3.1 **Performance Indicator**

The Trust set a target of reducing the total number of RIDDOR incidents by 10% per year. This figure has been missed although overall we have had a reduction in overall injuries by 2. We will continue to work to the Trusts 10% reduction target and therefore our aim is to reduce this number to no more than 43 reported incidents in 2014/15.

3.2 **Recommendations:**

- The Health and Safety Team will continue to aim for a 10% reduction in RIDDOR reportable incidents in the reporting year 2013 – 2014.

- The Health and Safety managers will visit all CMG's managers to advise on their priority risks identified in the audit analysis and assist with the development of action plans.

3.3 **RIDDOR Compliance with statutory reporting timescales**

During the year there were 49 incidents reported under RIDDOR. 24 of these reportable incidents were not reported within the time limits required by RIDDOR legislation. This is a compliance rate of 48%. Although an improvement on last year, this is not acceptable and UHL must make a significant improvement on this or else the HSE could take enforcement action.

3.4 **Recommendations:**

It is a requirement of RIDDOR legislation that all incidents falling within reportable categories are reported to the HSE as soon as practicable and in any event within 10 or 15 days of the accident depending on the category. To meet this deadline it is preferable that reportable incidents are notified to the Health and Safety team within 7 days of the incident. It is recommended that the following actions are completed to ensure compliance with reporting requirements, so far as is reasonably practicable.

a) Management Actions:

- Ensure all managers / Datix handlers are familiar with the categories of reportable incidents and timescales for reporting RIDDOR.
- All incidents that are reportable to the HSE are notified to the Trusts Health and Safety team within 7 days of the incident.

- Where incidents are re-categorised at the approval stage, the Health and Safety team are notified.
- Where managers are unsure of the category, advice is sought from the Health and Safety team.
- Incidents that are brought to the attention of managers outside the 10 day deadline are notified to the Health and Safety team forthwith.

b) Health and Safety Team Actions:

- Advise CMG/Department/Ward managers of the above
- Support managers to identify and categorise RIDDOR reportable incidents where the status may appear unclear
- Challenge CMG managers on RIDDOR reportable incidents that are notified to the HSS team outside of 10- 15 days as to the reasons why this has occurred

4.0 Health and Safety Training

4.1 There is a legal duty on employers to provide Health and Safety training. The Health and Safety team provide a range of Health and Safety courses to support managers and staff and enable them to deliver safer services. Similar to previous years, the Health and Safety Managers have provided a series of core training courses. Attendance on training has improved over the previous twelve months. Details can be found in Appendix 2

4.2 The compliance figure has markedly improved from last year, although looking at the previous years figures; it remains steadfastly low as a proportion of the entire Trust population. There is a requirement for managers to assess the risks to staff and others and ensure sufficient staff receive health and safety training competencies to identify and manage the hazards and risks within their service areas. Presently we are reporting that only **3.3%** of staff have received any form of Health and Safety training in 2013/14.

4.3 It is our opinion that a significant gap in knowledge and skills is evident in 2 key areas;

4.4 The knowledge and skills that managers require to ensure they are compliant with prevalent Health and Safety legislation in their area. Suitable training in this subject equips the manager to recognize Health and Safety risks and put control measures into place. Enabling managers to systematically review their risks would lessen the amount of untoward incidents and firmly place the ownership of risk where it belongs at a local level. This approach will allow Health and Safety services to better, pro-actively manage risk in the organisation making better use of our limited resource

4.5 All staff working in an organization need a basic understanding of Health and Safety legislation, their roles and responsibilities and actions necessary. This underpins the manager's responsibilities. Although this training has been delivered effectively in the past, it has been sporadic and not systematically embedded in the required training programme.

4.6 **Progress**

It was reported last year that he Health and Safety team will review their training programme with a view to developing E-learning packages where appropriate. I am pleased to report that there has been significant progress in this area. The development of a bespoke, UHL based Health and Safety training programme has been developed by the team in conjunction with OCB Media. This gives a basic overview of the required elements of an introductory course that firmly delivers the messages that health and safety is everybody's business.

4.7 The course went "live" 3 days before the end of this reporting period. However, early indications suggest that there has been a significant uptake to date.

4.8 Health and Safety training was not included in the required training report for 2013/14 but there will be a requirement this year. In effect this means that training will have to meet certain compliance targets and for this year that will be 80 %.

4.9 **Actions and Recommendations**

4.10 The HSS Team will develop and promote bespoke training programmes targeted at senior and departmental managers throughout the year.

4.11 This will be informed a by training risk assessment that will part of the overall approach to Health and Safety risk assessment throughout 2014/15

4.12 We will continue to offer courses on specific aspects of Health and Safety as informed by local Risk assessment where there is an identified need.

4.13 The HSS team will actively promote the Health and Safety e-learning programme for all staff

4.14 This will included a mandatory requirement that as part the General Trust Induction programme the Health and Safety e-learning module must be completed.

4.15 A reminder will be sent to all staff that this a required training element this year

4.16 The HSS team will gain editorial rights to ensure that the programme is kept up-to-date and reflects any changes in Legislation, and practice arrangements at UHL.

4.17 The HSS team will commit to ensuring that overall Health and Safety training compliance reaches the Trust target of 80% by March 31st 2015.

5.0 Health and Safety Executive Enforcement Action

5.1 Following an incident where a member of staff contracted active TB at work whilst treating patients, the Health and Safety Executive (HSE) carried out an investigation on 14-15th March 2013. This resulted in the HSE serving an Improvement Notice.

There were three main failures identified by the HSE and these are addressed in the action plan below:

1. **Material breach - Failure to report under RIDDOR regulations the other 10 cases of staff latent TB.**

2. **Failure to provide a suitable and sufficient risk assessment to protect staff in high risk areas of developing TB. It is important that UHL understands that the requirement is for ALL airborne contaminates, not just TB.**
   Risk assessment - Failure to adequately assess the risk of exposure, identify risk areas and implements suitable control measures required to reduce risk of harm to staff and others.

3. **Management failure to take swift action to protect staff once TB had been confirmed on the renal unit.**

CURRENT POSITION IN RELATION TO COMPLIANCE

Notice 304661440 served against UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST on 25/03/2013

Notice Type Improvement Notice

Description IN - You have failed to undertake a risk assessment to identify the work activities and areas within the Trust that present a high risk of exposure to inhale micro-organisms which may include tuberculosis.

Compliance Date 21/06/2013

Result Complied with

6.0 Reporting Structure

6.1 The Health and Safety committee structure has undergone transformation to reflect a proper line of reporting to through to the Trust Board.

6.2 This has resulted from the change management that took place when the estates and facilities function of the Trust was taken over by our partners Interserve. Beforehand, the estates team had actively managed and serviced the committee structure and reported issues onward to relevant Trust committees.

6.3 With the revision of the trust committee structure and the lack of clarity over Health and safety Committee roles, responsibilities and servicing, a process of review took place resulting in the present structure which has now been ratified and in place since November 2013. (Appendix 1)

6.4 This committee structure has been revised to ensure

- Each committee has an established representative and relevant membership
- The terms of reference are clear on the aims and objectives of each committee
- The Chair, Vice-chair and quorate arrangements are in place
- The line of reporting is clear and established
- The committees are adequately serviced with administrative support

6.5 I am pleased to report that the committee structure has been re-established and is once again fit-for-purpose. In this regard I am grateful to the Director of Safety and Risk for her hard work and commitment in enabling this to happen.

7.0 Quarterly Health and Safety reports

7.1 It is mandated that the Health and Safety Service Manager reports on a number of Health and Safety related topics, targets and issues for the Local and UHL Health and Safety Committees every quarter. Additionally this report is submitted to the Quality Assurance Committee.

7.2 In recent months this has come under close scrutiny with a suggestion that the reporting lines should be set against a number of Key Performance Indicators that for benchmarking.

7.3 The reporting of RIDDORs and the measurement of this against targets has taken place for the last 7 years. However, other topics are reported on when and if there are issues reported but have never been set against measurable targets.

7.4 This year the Health and safety quarterly report will be expanded to include additional items for performance measurement or benchmarking for onward measurement. These

will be, RIDDOR reportable injuries, Number of need stick injuries reported, Numbers of staff who have completed some form of approved UHL Health and Safety training, Number of IRMER reportable incidents, Number of settled Employee/Public Liability Claims against the Trust.

8.0 Communication

8.1 It has been identified that both the Health and Safety and the Manual Handling Webpages, currently on INsite need to be updated. Some of the previously implanted links don't work or connect to out-of-date documents. Some of the pages don't reflect the current working arrangements under the HSS banner and navigation can be difficult

8.2 It is crucial for effective communication that our webpages are constantly updated and are fit –for-purpose

8.3 In the interim, we have done much work to remedy the immediate problems, particular in relation to accessing the most up-to-date guidance and policies. We have updated the names and roles on the system and removed some of the old information.

8.4 Our long term plan will be to not only combine the current webpages under the Health and Safety Services title but to expand that to include the Security role. The aim is to have a "one stop" page that provides all the relevant information for all services under our remit.

8.5 As we have identified and actioned the priorities for the services in this years action plan then this will be reflected in the make-up of the new Webpage

8.6 <u>"Safety Matters".</u>

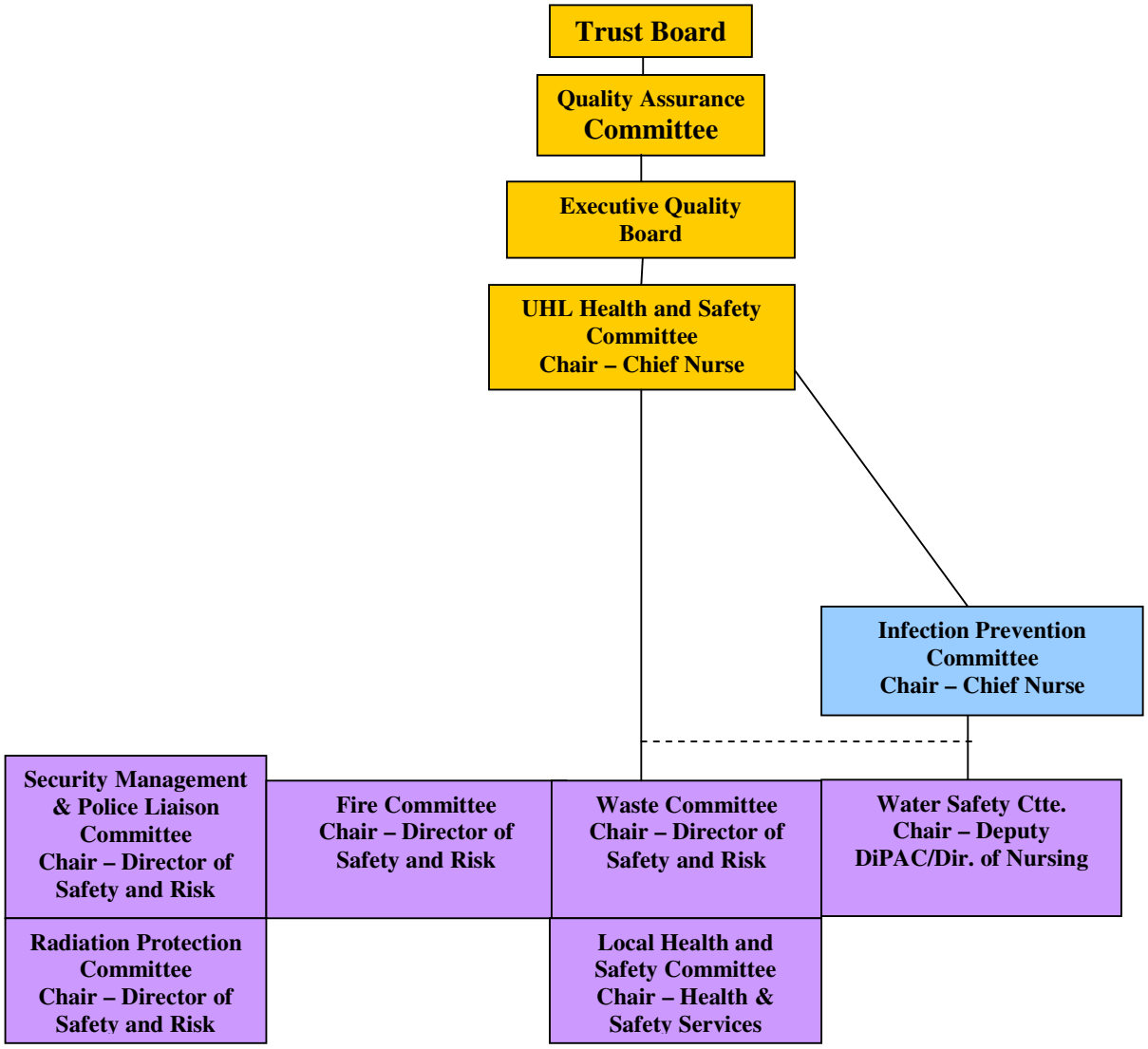
We are still committed to promoting all safety issues through the Trusts "Safety Matters" staff magazine. This is currently being issued every 2 months and is designed to further promulgate important messages to the organisation as a whole.

8.7 It is encouraging to see it is actively being used by all departments throughout the Trust in relation to their own Health and Safety items. We will continue to actively promote and support the on-going work of "Safety Matters" in the forthcoming year.

APPENDIX 1

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST

UHL HEALTH AND SAFETY COMMITTEE STRUCTURE



APPENDIX 2

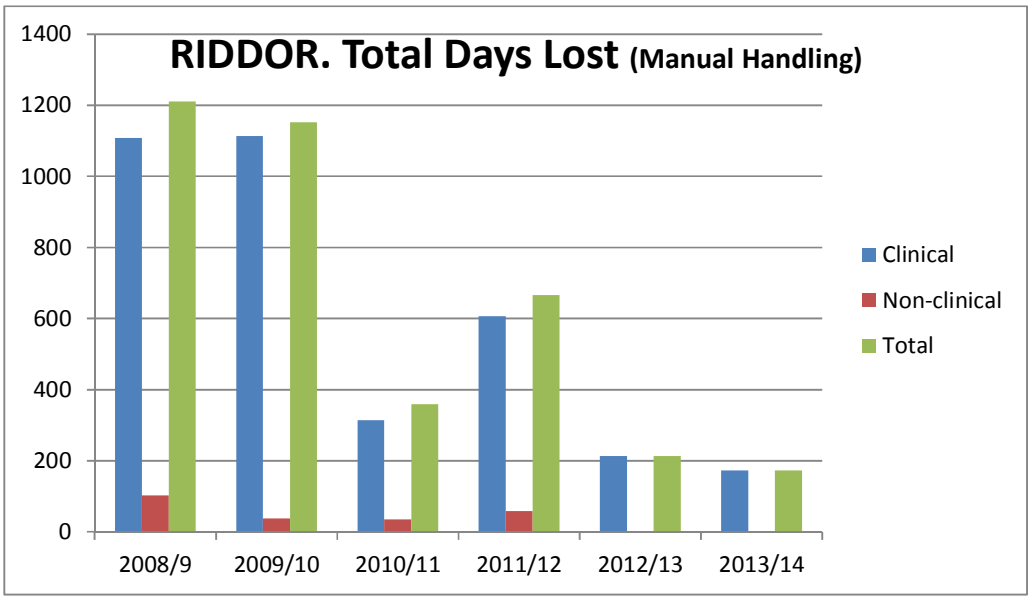
TRAINING FIGURES FOR 2013/14

Health & Safety	Admin and Clerical - Non Clinical	Allied Health Professionals & Healthcare Scientists	Doctors	Non-Qualified Nurses	Qualified Nurses and Midwives	Total
H and S - COSHH (controls of Substances Hazardous to Health) Risk Assessment	5	9	0	1	5	20
H and S - Display Screen Equipment Risk Assessment	9	3	0	2	3	17
H and S - Risk Assessment	3	6	0	1	22	32
Health and Safety (eLearning-OCB) (Mandatory Training)	7	1	1	3	12	24
Latex Allergy Training	5	3	0	32	0	40
Risk Assessment - (eLearning)	11	32	11	26	81	161
Risk Assessment (eLearning - eUHL)	0	0	0	0	0	0
Risk Assessment training	0	0	0	0	0	0
Stress Management and Emotional Resilience for Managers	13	41	4	1	47	106
Totals	**53**	**95**	**16**	**66**	**170**	**400**

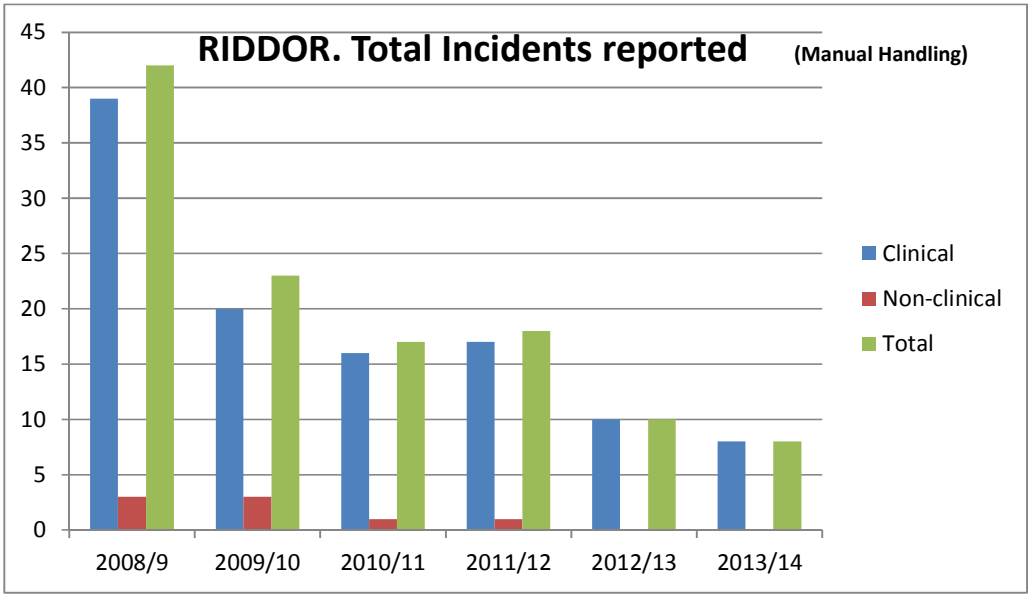
Section 4 - Manual Handling Annual Report – 2013/14

1. Accidents and Incidents

RIDDOR Reportable Incidents. 2013/2014.



PREVIOUS TRAINING FIGURES FOR THE LAST 2 YEARS									
	Risk Assessment	COSHH Assessment	DSE Assessment	Working Safely	Stress Management	Stress Awareness	Latex / Other	H&S Management	Total
TOTALS 2011-2012	20	9	15	14	38	0	495	0	591
TOTALS 2012-2013	22	12	14	2	7	13	30	88	188



(As clinical areas have undergone various name changes in the last 6 years, this classification is for all areas that currently sit under clinical management groups but were previously listed under divisions , directorates or Clinical Business Units)

1.1 The figure for RIDDOR Reportable Incidents (the most serious injuries or incidents) indicates a fall this year. There were 8 reported incidents compared to last year's figure of 10.

1.2 Last year, the total had decreased to 214 days lost. This year that figure fell further to 171. This represents a **20%** decrease in days lost and is the lowest this figure has been in the last 6 years.

1.3 For the second consecutive year we have zero reported incidents in the non-clinical divisions. However, a substantial amount of staff previously reported under UHL have moved to either Interserve or NHS Horizons employment and therefore figures are reported via these employers instead.

1.4 2 years ago, figures were alarming in that previously to this, we had seen a annual decrease in the amount of RIDDOR reportable incidents and days lost. As a result there was a refocusing from the team to concentrate on practical risk reduction methods. This impacted on the reduction seen last year and I am pleased to report that this trend has continued this year. One again the support lent to those areas dealing with Bariatric patients has proved very worthwhile. Timelier referral for patients of this type has allowed us to put systems into place before staff are getting injured. The embedding of a safer culture by emphasising, reinforcing and facilitation of good practice is essential to safer manual handling. The efforts of the Manual Handling advisors in this regard cannot be ignored either.

1.5 The Manual Handling service is always vigilant to any trends or themes that may occur in the RIDDOR injuries we investigate. There has been a lot of remedial work as a result of the injuries investigated. Short-staffing coupled with workload is always a high risk and the Trust must be aware of the risks taken when activity is high and staffing is low.

1.6 It is worth noting that RIDDOR reportable injuries changed so that incidents only become notifiable after 7 days. I reported last year that this had the potential to skew the figures for this and future year reports. However, I am confident that the incidents reported this year would have been the same if the 3 day reporting system was still in place. Therefore, we can be confident that there has been a real terms reduction in RIDDOR reportable injuries this year.

Summary

1 **There were 2 fewer RIDDOR reportable incidents in 2013/14, compared to the previous year**

2. **There has been a 20% decrease in RIDDOR reportable days lost in 2013/14, compared to the previous year**

3. **The above represents a dramatic turnaround compared to the increase we saw in both sets of figures 2 years ago**

4. **A concentration on practical assistance and particularly practical risk reduction methods has been particularly helpful in this regard.**

5. **We aim to reduce reportable days lost by 10% and maintain the low amount of incidents in 2014/15.**

Recommendations

6. To maintain success of injury reduction we have seen in the previous year.
7. To keep supporting the risk reduction culture by providing practical help and advice to the Trust
8. Maintain our role in RIDDOR investigation with a view to exploring any trends and taking appropriate action.

2.0 Servicing and Maintenance of Clinical Weighing Scales and Manual Handling equipment.

2.1 The estates and facilities management contract with Interserve had as a plan to have absorbed the current contracts for Weighing Scales and Manual Handling equipment. This still has not materialized and therefore I have extended the contract with our current provider CareTech UK Ltd and Scaleways by 12 months. For the Budget assertions in 2014/15 it was confirmed that the current arrangements would not be subject to change until the 2015/16 budget at the earliest

2.2 We have continued to enjoy the excellent service we have been accustomed to from CareTech and Scaleways Ltd and I foresee this continuing in 2014/15. I am very grateful for all there help and assistance and look forward to maintaining this excellent relationship in the forthcoming year

2.3 Planned replacement of motors and parts is still on-going although financially this will not be as big a problem as last year.

2.4 Having reviewed the situation, this year we will be recharging costs of this nature back to the clinical areas. Paying for avoidable damage is not only untenable but it is rewarding those areas that continually abuse the care of their equipment. I have already undertaken work to put this into place and let managers know of their responsibilities.

2.5 The Manual Handling service continues to communicate with the Trust to ensure that the use and care of the equipment is kept continually kept in mind. The reiteration of how equipment should be managed and used is very important to ensure that user errors in all respects are reduced.

2.6 Last year, I reported that I had reduced the stock of Manual Handling equipment by **4%**. Decommissioned equipment is used for spare parts by our servicing and maintenance partners. This year the stock has slightly increased with the net addition of 5 extra pieces of

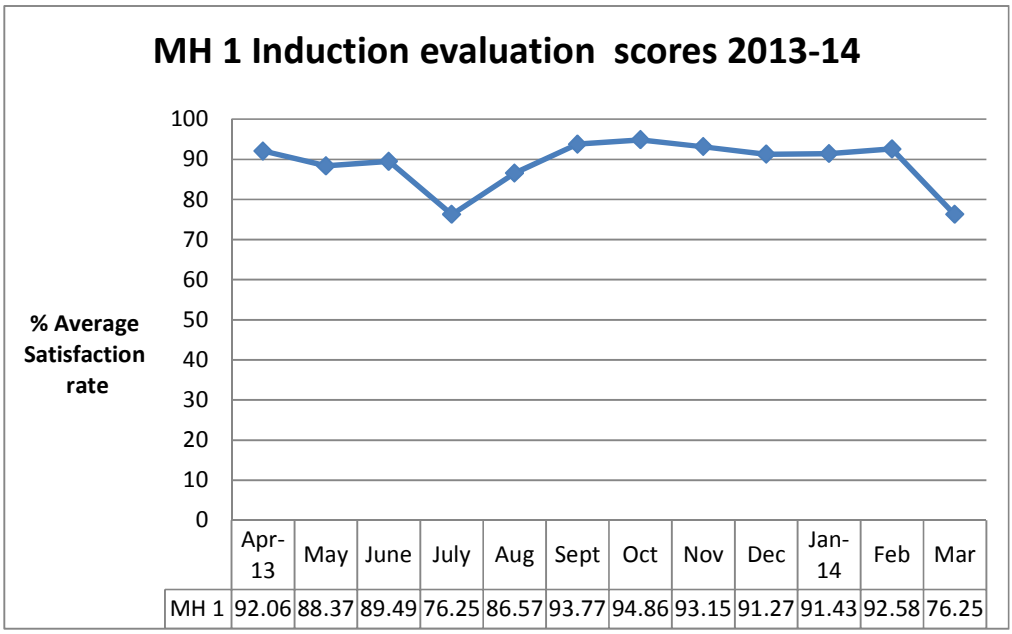
equipment. I am still confident that we have the right equipment in the right areas to ensure the continuance of safer practice.

Summary

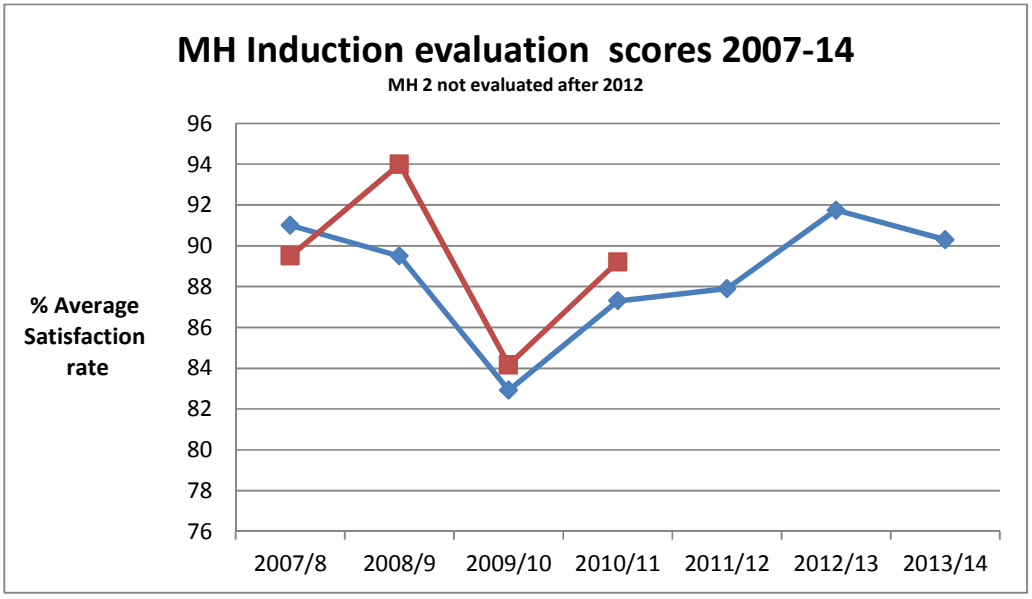
- **The servicing and maintenance of Manual Handling equipment continues to be of a high standard and certainly meets the minimum legal standards.**
- **We continue to maintain and improve on our impressive stock of Clinical weighing machines. There is a multiplicity of differing scales allowing us to accurately weigh patients (in accordance with the prevailing standards).**
- **The cost of erroneous call-outs and repairs caused by negligent damage will continue to be recharged back to the Wards/depts.**
- **It is anticipated that Health and Safety Services will retain the management of these contracts at least until April 2015.**

3.0 Manual Handling Training

Manual Handling on the UHL Induction training programme.



	Apr-13	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan-14	Feb	Mar
MH 1	92.06	88.37	89.49	76.25	86.57	93.77	94.86	93.15	91.27	91.43	92.58	76.25



3.1 We continue to receive formal feedback on a monthly basis in relation to Manual Handling 1, and I am pleased to report that overall the satisfaction rating was 90.3% over the year. To be clear, this means that the course has been evaluated at over 9 out of 10 consistently throughout the last 12 months.

3.2 This year saw the last of the Induction in its present format. From April 1st 2014, the new style induction programme commenced. Manual Handling 1 has been replaced with a requirement to complete the online manual handling e-learning programme as a pre-requisite for those going onto to do Manual handling 2; the patient handling session. In collaboration with our HR colleagues, we have been working to ensure that there is adequate provision of courses so that staff access training in a timely manner. This has meant the laying on of extra courses. To date, there have some initial problems, particularly with adequate practical skills training space. We will continue to work with HR training to refine the programme to maintain the overall quality.

3.3 Training for Trainers programmes

Number of Trainers

2005/6 - 199
2006/7 - 169
2007/8 - 173
2008/9 - 172
2009/10 - 218
2010/11- 188
2011/12- 165
2012/13 - 162
2013/14 - 171

3.4 As of May 2014, we have 171 practicing trainers in the Trust. This represents an increase on last year and furthers our aim of having the right trainers in the right place. I would like to take this opportunity to thank all our cascade trainers who continue to provide high quality safer handling programmes despite the pressures on their time. I am continually impressed

by their ability to deliver high quality training, risk assessments and advice in very challenging times with so much pressure on their time

3.5 Figures from e-UHL indicate that the entire Manual Handling Training* compliance dramatically increased from last years figure of 60% to 78% this year. This is in due in part to the refocusing on training compliance that the organisation has taken on key, core skills. Supported by a targeted campaign of awareness and the conversion and updating the Manual Handling e-learning course by OCB Media has helped achieve that figure. The aim will be to have Manual Handling training compliance at 80% by the end of March 2015.

*Taken from the 38 different Manual Handling courses on currently on offer throughout the Trust and listed on e-uhl

Other courses

3.6 We continue to support the volunteer induction programme with our "Back Injury Prevention" session. Once again the session has been very well received by the course participants. Volunteer services have now pioneered a training video in which we have taken part. We will continue to support this course.

Income generation

3.7 Medical Students

Despite the fact we have never received any **direct** income for this, our commitment to medical student training continues. The numbers have increased this year and we are lead to believe that the increase in service will continue. Once again Leicester University report that this session receives excellent reviews from the students.

We have recently reviewed training provision for Manual handling to Leicester University students. In line with some of the curriculum changes to Medical Student training it is likely that the type of provision, and frequency of delivery will change. At the time of writing, this work is in its very early stages and the impact on the service is as yet, unknown.

3.8 We have maintained the current business relationship we have with Rainbows charity, and various Private care agencies.

3.9 This year we have generated close to £1100 through private training particularly on the Training for Trainers course.

E-learning courses.

3.10 As reported earlier we have completely revised the e-learning Manual Handling course. This has allowed us to update the content and prepare the package for use on the new General Induction programme.

3.11 This year we will take complete control of this and (and other e-learning courses) by having administrator and editorial rights. This will allow us to reflect changes, update content and keep the courses relevant in a timelier manner. This level of control will be essential to in maintaining the overall quality of the course content.

3.12 This year we aim to build on the success of this course by putting on additional "bolt-on" courses that build on the current course as a foundation. Although, this is still to be confirmed, the risk assessment process and principles of inanimate load handling seem to be the current direction we will be taking.

International Nurse and "Bulk" Recruitments

3.13 In line with trusts requirement to recruit at certain times of the year and to source staffing form abroad there have been extra demand place on Training requirement for new

starters. Whereas the Manual handling service is always willing to support the training requirement it has proved very difficult to adequately plan do this in our existing workload.

3.14 Recruitments such as these have to be planned for in terms of adequate training space for clinical skills and this has been very difficult to facilitate this year. At times we have struggled to accommodate such requests.

3.15 There have been numerous discussions as to how best address this in the future and our conclusions lead us to believe that;

a) The International Nurses should be treated as a separate Induction. They are often well qualified but pose training challenges because of custom and practice learnt elsewhere. This means that the training input is greater than that of the general induction programme. It is our belief that International Nurses have their own "Bespoke" Manual Handling Induction course. It is not acceptable for them to be slotted onto the General Induction.
b) There is a tremendous strain on training resources and it is becoming even more evident that the UHL needs more clinical training space to support the demand. At the time of writing I am lead to believe this is being considered at a strategic level. This will be critical to supporting staff training need in the future.
c) Better communication between Nursing and Human resources is needed to identify peak periods of recruitment during the year. I am please to report that this is beginning to happen and therefore we will now be in a better position to accommodate such requests.

Summary & challenges for 2014/15

- **This year, the Induction programme has seen greater numbers of course participants but the course continues to be highly rated although the formal feedback on MH 2 has ceased.**
- **As of May 29th 2014, we have 171 practicing cascade trainers in the Trust**
- **The provision of Manual Handling Training programmes must not be compromised despite the change in Mandatory update requirements**
- **The reformatting of the first Manual Handling, e-learning course has been very successful**
- **We will be aiming for training compliance to hit 80% for 2014/15, an improvement of 5% on last years figures.**
- **International Nurse Induction should be conducted separately from the General Induction programme**
- **Additional, bespoke clinical training facilities at UHL are critical to the future of all practical based training.**

4.0 Bariatric report.

Patients requiring use of the specialist Bariatric equipment

ALL FIGURES EXCLUDE ANY PATIENTS USING WARD BASED 250KG BEDS, WIDE CHAIRS OR WIDE COMMODES AS THESE ARE NOT MONITORED BY M.H. SERVICE

	2005/6	2006/7	2007/8	2008/9	2009/10	2010/11	2011/12	2012/13	2013/14
Bariatric patients admitted	40	76	92	128	91	77 (+ 10 ***)	87	96	106
In-patient days	973	1253	1445	1702	1410	1197 (+ unknown **)	1104	1185	1586
Ave. length of stay	24.3 days	16.4 days	15.7 days	13.3 days	15.5 days	15.5 days	12.1 days	12.3	15
Ave. number of patients/day	2.6	3.4	3.9	4.6	3.9	3.2	4.0	3.2	4.3
Ave. weight of patients using equipment	Not monitored	158.9kg	181.3kg	166.72	163.8kg	162.57kg	162.35kg	151.67kg	173.43kg

* Note: usage less known Bariatric surgery patients in ( ) – approximate figures only

** Note :- waiting list gastric bypass patients no longer recorded as wd 22 has its own beds and chairs for 2009

*** For 2010/11, 40 wide chairs were introduced across the trust which were not monitored, although pts were included in the figures when known about. Therefore 10 pts have an unknown length of stay. 30 patients in the 2011/12 figures were not included as there was no recorded weight.

Commentary on Bariatric Figures

4.1 There has been a marked increase in the figures we report this year. It is representative of the National and international trends on Obesity and has meant that our Bariatric activity has never been busier. The rate has remained the same in that we continue to see a rise of 10 extra admissions compared to the previous year. This figure only relates to those patients referred to the Manual Handling Service and does not include those that are managed without our intervention; this usually applies to the Gastric Bypass patients at the LRI.

4.2 Last year we saw a 15% increase in the total amount of in-patient days and this year that figure has increased by **25.3%.** Consequently, the average length of stay has increased by **2.5** days this year.

4.3 The average patient weight this year has increased by **20** kgs

4.4 Our information on recorded weight indicates that there are **22**% of patients referred to the service who have no recorded weight. This is an improvement on last years position where **40**% of patient's has no recorded weight and is definitely a step in the right direction. However it is important to reiterate that it is essential information when patients are referred to us as this informs the advice we give. We will continue the message about having an accurate weight on all in-patients.

4.5 There has been no new Bariatric stock in the UHL since we took delivery of 2 new Bariatric beds in November 2012. The stock is actively managed by us and serviced by our partners Medstrom Ltd. However, at least 3 of the beds are coming to the end of their useful working lives and there has been a subsequent increase in downtime for repairs. Due to the increase in admissions and the lack of available equipment there has been a large rise in rental equipment this year.

4.6 The figures below represent the trust biggest outlay for rented equipment since we started keeping records 7years ago. It should also be noted that these figures are based on actual usage aligned to In–patients days. There have been an increasing number of occasions where Wards have failed to inform rental companies when the equipment is no longer needed and incurred costs for days rented that haven't been actually used.

No. of pts admitted	Total no. of in pt. days	Ave length of stay	Ave no. of pts/day using equipment
106	1586	15 days	4.3

The costs indicated are SAVINGS on rental, with actual rental costs in red

	No. of episodes (R=rental)	Days used (Inclusive of rental)	Rental days used	Pts/day using equipment	Potential cost (actual rental cost)
XL chairs	23 (1)	252	21	0.69	£9061.25 (£434.70)
XL shower/commode	7 (0)	85	0	0.23	£2340.85 (£0)
Hoists	10 (0)	139	0	0.38	£7,822.40 (£0)
Mattresses	21 (0)	292	0	0.8	£3211.24 (£0)
Rise/recline chair	4 (4)	137	137	0.37	£0 (£4,507)
Proaxis bed	14 (0)	97	0	0.26	£7,440 (£0)
1080 bed	28 (0)	362	0	0.99	£37,005 (£0)
460/560 bed	4 (0)	60	0	0.16	£4,320 (£0)
Baros bariatric bed	21 (15)	361 (262)	262	0.99	£7074 (£24,872)
Total Care bed	0 (0)	0	0	0	£0 (£0)
Wide Cefndy commode	6 (0)	109	0	0.29	£1876.50 (£0)
TOTAL COSTS	-	-	-	-	**£80,151.24** **£29,813.70**

4.7 As with every report for the last 9 years I include a report on the costs of Bariatric equipment We now have 7 years worth of these figures. We have spent **£76,150** on various pieces of Bariatric equipment over the last 6 years. When securing such funding I constantly sell the potential savings on purchase over rental. It is therefore incumbent on me to prove that this is so. We can demonstrate that when this equipment is used, we are not renting and this has meant we have saved **£651,641** over the past 6 years. **This means the equipment we have bought has paid for itself *8.5 times* over.**

4.8 With the increase in rental and delay in timely notification of the rental company for removal, there have been serious problems in the rental companies being paid in a timely fashion. Often the wards requesting have no idea of the relevant ordering codes or how to generate an order number on CEDAR. This year we have instituted a rental "call-off" system that has

helped to address this issue. It is an amendment to the BEM contract and allows the timely rental of equipment by using a list of pre-approved order numbers. This is accessible through the Manual Handling team and the Duty-managers and managed by Patient Surfaces Contract manager. At the time of writing, this system has only just been embedded but we anticipate that this will lessen the amount of erroneous day's rental and ensure the timely payment to the rental companies. In turn, this will drastically reduce the amount of wasted staff hours we have seen with this issue in the past.

4.9 **Overall, the increase in Length of Stay has lead to the increase in rented equipment. It is our view that this will continue to increase in 2014/15.**

4.10 Replacement of Bariatric equipment under the management of the Patient Surfaces Management Group (PSMG) is tabled as a regular item on the monthly contract review meetings. It is recognized that we need to replace existing bed stock and perhaps increase our overall Bariatric fleet.

4.11 At the time of writing, the options being considered are;

a) Replacing equipment as part of the Phase 3 programme for 2015/16
b) This recognizes that we have about 12 months of life left in the older Bariatric beds and there will be severe challenges to appropriate storage of theses beds at the LRI due to the new ED plans and reconfiguration of services/storage.

Summary & challenges for 2014/15

- **To continue the good work produced to date and promote and resolve Bariatric issues**
- **To emphasise the importance of weighing patients on admissions so that the Trust achieves a better compliance in timely accurate information.**
- **Monitor the new Rental ordering system for effectiveness and the reduction in erroneous costs**

APPENDIX 1

Reporting of Manual Handling training Compliance by Staff Group 2013/14

Staff Groups / Report Code	Admin and Clerical - Non Clinical	Allied Health Professionals	Doctors	Non-Qualified Nurses	Qualified Nurses and Midwives	Total
Moving and Handling	1496	985	699	1303	2392	6875

Manual Handling Training Courses available to UHL in 2013/14

- Imaging Directorate - Non Patient Manual Handling
- Lincoln Renal Unit Manual Handling (for patient handlers)
- Loughborough Dialysis Unit Manual Handling Update (for patient handlers)
- Manual Handling
- Manual Handling (Part of Mandatory Training Day)
- Manual Handling - Annual refresher update
- Manual Handling - Clerical and Administration
- Manual Handling - Medical Records Staff ONLY
- Manual Handling - Non Patient Handlers (part of Mandatory Training Day)
- Manual Handling - Patient Handlers (part of Mandatory Training Day)
- Manual Handling - Patient Handlers - Acute Care Division
- Manual Handling - Patient Movers - SERCO Staff Only
- Manual Handling - for the Infection Control Team - UPDATE
- Manual Handling 1 (as part of UHL Corporate Induction)
- Manual Handling 2 (as part of UHL Corporate Induction)
- Manual Handling Update
- Manual Handling Update (Pharmacy Only)
- Manual Handling Update for Consultants in Renal and Urology
- Manual Handling refresher for Transplant Laboratory staff
- Manual Handling Principles for Non-Patient Handlers (eLearning)
- Manual handling refresher for AICU GH
- Medical Physics & Pathology Mandatory Manual Handling Training (inanimate loads)
- Moving & Handling - Bank only nursing staff
- Moving & Handling - Cascade Trainers - Non-Patient Handlers Update 1/2 Day
- Moving & Handling - Cascade Trainers Update - PATIENT HANDLERS - 1 Day
- Moving & Handling - Health and Safety Week (Medical Students ONLY)
- Moving & Handling - Training for Trainers - Non-Patient Handlers 2 1/2 Days
- Moving & Handling - Training for Trainers - PATIENT HANDLERS - 5 Days
- Moving and Handling
- Moving and Handling For Non-Patient Handlers (eLearning-OCB)
- Musculoskeletal Directorate Manual Handling Update 2008
- Musculoskeletal Directorate Manual Handling for Admin and Clerical Staff
- Musculoskeletal Manual Handling (eLearning)
- Musculoskeletal Moving & Handling - (eLearning)
- Occupational Therapy - Moving & Handling UPDATE
- Pharmacy - Manual Handling
- Transplant Laboratory Manual Handling Update

Required Staff Groups:
- Admin and Clerical - Non Clinical
- Allied Health Professionals
- Doctors
- Non-Qualified Nurses
- Qualified Nurses and Midwives

Section 5 – Local Security Management Annual Report 2013/14

1. Introduction

1.1 The responsibilities of the Local Security Management Specialist (LSMS) sit outside the day-to-day security structure and include development of procedures, oversight of security functions and implementation of national policy by direction of NHS Protect, who monitors crime across the health service.

1.2 At the start of 2013 with advent of the Interserve Managed Facilities contract and the creation of NHS Horizons, the existing support structure had gone.

1.3 New arrangements for Security personnel now employed by Interserve, the Security Management and Police Liaison group stopped meeting and the systems that had been in place were left unsupported

1.4 These events coincided with the cessation of the Conflict Resolution Training (CRT) programmes offered by the Leicestershire Partnership Trust which came to an end in December 2013. This was the only training on various levels of Conflict Resolution that the trust had access to.

1.5 In 2013 the role of the LSMS was transferred to the portfolio of the Director of Safety and Risk (DSR) under the transfer of facilities management services to Interserve. In the interim period, the LSMS brief was supported temporarily by the Risk and Assurance management team.

1.6 To ensure resilience to this position the LSMS role has been combined with that of the Health and Safety Managers. This sits together with Manual Handling in the newly formed Health and Safety Services team

1.7 We have since been progressing the work needed to ensure that the UHL is compliant against the standards expected by NHS protect who are the strategic body responsible for work that identifies and tackles crime across the Health Service.

2 Local Security Management – Responsible Persons for the UHL

2.1 NHS protect are very specific in relation to roles and responsibilities under the Local Security Management Agenda. Officers nominated for the Trust have to be recognised by NHS Protect as being suitably qualified. There is also an expectation that the Trust will have a named person at Executive level who will take on the role of Security Management Director

2.2 As of November 2013, Rachel Overfield, Chief Nurse, has taken on the responsibility of the Security Management Director role for University Hospitals of Leicester

2.3 When combining the LSMS role as part of the Health and Safety mangers role both existing post-holders were seconded to the NHS Protect (LSMS) training programme as part of their formal appointment. I am pleased to report that David Lord has now completed his training and that Neil Smith is currently undergoing the LSMS course.

2.4 The combination role of Health and Safety Officer and Local Security Management Specialist is currently undergoing a review through the Job Evaluation process. The

Job description and Person specification has been agreed and signed off by the current post-holders, the HSS Manager and the Director for Safety and Risk. We are awaiting the outcome of the Job Evaluation panel.

2.5 There have been some discussions on what other personnel will be required to best drive the Health and Safety Officer and Local Security Management Specialist (H&S/LSMS) role forward. The outcome will partly be informed by the Job evaluation, the financial envelope for further developments and the likely support this role requires.

2.6 What is known that is that we will be recruiting a conflict management trainer (CMT) This post is currently being verified by the Job Evaluation panel. We anticipate that when this role has been approved, we will recruit quite rapidly.

2.7 In taking on the LSMS brief the most important aspect of our taking this forward is the resilience we create behind the overall responsibility. Therefore the HHS manager will undertake he NHS protect LSMS training in September to further support the current officers

3 Organisational Crime Profile and Security Management Work plan - 2014/15

3.1 It is a requirement from NHS Protect that all NHS organisations submit an Annual Organisational crime profile (The full template can be seen in Appendix 1). At the time of reporting there are still some parts of the profile that need populating.

3.2 Despite the incomplete data this will not alter our overall score profile from last year which will be the following

Category 1 - Violence, Counter-Terrorism, Violence and Theft.
Category 1- Economic crime

3.3 This is typical of a large acute trust with a significant annual operating budget and extensive procurement activities. It is also reflective of the geographical size and location of the trust properties and the amount of staff employed. The categories are an indicator of the scale of activity we should be taking in order to safeguard patients, staff, funds and other assets. This rating is therefore, in line with other large acute NHS organisations.

3.4 As required by the NHS Protect Agency Standards for providers. 2014/15 (security management), the Health and Safety Services team will be completing the Security Management Work Plan for UHL

3.5 The Annual Security Management Work Plan details the management and organisational arrangements fro security activities and requirements.

3.6 There are 15 criteria that are assessed on the following 4 categories

1 Strategic Governance
2 Inform and Involve
3 Prevent and Deter
4 Hold to account

3.7 Last years report represented a new format for reporting in this way. Nationally, this has created much debate as to best answer, evidence and populate the work plan. As a result of consultation amongst NHS organisations the Work plan profile for 2014/15 is still under consideration and the latest information suggests that NHS

protect will not issue the 2014/15 security standards until September 2014 with a submission date in November 2014.

3.8 This will act a template for organising and action our resources to meet the NHS protect requirements. In effect this is a Trust- wide Risk Assessment that we will utilize to compose a Trust- wide action plan.

There will be 3 main themes that develop from this work

1. Identify deficiencies in our security management compliance
2. A Trust wide training needs analysis that identifies risks and also best training measures needed for individual wards and departments.
3. Immediate actions for trust compliance

3.9 A longer term plan to meet our compliance requirements for security management will also result together with the result of the job evaluations

4. Conflict Management Training

4.1 During 2013/14, the Trust has trained 7,248 (1573 total in 2012/13) staff in various forms of conflict resolution training (split 2,286 face-to-face and 4,962 e-learning). This tremendous increase is a 400 % improvement on the previous year's figures but should be treated with caution.

4.2 A large proportion of the Training was delivered by the Conflict Resolution, e-learning programme that was developed in conjunction with OCB Media.

4.3 There were 3 factors affected our decision to use this as learning tool.

1. It forms one of the 10 core subjects that comprise the Required Training programme for all staff employed by UHL
2. The withdrawal of training services previously delivered by our LPT colleagues
3. Our inability as a result of the LPT withdrawal to offer alternative and approved NHS Protect training courses.

4.4 As an interim position it was agreed that all staff could access the e-learning module as it met the training requirement and a decision was take that some information giving was beneficial to staff rather than the alternative of nothing

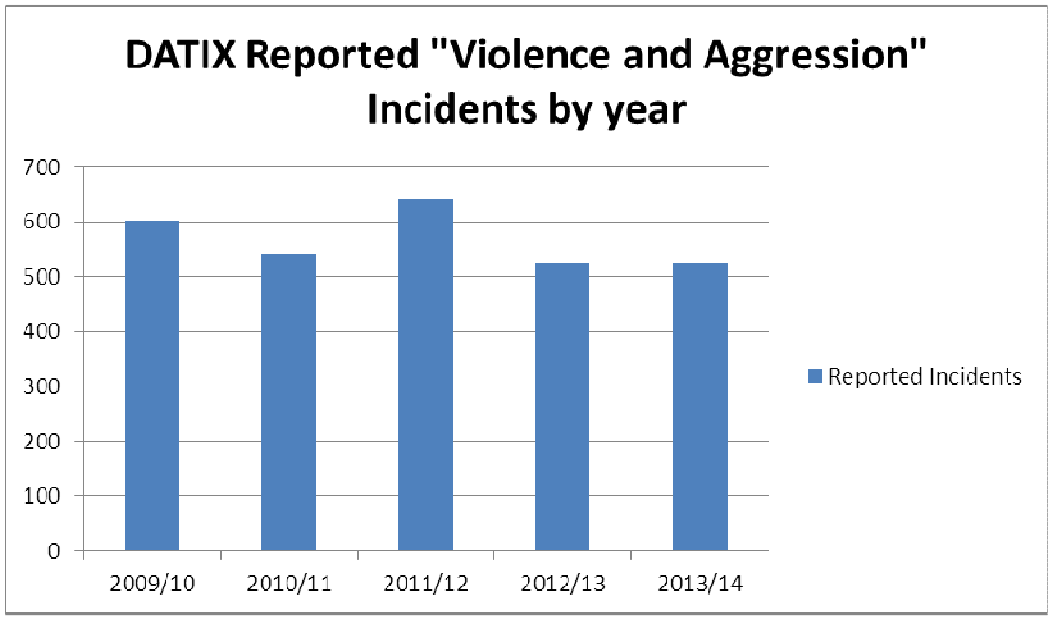
4.5 It is clear that NHS protect will not tolerate this as a medium, or long-term solution The training profile for the UHL should be based on assessment of the risk. It is clear that some staff that are exposed to higher levels of verbal and physical assault and would need a greater level of training input and support than can be had by an e-learning course.

4.6 Together with the appointment of the CMT post we will undertake a Trust-wide Risk Analysis of the training needs of our staff in relation to security issues.

4.7 This will the give us a template of what training is needed, by whom and when. The consequence of this is compiling and delivering a targeted, fit-for-purpose portfolio of courses that best meets the Security needs of our staff

4.8 Conversely it would also highlight those low-risk areas that have minimal exposure and may need very little training or any.

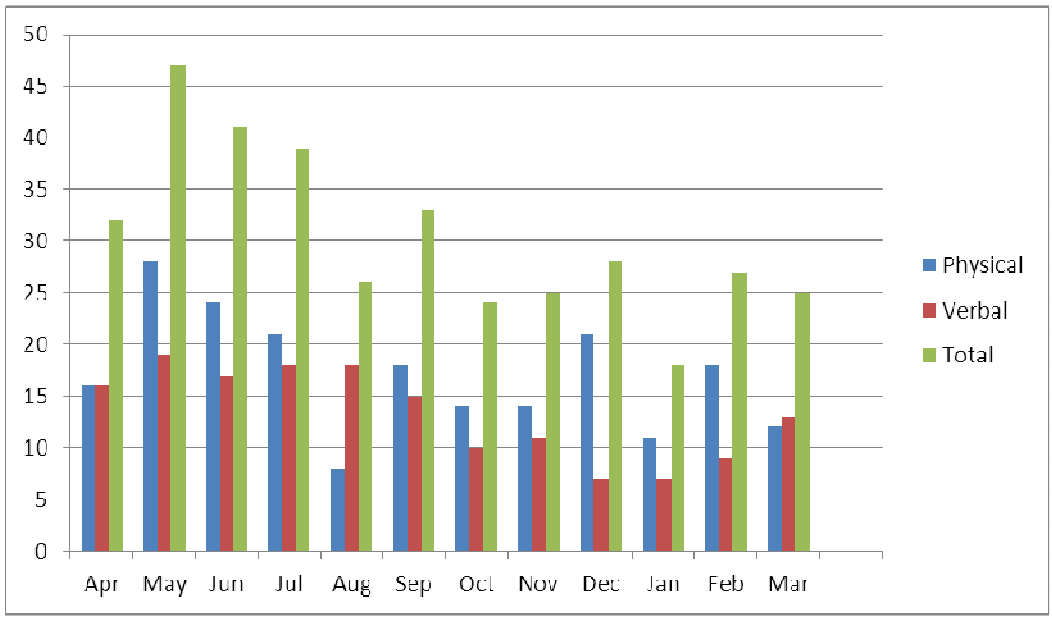
5 Reported DATIX figures for the amount of incidents per year.



5.1 The amount of reported incidents represented in the above graph are the annual totals of reports listed under the DATIX heading “Violence and Aggression” and therefore encompasses a whole range of incidents that include Physical and Verbal assault . This figure does not discriminate between those incidents that are deemed to be have been caused by the patients physical and mental wellbeing either.

5.2 The last 2 years figures have remained static in that 526 incidents were reported in both 2012/13 and 2013/14.

DATIX reported “Violence and Aggression 2013/14”



5.3 There is a requirement of Interserve management to provide figured on security interventions in the Trust. The reporting of security incidents encountered by the

security officers including breakdown of the type of incidents and intervention required has been sporadic this year and largely been form the LRI only.

5.4 This has occurred because of the changes in Interserve personnel but there is now an established structure to support the process in the future.

5.5 With the establishment of the new security management structure aided by the Security Management and Police liaison committee it is anticipated that accurate figures from all 3 UHL sites will be forthcoming on a quarterly basis and form a benchmark for onward progress.

5.6 **Communication to staff who have reported Assaults via DATIX**

5.7 It is stated in the NHS Protect 2013/14 Security Management Work plan under 2.7 that , "All staff who have been a victim of a violent incident have access to support services should they require it"

5.8 This year we have instituted a system whereby all staff who have reported verbal or no-verbal assaults will get a follow-up letter sent to them. The verbal assaults are signed by the HSS manager and the physical attack victims have a letter that is sent from the Chief Executive. (Appendix 2)

5.9 This is a commitment to our staff that all incidents of this nature are treated seriously. It also gives practical advice on whom to contact should they wish to discuss the incident further and also what the Trust offers in terms of support and counselling should they require it.

5.10 Last year we sent out 312 letters. Although those that replied were in the minority we have had 27 communications thanking us for our support and expressing gratitude that somebody has acknowledged the trauma that they suffered

5.11 We plan to continue this service in 2014/15 as it not only complies with NHS protect standards but more importantly it is in keeping with the Trust values and beliefs concerning care of our staff.

6 Security Management & Police Liaison Committee

6.1 The Security management and Police Liaison committee has been re-established this year. This follows a period where membership was uncertain and therefore attendance was poor. Consequently, the remit to oversee Security issues within the Trust dwindled.

6.2 The committee now has a confirmed membership that brings in the views and expertise form the key stakeholders around security issues. Chaired by the DSR, it has representatives from NHS Horizons and Interserve and as well as the Community Police responsible for the areas that cover Trust buildings. This is supplemented by members of the HSS team and representatives from security for LPT.

6.3 Since reconstitution, the terms of reference for the committee have been redrafted so that the there is a clear understanding of the work that it oversees and the scope of responsibilities and powers to promote a safer and secures environment for UHL.

6.4 We are very grateful to have the support form Ian Crowe, Non-Executive Director, who has taken a particular interest in Security issues. It is enormously helpful to have his guidance and expertise to help drive our Agenda through in the forthcoming year.

6.5 The committee meets on a quarterly basis and is part of the UHL Health and safety Committee Structure with direct reporting lines to the UHL Health and Safety Committee and onwards.

7. NIS security and use of Interserve Security for Medical Interventions

7.1 Although it difficult to predict what priorities will be highlighted in the Annual Security Management Work Plan, there are 2 issues that will be addressed this year.

7.2 The use of the NISE Security agency. This agency provides staff to monitor and sit with confused/agitated patients throughout the Trust. We will be exploring if this provides the best care available for this service based on

1 Are private security guards the best equipped personnel to provide this service?
2. Do we get best value for money?
3. What are the viable alternatives?

7.3 There is evidence that this service cost the Trust **£370K** last year alone at the LRI. Many of the CMGs have a stated aim of reducing this commitment as part of their cost improvement plans and we will be working with clinical colleagues to progress this.

7.4 We are working with Interserve to resolve issues of vicarious liability for security staff to intervene at the request of clinical colleagues to assist in the medical treatment for patients deemed to lack mental capacity.

(Risk register ref.2325. *There is a risk to patient and staff safety caused by security staff employed by Interserve not assisting with the physical restraint of patients that require essential clinical intervention when they lack capacity*.) Presently this is a service that Interserve argues they are not covered for or is contracted for within the present service arrangements

7.5 A task and finish meeting has been convened to address and resolve the matter urgently. The first meeting took place on the 28th April and work is progressing to fully understand the issues and agree a mutually convenient way forward. To date a paper on the progress is being drafted for EQB.

7.6 The basis of the report will detail the work that has been done so far and will include the downgrading of the risk rating to 15 for patients and staff in regard to the actual reported occurrences on DATIX. This is far fewer than thought although does raise the issue of timely and appropriate reporting

7.7 There are on going discussions between the HSS team, Interserve management and the Trusts legal team to progress this forward.

8 Freedom of Information requests and Media Coverage

8.1 The following requests were made under the freedom of Information in 2013/14

F.O.I. 16769 - Attacks on Spiritual Rooms
F.O.I. 16769 - Patient on Patient Attacks

Detailed response can be found in (Appendix.3)

8.2 There was one media enquiry concerning the rise in staff assaults submitted by University Hospitals of Leicester to NHS Protect for 2013/14. This was specifically concerning non-verbal attacks on staff that came from patients whose physical/mental condition was not considered to be an underlying factor.

8.3 This lead to a Radio interview on the subject that was conducted on behalf of the Trust by the Health and Safety Services manager.

APPENDIX 1

NHS Protect

Organisation Crime Profile

BRIBERY, CORRUPTION, FRAUD, UNLAWFUL ACTION

19.	What is the total combined annual value of NHS Standard Contracts and NHS funding from all Clinical Commissioning Groups and other types of NHS bodies? *(Please select from list)*	Over £400 million
20.	Please list the names of Clinical Commissioning Groups and NHS bodies the contracts are held with (for multilateral contracts, please name only the lead commissioner). *If this list is extensive, please provide in a separate Microsoft Word or Excel document*	See Tab: Q20
21.	What is the value of NHS funds that are allocated to payroll? *(Please select from list)*	Over £240 million
22.	How many procurement exercises are undertaken directly by the organisation, in excess of Official Journal of the European Union limits annually? *(Please insert number)*	Approximately 10 including mini-competitions on frameworks.
23.	What is the total value of procurement exercises undertaken directly by the organisation, in excess of Official Journal of the European Union limits annually? *(Please insert value)*	Approximately £3m (this can change year to year)
24.	How many procurement exercises are undertaken by external providers on behalf of the organisation, in excess of Official Journal of the European Union limits annually? *(Please insert number)*	Approximately 10 although Supply Chain would be able to provide more detail.
25.	What is the total value of procurement exercises undertaken by external providers on behalf of the organisation, in excess of Official Journal of the European Union limits annually? *(Please insert value)*	Approximately £3m (this can change year to year)
26.	What is the organisations threshold above which quotations or formal tenders must be obtained? *(Please insert value)*	£50,000.00
27.	How many procurement exercises were carried out above that level, but below Official Journal of the European Union limits annually? *(Please insert value)*	16 in total
28.	What is the total value of procurement exercises undertaken in excess of the organisations formal quotation and tender threshold limit, but below Official Journal of the European Union limits annually? *(Please insert value)*	£1,130,099.00
29.	How many invoices does the organisation process annually (if processing has been outsourced to an external provider, please state how many are processed by them on the organisation's behalf)? *(Please select from list)*	Over 100,000
30.	What is the value of the invoices processed annually (if processing has been outsourced to an external provider, please state the value of invoices processed by them on the organisation's behalf)? *(Please select from list)*	£30 - £60 million
31.	Are invoices processed internally or outsourced to an external provider? *(Please select from list)*	Internally
32.	How many fraud, bribery and corruption allegations involving NHS funds has the organisation received in last financial year? *(Please insert number)*	34 referrals received with 15 carried over from 2011/12
33.	How many fraud, bribery and corruption allegations involving NHS funds developed into full cases and were investigated by the organisation within the last financial year?	16 full Investigation cases for the 2012/13 Financial year
34.	What is the value of the organisations known NHS losses as a result of fraud, bribery and corruption within the last financial year? *(Please insert value)*	£198,556.00
35.	What is the value of the organisations NHS recoveries as a result of fraud, bribery and corruption investigations conducted within the last financial year? *(Please insert value)*	£8,939 (the majority is ongoing recovery)

NHS Protect

Organistion Crime Profile

VIOLENCE

10.	Does your organisation provide 'out of hours' services? *(Please select YES or NO)*	YES
11.	How many sites do you provide services from? *(Please select from list)*	10 or less
12.	What is the total number of reported staff assaults involving physical contact your organisation has received between 1st April 2012 and 31st March 2013? *(Please select from list)*	200 or more
13.	How many incidents of violence and aggression were 'RIDDOR' reportable between 1st April 2012 and 31st March 2013? *(Please select from list)*	1 - 10
14.	How many 'serious untoward' incidents of violence and aggression did you organisation have reported in the period 1st April 2012 to 31st March 2013? *(Please select from list)*	0

SECURITY PREPAREDNESS

15.	How many other 'security related incidents' has your organisation had reported in the period 1stApril 2012 to 31st March 2013? *(Please select from list)*	51 - 150
16.	How many other security related incidents were 'serious untoward' incidents in the period 1st April 2012 to 31st March 2013? *(Please select value)*	0

CRIMINAL DAMAGE, THEFT

17.	What is the total financial value of your NHS capital assets? *(Please select value)*	£500,001 or more
18.	What has been the total financial loss to the organisation through theft and criminal damage to NHS premises and property in the last financial year (excluding any involving a natural disaster)?(excluding any involving a natural disaster)? *(Please select value)*	Less than £5,000

NHS Protect

Organisation Crime Profile

BRIBERY, CORRUPTION, FRAUD, UNLAWFUL ACTION

19.	What is the total combined annual value of NHS Standard Contracts and NHS funding from all Clinical Commissioning Groups and other types of NHS bodies? *(Please select from list)*	Over £400 million
20.	Please list the names of Clinical Commissioning Groups and NHS bodies the contracts are held with (for multilateral contracts, please name only the lead commissioner). *If this list is extensive, please provide in a separate Microsoft Word or Excel document*	See Tab: Q20
21.	What is the value of NHS funds that are allocated to payroll? *(Please select from list)*	Over £240 million
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35.	What is the value of the organisations NHS recoveries as a result of fraud, bribery and corruption investigations conducted within the last financial year? *(Please insert value)*	£8,939 (the majority is ongoing recovery)

APPENDIX 2

Attachments: Staff Counselling Service (AMICA).doc

Dear

It has been brought to my attention, through the internal incident reporting system, you were the victim of a verbal assault on (DATE) whilst on duty on the (LOCATION) at the (HOSPITAL) and I very much regret any distress caused.

The Trust is committed to do everything it can to protect staff from such incidents and support staff who are the victims of abuse. To this end, I will be working with security colleagues to monitor the assault cases reported on the internal incident database to identify any trends or persistent offenders.

As part of the support service offered to staff, the Trust has an arrangement in place that enables you to access a confidential counselling service, independent of myself or your manager. Amica is a self referral, staff counselling service that provides telephone counselling, 365 days a year, with direct access to a qualified/ experienced counsellor. I have enclosed the contact details for this service for your information.

Once again, I am sorry that you have suffered this experience and if you would like to discuss any aspect of this incident please do not hesitate to contact me

Kind regards

Nick Howlett

Health and Safety Services Manager

Attachments: Staff Counselling Service (AMICA).doc

Dear

I am very sorry to hear you were a victim of a physical assault whilst on duty at (LOCATION) at the (HOSPITAL) on the (DATE) and I regret any distress this ahs caused

My executive colleagues and I recognise that our staff are our most valuable asset and where situations occur we need to provide support to you, and learn nay lessons we can to reduce the risk of further incidents. Where assaults have criminal intent we are fully committed to working with Police to bring about prosecution where appropriate, and manage or exclude the assailant in keeping with national guidelines

To this end, I have instructed our Health and Safety Services Team to manage this matter and ensure action as necessary is taken.

In the meantime, should you require any support in relation to this incident, please contact your line manager or access our independent counselling services, Amica who are available 7 days a week between 8.30am and 8.30pm by calling 0116 254 4388. Amica can provide both telephone based support and if required face-to-face counselling.

Again, please accept my apologies that you have been a victim in this situation

Yours sincerely

John Adler

Chief Executive

APPENDIX 3

HM/FOI/16769

1. Data concerning vandalism to religious/spiritual rooms and buildings in the hospital (e.g hospital chapels and prayer rooms) from January 2009 to as recently as possible.

I am advised that the Trust is not aware of any vandalism to religious/spiritual rooms and buildings across the three hospital sites.

2a.Please include a breakdown of the damage caused and the cost incurred, as well as the time period during which incidents occurred.

N/A

2b. Please also include any reports submitted by hospital staff and, where possible, data concerning assaults, intimidation or threatening behaviour towards hospital chaplains and other hospital staff employed in a spiritual or religious role.

I am advised that the Trust has no incidents recorded in relation to assaults, intimidation or threatening behaviour towards hospital chaplains and other hospital staff employed in a spiritual or religious role.

KR/FOI/16808

1. How many patient-on-patient attacks* have been recorded in the previous five calendar years (2009, 2010, 2011, 2012, 2013)
a) How many of these attacks resulted in an injury?
b) How many of these attacks did not result in an injury?

Please submit your data in the following tables:

2009				***2010***			
Total attacks	***Injury***	***No injury***	***Unknown if injury or not***	***Total attacks***	***Injury***	***No injury***	***Unknown if injury or not***
11	7	4	N/A	12	7	5	N/A

2011				***2012***				***2013***			
Total attacks	***Injury***	***No injury***	***Unknown if injury or not***	***Total attacks***	***Injury***	***No injury***	***Unknown if injury or not***	***Total attacks***	***Injury***	***No injury***	***Unknown if injury or not***
18	9	9	N/A	6	2	4	N/A	8	4	4	N/A

2. *Please give us a brief description of each attack, if possible within the cost limit.*

I am advised that it has not been possible to provide a brief description of each attach within the appropriate 18 hour limit provided for under section 12 of the Freedom of Information Act. Consequently the Trust will not be progressing this section of your request any further.

By 'patient-on-patient attacks' we mean a patient making a physical assault on another patient.

Section 6 – Health and Safety Services Action Plan – 2014/2015

Health and Safety Services Action Plan 2014 -15

Objective	Action Required	Timescales	Accountable Officer	Lead Officer	Outcome/Evidence
Health and Safety					
To review and update the Health, Safety and Environment Risk Audit (HSER), to reflect Policy, Present practice and organizational change	▪ To critically review the present Audit tool, update the content and ▪ Verify validity of audit tool with CASE team.	July 2014	N. Howlett	D. Lord N. Smith	An agreed Audit tool that can be utilised across the Trust that accurately measures H&S performance
To measure the Trust's Management of Health and safety systems by re-launching Health, Safety and Environment Risk Audit (HSER)for all wards, departments and sites at UHL	Launch the Audit in September 2014 to all wards, areas and departments Help and engagement with Trusts CASE team to apply and collate the tool and collate the results	September 2014 September 2014	N. Howlett CASE Team	D. Lord N. Smith	Audit completed , results collated and supplied to the HSS team by October 6th 2014
A10% reduction in RIDDOR reportable incidents in the reporting year 2013 – 2014.	Targeted campaigns of work as informed by the HSER Audit to tackle areas of concern , higher risk activities and higher risk work areas The Health and Safety managers will visit all CMG's managers to advise on their priority risks identified in the audit analysis and assist with the development of action plans.	November 2014 – March 2015	N. Howlett	D. Lord N. Smith	At least 5 fewer RIDDOR incidents than that reported in 2013/14

Objective	Action Required	Timescales	Accountable Officer	Lead Officer	Outcome/Evidence
To increase compliance rate of RIDDOR incidents falling within reportable categories are reported to the HSE as soon as practicable and in any event within 10 or 15 days. Target will be to increase timely reporting from 48% to a year end position of 75%	Advise CMG/Department/Ward managers of the above Support managers to identify and categorise RIDDOR reportable incidents where the status may appear unclear Challenge CMG managers on RIDDOR reportable incidents that are notified to the HSS team outside of 10- 15 days as to the reasons why this has occurred Monitor and report this in the Quarterly Health and Safety report	March 2015 Monitored quarterly during 2014/15	N. Howlett	CMG/Department/ Ward managers HSS Team	That there is evidence at the year end that compliance is 75% or more.
The HSS Team will develop and promote bespoke training programmes targeted at senior and departmental managers throughout the year.	Through the HSER we will identify the training needs of managers throughout UHL. To amend and redesign present managerial level Health and Safety courses. We will launch and conduct these courses throughout the year. We will conduct work to explore the feasibility of making this a Mandatory requirement for all Managers (to be defined) as part of their learning needs	January 2015	D. Lord N. Smith	D. Lord N. Smith N. Howlett	Suitable Heath and Safety courses for managers will be established and available by April 1st 2015.

Objective	Action Required	Timescales	Accountable Officer	Lead Officer	Outcome/Evidence
The Health and Safety e-learning module must be completed on the Trust General Induction programme	It will be requirement that all new starters to the Trust will be have to complete the H&S E-learning module as mandatory requirement of completing the Induction programme	April 1st 2014. To be reviewed quarterly	N. Howlett	N. Howlett HR Training Administration	All new starters to be compliant with this requirement from April 1st 2014 as evidenced by the e-uhl training reports.
The HSS team will commit to ensuring that overall Health and Safety training compliance reaches the Trust target of **80%** by March 31st 2015.	Together with the above actions we will, Ensure that timely reminders are sent via e-UHL administration to ensure that staff are required to have completed Healthand safety training by April 2015 (If they haven't already done so) The HSS team will gain editorial rights to the available e-learning courses to assure that all information is up-to-date and relevant This issue will be actively promoted through the new HSS webpage and "Safety Matters".	To be completed by March 2015	N. Howlett D. Lord N. Smith	N. Howlett D. Lord N. Smith e-UHL administration	UHL Health and Safety Training will be 80% compliant with this requirement at April 1st 2015 This will be monitored in the quarterly H&S reports.

Objective	Action Required	Timescales	Accountable Officer	Lead Officer	Outcome/Evidence
This year the quarterly report will include the following as regular items for performance measurement or benchmarking for onward measurement. • RIDDOR reportable injuries • Number of need stick injuries reported. • Numbers of staff who have completed some form of approved UHL Health and Safety training • Number of IRMER reportable incidents • No of settled Employee/Public Liability Claims against the Trust. (To be serviced by the Trusts Legal affairs team).	Collate figures for the quarterly Health and Safety report Comment on performance against targets or benchmarking.	August 2014	N. Howlett	N. Howlett	The UHL H&S Committee, Local Health and Safety Committee and the QAC are assured that this information is available and is an accurate reflection of the figures represented.

Objective	Action Required	Timescales	Accountable Officer	Lead Officer	Outcome/Evidence
Manual Handling					
We will be aiming for training compliance to hit 80% for 2014/15, an improvement of 5% on last years figures.	It will be requirement that all new starters to the Trust will be have to complete the Manual Handling E-learning module as mandatory requirement of completing the Induction programme	April 1st 2014. To be reviewed quarterly	N. Howlett	P. Ayrton A. Lewitt HR Training Administration	All new starters to be compliant with this requirement from April 1st 2014 as evidenced by the e-uhl training reports
	Progress with Corporate Nursing, HR Training and strategic planning to identify additional, bespoke clinical training facilities at UHL are critical to the future of all practical based training.	By April 1st 2015	Strategic Planning	P. Ayrton A. Lewitt	The provision of bespoke, additional Clinical training facilities
	International Nurse Manual Handling Induction should be conducted separately from the General Induction programme	From June 2014	Corporate Nursing	P. Ayrton A. Lewitt	An established, bespoke course for International Nurses needs only
Replacing bariatric equipment as part of the Phase 3 programme bed and equipment contract for 2015/16	Identify appropriate Bariatric bed technology to replace current stock of Nightingale Pro-Axis beds .	November 204	Patient Surfaces Management Committee	N. Howlett	To have 3 new bariatric beds ready for delivery and install after April 1st 2015

Objective	Action Required	Timescales	Accountable Officer	Lead Officer	Outcome/Evidence
To emphasise the importance of weighing patients on admissions so that the Trust achieves a better compliance in timely accurate information.	Reinforce the importance of weighing message throughout all manual handling course by updating course content Regular news –items to appear in "Safety Matters"	Throughout 2014/14	P. Ayrton A. Lewitt	P. Ayrton A. Lewitt	Accurate data on patient weight is seen in at least 80% of the bariatric referrals made to Manual Handling
Monitor the new Rental ordering system for effectiveness and the reduction in erroneous costs	Ensure that rental companies are paid in a timely manner Monitor rental usage on a monthly basis and report finding to the PSM Core group .	Monthly review	H. Walker – Patient Safety Services Contract Manager	P. Ayrton A. Lewitt	Erroneous non-clinical rental days cost to be cut by 50%
Objective	**Action Required**	**Timescales**	**Accountable Officer**	**Lead Officer**	**Outcome/Evidence**
Local Security Management					
Annual Security Management Work plan to follow					

To:	**Trust Board**
From:	**Chief Nurse**
Date:	**31st July 2014**

Title:	**'Sign Up to Safety'**

Author/Responsible Director: Director of Safety and Risk

Purpose of the Report:

- To provide an overview of the national Sign Up For Safety campaign.
- To provide organisational improvements/recommendations for inclusion in the 'Sign up to Safety' campaign.

The Report is provided to the Board for:

Decision		Discussion	X
Assurance	X	Endorsement	X

Summary / Key Points:

- Introduction to the national Sign Up to Safety campaign
- Organisational improvements/recommendations are identified in this report for inclusion in the UHL 'Sign up to Safety' campaign under the following five domains;
  - Put Safety First
  - Continually Learn
  - Honesty
  - Collaborate
  - Support

Recommendations:

Trust Board is invited to note the content of this paper and:-

- Note the Government launch of the 'Sign up to Safety' movement;
- Support the organisational improvements/recommendations identified in this report for inclusion in the 'Sign up to Safety' campaign.

Strategic Risk Register Linked with relevant risks on SRR and operational risk register.	Performance KPIs year to date CQC outcomes Quality Schedule requirements CQUIN Framework

Resource Implications (e.g. Financial, HR) Not yet known to be reported via EQB and QAC.

Assurance Implications Relevant CQC, NHSLA, PHSO and NHS complaint regulations compliance

Patient and Public Involvement (PPI) Implications Engagement with public and patients in LLR as part of plan. A stand is planned at the Annual Public Meeting in September 2014.
Equality Impact None
Information exempt from Disclosure None
Requirement for further review? Monthly updates to QAC.

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST

REPORT TO: **TRUST BOARD**

DATE: **31ST JULY 2014**

REPORT BY: **CHIEF NURSE**

SUBJECT: **'SIGN UP TO SAFETY'**

---

1. INTRODUCTION

1.1 On the 24th June, the Secretary of State for Health launched a package of measures aimed to support transparency with regard to reporting on patient safety.

1.2 A new campaign 'Sign up to Safety' will be led by Sir David Dalton, Chief Executive of Salford Royal NHS Foundation Trust, inviting all healthcare organisations to commit to delivering a safety plan, reviewed and supported by the financial incentives from the NHS Litigation Authority, which will help contribute to the Government's ambition to reduce avoidable harm by half (an estimated 6000 lives) over the next three years. To be approved, the plans must include information on how the organisation will meet two national patient safety priorities and two local priorities.

1.3 Its principle is about **listening** to patients, carers and staff, **learning** from what they say when things go wrong and take **action** to improve patients' safety.

1.4 Organisations are invited to sign up to the campaign by setting out what the organisation will do to strengthen patient safety by:-

- Describing the actions that the organisation will undertake in response to the five Sign up to Safety pledges and agreed to publish this on your organisation's website for staff, patients and the public to see.
- Committing to turn proposed actions in to a safety improvement plan which will show how the organisation intends to save lives and reduce harm for patients over the next three years.
- Within the safety improvement plan, will be asked to identify the patient safety improvement areas that will be focused on.

1.5 This will become an integral part of the UHL Safety and Quality work led by the Director of Safety and Risk and will be reported monthly to Executive Quality Board and Quality Assurance Committee.

2. UHL AND 'SIGN UP TO SAFETY'

2.1 UHL will be signing up to this campaign and use the pledges as a vehicle to formulate a comprehensive safety improvement plan. This will integrate with the implementation of the existing safety programmes within the Quality Commitment. It will also support the actions required in response to the "Learning Lessons to Improve

Care" review that was recently undertaken by LLR and support improvements to the Emergency Care System within LLR.

2.2 The five domains are as follows:-

i. Put Safety First

UHL will develop and deliver a framework for "safety culture" across the organisation. The "UHL Safety Culture" will have three broad strands:-

- The psychological aspect of safety (how people feel): what are the values, beliefs and perceptions regarding patient safety.
- The behavioural aspect of safety (how people behave): safety related actions and behaviours of leaders and the workforce; a programme that supports professionalism by addressing unprofessional behaviours that undermine a culture of safety.
- The situational aspect of safety (what does the organisation have): policies, procedures, regulations, structures and management - how are they aligned with delivering safer care

The outcomes of this project would include:-

- Observable degree of effort by which all organisational members direct their attention and actions to improve safety on a daily basis. This would be measured directly (safety questionnaires) and indirectly (evidenced through improvements in safety reporting and learning systems).
- Measureable degree of reduction in harm to patients across non-elective and elective care.
- Provide value for money – this would be triangulated from reductions in avoidable harm.

The "safety culture" approach will link the four pillars on quality, workforce, strategy and finance as part of UHL's "Delivering Care at its Best".

This has been detailed in the Trust's Quality Commitment and reflects the known standards and targets for 2014-15 including key quality improvement initiatives as deemed from recent review. This includes the CQC visit and the LLR 'Learning Lessons to Improve Care" review. It also recognises specific work streams around the Emergency Care programme. We will continue to make sure that the Quality Commitment reflects the change in circumstances after outcome of review. In order to continue delivering the Quality Commitment, we will strengthen our "safety culture".

ii. Continually Learn

Make our organisation more resilient to risks, by acting on the feedback from patients and by constantly measuring and monitoring how safe our services are.

- We will modify the "bed rounds" to include data on staffing, equipment, patient and family concerns, staff concerns and census (influenced by the 'safety huddles' from Cincinnati Children's Hospital Medical Centre. http://www.ihi.org/resources/Pages/AudioandVideo/WIHISituationalAwarenessPtSafety.aspx

- We will develop the UHL Patient Safety Learning Portal to ensure all staff have easy access to safety messages, safety tools, RCA reports and safety alerts (in development; reported on to EQB and should be going live in August/September 2014) and promote the profile of safety across the organisation.
- We will encourage all areas to develop safety briefings that can be used for staff induction and on-going training.
- UHL will track and monitor the trend chart regarding harm events within the Trust; report this monthly to EQB and publish on the public website. This would also be shared with every service as part of an improvement drive.
- The patient satisfaction and experience survey will be used to develop and deliver improvements in services.
- The constant learning from the themes of incidents, complaints, claims and inquests is a necessity to enable us to feedback to the CMGs regularly. We will use the CMG Performance Review meetings to allow a more thorough response to learning within the CMGs and services.

iii. Honesty

Be transparent with people about our progress to tackle patient safety issues and support staff. To be candid with patients and their families if something goes wrong.

- UHL will track and monitor our “Duty of Candour” compliance and publish this on our public website.
- We will publish the LLR "Learning Lessons to Improve Care" review and commence actions for improvement that affect UHL and co-lead on interventions across LLR that reduce mortality and avoidable harm.
- We will engage with patients and the public of LLR to publish outcome and safety data.
- We will refine the Datix reporting system to enable feedback to staff to improve reporting of patient safety incidents and of unprofessional behaviours that undermine a culture of safety. This will include work to support the Doctors in Training LiA action group to improve feedback from incidents for those who report.

iv. Collaborate

Take a leading role in supporting local collaborative learning, so that improvements are made across all of the local services that patients use.

- UHL will implement the LLR Better Care Together programme in collaboration with our health and social care partners. The strategic outcome of this being to provide the highest levels of quality care, as assessed by clinical outcomes, patient satisfaction and patient safety.
- We will launch the Leicester Innovation and Improvement in Patient Safety (LIIPS) Unit (UHL with academic health partners) to implement and embed quality improvement methodologies and improvement science. We will implement two to three demonstrator projects from September 2014 – 2015. It is envisioned that this unit will remain as a “shadow” unit over this period. The initial projects will include an e-learning project, “Introduction to Quality

Improvement", which will be followed up by further projects on quality. As part of this work, an MSc in Quality and Safety will be developed.

v. Support

Help people understand why things go wrong and how to put them right. Give staff the time and support to improve and celebrate the progress.

- In order to transform in to a "High Reliability" safety organisation, we need to support people effectively. This will include implementing our safety culture with specific work streams dedicated towards improving our finest safety surveillance system – the workforce. We will also develop further the technological aspects of safety surveillance in conjunction with application of Human Factors design. In addition to learning safety systems and supporting the front line through effective processes, we would explore the development and delivery of a "Second Victim" programme to support staff and families. This has been implemented across many hospitals in the UK and USA with demonstrable improvements in staff learning and engagement on safety. (For such a programme please see MITSS: http://mitss.org).
- We will promote and develop the organisational safety culture work with Trust Board and the CMGs by making certain that safety is one of the principle features in all decision making.
- We will support Human Factors work and monitor outcomes including reductions in avoidable death and harm. A Fellowship to support this work will be developed within UHL in collaboration with academic health partners.
- We plan to hold an annual patient safety conference at UHL showcasing projects with improved outcomes that will be another way of celebrating success.

3. RECOMMENDATIONS

3.1 Trust Board is invited to note the content of this paper and:-

i. Note the Government launch of the 'Sign up to Safety' movement;
ii. Support the organisational improvements/recommendations identified in this report for inclusion in the 'Sign up to Safety' campaign.
iii. Regular updates to be provided to Executive Quality Board and Quality Assurance Committee as part of the Patient Safety report.
iv. To receive further updates on this initiative in the coming months.

Dr. Jay Banerjee
Associate Medical Director/
Claire Rudkin, Critical Safety Action Lead
July 2014

Trust Board paper R

To:	**Trust Board**
From:	Kate Shields – Director of Strategy
Date:	**31 July 2014**
CQC regulation:	

Title:	**Approval of the Vascular Outline Business Case (OBC)**

Author/Responsible Director:
Rachel Griffiths - Project Director;
Kate Shields - Director of Strategy/Responsible Officer

Purpose of the Report:

To seek approval to submit the Vascular OBC to the:

- National Trust Development Agency (NTDA) in August 2014.

The Executive Summary of the Vascular OBC was considered by the Capital Monitoring & Investment Committee on the 27 June 2014, at which the principle of the case was supported for consideration by the Executive, subject to additional analysis and update in the following areas:

- Align to the Blueprint for Health & Social Care in LLR 2014 – 2019 and UHL's Five Year Integrated Business Plan (IBP)
- Review the specific costs attributable to vascular and present a clear analysis of the opportunities to realise a breakeven position by year 6.
- Strengthen the clinical case, ambition of the service and interdependency between vascular and cardiology within the Executive Summary
- Overall recognising the level of detail within the main body of the OBC strengthen the Executive Summary to present a compelling case for investment

The case has been updated in line with this feedback and supported by Executive on the 15 July to proceed via F&P to Trust Board.

The Report is provided to the Committee for:

Decision	X	Discussion	X
Assurance		Endorsement	

Summary / Key Points:
The Vascular OBC incorporates the transfer of vascular and supporting services from the LRI to the GH site including an inpatient ward and surgical admissions area; vascular studies unit; angiography and the provision of a new hybrid theatre.

The service move to GH releases prime in patient and theatre space at the LRI plus supporting infrastructure/services.

Recommendations:
The Trust Board is asked to:

- support the submission of the OBC to the NTDA.
- support the approval of the case in the knowledge that the transition move costs will be addressed through the five year strategy; and the opportunity costs will afford the scope for future service reconfiguration to deliver a two site solution.
- agree that the future bed modelling will incorporate provision of the release of ward 24 at the Glenfield Hospital as an enabler to the vascular project.
- Recognise that as part of the future capacity review and reconfiguration of services, consideration will be given to the requirement for ITU beds on the GH site
- accept the timescale for delivery of the OBC and subsequent FBC at risk, subject to addressing the above

Previously considered at another corporate UHL Committee?

Vascular Project Board - 16 June 2014.
Capital & Investment Monitoring Committee - 27 June 2014
Executive Team - 15 July 2014.
Finance & Performance Committee - 30 July 2014

Board Assurance Framework:	**Performance KPIs year to date:**

Resource Implications (e.g. Financial, HR):
Detailed within the OBC

Assurance Implications:

Patient and Public Involvement (PPI) Implications:
The transfer of services to GH will require consideration through the Overview and Scrutiny Committees supported by on-going dialogue with patient representative groups.
In the short term outpatient services will remain on the LRI site

Stakeholder Engagement Implications:

Equality Impact:

Information exempt from Disclosure:

Requirement for further review?
Trust Board update reports at key milestones.

Approval of the Vascular Outline Business Case (OBC)

1. PURPOSE

a. To seek approval to submit the Vascular OBC to the National Trust Development Authority (NTDA) in August 2014

b. To provide the Executive Summary of the Vascular OBC to the Trust Board for specific consideration of the:

   i. Strategic context; alignment to the Trusts future service configuration
   ii. Capital costs
   iii. Revenue impact including potential future opportunities
   iv. Transitional costs to UHL in line with the Five Year Strategy
   v. Programme for delivery of both the OBC and the Full Business Case (FBC)
   vi. Future Trust Assurance on cost base for delivering the FBC

c. The Vascular OBC; Estate Annex and Operational Policy are available for consideration by the Board` if additional detail is required.

2. BACKGROUND

a. On the 2nd July 2013 the Executive Strategy Board (ESB) supported the feasibility for the relocation of vascular services and the necessary resources to develop and undertake design development and the production of the FBC.

b. On the 16th July 2013 ESB approved the commencement of the detailed design development work to support the vascular FBC this was revised on 1st October 2013 when ESB considered a paper following the NTDA feedback outlining the revised approach to vascular; the need to develop an OBC in advance of the FBC.

c. On the 4 March 2014 ESB considered an update on the project and the then revenue cost impact of £2.7m. It was agreed that further detailed analysis would be undertaken including a Confirm and Challenge programme to address the cost base and differentiate specific vascular costs from those attributable to the Five Year Strategy reconfiguration of service moves and changes.

d. The original driver for the relocation of vascular services from the Leicester Royal Infirmary (LRI) to the Glenfield Hospital (GH) was as an enabler to support delivery of a single site surgical take. In addition, the co-location of vascular and cardio/thoracic services is a key factor underpinning the NHS England standard contract for Specialist Vascular Services.

3. KEY HEADLINES AND/OR CHANGES

SERVICE PLANNING

a. The vascular OBC is in support of realising the service ambition to become a Level One Regional Centre for complex endovascular services, supported by exceptional clinical outcomes. The case incorporates the transfer of vascular and supporting services from the LRI to the GH site, including an inpatient ward; surgical admissions area; vascular studies unit; angiography and the provision of a new hybrid theatre.

b. In the short term vascular outpatients will be retained on the LRI site pending a longer term approach to the provision of a dedicated OP/DC hub which will incorporate these services. This will be subject to public consultation as part of the future configuration of services with the development of the proposed OP/DC hub at GH.

c. The relocation of vascular services has been agreed as a priority for delivery within the next two years Trust Operational Plan and is integral to delivery of the Trust's Clinical and Five Year IBP as an enabler for the release of space on the LRI site.

d. Addressing the main factors contributing to mortality including cardio-vascular disease is key to the Blueprint for Health & Social Care in LLR 2014 – 2019. Cardio-vascular disease affects 50% of the 'older' population and has a significant affect on quality of life and longevity.

e. The move of vascular services supports the re-designation of UHL as a lead, level one centre and thereby ensures the long term sustainability of vascular, cardiac and cardiology services. The move is supported by both vascular and cardiology clinical teams. The co-location of vascular services with cardiology/cardiothoracic surgery at GH is a key foundation in the re-designation process for vascular services; and likewise any future designation as a thoracic aortic disease centre.

f. Loss of designation would likely incur a minimum loss of income to the Trust of circa £750k per annum and does not account for the potential impact on other associated services through the loss of specialist vascular provision locally.

g. Re-designation not only secures service sustainability but offers patients a high quality streamlined service supported by 21st century imaging solutions.

h. The main objective is ensure that all patients with vascular disease have 24/7 access to a specialist vascular team with a thorough understanding of their condition, who are able to organise all appropriate investigations and treatment, and manage their post-operative care.

i. During 8am to 5pm (week days) there will be a dedicated consultant vascular surgeon at LRI site to provide support to ED, medical wards and in-house emergencies at LRI site. There will be daily consultant ward rounds of all vascular in-patients, with effective hand-over practices in place. The LRI based consultant will triage ED patients; give inpatient opinions and operate on emergency cases that are too unstable to transfer to GH. The future pathways of care are outlined in the vascular operational policy in support of this OBC.

j. The move of vascular services provides the opportunity to maximise service co-locations and enhanced efficiency. The defined efficiency measures within the OBC have been reviewed as part of the Vascular Service Review supported by Ernst & Young to assess the deliverability. There are further potential efficiencies to be realised through combined workforce solutions and enhanced space utilisation through design. The detailed findings of the Service Review and agreed performance measures will be available in August and will be reflected in the Full Business Case. At this stage the observations and benefits identified can be summarised in the table overleaf:

Business Case Benefits	Service Review Observations	Target/Benefit
Reduces average length of stay	High LOS observed e.g. amputation of leg – delays to discharge Average LOS between 3.63 and 22.76 days for top 10 procedures	Reduce LOS – reduce no of bed days – increase efficiency and throughput Improve outcome for patients on defined clinical pathways
Reduced cancellations	13% (1,143) hospital outpatient cancellations in 2013/14	Outpatients increased efficiency – reduced level of cancellations and improved slot utilisation
Increased elective procedures	Opportunity to become service provider of choice in the East Midlands Region	Enhancing market share within East Midlands Improved capture of activity undertaken through enhanced coding
Improved theatre utilisation	Opportunity to improve theatre utilisation by eliminating delayed starts – 172 hours over the year (2013/14) Unavailability of ward beds is the primary reason for hospital cancellations	Improve utilisation of resources and theatre time – patient readiness for theatre; managing patient flows Dedicated bed base for vascular. Defined day case beds supporting angiography

4. FINANCE

a. The identified capital costs are £11.9m assuming VAT reclamation at circa £450k.

b. This project is identified within the Trust's Capital programme as requiring external loans for the main scheme up to £11.9m.

c. The Trust has appointed Holbrow Brookes to act as independent technical adviser and to undertake due diligence on the costs and detail outlined in both the OBC and the supporting Estate Annex.

d. A Confirm and Challenge panel reviewed all revenue costs within the OBC and costs were differentiated on the basis of:

i. Direct costs attributable to vascular
ii. The cost of transition pending the final reconfiguration of services by site
iii. Opportunity costs afforded by the release of capacity on the LRI site

iv. Total impact on the Trust including depreciation and capital charges £2.1m by 2022/23 (includes £1.2m staff resource costs that provide additional capacity/opportunity at the LRI)

e. The high level outcome of this is outlined in Table 1 (page 8 of the Vascular OBC) with detailed financial analysis provided in section 5 of the full OBC document.

f. At this stage the steady state assumes an additional £602k per annum, this is mitigated through the additional opportunities/validation identified including:

i. work currently being undertaken to address the current coding challenges within vascular. Coding indicates opportunities to further improve income recovery for both elective and non-elective spells.
ii. anomalies within the PLICs data.
iii. changes to the income profile in respect of future partnerships. A prudent approach has been taken in respect of additional activity which will be fully addressed through the development of the FBC.

g. On the basis of the above, vascular is estimated to have a surplus net position by 2019/20.

h. Through OBC to FBC the robustness of the costs will be further reviewed and confirmed.

i. Further market analysis will be undertaken building on the high level review as part of the Five Year IBP; and progressing the development of partnership working.

5. DELIVERY/TIMESCALE

a. A series of enabling moves are required to deliver the vascular project and the timescale for approval is critical to this scheme. A key challenge is the available inpatient space at the GH site and the release of 27 beds from spring 2015.

b. Subject to approval of the above the current timescale for delivery and approval of the Outline and Full Business Cases is now as follows:

- NTDA August 2014
- FBC to CMIC & ESB February/March 2015
- FBC to Trust Board March 2015
- FBC to NTDA March/April 2015
- Construction commences Summer 2015
- Delivery and Commissioning of the new facilities Summer 2016

c. This timescale is on the basis that detailed design development will commence at risk in advance of the NTDA approval of the OBC. The previously approved costs for production of the FBC through Capita are £602k, recognising this excludes Trust costs. A detailed brief for developing the FBC has been issued to Interserve Construction to provide a revised cost base for development of the FBC. The response to the brief and associated costs will be evaluated to ensure the most appropriate and cost effective delivery of the FBC.

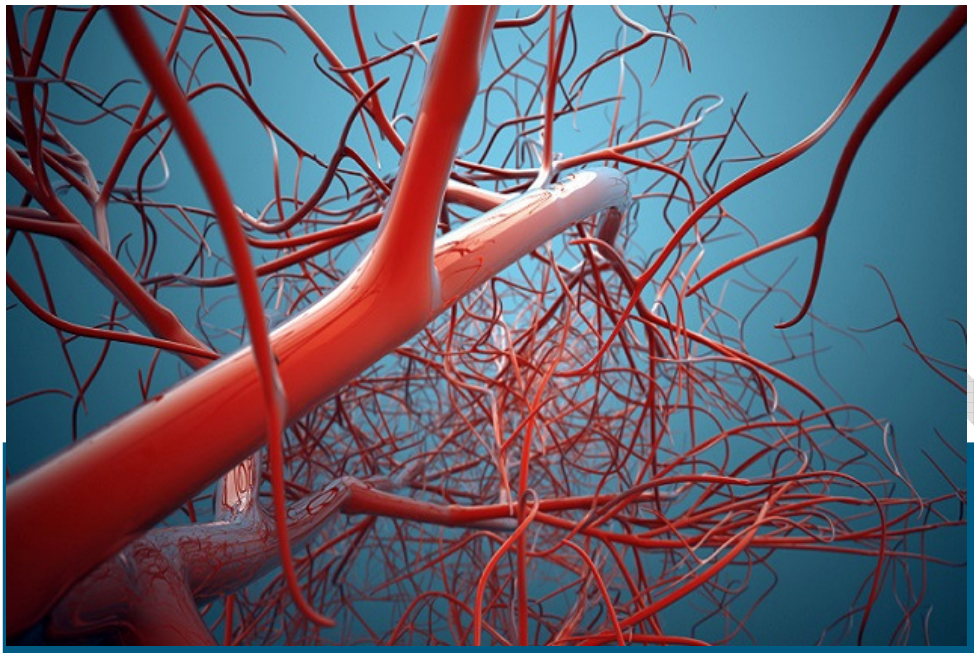
6. RECOMMENDATION

a. To support the submission of the OBC to the NTDA.

b. To support the approval of the case in the knowledge that the transition move costs will be addressed through the five year strategy; and the opportunity costs will afford the scope for future service reconfiguration to deliver a two site solution.

c. To agree that the future capacity and bed modelling will incorporate provision of the release of ward 24 at the GH as an enabler to the vascular project; and the level of ITU provision required on the GH site.

d. To accept the timescale for delivery of the OBC and subsequent FBC subject to addressing the above.



Outline Business Case
Executive Summary

Vascular Services, Angiography & Hybrid Theatre
July 2014

Version: 1.32 – Trust Board Issue

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Contents

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Checked by	Chris Sellars – Capita (Senior Consultant)
Authorised by	Tom Myers/Chris Turner – Regional Operations Director (s)

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1.1	25/11/13	Update	C Mulholland
1.2	28/11/13	Update – workforce; pt involvement sections	C Mulholland
1.3	29/11/13	Updated post-review with C. Sellars	C Mulholland
1.4	04/12/13	NTDA checklist alignment	C Mulholland
1.5	05/12/13	Update	C Mulholland
1.6	11/12/13	Non-financial scoring info added	C Mulholland
1.7	13/12/12	Update – risks; mgmt section	C Mulholland
1.8	16/12/13	Management Section	C Sellars
1.9	17/12/13	Commercial/Procurement Amendments	D Chambers
1.9	18/12/13	Updated post CT/DC review	C Mulholland
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1.17	03/02/14	Updated	C Mulholland
1.18	11/02/14	Updated Procurement, Strategic case	C Mulholland
1.19	25/02/14	Updated re Finance / Programme	CM / CS
1.20	18/03/14	Updated following Project Board actions	C Mulholland
1.21	27/03/14	Economic Model added	C Mulholland
1.22	28/03/14	Financial and Economic Model added/DC Review	C Sellars
1.23	07/05/14	Updated following Trust Review	C Mulholland
1.24	14/05/14	Updated prior to ESB submission	C Mulholland
1.25	15/05/14	Updated following Estate Annex feedback& Revised Financial Section	C Sellars
1.26	23/05/14	Updated following Project Board approval	C Mulholland
1.27	28/05/14	Updated following RG meeting	C Sellars
1.28	12/06/14	Revenue Amendments	V Chalmers
1.29	20/06/14	Financial Amendments & Further changes	V Chalmers
1.30	08/07/14	Strategic Context; Financial Amendments; post Capital Monitoring & Investment Committee	R Griffiths
1.31	09/07/14	Finance Assumptions; formatting and further amendments post Capital Monitoring & Investment Committee	R Griffiths
1.32	17/07/14	Amendments to BCT and Vascular Diagram & Updated following ESB	RG/CS

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1 | Executive Summary

1.1 Introduction

This Outline Business Case (OBC) is to support the University Hospitals of Leicester NHS Trust's (UHL) ambition to become a Level One regional centre for complex endovascular services supported by exceptional clinical outcomes. This case encompasses the transfer of Vascular Services (Vascular inpatient accommodation and Vascular Studies Unit) from the Leicester Royal Infirmary (LRI) to Glenfield Hospital (GH); the co-location of vascular services with cardiology/cardiothoracic surgery at GH is a key foundation in the re-designation process for vascular services. The ability for a single site to accept all referrals for vascular disease from aortic valve to distal foot vessels is of significant importance to future patient care and will likewise attract additional high profile work. This case includes the development of a dedicated vascular inpatient unit; creation of an angiography suite and provision of a Hybrid theatre at GH. This is equally a key first stage enabling move towards the delivery of UHL's Five Year Integrated Business Plan and the release of prime inpatient and theatre accommodation on the LRI site.

The University Hospitals of Leicester NHS Trust's Vascular Surgery Unit is one of the UK's premier units providing comprehensive, high-quality care for patients with peripheral vascular diseases. It is formed of a multidisciplinary team of nurses, occupational therapists, physiotherapists, radiologists, anaesthetists and surgeons working in a synergistic manner to achieve excellent patient outcomes. This is evidenced by both local patient survey data[1] and national audit outcome data[2]. Furthermore, the unit has a strong track-record of innovation and research, from the invention of sub-intimal angioplasty[3] to the early implementation and refinement of endovascular aneurysm repair[4], and more recently leading worldwide collaborative research projects that have both informed clinical care pathways[5] and identified new paradigms for the basis of aneurysmal disease[6].

However, despite this record of excellence there are significant challenges facing the University Hospitals of Leicester Vascular Unit. The national provision of many aspects of vascular surgery now falls under the remit of specialised commissioning groups and there is a national move to locating tertiary services in fewer, larger units (level one centres). In order to ensure the long-term survival of the vascular unit and build upon the current success it is necessary to invest in the development of the service and thus place the unit at the forefront of both regional and national contenders to continue providing vascular services. In particular, it is necessary to provide the infrastructure (both material and human resources) to be able to build upon the current tertiary referral practice and develop a quaternary referral practice.

The principle barriers to moving the current service forward are;

[1] Ward 21 Friends and Family Test
[2] Vascular Society of Great Britain and Ireland. National Vascular Registry 2013 Report on Surgical Outcomes, Consultant-level Statistics. http://www.vsqip.org.uk/surgeon-level-public-reporting/ [accessed 1 June 2014].
[3] Recanalisation of femoro-popliteal occlusions: improving success rate by subintimalrecanalisation. Bolia A, Brennan J, Bell PR. ClinRadiol. 1989 May;40(3):325
[4] Endovascular stenting of abdominal aortic aneurysms. Sayers RD, Thompson MM, Bell PR. Eur J Vasc Surg. 1993 May;7(3):225-7.
[5] Surveillance intervals for small abdominal aortic aneurysms: a meta-analysis. RESCAN Collaborators: Bown MJ, Sweeting MJ, Brown LC, Powell JT, Thompson SG. JAMA. 2013 Feb 27;309(8):806-13
[6] Abdominal aortic aneurysm is associated with a variant in low-density lipoprotein receptor-related protein 1. Bown MJ et al. Am J Hum Genet. 2011 Nov 11;89(5):619-27

- The current location of the service at the Leicester Royal Infirmary site, separate from cardiac and cardio-thoracic surgery, both of which are at the Glenfield Hospital, and
- The lack of in-theatre high-quality radiological imaging facilities (a 'hybrid' theatre). Both the co-location of vascular surgical services with cardio-thoracic surgery and the provision of a hybrid theatre are pre-requisites for the commissioning of complex vascular surgery[7].

Our vision is to create a comprehensive centre for cardiovascular medicine and research. In moving the vascular surgery unit to the Glenfield Hospital site this brings together not only the clinical services, but also the strong academic components of these services. This will build upon the previous investments in the NIHR Leicester Cardiovascular Biomedical Research Unit and the BHF Cardiovascular Research Centre and strengthen the world-leading position of Leicester as a centre for cardiovascular research excellence.

- Why are we doing it?

- Increasing vascular activity due to greater prevalence of vascular disease
- National Specialised Services re-designation ongoing, need to attain Level One to maintain activity/reputation
- Moving Vascular will increase potential of achieving Level One re-designation through
  - Closer working relationships with Cardiothoracic Services
  - Provision of a Hybrid Theatre to provide state-of–the-art imaging facilities
- Ensures the long term sustainability of vascular, cardiac and cardiology services – no change in the current service provision would result in a major risk of loss of designation and the secondary effects of this on cardiovascular services as a whole.
- A key consideration for future designation as a thoracic aortic disease centre will be the requirement for an integrated endovascular, vascular and cardiac surgical team. The development of an integrated aortic disease service will form an increasingly important source of revenue for the Trust as other procedures e.g. coronary artery bypass grafts (currently 50% of income) declines
- Leicester has been a pioneering centre in the use of stent grafts in the UK, to sustain and develop such techniques requires a match in the technology available through the provision of a hybrid theatre. The provision of a hybrid theatre is key to enabling highly specialised activity to continue to be undertaken in Leicester.
- The new 'Shape' GMC training specifications will be supported by the new model proposed with an integrated cardio-vascular service centred on the GH site.
- Aligns with the Trust's Five Year Integrated Business Plan, Clinical Strategy and Estate Development Strategy. It is anticipated that within three years of moving vascular services, renal and transplant services will re-locate to the GH, thereby enhancing future clinical interdependencies and a change in workforce provision.

- What benefits will it bring?

- Improved services for patients including 21st Century imaging solutions through the provision of the Hybrid Theatre – this will be dual use between vascular, cardiology/cardiothoracic surgery with a joint approach being taken to its development

[7]NHS England. 2013/14 NHS Standard Contract for Specialised Vascular Services (Adults).http://www.england.nhs.uk/wp-content/uploads/2013/06/a04-spec-vascu-adult.pdf [accessed 1 June 2014]..

- A comprehensive programme to clinically manage and surgically treat patients with aortic pathology, this is a primary aim of the cardiac, thoracic and vascular surgeons and reflected in the Five Year IBP to be realised in the next two years.
- A hybrid theatre will afford the potential to expand the vascular and cardiac surgery portfolio of services, including complex thoracic-abdominal aneurysms which not only offer patient benefits but increases the income potential for the Trust
- Cost Efficiencies through streamlined patient processes
- Future-proofed, updated facilities
- First step in Trust's strategy towards achieving a two site solution
- Enhanced staff recruitment, development and retention
- Alignment of clinical and research facilities on the GH site. Cardiovascular research has been a major strength of the Leicester Medical School, University of Leicester (UoL) since its inception. This was recognised through the award of a National Institute of Health Research (NIHR) Biomedical Research Unit (BRU) in cardiovascular disease to a partnership between UHL and UoL. The BRU has state of the art facilities for clinical research on the GH site. The opening of the £12.5m Cardiovascular Research Centre (CRC) at GH further re-enforces the centralisation of services on the GH site

▶ Can we afford it?

- The capital costs are £12.3m. This is accounted for in the Trust's approved Capital programme over the next two financial years
- The total additional revenue costs of the scheme in steady state (2022/23) are c£602k per annum (see *additional true cost to vascular* in table 1 overleaf)
- The revenue costs assume a prudent approach to potential additional income (see overleaf)

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Table 1 Summary Financial Position

	2013/14	2014/15	2015/16	2016/17	2017/18	2018/19	2019/20	2020/21	2021/22	2022/23
Baseline Costs										
Income	10,842	10,625	10,625	10,625	10,625	10,625	10,625	10,625	10,625	10,625
Expenditure	9,070	9,070	9,070	9,070	9,070	9,070	9,070	9,070	9,070	9,070
Overheads	2,784	2,784	2,784	2,784	2,784	2,784	2,784	2,784	2,784	2,784
I&E	-1,012	-1,229	-1,229	-1,229	-1,229	-1,229	-1,229	-1,229	-1,229	-1,229
Single Site Move Costs										
Additional Income				276	368	368	368	368	368	368
Recurrent costs				421	561	561	561	561	561	561
Depreciation & Capital Charges				359	467	456	444	432	420	409
Transitional Costs				467	406	333	83			
Total				-971	-1,066	-982	-720	-625	-613	-602
Financial Position Post Site Relocation	**-1,012**	**-1,229**	**-1,229**	**-2,200**	**-2,295**	**-2,211**	**-1,949**	**-1,854**	**-1,842**	**-1,831**
Further Additional Opportunities/Validation										
Clinical Coding (Pending Outcome of E&Y Service Review)			488	975	975	975	975	975	975	975
Improvement in PLICS position following ongoing internal review		450	450	450	450	450	450	450	450	450
Future partnership working increasing activity					271	271	271	271	271	271
Counting & Coding unbundled imaging tariff			167	167	167	167	167	167	167	167
Further efficiencies, increases in market share and Transformation							150	150	150	150
Total of Further Opportunities and Validation	0	450	1105	1592	1863	1863	2013	2013	2013	2,013
Net Position	**-1,012**	**-779**	**-124**	**-608**	**-432**	**-348**	**64**	**159**	**171**	**182**
Vacated Capacity (LRI)				761	1,424	1,424	1,424	1,424	1,424	1,424

The '**Income'** position reflects the existing position of Vascular. There is also an offset due to the reduction of the Payment by Results tariff from 14/15 onwards (c. 1.2% reduction compared to 13/14). The model does not include any additional future year on year savings targets.

The project assumes a steady state in relation to potential income. The vascular income position will be significantly improved following the below and we believe that the outcome of these will mitigate the additional true costs to vascular:

- Clinical coding (pending outcome of Vascular service review)
- Improvements to PLICS position following ongoing internal Trust review
- Future partnership working increasing activity (income)
- Re-designation as Level One Cardio-Vascular service increasing tertiary activity (income)

Further work will be undertaken during the development of the Full Business Case (FBC) to ensure an accurate and robust income forecast is shown.

The '**Transitional Costs'** recognises the transfer of vascular services as the first stage in the transformation of the UHL estate. Additional staff support vascular until the single site surgical take (assumed at 12 months post vascular transfer), and the transfer of Renal Services / HPB from LGH to GH (assumed as three years following the move of vascular). These transitional costs are therefore only incurred until 2019/20.

Current Market Share Analysis – Vascular Services

Within the Five Year Integrated Business Plan a high level market share analysis was undertaken of the Trust's specialised markets pending further data being made available through NHS England. Further detail is outlined within section 2.9 of the main OBC.

It should be noted that the Vascular Services Chapter (Chapter Q) captures activity associated with adults and children.

The total elective income (specialised and non-specialised) associated with vascular services (HRG Chapter Q) in 2013/2014 in this analysis was £75,695,431 of which £20,437,766 (27%) was designated as specialised.

The peer group selected for market analysis was:

- University Hospitals of Leicester
- Coventry and Warwickshire University Hospital
- University Hospitals of Birmingham Foundation Trust
- Cambridge University Hospitals Foundation Trust
- Royal Liverpool and Broadgreen University Hospitals NHS Foundation Trust

The total elective **specialised activity** associated with this peer group and HRG Chapter Q in 2013/2014 was 2430 spells (18%) of the specialised activity associated with Chapter Q.

The total elective **specialised income** associated with this peer group and HRG Chapter Q in 2013/2014 was £4,427,047 (17%) of the specialised activity associated with Chapter Q.

Based on the **peer group** analysed and the methodology adopted UHL has 19% of the activity associated with Chapter Q for this peer group. Its key competitors in activity terms are

Cambridge (26%) and Birmingham (29%). In respect of surrounding hospitals the level of activity undertaken by UHL exceeds that of Liverpool (14%) and Coventry and Warwickshire (12%). More detailed analysis is required to accurately assess the impact Nottingham has in this market. This will be undertaken in support of the FBC.

The outcome of the updated market analysis to be undertaken needs to be carefully considered when assessing the target market for expansion of specialised vascular procedures. The intial focus will centre on developing pertnership working arrangements with Lincolnshire and Northamptonshire.

Future Capacity

Moving vascular services from LRI to Glenfield Hospital will afford the vascular service a dedicated base of 32 beds including 8 assessment unit beds (see Appendix 1 for activity modelling information).The team have identified a number of efficiencies that the can be made to ensure that 32 beds provide the required capacity for their service. This will facilitate and expedite admissions for emergency flow and will also reduce the amount of elective cancellations on the day. Cancellations on the day of surgery are currently experienced by the service as a direct consequence of other specialities competing for beds on the LRI Site and the inability to secure ITU/HDU beds. This reconfiguration will be supported by a Consultant Vascular Surgeon based at the Leicester Royal (LRI) site who will triage ED, give inpatient opinions and operate on emergency cases which are too unstable to transfer to GH. Locating vascular surgery at GH will also allow the development of a seamless service for patients with complex aneurysm disease.

With the likely retirement of 2-3 vascular surgeons over the forthcoming 5-10 years; in order to attract individuals of a similar calibre and maintain the endovascular trained surgeons already present the department will need to ensure endovascular opportunities are made available including the complex major FEVAR/BEVAR etc. Furthermore, trainees will not choose to come to a unit that doesn't offer the full spectrum of open and endovascular training in line with the new vascular curriculum. Since the East Midlands regional vascular surgical training programme is based upon trainee's choosing their training centres, any failure to attract trainees would negatively impact upon the service.

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1.2 Strategic Case

A Blueprint for Health & Social Care in LLR 2014 - 2019

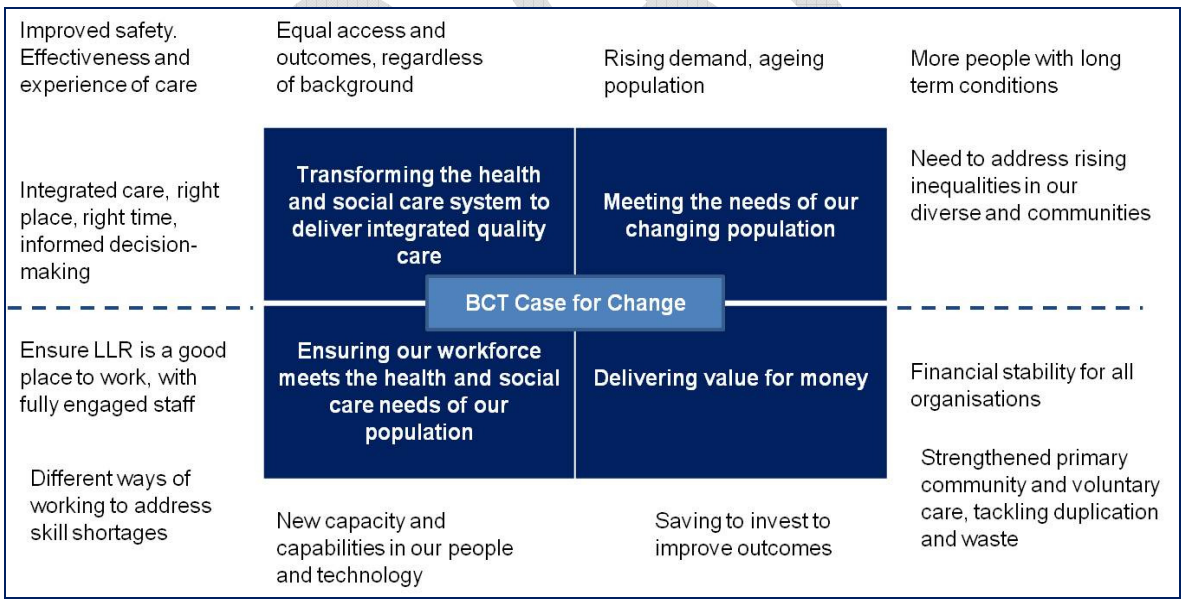
The Better Care Together (BCT) programme represents the biggest ever review of health and social care across Leicester, Leicestershire & Rutland (LLR). The programme represents a partnership of NHS organisations and local authorities across LLR, working together to achieve major transformation in the current and future delivery of services that are of the highest quality and are capable of meeting the future needs of local communities.

The programme is underpinned by a clear case for change, the impact of this for UHL is:

- Smaller hospitals overall
- Fewer acute hospital beds
- A greater focus on specialised care, teaching and research
- Re-developing the Accident and Emergency department at the LRI
- Concentrating acute services on two sites rather than three
- Reshaping services on the Leicester General Hospital site including community beds and the Diabetes Centre of Excellence.

The BCT case for change is summarised in the diagram below:

Figure 1 Better Care Together Case for Change



The transfer of vascular services from LRI to GH releases key clinical space at LRI that will facilitate the delivery of a one site surgical take at the LRI. This will also allow co-location of cardio-vascular service in one place, at the GH thereby providing the right environment to drive up clinical and patient reported outcomes. This is integral to UHL's Five Year Strategy. .

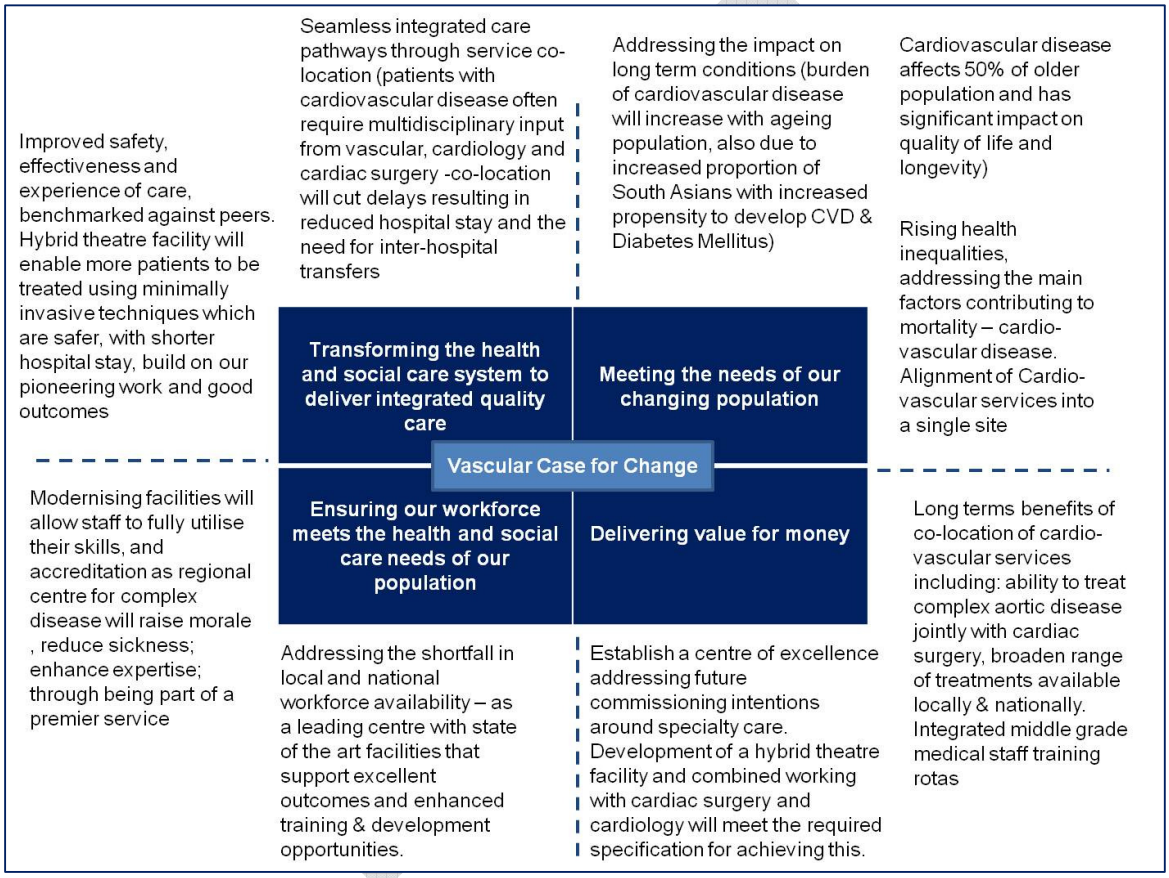
- The Trust will build on its strengths in specialised services, research and teaching; offering faster access to high quality care, developing staff and improving patient experience. The Trust refers to this vision as 'Caring at its best'.

The future co-location of cardiology and vascular services at the Glenfield Hospitals supports the delivery of:

- Specialised hospital focus with the intention for cardiology; vascular; respiratory and renal services ultimately being located on the GH site
- Co-location and shared management plans to focus on identified health need requirements and a more holistic approach to care delivered

Utilising the BCT Case for Change Framework this can be summarised in the diagram below:

Figure 2 Vascular Services Case for Change



In addition the transfer of vascular services supports the following Trust aims and objectives:

- An effective, joined up emergency care system
- Responsive services which people choose to use
- Integrated care in partnership with others
- Enhanced reputation in research, innovation and clinical education
- Delivering services through a caring, professional, passionate and valued workforce

- A clinically and financially sustainable NHS Foundation Trust

A corporate decision has been taken that this project will progress outside and ahead of the site-wide reconfiguration programme. The rationale for this decision being that the creation of additional theatre and imaging capacity, along with the conversion of inefficient clinical space into ward accommodation will strengthen the provision of services on the Glenfield Hospital site, in alignment with the general direction of the Trust's published Strategic Direction 2012-2022.

The strategic drivers for this project are identified as:

Enhancement of the quality of care in terms of both the seamless pathways for the model of care and patient flow.

- The requirement for closer working with Cardiology /Cardiothoracic Surgery services in order to improve the patient experience and achieve re-designation as a Level One vascular unit.
- A comprehensive integrated cardiology, cardiac surgery, and vascular service will provide the best possible care to our patients with cardiovascular disease. It will also build on our existing achievements to maintain Glenfield as a centre of excellence for the management of cardiovascular disease.
- Vascular surgery (and interventional radiology) is essential for the sustainability of the cardiac surgery and cardiology services. In the main this is because both cardiology and cardiac surgery patients often suffer complications that require immediate treatment by the vascular team.
- Current approaches to hybrid procedures are relatively inefficient requiring surgical and anaesthetic teams to operate in an environment that is not conducive in accommodating large numbers of people and equipment. A purpose built Hybrid Theatre facility embedded within the existing theatres complex will improve efficiency in the provision of these services thus enabling full utilisation of existing theatre and recovery facilities which this activity requires.
- Increasing the acute inpatient bed base at Glenfield Hospital, recognising its position as a provider of specialist care
- Maximising the utilisation of theatre capacity at Glenfield Hospital, recognising its position as a provider of specialist care
- Vacating acute inpatient bed base at Leicester Royal Infirmary in anticipation of the single site take for surgery project
- Ensuring that the health needs and expectations of the local population are met, in line with Trust clinical strategy and National ,Trust and local health economy KPI's
- Ensuring the built environment enhances clinical practice that supports clinical effectiveness, improved patient outcomes and enhanced patient safety

The Vascular Project is key in supporting the Trusts Five year plan and service strategies for the future, by increasing specialist services on the GH site and by releasing both bed and theatre capacity at the LRI. In the context of national, regional and Trust strategies, it is recognised 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.

1.3 Economic Case

Using critical success factors as criteria a long list of options was compiled and then this was appraised to identify a short list of options to take forward into a full appraisal process. Following

the conclusion of this detailed long-listing and short-listing process the preferred option both clinically and financially is:

Option A	Refurbishment of existing space on the first floor at Glenfield Hospital to include Vascular Ward (Ward 23a), Angiography Suite and a new build extension to incorporate the Hybrid Theatre - additional office accommodation to be provided from within the retained estate.

The 'Do Nothing approach' is not a viable solution for this project. Future designation of vascular services is dependent upon the co-location of Cardiology/Cardiothoracic services and the provision of a Hybrid Theatre. The 'Do Nothing' option (i.e. not transferring the service) not only jeopardises the future provision of vascular services at UHL but also impacts upon UHL's site wide reconfiguration programme of which this project is seen as the first key enabler.

The transfer of Vascular Services facilitates the following service efficiencies:

Table 2 Service Efficiencies

Efficiencies	Measured
Reduced average length of stay (including pre and post-op LOS)	Activity Data
The Hybrid theatre will enable a significant number of patients to be treated in a single session rather than separate radiological and surgical procedures as is current practice.	Activity Data
Increase in minimally invasive procedures reduces time spent in Critical Care beds	Activity Data
Co-location with cardiology/cardiothoracic services will reduce journeys for cardiac patients who currently travel from GH to LRI for scans	Patient Satisfaction / Activity Data
Hybrid Theatre facilitates increasingly complex procedures, yet offers flexibility to revert to open procedure if required	Activity Data / Consultant Information
Reduction in cancelled operations due to dedicated bed base	Activity Data
Dedicated beds for Angiography day cases will reduce cancellation rates for patients as well as relieving pressure on inpatient beds	Activity Data
Better patient experience through improved and optimised pathways including reductions in readmissions	Patient Satisfaction / Friends & Family Test
Increased surgical assessment unit capacity at LRI will improve patient flow and streamline the admission process from the front door	Patient Satisfaction / Activity Data
Positioned as pre-eminent total Cardiovascular Institute serving the region and beyond	Re-designation as Level One service

1.4 Commercial Case

Early appointment of contractors to work in partnership with the Trust to deliver the Full Business Case (FBC) can reduce significant elements of risk associated with the detailed design process. The following options are available to the Trust for procurement of construction:

Table 3 Summaries of Procurement Options

	Option	Comment
1	Traditional Tender	OJEU Tender routes; minimum 4 months to appoint contractors following approval of FBC; full specification and schedule of works for tender would be drafted without construction input, bringing potential additional risk.
2	Procure 21+	High Level Information Pack (HLIP) could be issued now to engage PSCP at stage 3 such that they work up the FBC/GMP in partnership with the Trust. Approx 4-6 weeks to appoint a PSCP (post HLIP issue). 4-6 months following appointment to achieve GMP for FBC approval. No further tender time required. Risk sharing partnership approach.
3	Procure the scheme through UHL's framework partnership with Interserve Facilities Management (IFM)	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 an NEC3 Option C (Target Contract with Activity Schedule). Cost savings and overspends are split between the Trust and the Client based on previously agreed splits which will engender a spirit of partnering and collaboration within the Project Team. The risk of cost overrun is transferred to IFM once the GMP has been agreed and construction stage commenced.

It is recommended that the scheme will be procured through Option 3; UHL's framework partnership with Interserve Facilities Management (IFM).

Following the decision to award the contact there is an opportunity for the Hybrid Theatre to be procured via a subcontractor to the main contractor or alternatively a Turnkey provider can be engaged to bring expertise to the process.

1.5 Financial Case

The transfer of Vascular Services is a first stage enabler for the Trust's Strategic Outline Case / Development Control Plan and as such it should be borne in mind that the cost basis of this move has a 'bigger picture' impact for the Trust.

The **capital costs** of the preferred option total **£12.3M*** including decant costs & forecast out-turns inflation (£11.9m with a c£450k VAT recovery allowance).

The total additional **revenue costs** of the scheme in steady state (2022/23) are **c£602k** per annum.

Table 4 Summary Financial Position

	2013/14	2014/15	2015/16	2016/17	2017/18	2018/19	2019/20	2020/21	2021/22	2022/23
Baseline Costs										
Income	10,842	10,625	10,625	10,625	10,625	10,625	10,625	10,625	10,625	10,625
Expenditure	9,070	9,070	9,070	9,070	9,070	9,070	9,070	9,070	9,070	9,070
Overheads	2,784	2,784	2,784	2,784	2,784	2,784	2,784	2,784	2,784	2,784
I&E	-1,012	-1,229	-1,229	-1,229	-1,229	-1,229	-1,229	-1,229	-1,229	-1,229
Single Site Move Costs										
Additional Income				276	368	368	368	368	368	368
Recurrent costs				421	561	561	561	561	561	561
Depreciation & Capital Charges				359	467	456	444	432	420	409
Transitional Costs				467	406	333	83			
Total				-971	-1,066	-982	-720	-625	-613	-602
Financial Position Post Site Relocation	**-1,012**	**-1,229**	**-1,229**	**-2,200**	**-2,295**	**-2,211**	**-1,949**	**-1,854**	**-1,842**	**-1,831**
Further Additional Opportunities/Validation										
Clinical Coding (Pending Outcome of E&Y Service Review)			488	975	975	975	975	975	975	975
Improvement in PLICS position following ongoing internal review		450	450	450	450	450	450	450	450	450
Future partnership working increasing activity					271	271	271	271	271	271
Counting & Coding unbundled imaging tariff			167	167	167	167	167	167	167	167
Further efficiencies, increases in market share and Transformation							150	150	150	150
Total of Further Opportunities and Validation	0	450	1105	1592	1863	1863	2013	2013	2013	2,013
Net Position	**-1,012**	**-779**	**-124**	**-608**	**-432**	**-348**	**64**	**159**	**171**	**182**
Vacated Capacity (LRI)				761	1,424	1,424	1,424	1,424	1,424	1,424

The '**Total Income'** position reflects the existing position of Vascular. There is also an offset due to the reduction of the Payment by Results tariff from 14/15 onwards (c. 1.2% reduction compared to 13/14).

The '**Single Site Move Costs'** reflects additional costs incurred by Vascular minus the predicted additional income. These vary annually incorporating changes resulting from the single site surgical take commencing at LRI and the transfer of Renal / HPB Services from LGH to GH – until a 'steady state' position is achieved in 2022/23 of £602k p.a.

The Vascular Surgery Service is projected to have a surplus net position in the financial year 2019/20.

The project assumes a steady state in relation to baseline income. The vascular additional income position will be significantly improved following the below and we believe that the outcome of these will mitigate the additional true costs to vascular:

- Clinical coding (pending outcome of Vascular Service Review supported by EY)
- Improvements to PLICS position following ongoing internal Trust review
- Future partnership working increasing activity (income)
- Re-designation as Level One Cardio-Vascular service increasing tertiary activity (income)

1.5.1 Vascular Service Review

The move of vascular services provides the opportunity to maximise service co-locations and enhanced efficiency. The defined efficiency measures within the OBC have been reviewed as part of the Vascular Service Review (supported by Ernst & Young) to assess the deliverability. There are further potential efficiencies to be realised through combined workforce solutions and enhanced space utilisation through design. The full findings of the Service Review (EY) will be available in August and will be reflected in the Full Business Case. At this stage the observations and benefits identified can be summarised as:

Table 5 Service Review

Business Case Benefits	Service Review Observations	Target/Benefit
Reduces average length of stay	High LOS observed e.g. amputation of leg – delays to discharge Average LOS between 3.63 and 22.76 days for top 10 procedures	Reduce LOS – reduce no of bed days – increase efficiency and throughput Improve outcome for patients on defined clinical pathways
Reduced cancellations	13% (1,143) hospital outpatient cancellations in 2013/14	Outpatients increased efficiency – reduced level of cancellations and improved slot utilisation
Increased elective procedures	Opportunity to become service provider of choice in the East Midlands Region	Enhancing market share within East Midlands Improved capture of activity undertaken through enhanced coding

Improved theatre utilisation	Opportunity to improve theatre utilisation by eliminating delayed starts – 172 hours over the year (2013/14) Unavailability of ward beds is the primary reason for hospital cancellations	Improve utilisation of resources and theatre time – patient readiness for theatre; managing patient flows Dedicated bed base for vascular. Defined day case beds supporting angiography

A key element of the Service Review is targeting the PLICS data and the future accurate baseline costs to underpin the service.

Observations include:

- Outpatients first and follow-up make a significant loss c£630k
- Medical staffing costs for electives is twice that of non-electives
- Imaging costs are 11% of the total expenditure

1.5.2 Workforce Statement

The total additional long-term staffing requirements for Vascular, to support the move from LRI to GH, are 9.56wte. These comprise:

- **6.59wte** Imaging Staff: recognising that the transfer from LRI to GH requires Angiography Imaging on all three UHL sites (as opposed to two as at present).
- **1.97wte** Vascular Nursing: recognising the higher acuity of emergency admission patients that will be treated on the VEAU. The co-location of VEAU immediately adjacent to the vascular ward ensures the optimum care for vascular patients.
- **1wte** Vascular Medical: to be based at LRI to triage ED, give inpatient opinions & operate on emergency cases that are too unstable to transfer to GH.

The final workforce model has been through a rigorous 'confirm and challenge' process (see 3.4.1) with representatives from all services involved. As a result of this there have been significant reductions in the numbers of staff required to support the transfer of vascular services long-term.

13.83wte transitional staff is required; this figure recognises the transfer of vascular services as the first stage in the transformation of the UHL estate. The additional staff support the position until the single site surgical take (assumed at 12 months post vascular transfer), and more pertinently the transfer of Renal Services / HPB from LGH to GH (assumed as three years following the move of vascular). These transitional costs are therefore only incurred until 2019/20.

36.13wte staff is included within the 'double running' costs; this figure reflects the staff resource that remains at LRI and can be deployed on alternative patient service improvement and income generating activities.

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Each CMG has signed off the baseline workforce information and, where applicable, the additional workforce required. The key stakeholders from each service have been represented in the Project Board.

The full workforce model is detailed in Table 38.

1.6 Management Case

The programme anticipating completion is set out below:

Table 6 Project Programme

Milestone	Date
Capital Planning & Investment Committee	27th June 2014
Executive Board recommendation to support OBC	15th July 2014
Finance & Performance Committee support for OBC to be approved by TB	30th July 2014
Trust Board Approval of OBC	31st July 2014
NTDA submission of OBC for approval	4th August 2014
Detailed Design & Full Business Case (FBC) Development	August 2014 – January 2015
Capital Planning & Investment Committee	February 2014
Executive Strategy Board recommendation to support FBC	March 2015
Finance & Performance Committee support for FBC to be approved by TB	March 2015

**Detailed design period assume progression of design prior to NTDA approval*

The project will be managed using PRINCE 2 compliant methodology and project management tools such as Gantt charting and critical path analysis. Project direction and management will be determined by the Project Board. It is critical that a project lead is identified on both the Estates and Clinical sides, and that personnel are given the appropriate resources, particularly time, to fulfil their roles.

1.7 Conclusion

The business case is central to the realisation of the vision for Vascular Services and is a key first stage move in the Trust's Five Year Strategy. Each of these objectives link to the long-term strategy of the service and the wider Trust:

- A comprehensive integrated vascular, cardiology and cardiac surgery service will provide the best possible care to our patients with cardiovascular disease.
- Vascular service re-designation; Aortic Service designation
- Improved efficiencies through dedicated vascular imaging capacity
- Increasingly complex activity undertaken generating additional income for the Trust
- Redevelopment and increased capacity providing opportunities for the Trust to fulfil the Trusts overall strategic transformation programme

The costs associated with this service move are:

- Capital Costs: £12,349,819 (accounted for in approved Capital Programme 14/15 & 15/16)
- Revenue Costs: The total additional costs of the scheme in steady state (2022/23) are c£602k per annum
- Loss of Status without re-designation: not financially quantifiable

The key actions and decisions required to realise this vision are:

- Support for the capital investment
- Support for the additional revenue costs recognising that a significant amount are time-limited
- Confirmation of the preferred route for the procurement of the construction
- Confirmation as to the preferred route for the procurement of the specialist Hybrid Theatre equipment
- Approval for the business case to be submitted to the NTDA.

Signed:.....
Senior Responsible Owner
Signed:.....

Signed:.....

CMG Director (s)
Signed:.....
Clinical Lead
Signed:.....
Executive Sponsor

Date:.....

DRAFT

CAPITA

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UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST

REPORT TO: **TRUST BOARD**

DATE: **31ST JULY 2014**

REPORT FROM: **SIMON SHEPPARD - ACTING DIRECTOR OF FINANCE & PROCUREMENT**

SUBJECT: **CAPITAL FUNDING FOR RE-PROVISION OF CLINICAL SPACE/ MODULAR WARDS**

---

1. PURPOSE

1.1 This paper seeks to update the Trust Board on:

- The replacement support accommodation required at the Leicester Royal Infirmary (LRI) site and the requirement for a new modular ward at the LRI to support additional bed capacity

- The financial support required from the National Trust Development Authority (NTDA) via Public Dividend Capital (PDC) funding to support the projects (£8.0m)

2. BACKGROUND

2.1 Strategic Need

2.1.1 UHL is currently developing a Business Case for the re-development of the Emergency Department (ED), creating a new emergency floor at the LRI site of University Hospitals of Leicester NHS Trust. The LRI provides Leicestershire's only accident and emergency service (ED). An emergency floor concept will be developed 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.

2.1.2 The existing facilities do not meet the current demands or the projected requirements over the next 5-10 years. The current ED is designed for approximately 100,000 attendances per year; there are currently 160,000 attendances per year, which is expected to grow at the rate of 3% per annum, taking into account a shift in activity to primary care.

2.1.3 Whilst process re-design 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. There is an 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. This has been highlighted in two external reviews by ECIST and CQC.

2.1.4 This Business Case is aligned with the Trust's Integrated Business Plan and its long term Estate Strategy.

2.2 Business Case Development to date

2.2.1 The Strategic Outline Case was approved at the Midlands and East Capital Investment Group meeting on 14th January 2014.

2.2.2 The Outline Business Case was submitted to the NTDA for review in November 2013. An OBC Estates Annex has subsequently been submitted for consideration and the OBC will be re-submitted following submission to the NTDA on 20th June 2014 of the whole health economy long term financial plan, along with the Trust's Integrated Business Plan.

2.2.3 Design development for the Full Business Case is being progressed.

2.2.4 The Full Business Case will be ready for submission to the NTDA at the end of November 2014.

3. PROJECT TIMESCALES

3.1 In order for the project to be delivered as soon as practicably possible, there is a requirement for the delivery of two discrete phases:

- Phase 1 is the provision of 2 x 28 bed modular wards to create decant space for Victoria inpatient accommodation to be demolished in order to create development space for the emergency floor - £3.8m

- Phase 2 is the relocation of other functions in order to vacate buildings to be demolished as part of the development - £4.2m

Project	**Cost £000s**
Relocation of the Urgent Care Centre into Clinics 1 & 2	714
Relocation of Medical Physics into the old Victoria Linac	1,050
Relocation of Office Accommodation into Oliver, St Marks & St Lukes wards in Victoria	1,260
Relocation of Clinical Genetics into the diabetes outpatients department once they have relocated to ward 4, LGH	158
Relocation of the Chapel into an interim location and safe storage of the artefacts	415
Re-development of the Victoria Main Reception to open the front of the building	575
TOTAL	**4,172**

4. FINANCES

4.1 The two schemes are identified in the 2014/15 capital programme which was signed off by the Trust Board in March 2014, and were also part of the Emergency Floor Scheme (OBC) approved by the Trust Board. However, as the Trust Board is aware, the Capital Programme is over committed and, as such, every attempt needs to be made to mitigate risk to the Trust by obtaining external funding.

4.2 The Trust will be applying for longer term borrowing/permanent PDC funding of approximately £69.5m in August 2014. This is to cover our £40.7m deficit for the current year, £12.5m of backlog creditors brought forward at the prior year end and £16.3m of capital expenditure (inclusive of the two schemes described in this paper).

4.3 We will submit an application to the NTDA's Independent Trust Financing Facility (ITFF) by 22nd August 2014 and, following the review and approval process, we should receive this funding in mid-November 2014.

4.4 The Capital Monitoring & Investment Committee is formally reviewing the 2014/15 capital programme at its next meeting in August 2014 to identify potential schemes to mitigate the risk of an over-committed capital programme. This will then be reported to the Executive Team and Finance & Performance Committee.

5. RECOMMENDATIONS

5.1 The Trust Board is asked to:

- **Note** the application being made for PDC (£8m) via the ITFF
- **Recognise** that, whilst funding is allocated in the capital scheme for these projects, the capital scheme is over committed so if additional PDC funding is not forthcoming from the NTDA, the pressure on the programme remains. Actions to mitigate this will be reported to Executive Team/Finance & Performance Committee in August 2014.

Simon Sheppard
Acting Director of Finance & Procurement

25 July 2014

University Hospitals of Leicester NHS
NHS Trust

Trust Board paper T

To:	**Trust Board**
From:	**John Adler – Chief Executive**
Date:	**31st July 2014**
CQC regulation:	

T

Title:	**Managed Print LRI – Business Case**

Author/Responsible Director: Sarah Remington (IBM) / John Clarke, Chief Information Officer

Purpose of the report: To present the Business Case for the Managed Print LRI solution for approval.

The report is provided to the Capital Monitoring and Investment Committee for:

Decision	X	Discussion	
Assurance		Endorsement	

Summary/Key points:

Following the deployment of the Managed Print solution at the Glenfield Hospital this paper sets out the business case for extending the solution to the Leicester Royal Infirmary.

The Managed Print project delivers printing throughout the Trust on a central 'hub' based solution rather than the current local device estate, enabling users to securely release their print jobs from any device across the Trust. This approach is supported through on-site resources who actively monitor the devices, ensuring delays associated with consumables running out or faults are kept to an absolute minimum. Experience from the Glenfield implementation has shown that in addition to the benefits that were expected such as security of printing and a reduction in support calls due to active remote monitoring, the transformation in the way of working has also resulted in some additional value-added outcomes. These include shortening the process for out of hours Pharmacy requests and effectively digitising ward cleaning rotas.

This Business Case has been developed in conjunction with UHL and the implementation reflects the learning and experience from the Glenfield rollout.

Recommendations:
The Board is asked to review and approve the Managed Print LRI Business Case in order for the contract to be signed and work to commence in August.

Previously considered at another corporate UHL Committee?
Earlier versions reviewed and approved by the Transformation Sub Board, Commercial Sub Board, Joint Governance Board, Capital Investment and Monitoring Committee and the Finance and Planning Committee.

Board Assurance Framework: -	**Performance KPIs year to date:** N/A

Resource implications (e.g. Financial, HR): - n/a

Assurance implications: Yes

Patient and Public Involvement (PPI) implications: -
No

Stakeholder Engagement implications: -
No

Equality impact: considered and no impact

Information exempt from disclosure: - No

Requirement for further review:
No

This document expands on the details provided in the preceding Project Outline Document (POD) and is required when the Project has a value exceeding £100,000 and has been approved to proceed through the approval gateways as part of the Investment Approvals process (Appendix 1).
Information previously provided within the POD will require expanding to enable the Project to secure approval and funding to proceed. This template is not to be used for new consultant posts solely.
Projects with a value of above £3million (or £1m if Trust in financial deficit) will require final approval from the Strategic Health Authority.

Section 1: Business Case Details

CORPORATE/DIVISION/CBU	*IM&T / Clinical*
TITLE OF PROJECT:	Managed Print Service for the Leicester Royal Infirmary
PROJECT SPONSOR:	John Clarke
CLINICAL LEAD:	Steve Jackson
PROJECT MANAGER:	tbc
AUTHOR/CONTACT DETAILS:	Sarah Remington – sarah.j.remington@uk.ibm.com
CREATED ON:	14th March 2014

The business case is classified as:

1. Business Expansion	
2. Essential Replacement	**X**
3. Health & Safety	
4. Cost Reduction	**X**
5. New Legislation	
6. Research & Development	

Mark principal reason only.

Note differential evaluation criteria will be applied depending on the project classification

Section 2: Summary of Business Case (Strategic Case)

PROJECT PROPOSAL SUMMARY	Managed Print is one of the first projects being undertaken as part of the Digital Healthcare transformation programme through the Managed Business Partnership. It is a key enabling project focused on transforming and rationalising the existing, ageing

	footprint of printers and copiers, and replacing these with modern, efficient multi-function devices that are proactively monitored and maintained. Managed Print supports the Trust's overall strategic agenda, outlined in the document 'Strategic Direction – Caring at its Best', reducing the amount of time currently spent on the management and maintenance of the existing devices both at a clinical and an administrative support level. . Implementing the Managed print solution will benefit the trust in a number of ways. • Financial savings through the de-commissioning of the existing printer estate, including items like Ricoh lease costs, non-Ricoh expenditure on consumables and paper. • New ways of working across the Trust that address some of the risks currently associated with data loss and breaches of security, improve clinical and administrative efficiency through less time spent on printing type issues, and the ability to print from any printer anywhere across the estate Managed Print delivers printing throughout the Trust on a central 'hub' based solution rather than the current local device estate. This is supported through an on-site resource who actively monitors the devices, ensuring delays associated with consumables running out or faults are kept to an absolute minimum. By engaging with IBM to transform the printing solution across the Trust, UHL is able to gain control and a better awareness of print expenditure and have a central reporting facility that properly details print costs, which departments make the most use of printing and to understand the actual costs associated. A fixed cost platform with enhanced management information will enable the Trust to regularly report on usage, costs and service incidents on a device, user or departmental basis. Managed Print is in the process of being implemented at Glenfield Hospital, where the change has been managed successfully in wards, clinical areas, administrative and management offices. A summary of some of the key lessons learnt from this first phase is included at Appendix A. This Business Case outlines the proposal to extend the current Managed Print solution to the Leicester Royal Infirmary (LRI). It uses the data collected from an audit of the existing devices located within the LRI as an input, the details of which are captured in a report submitted to the Trust on the 15th January 2014. Using this data a proposal has been put together for a reduced number of devices strategically placed throughout the LRI to ensure the delivery of an efficient and secure printing solution. A summary of this proposal is that 1,338 devices, including printers, copiers, scanners and faxes, will be removed across the LRI estate and replaced with 364 new multi-function devices.
PROJECT DELIVERABLES	The implementation at the LRI will be based on the same approach as for the Glenfield, adapted where appropriate to reflect key lessons learnt, a summary of which are included at Appendix A. The following table contains the specific Project deliverables for the LRI implementation which have been based on those delivered at the Glenfield.

LRI – Implementation	Format
• Implementation Plan	• MS Project
• Delivery / Installation Schedule	• Word document
• End User Training	• Physical Training
• Installed Devices	• Hardware
• Readiness for Service Checks	• Word document

• Project Closure Report for LRI phase	• Word document

A key learning from our work at the Glenfield is that a significant level of due diligence is required to confirm the solution meets the varied requirements throughout LRI, and UHL as a whole. It is therefore proposed that the following information is confirmed and agreed with the individual LRI departmental areas prior to a commercial check point and the actual deployment;

- Device location.
- Network & power requirements
- Network port allocation.
- Application use.
- Departmental requirements.
- Paper usage.

This information will be compiled (building on information gathered during the Audit) by the onsite team through close interaction with departmental leads, Matrons etc. Any changes which result from this exercise will be presented to UHL at the Managed Print Commercial Board.

Signoff will be collected in relation to every device as part of this process. Should any future changes be requested, UHL will be able to refer back to these signoffs to establish the degree of change, and rationale.

PROJECT SCOPE AND IMPACT ON OTHER DIVISIONS/CLINICAL SERVICES

In this Project the Contractor will carry out the following phase of the UHL Managed Print Service implementation strategy:

Phase - LRI	Implement & Manage
Description	Using information gathered during Phase 3, the existing printers, copiers, scanners and fax machines at LRI will be transformed using standardised technologies approved during Phase 1 (Infrastructure Proving) and implemented during Phase 2 in GGH (Glenfield Hospital – Implementation).
Value	A detailed Project plan will be created with the Authority which will detail all aspects of the implementation phase, minimising the disruption to LRI and ensuring the Authority move to a live service at the LRI as smoothly as possible to start benefiting from the financial and technological advances provided.

All services to be implemented will be undertaken utilising the following process :

Pre-Implementation Checks

- Infrastructure set up and testing
- Due diligence
- Implementation & Communications plan

Implementation

- Implementation Schedule
- Delivery
- Installation
- Training of end users (see Appendix C)
- Device disposal (unwanted existing equipment)

	• MPS Readiness
OPTION APPRAISAL	In 2013, a business case was produced for the Glenfield Hospital and submitted to the Trust for approval. As part of this process a detailed procurement exercise was carried out in partnership with IBM to identify cost savings associated with 5 and 7 year contract options which included a basic managed print solution and a fully managed, secure solution. The preferred option was to proceed with the fully managed solution providing enhanced security and confidentiality. The subsequent implementation in progress at Glenfield Hospital has proved the technology compatibility of the solution and identified further potential to add additional value in the future through the introduction of enhanced features, such as stored templates for letterheads and commonly used forms.
OPERATIONAL SUSTAINABILITY	The transition period has been considered and will be included in the implementation plan taking on-board the learning from Glenfield and allowing for a short period of potential dual running to ensure each department has full confidence in the capability and usability of the new solution before removing the previous devices. Experience from the implementation at Glenfield confirms that each department should have a number of trained 'Printer Champions' who will be able to train new people coming into the department and perform basic checks when faults occur.

Section 3: Project delivery (Management Case)

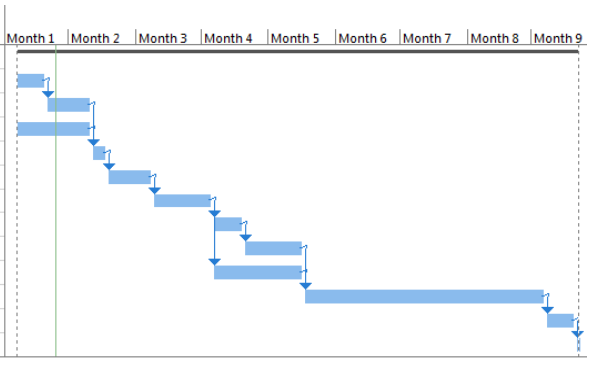
PROJECT MANAGEMENT	The project will be managed using IBM's project management method that is used globally, known as the Worldwide Project Management Method (WWPMM). This is compatible with PRINCE2/MSP. The management and control of the project will be exercised as follows: • The **IBM Project Manager**– will control and manage the inputs from IBM, NTT and Bytes, reporting to the MBP Programme Executive. • Overall guidance of the Project team will be achieved through: – The CIO and CMIO for the Managed Print Service Project – Representatives from the UHL stakeholder groups (e.g. Clinician Advisory Group) Up to go-live, the IBM PM will report progress or escalate issues through the Transformation Sub-Board which is part of the overall MBP Governance Structure. Following go-live of the MPS issues will be escalated through the Service Delivery Sub-Board. During implementation, the IBM PM will produce a weekly report. A Managed Print Project Board has been created and currently meets weekly to monitor progress of the Glenfield implementation. It is proposed that the Project Board remains in place for the LRI implementation but that the frequency be moved to bi-weekly as it is a longer project due to the size of the location.
DESCRIBE THE PROJECT MANAGEMENT ARRANGEMENTS	Reporting will be via the MBP governance framework and through to the Executive Team and the Trust Board where applicable. Weekly project management reporting sessions will include IM&T, clinical and IBM representation. Consolidated reports will be created as per the existing governance arrangements for the programme e.g. Transformation Sub Board, Joint Governance Board.

KEY RISKS AND PROPOSED MITIGATION

Risk	Mitigation
Project is delayed, or timescales slip.	The project has been costed on a fixed price basis so no cost impact. Clear communications required on responsibilities and timescales to all parties during project execution to gain early view of any issues.
There is a risk of additional cost to UHL for additional infrastructure in cases where proposed printer locations require additional network points or power sockets.	Experience from Glenfield shows that 20% of the 125 devices required either network, power or both. The proposal for LRI specifies 364 devices, but the recommendation is that the percentage assumed to need additional infrastructure be increased to 30% to allow for the age of the buildings and likelihood that power and network points will be less available than would be the case in Glenfield. Using the average costs of the Glenfield work this suggests UHL should plan for a minimum contingency of £40k for this possibility, which the Authority may wish to consider adjusting to £50k on the basis of anecdotal evidence that the cost of this sort of work is higher at LRI due to the age of the buildings.
There will be a lack of buy-in from the clinical community and they will not use the proposed solution.	Appoint credible clinical champions with knowledge and experience of the Glenfield implementation to work alongside the project team to promote clinical adoption through highlighting the benefits of the managed print solution to the wider clinical community.
Impact on current service quality	Where possible, old devices will remain available for a short period until the capability and operability of the new devices not impacting patient flow is assured. Contingency plans will be put in place to return to previous ways of working in the event of solution failure or other issue.
Dependencies on third party suppliers	Third parties will be managed and monitored using best practices in the PRINCE2 / IBM proven project management methodologies.
Project does not realise all benefits.	Joint UHL and IBM activity to identify, measure, track and assess benefits.

PROJECT TIMELINE AND MILESTONES

ID	Task Mode	Task Name	Duration
1		**Managed Print at Leicester Royal Infirmary**	**186 days**
2		Logistics (Test & Training Devices)	10 days
3		Testing	15 days
4		Due Diligence	25 days
5		Report on Due Diligence & Testing	5 days
6		Commercial Documentaion Revisions	15 days
7		UHL Sign Off & Approval Cycle	20 days
8		Logistics (Full Compliment of Devices)	10 days
9		Preparation for Delivery (IP & MAC Addresses	20 days
10		User & Printer Champion Training	30 days
11		Rollout of Devices	80 days
12		Final Acceptance	10 days
13		Lessons Learned & Close	1 day



Milestone	Estimated Date
Signed Project Order received	Day 1
Contractor orders hardware for Testing and Training	Day 1
Checkpoint - Test Plan signoff	Day 5
Authority confirms the remainder of hardware that needs to be ordered – non test	Day 80
Checkpoint - Rollout Readiness Review	Day 90
Commencement of equipment roll-out (This milestone will represent the commencement of service and MPS support)	Day 95
Authority confirms acceptance of a fully live service	Day 180
Project close meeting with Lessons Learned review	Day 185

Section 4: Financial and Benefits Management (Economic & Financial Case)

REQUEST FOR FUNDING

The Managed Print solution at Glenfield is based on a 5 year lease arrangement using IBM Global Finance (IGF).

The Trust have requested that for the LRI rollout this approach is changed and that the project be treated as a capital investment project. The implementation of the devices will be paid for on a milestone delivery type approach with an on-going monthly support charge for the next five years.

The indicative price for Managed Print LRI is shown in the table below and comprises the following elements:

- Hardware – made up of the purchase prices for the 364 new devices
- Software – includes licences for Equitrac, Rightfax, Enhanced Volumetrics and Print on Demand
- Implementation Services – includes installation of devices, associated implementation services and project management
- Software Warranty – 5 year price for Equitrac software support (paid as an upfront one-off sum)
- Service Charge – 5 year price for on-going support of the solution including 2 onsite Docuhead resources
- Software Support – 5 year price for Rightfax, Planet Press, Enhanced Volumetrics and Print on Demand software support

Indicative IBM Price - Capital	
Hardware	£1,193,912
Software	£247,063
Implementation Services	£412,402

Software Warranty	£61,876	
Service Charge	£494,761	
Software Support	£68,200	
Sub Total	**£2,478,214**	
Annual Print variable estimate	£729,421	
UHL Ricoh write-off	£88,857	
Total Price	**£3,296,492**	
Project contingency	**£100,000**	

CONFIRM THE PROJECT BENEFITS (NON FINANCIAL)

The expected benefits and return on investment from proceeding with the Managed Print Service in its entirety are set out in "*UHL Transformation Business Case Managed Print – Final v1.2.docx*" produced prior to the Glenfield implementation in 2013.

Some of the non-financial benefits associated with this solution include the following;

- Secure print functionality increases security and confidentiality where sensitive or restricted material is printed, reducing the risk of material being left unattended or collected in error with other print jobs.
    - Print jobs do not interleave with photocopy runs, a common issue previously, resulting in lost letters and sensitive material getting mixed in with other jobs for other people.
    - Staff who are short of time, who forget, or choose not to retrieve a print job, can collect at another device or choose not to retrieve at all, reducing the instances of a job being printed multiple times.
- Multi-function devices remove the need for separate fax, scanner, copier and printer which makes more space available and simplifies cabling and use of network / power outlets.
    - In most cases, the Xerox devices are faster than the devices they replace which will improve patient flow and reduce frustration for staff having to wait for large documents to print.
    - Particularly in Ward areas, space is a key issue, where clinical staff frequently need a small area of desk space to make notes or update records.
    - Having a fax capability on more devices can speed up patient flow where staff don't have to wait to access a sisters office to send documentation to external parties
- Managed devices being remotely monitored reduces staff time spent on support calls or managing consumable stocks.
    - **A quote from Arvin Mistry, leader of the Desktop Support Team:** "*The call volumes for*

printer faults have dropped dramatically, we do get the odd few calls, which the team resolve. In relation to managed print issues, these were ironed out in the early stages and go directly to the Managed Print Docuhead. When I spoke to Neil Loach (Occupational Health), he was happy with Managed Print as confidential documents cannot be printed off and left for others to read/collect. Ben Hyde (Matron) is also happy with this solution."

- Onsite support reduces downtime in the event of a fault or failure and provides a point of contact to manage the problem and an interim replacement should there be a need for the device to be removed and repaired offsite.
    - When printers stop working this can result in a number of critical tasks being stopped, such as admissions, patient discharge, provision of scans, tests, test results and referrals to other departments. In most cases manual processes are either impossible, or take too long to implement. Being able to print at another device or get immediate support, maintains patient flow and supports patient safety.
    - The project team occasionally receive calls from users worried that their device is low on ink. To date, in every case the Docuhead has already been aware thanks to the remote monitoring tool and by the time a support call is logged he has either resolved the issue already, or contacted the department to schedule his visit.
    - Almost all faults are resolved in the same working day. In the rare instances when a Xerox engineer has been called out, the engineer coordinates with the onsite Docuhead for information / actions / follow up, leaving the clinical team free to concentrate on patient flow.
    - The provision of replacement modern, faster printers will help with current delays caused by printing on wards (i.e. iCM blood forms or ICE discharge letters), reducing the stress this causes to the ward staff involved and encouraging a better patient experience.
- It becomes possible to store templates for commonly used forms or letterheads on a device, removing the need to maintain large stocks printed externally and making plain paper the common medium for any type of print.
    - This is a major item which the project team are being pressed to accelerate. Users will be able to print commonly used forms 'on demand' without going via the Interserve Print Service.
    - The correct letterhead would be printed as part of the document, meaning only plain paper would be needed, which simplifies the needs for multiple trays and settings.
    - Letterheads frequently change. Using an electronic template would mean a vast reduction in discarded letter headed paper which cannot be used due to it being out of date.
- Secure print provides more flexibility for staff to collect print when and where it best suits their working routine.
    - Greater efficiency and productivity is possible when staff don't have to worry that their confidential print needs immediate collection for every job. Print jobs can be sent throughout the day and collected in batches to coincide with breaks, or other tasks, at the convenience of the user.
- Standardisation of hardware and print queues makes it easier for mobile staff to work in multiple locations because the equipment used will always be familiar and accessible.
    - With more staff travelling between sites the ability to retrieve printing at destination reduces the potential for sensitive material to be lost in transit in public places
- Detailed reporting brings the ability to monitor volumes and investigate peaks or troughs by device, or by department and user if needed. Over time volumes and therefore costs become more predictable.

Additional Value-Add Outcomes from Managed Print at Glenfield

Out of Hours Pharmacy Process

The project team were contacted by the Pharmacists (Alison Brailey) with regard to the current process when the Glenfield wards need a prescription from the pharmacist at LRI. This requires the wards to take apart the patients drug chart, copy the relevant pages and fax these to LRI, where they arrive, frequently illegible.

The team were able to improve this process by enabling scanning to deposit the resulting PDF document into a fixed folder accessible by the Pharmacists within LRI. The wards can now scan the relevant pages without taking apart the chart, and the fax step is removed. This has simplified the process for the wards, provided the pharmacists with far more readable documentation and shortened the whole process significantly.

Ward Cleaning Records

The wards are required to keep records proving cleaning is taking place and signed off at regular intervals during the day. On ward 23a, the Ward Sister (Sue Bell) has identified a use for the Xerox scanner to hold these records as electronic PDF files in a network folder, making it simple to locate the record for any given day and removing the need for large folders of historical record in her office.

Phlebotomists

The Phlebotomists have been struggling to follow established process as the mobile printers attached to their Computers On Wheels (COWs) are unreliable and often inoperative. The introduction of managed print has made their jobs far easier as they can now print to the 'cloud' from their COW's and then choose to collect their print from a number of devices either on the ward where they are working or along their route to the next destination.

Reduction in Time Spent Maintaining Printers

Within Glenfield Hospital, there are 510 print devices (excludes Ricoh & fax machines) which are made up of 322 mono (black only) and 188 colour capable units. The mono are predominantly laser devices using black toner cartridges and the colour devices are inkjet with only 2 exceptions which are colour lasers.

Based on average annual volumes of print for both colour and mono from the audits, it has been determined that each device would use on average 3 toners or 'sets' of colour ink cartridges in one year of operation.

Assuming that a user or stationary clerk for each device would need to spent 5 minutes per toner calling to order, a further 5 minutes following up or receiving the order, and 15 minutes to unpack and install the items, this means that for every device, regardless of colour or mono, there are 75 minutes (1.3 hours) spent dealing with refills every year.

When this calculation is scaled up to the number of devices this means that collectively, between all the staff that need to use printers, 638 hours, or 80 man days, are spent, per year, just sorting out and installing ink or toner. Assuming 20 working days in a month this is 4 months of every year, and this is only for Glenfield Hospital.

CONFIRM THE PROJECT BENEFITS (FINANCIAL)

The following table details the outcome of discussions with UHL Procurement and Finance around what the current level of annual expenditure is in relation to the LRI printer estate.

		Annual	5 Year Total
Cost Savings			
Ricoh Lease and print costs	Direct Savings	£185,732	£928,660

Equipment purchase	Direct Savings	£35,369	£176,847
Non-Ricoh Print and Consumables	Direct Savings	£265,690	£1,328,450
Paper	Direct Savings	£129,134	£645,670
Planet Press	Direct Savings	£3,063	£15,315
Power Spend	Indirect Savings	£57,918	£289,590
Invoice Costs	Indirect Savings	£9,900	£49,500
Existing Telephony	Indirect Savings	£26,544	£132,720
Totals		**£713,350**	**£3,566,752**

NB: The figure for Equipment Purchase view has been provided by UHL Procurement.

Using these numbers as the comparator results in the following commercial case for the LRI Managed Print solution.

Indicative IBM Price - Capital	
Hardware	£1,193,912
Software	£247,063
Implementation Services	£412,402
Software Warranty	£61,876
Service Charge	£494,761
Software Support	£68,200
Sub Total	**£2,478,214**
Annual Print variable estimate	£729,421
UHL Ricoh write-off	£88,857
Total Price	**£3,296,492**
Project contingency	**£100,000**
Direct Costs Saving	£3,094,942
Net Savings before contingency	**-£201,550**
Net Savings after contingency	**-£301,550**
Direct + Indirect Costs Savings	£3,566,752
Net Savings before contingency	**£270,260**
Net Savings after contingency	**£170,260**

CONFIRM CONSULTATION WITH THE FOLLOWING GROUPS *Signatures required*	ESTATES CAPITAL GROUP	IT GROUP	MEDICAL EQUIPMENT PANEL	INFECTION PREVENTION TEAM
	N/A	***John Clarke***	***N/A***	***N/A***

DUE REGARD - ASSESSMENT	Please see appendix 3.

Section 5: Conclusion and approvals

HAS THE PROJECT BEEN APPROVED BY THE RELEVANT DIVISIONAL BOARD	*(Yes/No Date)*
HAS THE PROJECT BEEN APPROVED BY THE SITE RECONFIGURATION BOARD (IF APPLICABLE)	*(Yes/No Date)*

SET OUT CLEARLY THE RECOMMENDATION	

Sign off

Name	Project role	Signature and date
Sarah Remington	Project Manager	
John Clarke	Project Sponsor	
Peter Hollinshead	Finance Director	
John Adler	Chief Executive	
Steve Jackson	*CMIO*	

Make reference to the Trust's delegated scheme of authority

Appendix A

Key Learning Points	
Learning Point	**Action to Address**
Improved understanding of each ward / deployment and the circumstances within it would allow for a smoother roll out.	Key resource with UHL knowledge involved in the project from Day 1 helping to shape the solution for each individual deployment.
In addition to the applications already known, new apps were discovered during roll out which affected the time taken to test and problem solve.	Due diligence will be geared to looking for these additions in each department.
The complexity of change was over and above that for which planned resource was in place.	The LRI rollout has been specifically structured to validate the initial solution fully and has planned a checkpoint to manage change and re-baseline with UHL before proceeding to rollout.
Insufficient time was allowed for changes to infrastructure, such as additional power or network sockets	The project has planned time for this to be initiated as soon as the solution is validated and signed off, which leaves time for the work to be completed and incorporated into the rollout phase.
Project communications were poorly disseminated after the initial delivery, resulting in many interpretations of what Managed Print was about.	CMG Leads and key Service Managers are being identified in advance to work closely with the project from the start and have regular input via the Project Board, LiA events and CMG meetings at which Managed Print will schedule regular slots.
Training sessions could have had better attendance and should be structured to cover all basic user operations consistently each time before addressing specific questions from attendees.	Early communications will include training awareness and due diligence will actively encourage people to attend training, identifying key 'Champions' to be invited to training when sessions are booked. Training will run for 6 weeks in total for LRI prior to the rollout, with additional refresher training delivered as part of each deployment for those staff available to attend. Users requesting specialist or tailored training can have specific sessions scheduled.
Testing was insufficient for some applications which were later found to be used in different situations or for different tasks.	Key UHL knowledge involved in the project from Day 1 helping to shape the solution for each individual deployment and identifying user groups to assist in testing of applications specific to LRI, not already tested for the Glenfield deployment.
There has been a lack of clarity on staff that should be using Smart Cards and Staff that should have 'stickers'	There is now a better understanding of which staff should be using a smart card as part of their job role and they will be encouraged to upgrade to an '05' card where needed. Staff will be identified earlier through due diligence so will have a much greater window within which to upgrade their card before the rollout occurs. Departments with a critical need to have print released immediately with no delay are being specifically catered for (ie. The Emergency Department)

Initial problems with the Managed Print solution moving into BAU support arrangements.	The Service Desk and Service Delivery managers will be included in the communications plan and will have responsibility for the support of the devices as soon as installed and signed off as complete by the Project team. This will provide a consistent level of support for all departments and staff.
The process for decommissioning old devices for re-use at other locations had some ambiguity.	A workshop will be held with all concerned parties to review the process as it exists today address any improvements and ensure a comprehensive awareness of the devices to become available from the LRI once the deployment begins.

Appendix 2 – Financial Analysis

MANAGED PRINT LRI FINANCIAL SUMMARY											
	2014/15	2015/16	2016/17	2017/18	2018/19	2019/20	2020/21	2021/22	2022/23	2023/24	Total
	£k	£k	£k	£k	£k	£k	£k	£k	£k	£k	£k
INCOME AND EXPENDITURE											
Revenue income	-	-	-	-	-	-	-	-	-	-	-
Operating costs	(266,238)	(400,461)	(270,986)	(255,147)	(241,112)	(109,170)	-	-	-	-	**(1,543,115)**
Cash releasing benefits	-	713,350	713,350	713,350	713,350	713,350	-	-	-	-	**3,566,752**
Operating costs	**(266,238)**	**312,889**	**442,364**	**458,204**	**472,238**	**604,181**	**-**	**-**	**-**	**-**	**2,023,637**
Non-operating costs increase	-	(370,675)	(370,675)	(370,675)	(370,675)	(370,675)	-	-	-	-	**(1,853,377)**
Revenue expenditure	**(266,238)**	**(57,786)**	**71,689**	**87,528**	**101,563**	**233,505**	**-**	**-**	**-**	**-**	**170,260**
REVENUE SURPLUS/(DEFICIT)	**(266,238)**	**(57,786)**	**71,689**	**87,528**	**101,563**	**233,505**	**-**	**-**	**-**	**-**	**170,260**
CAPITAL EXPENDITURE											
Implementation Services	(412,402)	-	-	-	-	-	-	-	-	-	**(412,402)**
Hardware	-	(1,193,912)	-	-	-	-	-	-	-	-	**(1,193,912)**
Software	-	(247,063)	-	-	-	-	-	-	-	-	**(247,063)**
TOTAL CAPITAL EXPENDITURE	**(412,402)**	**(1,193,912)**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**(1,853,377)**
CASHFLOW											
Cash flow	(678,640)	(1,128,086)	442,364	458,204	472,238	604,181	-	-	-	-	**170,260**
Cumulative net cash flow	(678,640)	(1,806,726)	(1,364,362)	(906,158)	(433,920)	170,260	170,260	170,260	170,260	170,260	
Payback (years)						**5.7**					
Discounted cashflow (NPV)	(678,640)	(1,088,603)	411,941	411,757	409,515	505,596	-	-	-	-	**(28,435)**
BENEFITS SUMMARY											
Income	-	-	-	-	-	-	-	-	-	-	**-**
Cash releasing	-	713,350	713,350	713,350	713,350	713,350	-	-	-	-	**3,566,752**
Non cash releasing											**-**
	-	**713,350**	**713,350**	**713,350**	**713,350**	**713,350**	**-**	**-**	**-**	**-**	**3,566,752**

Appendix 3

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST

Due Regard and involvement assessment

Division:
Date:

1.	**Describe the service/ policy change**		
2.	**What are the aims of the service/ policy change including expected outcomes**		
		Yes/No	**Comments**
3.	**Is there a possibility that one or more of the groups listed below will be <u>less</u> or <u>more</u> favourably affected by the change if so describe the likely effect:**		
	• Race/ethnicity	No	
	• Sex	No	
	• Religion or belief	No	
	• Gender Reassignment	No	
	• Sexual orientation including lesbian, gay and transsexual people	No	
	• Age	No	
	• Marriage and Civil Partnership	No	
	• Disability - learning disabilities, physical disability, sensory impairment and mental health problems If so what is the evidence /data :	No	
4.	What alternatives are there to achieving the change without	N/A	

	having the impact?		
5.	Which specific group do you need to speak to / involve	N/A	
6.	If challenged are you confident that the change and its implementation will: • Be non discriminatory • Not damage equality of opportunity • Not damage relations with the protected groups listed above	Yes	
7.	More generally please provide details on: a) Who you will consult/involve? b) At what point in the process? c) How will you communicate the service change once implemented?	N/A	

Assessment completed by: Date:

Signed:

If you require further advice please contact Deb Baker, Equality Manager on 0116 2584382 or Karl Mayes PPI and Membership Manager on 2588685

Trust Board paper U

To:	**Trust Board**
From:	**ACTING DIRECTOR OF FINANCE**
Date:	**31 July 2014**
CQC regulation:	N/A

Title:	**Orthopaedic Trauma CMF Implants and Associated Products Framework**

Author/Responsible Director: INTERIM DIRECTOR OF FINANCIAL STRATEGY

Purpose of the Report: To seek approval of the Orthopaedic Trauma CMF Implants and Associated Products Framework

The Report is provided to the Committee for:

Decision	✓	Discussion	
Assurance		Endorsement	

Summary / Key Points: This decision will allow for the award of a Orthopaedic Trauma CMF Implants and Associated Products Framework covering UHL's entire network. This framework will allow UHL to call-off future contracts in an agile manner in the future, including subsequent to mini-competitions.

Recommendations:

1. To approve the Orthopaedic Trauma CMF Implants and Associated Products Framework Contract
2. To delegate the authority to an Executive Director to award contracts within the framework following a mini-competition without the requirement for this to be approved by Trust Board.

Previously considered at another corporate UHL Committee?

Strategic Risk Register: N/A	**Performance KPIs year to date:** N/A All KPI's will be specified within the mini-competitions under the framework.

Resource Implications (e.g. Financial, HR): None

Assurance Implications: N/A

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

Stakeholder Engagement Implications: N/A

Equality Impact: N/A - Goods

Information exempt from Disclosure: N/A

Requirement for further review? None – Delegated responsibility to the Executive Directors.

1. Project Outline

The Musculoskeletal theatres total spend for the supply of Orthopaedic, Trauma, Craniomaxillofacial (CMF) and Associated products is £4.34million. Due to this significant spend in this area and compliance with EU procurement requirements the CMG initiated a formal tender process to ensure the most cost and clinically effective products were available.

Elective orthopaedics during 2013/14 delivered joint replacements as shown below generating a total income of £25 million.
The cost of prostheses in undertaking these procedures was £2.78 million.

Procedure	**Activity 13/14**
Primary Total Hip Replacement	913
Revision Total Hip Replacement	112
Primary Total Knee Replacement	1090
Revision Total Knee Replacement	65
Arthroscopy	716

Trauma treated 3257 patients in 2013/14 and is forecast to treat 3445 patients in 2014/15 and generates a total income of c. £12.7million.

It was the intention of this exercise to let a framework agreement to a range of suppliers in order to ensure that the best products are available for patient use and to ensure on-going competition.

A framework agreement does not commit the Trust to purchase product, each individual order creates a contract. Therefore use of a Framework provides maximum flexibility in product selection and market share to generate competition amongst suppliers. This will enable cost control throughout the lifetime of the contract using a number of purchasing techniques catered for in the framework such as bulk purchase and use of market share to achieve best price banding. Other contracting solutions would not provide such flexibility.

The framework agreement will be awarded for three years, with prices fixed for two years, and an option to extend for a further one year.

The contract was advertised in the European journal in January 2014 as an open procedure, for two lots; Lot 1 Orthopaedic Trauma CMF Implants; Lot 2 Tools and Consumables received 57 expressions of interest were received, from which 35 tenders were returned (15 for Lots 1 & 2; 12 For Lot 1 only; 8 for Lot 2 only)

This recommendation concerns Lot 1 only.

2. Scoring & Award

The evaluation criteria used for the evaluation were as follows:

Quality (60%)
Capabilities (39%)
Clinical (21%)
Commercial (40%)
Cost (30%)
Added Value (10%)

An evaluation team was put together comprising Orthopaedic and Musculoskeletal Surgeons, Theatre Staff, CMG Management, Procurement and Finance. Each of the submissions was scored, by section, according to the above criteria by members of the evaluation team.

It had been agreed that tenderers with an acceptable clinical score and an overall score in excess of 50% would be admitted to the framework agreement. The proposed suppliers to be admitted to the framework Agreement are:

Section / Supplier	Hips	Knees	Trauma lower limb	Trauma upper limb	Spine	Hands	Shoulders	External Fixation	Arthroscopy	CMF
Acumed Ltd				✔		✔				
Arthrex		✔								
ArthroCare UK									✔	
B Braun Medical Ltd	✔	✔	✔							
Biomet UK Ltd	✔	✔	✔	✔	✔	✔	✔			✔
Conmed Linvatec										✔
DePuy International ltd	✔	✔	✔	✔	✔	✔	✔		✔	✔
DP Medical Systems Ltd					✔					
Exactech (UK) Ltd		✔		✔			✔			
Joint Replacement Instrumentation Ltd	✔	✔	✔							
Karl Storz Endoscopy (UK) Ltd		✔								
Medartis Ltd				✔		✔				
MicroPort Orthopaedics Ltd		✔	✔							
Smith and Nephew Orthopaedics	✔	✔	✔	✔				✔	✔	
Stryker UK Ltd	✔	✔	✔	✔	✔	✔	✔			✔
Xpert Lima Orthopaedics	✔									
Zimmer Ltd	✔	✔	✔	✔			✔	✔		

3. Financials

This framework will cover UHL's entire Orthopaedic Trauma CMF Implants, covering an annual spend of c. £4m.

	Award of this framework will have a saving of £142,226, as part year effect for 2014/15 and netting the fee payable to Accenture of £197,621. The full year effect savings to be realised for 2015/16 are £718,624 for FY15/16 – any future call-offs from this framework will be made with consideration to improving UHL's financial contribution.
4. Recommendation & Benefits of Decision	4.1: Recommendations: Based on the above, on behalf of the project steering group, I make the following recommendations to the board: Award all 17 eligible suppliers Acumed Ltd Arthrex ArthroCare UK B Braun Medical Ltd Biomet UK Ltd Conmed Linvatec DePuy International ltd DP Medical Systems Ltd Exactech (UK) Ltd Joint Replacement Instrumentation Ltd Karl Storz Endoscopy (UK) Ltd Medartis Ltd MicroPort Orthopaedics Ltd Smith and Nephew Orthopaedics Stryker UK Ltd Xpert Lima Orthopaedics Zimmer Ltd to UHL's new procurement Framework. To delegate the authority to an Executive Director to award contracts within the framework following any mini-competition without the requirement for this to be approved by Trust Board. 4.2: Benefits of Decision: Award of this framework will have the following benefits to UHL: **Responsive Award of Prosthesis Call-Offs:** • A framework agreement does not commit the Trust to purchase product, each individual order creates a contract. Therefore use of a Framework provides maximum flexibility in product selection and market share to generate competition amongst suppliers. This will enable cost control throughout the lifetime of the contract using a number of purchasing techniques catered for in the framework such as bulk purchase and use of market share to achieve best price banding. Other contracting solutions would not provide such flexibility **Added Value Schemes** • Each of the companies have offered additional schemes, such as Theatre efficiency programmes, HRG coding guides, enhanced recovery programmes and pathway performance programmes which will allow UHL to reduce costs.

	Consignment Stock: • The main suppliers all offer consignment stocks, (stock wholly owned and managed by the supplier and paid for as used) which will allow UHL to reduce stock costs. Financial savings are expect to begin to impact after the framework is fully implemented which will take up to eight weeks. This period is required for any new suppliers to place instrumentation and stocks of implants with the Trust.

Trust Board Paper V

To:	**Trust Board**
From:	Kate Shields
Date:	**31 July 2014**
CQC regulation:	

Title:	**Developing a strategic planning function for 2014/15 and beyond**

Author/Responsible Director:
Kate Shields

Purpose of the Report:

The paper describes

- The revised strategic planning process that University Hospitals Leicester (UHL) will put in place across the organisation from 2014/15 onwards.
- The process for engaging clinical management groups in directing and owning strategic planning
- How the external environment will be assessed and managed over the period of our 5-year strategic plan
- The development of 'business rules' for 2014/15

The Report is provided to the Board for:

Decision		Discussion	X
Assurance		Endorsement	

Summary / Key Points:

Recommendations:
The Board are asked to:

- Endorse the approach to strategic planning
- Note the process of engaging Clinical Management Groups (CMGs)
- Agree the minimum products that each CMG should produce in this planning round
- Agree the Trust Board calendar for 2014/15

Previously considered at another corporate UHL Committee?
July Trust Board development session

Board Assurance Framework:	**Performance KPIs year to date:**

Resource Implications (eg Financial, HR):

Assurance Implications:
yes

Patient and Public Involvement (PPI) Implications:
yes

Stakeholder Engagement Implications:
yes

Equality Impact: Considered and no impact
Information exempt from Disclosure:
Requirement for further review? Yes – See appendix one

Developing a strategic planning function for 2014/15 and beyond

Purpose

1. This paper will describe

   - The revised strategic planning process that University Hospitals Leicester (UHL) will put in place across the organisation from 2014/15 onwards.
   - The process for engaging clinical management groups in directing and owning strategic planning
   - How the external environment will be assessed and managed over the period of our 5-year strategic plan
   - The development of 'business rules' for 2014/15

Action required

2. The Board are asked to:

   - Endorse the approach to strategic planning
   - Note the process of engaging Clinical Management Groups (CMGs)
   - Agree the minimum products that each CMG should produce in this planning round
   - Agree the Trust Board calendar for 2014/15

Background

3. During 2013/14 work was done to develop a 5-year Integrated Business Plan and a Long Term Financial Model for the organisation. This was done in partnership with the Clinical Commissioning Groups (CCGs) and NHS England's Area Team and therefore presents for the first time UHL's component of an Integrated strategic plan that covers the health and social care community of Leicester, Leicestershire and Rutland.

4. As part of this work the strategic planning function for UHL has been subject to review.

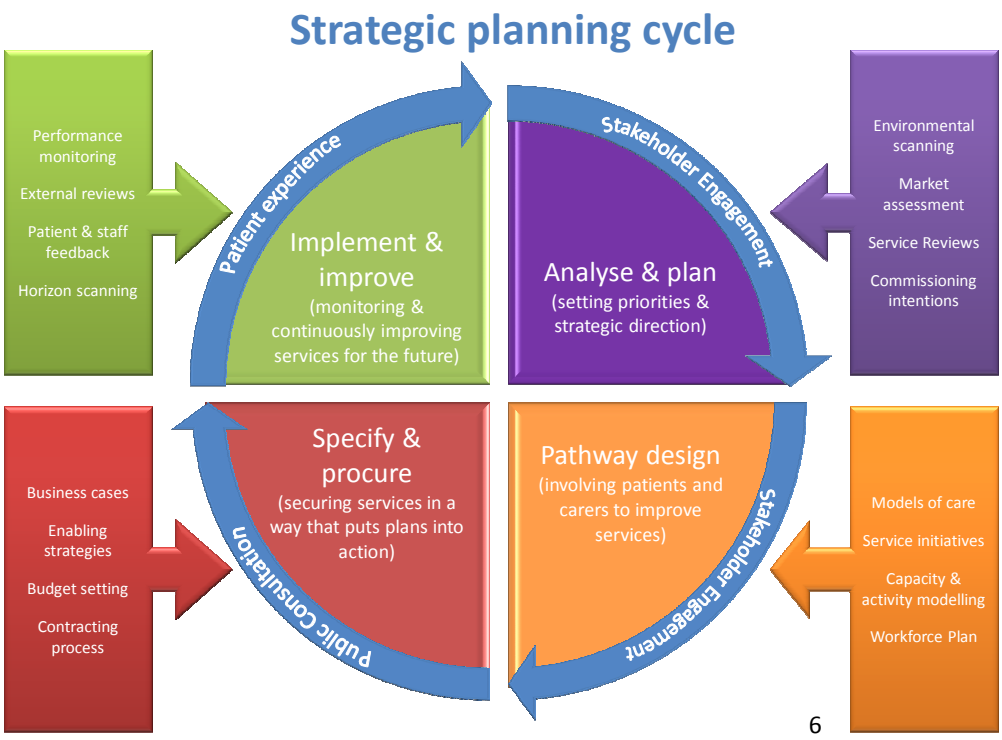
5. This paper will describe the next step in developing a 'fit for purpose' strategic planning and delivery function across UHL.

6. It should be noted that further work is taking place to agree how our 5-year strategic planning and the Better Care Together Programme will be aligned annually.

Strategic planning for 2015/16 and onwards

7. For 2015/16 a clear and transparent process for business planning will be put in place.

8. The process is shown diagrammatically below.



9. It can be split into four discrete components that start with needs assessment and review of the external environment and finishes with performance review and analysis of the outputs of the previous year's planning round.

10. For UHL this 'implement and improve' phase has been the quarterly review of the annual operating plan, this now needs to align with the internal performance meetings with the CMGs and the delivery of cross cutting themes led through the Cost Improvement Programme (CIP) Project Management Office (PMO).

11. All four sectors of the planning cycle will be refreshed for 2015/16 with clear executive director and CMG accountabilities for each phase of the process. This will support the 'refresh' of our 5-year plan that is required for September and sets the parameters for the CMGs as to what the overarching requirements are for activity, capacity planning, workforce and financial planning

12. Key to successful business planning will be ownership of the process and the outputs of the process by the CMGs.

13. Each section of the planning cycle will have an executive lead with clear accountability for delivering the core tasks contained within it. Further discussion will take place amongst the Executive Team as to how this will be shared and a project plan will be available for the September Trust Board meeting.

14. Careful consideration will be given to ensuring that internal arrangements for CIP development and delivery and the external arrangements supporting the delivery of Better Care Together and QIPP are aligned and that this alignment supports the detail of our contract with commissioners

Core products

15. For 2015/16 there will be an expectation that each CMG will produce a number of 'core' products that describe at a reasonable level of detail, what each of the 49 service lines does.

16. These core products will be:

- **Operational policy** for the service line – this will describe how a service is delivered and critically what the expectations are of other CMGs and/or support services such as theatres, ITU and diagnostics.
- **A response to the operational expectations detailed in year 2 of our 5-year strategic plan**. This will include trajectories for service change eg movement to out of hospital care, progress with moves from in-patient surgery to day case
- **A plan on a page** that shows the operational and strategic ambition of the service

17. At a high level this will provide a detailed introduction to service reviews, which each of the 49 service lines will undertake over the next 24 months.

Developing business rules for the organisation

18. UHL will need to respond to the 'business rules' set by the Department of Health (DH). In the past this would have been reflected in the 'Annual Operating Framework' or the "Everyone Counts" produced last year for the first time by NHS England.

19. For 2015/16 we know that NHS England will be producing a directional strategy for the NHS for the next 5 years and we expect that this strategy will require year on year efficiencies and productivity gains. The strategy will be published in September.

20. We will also develop our own 'business rules' to give clarity and a clear framework to CMGs for delivery. The draft framework will come to the Trust Board in September for approval and a programme of work is in place to take it through internal discussion and via the Executive Committees prior to formal sign off.

Ownership by Clinical Management Groups

21. Key to the development of meaningful plans and the delivery of them is the engagement and ownership of the CMGs.

22. An engagement programme is being developed for the CMGs with a clear timeline for product development and clear expectations around outcomes. A planning team will be established to steer the process.

23. A review meeting to evaluate how well last year's planning process went took place on the 22nd July it was well attended by CMGs who have asked for better co-ordinated working between CMGs to be a feature of this year's planning.

24. In September the CMGs will come together as integrated teams to present their plans for this year and the requirements they have for support from other CMGs.

25. They will then present their outline plans for next year so that each CMG are aware of the expectations or requirements between them for service delivery.

26. In November a workshop will be held with the Executive Team to look at indicative plans for 2015/16, this will include all detail of business case delivery, cost improvement plans, response to commissioner QIPP, service developments, capital planning, counting and coding and any other contractual requirements. This will give the whole Executive Team an opportunity to discuss the detail within the plans and the level of ambition and integration. It also at an early point in the planning round facilitates a cross Trust discussion about workforce, capacity plans and finance.

27. In January the CMGs will repeat this and this will then become the final capacity, activity, finance and workforce plan for each part of the organisation.

Summary

28. This paper presents a starting point in next year's planning. Further detailed updates will come to the Trust Board in line with the planning calendar (appendix 1).

Action required

29. The Board are asked to:

- Endorse the approach to strategic planning
- Note the process of engaging CMGs
- Agree the minimum products that each CMG should produce in this planning round
- Agree the Trust Board Calendar for 2014/15

UHL Trust Board Calendar for 2014/15

Jul 2014	Aug 2014	Sept 2014	Oct 2014	Nov 2014	Dec 2014
TB review strategic planning cycle TB approve Vascular OBC TB review Q1 2 year plan quarterly review		TB approve Development Support Plan	TB review Strategic Objectives TB approve prioritised initiatives TB review Q2 2 year plan quarterly review	TB approve Emergency Floor FBC TB approve prioritised initiatives	
Jan 2015	**Feb 2015**	**Mar 2015**	**Apr 2015**	**May 2015**	**Jun 2015**
TB review INITIAL 2 year plan TB review Q3 2 year plan quarterly review	TB review DRAFT 2 year plan TB approve NTDA 2 year plan assurance template	TB approve FINAL 2 year plan TB review 5 year plan storyboard	TB review Q4 2 year plan quarterly review	TB review DRAFT 5 year plan	TB approve FINAL 5 year plan

Trust Board paper W

	TRUST BOARD
From:	Kevin Harris, Medical Director Kate Bradley, Director of Human Resources
Date:	**31st July 2014**
CQC regulation	All

Title:	**Medical Workforce Strategy**

Author/Responsible Director:
Louise Gallagher, Workforce Development Manager

Purpose of the Report:
To present the proposed Medical Workforce Strategy to support the Trust's Five year Workforce Plan. The strategy describes four aspects to support the medical workforce with particular emphasis on mechanisms to address future shortages in supply particularly the junior medical workforce.

The Report is provided to the Board for:

Decision		Discussion	√
Assurance	√	Endorsement	√

Summary / Key Points:

The overarching Five Year Workforce Plan 2014/19 sets a direction of travel in relation to our workforce capacity and capability requirements. This plan is based around six pillars of delivery that relate to both efficiency and productivity and how we will transform our workforce to support high quality patient care in the future. The plan describes new models of care and areas for future investment in relation to specialised services and as such there are important implications for the medical workforce.

The Medical Workforce Strategy and its supporting action plan, covers a range of initiatives relating to the attraction, shaping, development and engagement of the medical workforce to meet the needs of the Five Year Workforce Plan. Many of these initiatives are already in train and this strategy pulls together existing workstreams into an overarching vision for the medical workforce.

The paper describes our core priorities which focus on reshaping the medical workforce including developing non medical solutions in recruitment hotspot areas and improved alignment of Job Plans with activity.

A range of short term tactics to address our immediate recruitment shortfalls are also described.

The paper also describes the quality measures and ongoing assurance mechanisms

Recommendations: Members to note and endorse the Medical Workforce Strategy	
Strategic Risk Register Risks 13,14,15,16	**Performance KPIs year to date** Vacancy rates, junior doctor fill rates, paybill expenditure
Resource Implications (eg Financial, HR) Risk of higher levels of premium payment	

expenditure
Assurance Implications Underachieved targets will impact on achievement of the Workforce Plan and NTDA measures relating to this
Patient and Public Involvement (PPI) Implications Underachievement of targets potentially has a negative impact on patient experience and Trust reputation
Equality Impact considered and no impact
Information exempt from Disclosure N/A
Requirement for further review? Review and monitor through the Executive Workforce Board

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST

REPORT TO: **TRUST BOARD**

DATE: **31 JULY 2014**

REPORT FROM: **KEVIN HARRIS, MEDICAL DIRECTOR/ KATE BRADLEY, DIRECTOR OF HUMAN RESOURCES**

REPORT BY: **LOUISE GALLAGHER, WORKFORCE DEVELOPMENT MANAGER**

SUBJECT: **MEDICAL WORKFORCE STRATEGY**

1.0 Background

1.1 As part of the five year planning cycle, we have developed and refreshed our Five Year Workforce Plan 2014-19 to set a direction of travel in relation to our capacity and capability requirements. This plan is based around six pillars of delivery that relate to both efficiency and productivity and how we will transform our workforce to support high quality patient care in the future. The plan describes new models of care and areas for future investment in relation to specialised services and as such there are important implications for the medical workforce.

1.2 In order to support delivery of this plan we have pulled together a number of existing pieces of work into an overarching Medical Workforce Strategy and action plan (attached as appendices 1A and 1B). There is an increasing urgency for a focus on the medical workforce given the widening gap between supply and demand particularly in relation to junior doctors and the need for innovative solutions to more efficient ways of working particularly in integrated ways across health and social care.

2.0 Introduction

2.1 The purpose of this paper is to receive feedback from the Trust Board on the proposed Medical Workforce Strategy 2014-16 and the initial quality measures relating to this.

2.2 The Medical Workforce Strategy has received initial input from the Associate Medical Director for Education and the Trust's medical engagement lead. Feedback has also been received from the Executive Team.

3.0 The Strategy

3.1 There are four work streams identified within the strategy:

- Recruit and retain a high quality medical workforce proactively (attract)

- Shape a workforce to be efficient and effective and focused on quality. Shape new roles which support new models of healthcare delivery and support the closure of gaps in traditional hot spot areas (shape)

- Develop a learning organisation approach to education and training and enhance our reputation as a teaching trust (develop)

- Establish a culture of engagement and innovation (engage)

3.2 Each workstream has an associated set of outcomes and a series of short term and long term initiatives designed to achieve the high level outcomes. Initiatives include innovative approaches to recruitment and retention in hotspot areas, redesign of the workforce to introduce non medical solutions, sharpening our processes for the management of Job Plans and ensuring good governance in relation to pay. We also describe how we aim to become a learning organisation and improve our levels of engagement with the consultant workforce.

4.0 Core Priorities

4.1 The 'shape' workstream is the highest level of priority if we are to deliver our vision of a transformed workforce which can deliver healthcare in a sustained way in the future. We know that there are future plans to further reduce the number of training posts and we are consistently seeking to source workforce from an area of limited supply. Our planned transformation of services presents significant opportunities to review what functions need to be carried out, in what settings and how. This will entail constructing a workforce model to deliver the planned operational model and then giving consideration to the education and governance arrangements arising from this remodelling. We have good practice in many parts of the Trust for example trauma coordinators in trauma and orthopaedics or advanced nurse practitioners in the Emergency Department. We need to ensure that we develop an overarching strategic approach which allows flexibility at specialty level based on a baseline definition of functional responsibility, educational requirements and good governance in respect of policies and procedures.

4.2 Advanced practitioners are the most developed form of non medical workforce solution and have been introduced in response to specific specialty hot spot areas. A more planned approach is being developed which will entail adoption of an East Midlands wide competency framework, with educational input and competency sign off designed and delivered locally.

4.3 Work is underway to review the introduction of Physician Assistants based on good practice in both the United States and locally. The focus here will be on scoping our requirements and developing an education programme to ensure delivery. This will not only support recruitment hotspots but also support the delivery of seven day service provision.

4.4 Work is being undertaken to attract and provide CPD support to non traditional medical workforce posts such as career grade and specialty doctors. A workforce of this nature can deliver stability and enable trainee doctors to have better supported educational programmes.

4.5 The work underway to review consultant job plans is a key mechanism for aligning workforce with activity but also to create opportunities for additional portfolio programmed activities which underpin our vision to be leaders in education and research thereby attracting and retaining talent for the future.

5.0 **Short term Tactical Approaches**

5.1 As work progresses to develop new and innovative roles, there are a number of short term approaches being adopted to attract trainee and substantive staff to the Trust. Initiatives include:

- the development of multispecialty roles such as geriatrics and emergency medicine
- opportunities for out of programme experiences and training
- the development of a collaborative approach to cover gaps in our trainee medical workforce. In this a single agency supplier has been commissioner to supply doctors across the East Midlands which can offer rotations to new and different specialties through a pooled approach.

6.0 **Measurement of the Medical Workforce Strategy**

6.1 The action plan and local CMG action plans (collated through the Delivering Caring at its Best Workforce Plan workstream) will be monitored via the Executive Workforce Board.

6.2 Gaps in relation to consultant and trainee medical workforce will be monitored via the Executive Workforce Board and reported to the Clinical Quality Review Group.

6.3 Performance in relation to medical workforce engagement will be monitored through the Staff Survey.

6.4 Education Quality will be monitored and measured through LETB Quality Dashboards and GMC quality measures and trainee feedback.

7.0 Summary and Recommendations

This paper has captured the principle priorities from the Medical Workforce Strategy which are detailed in the outcomes and action plan

6.1 The Board is asked to approve the Medical Workforce Strategy

6.2 Note the assurances to be provided and measurement mechanisms.

University Hospitals of Leicester NHS
NHS Trust

Caring at its best

UHL Medical Workforce Strategy

2014- 2016

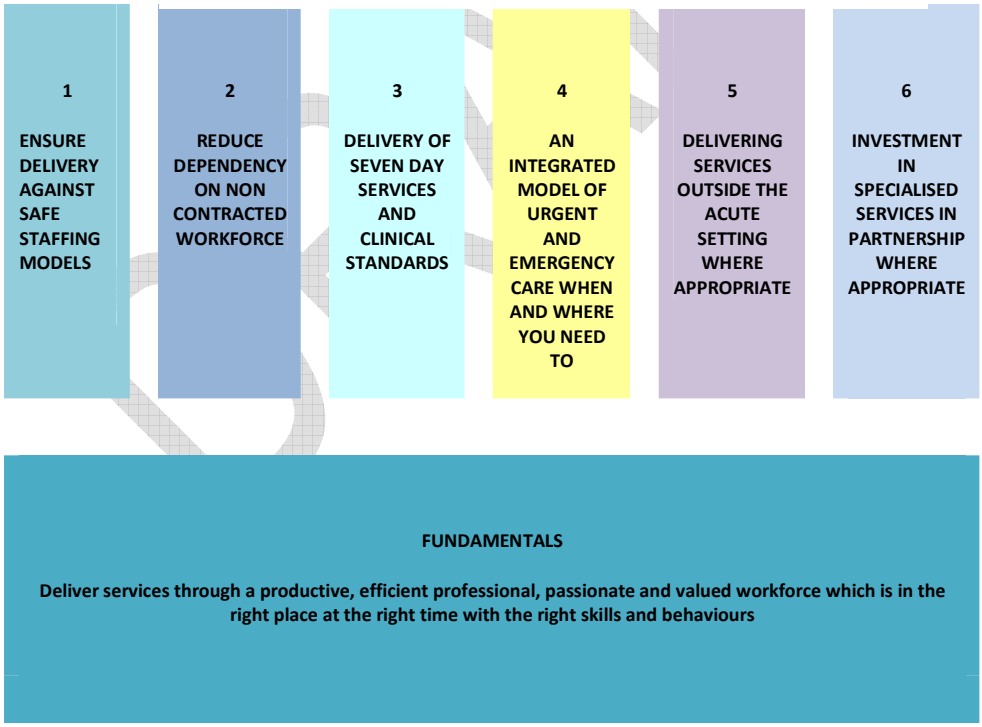
DRAFT

Foreword

OUR VISION: We will become a successful Foundation Trust (FT) that is internationally recognised for placing quality, safety and innovation at the centre of service provision. We will build on our strengths in specialised services, research and teaching; offer faster access to high quality care, develop our staff and improve our patient experience. We call this …

…Caring at its best

Our overall Five Year Workforce Plan for 2014 -19 describes six pillars of delivery to shape the workforce model for delivery of the overall Better Care Together Strategy for the Leicester, Leicestershire and Rutland (LLR) health community:



The purpose of the Medical Workforce Strategy is to draw together a number of medical workforce workstreams to describe how we will progress towards the overarching workforce plan specifically in relation to medical staffing. As such the strategy will embrace both consultants and training staff who provide core aspects of service delivery. It will also include our growing non training workforce of Specialty and Career Grade Doctors and describe plans for the

introduction of non medical workforce roles to support multiprofessional approaches to care and address recruitment hotspots. A number of recruitment hotspots are replicated nationally and we recognise the need to transform our workforce in order to address these gaps in new and innovative ways.

The strategy will initially span a period of two years with a predominant focus on the first three pillars of the workforce plan as we await more detail on the Greenaway 'Shape of Training Review' (2013) and the evolution of new models of care in the LLR health community. In addition to being driven by the Trust's Five Year Workforce Plan, this strategy is underpinned by:

- UHL Clinical Strategy
- UHL Organisational Development Plan 2013-2016
- A Strategic Vision for Medical Education and Training in UHL
- The Medical Productivity CIP Cross Cutting Theme
- The Nursing Productivity CIP Cross Cutting Theme (with particular emphasis on new role development)
- New initiatives around medical engagement including the Junior Doctors in Training Committee and Clinical Senate
- Listening into Action

1 Our Values

Our values have a key influence on shaping our workplace in terms of culture and behaviours. The values are also key to shaping medical workforce strategy and planning in that we need to ensure a focus on high quality care is embedded in all employment practices and plans.

2 Our Medical Workforce Strategy – Principles and Aims

Our Strategy will focus on attracting, recruiting, shaping, developing and engaging the medical workforce to support delivery of the Trust's Strategic Direction:

Our Strategy is underpinned by the following principles:

- Ensure our medical staff are supported to work safely in order that they can deliver high quality patient care and experience
- A focus on ensuring transparency in the allocation and expenditure of the Trust's resources with patient needs at the heart of our planning processes
- Ensure mechanisms are in place to respond quickly and proactively to recruitment hotspots and high risk areas both at the current time and in response to known risks on the planning horizon
- Ensure workforce plans are influenced and shaped through engagement and innovation
- Deliver high quality training and education at undergraduate and postgraduate levels
- Listening into Action principles will underpin our approach to medical staff engagement

Working with these principles we aim to:

- Manage our skill shortage areas and recruit high calibre staff ensuring a consistent flow of applicants for all levels of medical staffing to meet our needs
- Improve staff engagement in order to limit turnover
- Invest in the development of new non medical roles to support future gaps in the supply of traditional workforce

DRAFT

- Shape our workforce to ensure rotas and job plans are created to meet service needs on an ongoing basis and specifically to meet the requirements of seven day service provision
- Shape rotas and job plans to maximise efficiency and productivity and ensure use of non contracted payments to supplement gaps is minimised
- Invest in the development and education of our workforce, ensuring we enhance our reputation as one of the largest Teaching Trusts – ensuring investment in both facilities and methodology as well as the quality of traditional education and mentorship
- Embed engagement and involvement in working practice including more routine adoption of service improvement techniques

3 Where are we now and where do we want to get to?

From	***To***
Pay for time served and grade	*Pay driven by achievement of goals – the what and the how*
Job Plans that are inconsistent and limited in the provision of detail	*Clear and consistent job plans throughout the Trust*
Recruitment that is reactive and in direct response to vacancies as they arise	*Predicting the shape of the future workforce and transform the workforce by developing new roles and rotas to meet changes in technology, settings of care, patient expectations, demographics and acuity and dependency*
Limited internal measures of productivity and quality	*Clear and transparent objectives and defined measures of productivity*
Complex training and education funding arrangements	*Transparency in relation to education and training funding*
Medical workforce has a passive role in shaping and directing the future of services	*Medical workforce given extensive opportunity to engage in the future direction of the Trust and shape clinical services*
High premium paybill for medical staff cover and capacity issues	*A flexible workforce that provides sufficient capacity 24/7*

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4 How will we structure our approach to planning the medical workforce

To deliver this Strategy, we have developed our work by focusing on the consultant, trainee and non medical and non training workforce under four key headings (not necessarily mutually exclusive) which each contain desired outcomes, initiatives and measures of success. This is an iterative strategy which will be shaped over time and refreshed.

RECRUIT AND RETAIN A HIGH QUALITY MEDICAL WORKFORCE PROACTIVELY:	SHAPE A WORKFORCE TO BE EFFICIENT AND EFFECTIVE AND FOCUSED ON QUALITY. ADOPT NON MEDICAL SOLUTIONS:	DEVELOP A LEARNING ORGANISATION APPROACH TO EDUCATION AND TRAINING AND ENHANCE OUR REPUTATION AS TEACHING TRUST:	ESTABLISH A CULTURE OF ENGAGEMENT AND INNOVATION:
ATTRACT	SHAPE	DEVELOP	ENGAGE

5 What will our priorities be?

Under each of the four key themes outlined above, we will describe high level desirable outcomes and both short term and long term initiatives to support the delivery of these outcomes and how we will measure our achievement of these.

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6 Work Stream 1: Recruit and Retain A High Quality Medical Workforce Proactively

Desired Outcomes

To ensure all roles attract sufficient high calibre applicants to ensure excellence in clinical skills is complimented by behaviours that support the Trust values and a commitment to work effectively in multidisciplinary teams**.**

What steps will we take to achieve this?

WORK STREAM 1: ATTRACT	
2014/15 Priority Initiatives	**Consultants** • **Ensure proactive and responsive management of the consultant appointments process** • **Embed values based recruitment into the appointments process including the potential introduction of assessment centres** • **Provide robust training for those supporting consultant panels** • **Monitor recruitment hotspots and develop innovative approaches to fill posts including development of strategic alliances where appropriate eg radiology, cancer services and shared community and acute posts in geriatrics** • **Develop innovative roles to attract high calibre applicants eg roles which provide opportunities for education or roles that deliver services to more than one specialty eg ED consultants with a special interest in geriatrics** • **Fully exploit the outstanding reputation of research and development to attract consultants and enable the development of specialised services** • **Identify schemes to attract high calibre leaders for academic and senior management positions**

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Training Posts

- **Proactively track and monitor gaps in fill rates and seek opportunities to proactively recruit to Locum for Service Posts particularly in medicine, ED and anaesthetics**
- **Develop innovative trainee posts eg Emergency Care roles with OOPE and OOPTE opportunities particularly where there are predicted benefits in long term service delivery priorities**
- **Work with Health Education East Midlands to market the East Midlands and learning and education facilities at Trusts within a particular rotation**
- **Encourage support for MTI schemes which attracts good doctors from abroad and can support developing nations**
- **Work with Health Education East Midlands and Training Programme Directors to ensure the timely notification of proposed training rotas**

Longer Term Initiatives

- **Dependent on the outcome of the 'Shape of Training Review' determine where the Trust will offer credentialing opportunities in order to develop and enhance specialised services**

Measures

- **Numbers of applicants per post**
- **Number of posts vacant**
- **Training post fill rates**
- **Compliant rotas**

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7 Work Stream 2: Shape a Medical Workforce to be Efficient and Effective and Focused on Quality adopting non medical models where appropriate

Desired Outcomes

We will have robust and systematic Job Plans and rotas that are closely aligned to activity and service priorities including the compliance with Seven Day Service Clinical Standards. They will also ensure that working practices are safe and adhere to regulations contained within the European Working Time Directive.

We will have clear policies and practices in place for the management of additional PA s and Special PA s to ensure transparency and added value. The design of additional PA s will recognise the added value of externally funded national and international roles which bring important influence and kudos to the Trust. This will also impact on the recruitment and retention of future consultants.

All forms of additional payment will be transparent and relating to service or levels of responsibility.

We will have clear and transparent processes in place for approving new medical staffing posts which are confirmed and challenged to ensure they are closely aligned to capacity requirements. This will be supported by a robust approach to service line reporting where activity is closely aligned to income streams and with accountability for delivery clearly defined.

We will be in the upper quartile of efficiency and productivity through the adoption of lean and systematic process redesign particularly in relation to theatres.

New roles will be in place for Assistant and Advanced Practitioners and Physician Assistants in order to support the closure of gaps in the supply of trainees particularly in surgical specialties. Specialty and Trust Grade doctors will also be employed to support safe senior rotas. These will be supported by specific development programmes to ensure re entry onto training routes where appropriate and continuous professional development.

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What steps will we take to achieve this?

WORK STREAM 2: SHAPE

2014/15 Initiatives

Consultants

- **Launch the UHL Job Planning Framework and Consistency Panel and ensure all reviewed Job Plans aligned to activity are in place for November 2014**
- **Additional payments such as management allowances will reflect market rates and levels of accountability. On call arrangements will reflect demand for out of hours services and will be assessed to ensure they represent best value as a working arrangements**
- **Undertake systematic review of all additional payments and confirm and challenge the purpose of such and whether to continue remuneration**
- **Utilise the baseline Seven Day Services to develop and cost actions to ensure compliance. Review workforce implications from three perspectives in conjunction with East Midlands colleagues – contractual levers, culture and workforce planning (eg new roles to support service in new and innovative ways)**
- **Develop clear and transparent set of measures for determining productivity which is aligned to service line reporting**
- **Ensure compliance with appraisal and revalidation requirements in order to support safe and high quality delivery**
- **Develop clear and transparent set of KPIs for consultants relating to quality, workforce, finance and delivery and implement clear and robust relationship to pay progression as defined in the 2003 consultant contract**
- **Involvement of clinicians in service and operational policy redesign particularly in relation to two site reconfiguration programmes in order that opportunities to reach upper quartile of productivity are maximised. Adopt programmes of expert challenge where appropriate**

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- **Ensure all new posts are approved through the Revenue Investment Committee**

Trainee Workforce

- **Scope roles where fill rates are poor/ there is a strong likelihood of reduced future investment and determine how and who can undertake role in the future. Determine competencies based on generic model and devise and commission where appropriate an supporting educational model**
- **Implement governance framework for new roles**

Overall

- **Develop conversion strategy in areas that consistently utilise agency and non contracted payment to address gaps eg convert to additional PA s or appoint to short term locum**
- **Adopt strict authorisation processes for the agreement to agency/ non contracted cover arrangements and monitor reasons for use of non contracted workforce. Utilise information to inform conversion strategy**
- **Review most cost effective payments for additional work eg fee for service**
- **Agency, medical locum and waiting list initiative payments will be used in a planned way where need is required by the service. Payments and usage will be monitored to ensure efficiency, good governance and high quality patient care**
- **Review rotas to ensure the most efficient and effective deployment of trainee and non consultant medical staff.**

Longer Term Initiatives

- **Develop systematic approach to reconfiguration programmes and workforce design for two sites**

Measures

Gap fill rates

Job Plan Completion rates

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Non contracted expenditure levels

Productivity rates

Revalidation and appraisal completion

8 Work Stream 3: Develop a Learning Organisation Approach to Education and Training and Enhance Our Reputation as a Teaching Trust

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Desired Outcomes

To deliver the objectives identified with the Medical Education Strategy ie:-

- Enhance the recruitment and retention of staff through the provision of excellent training
- Ensure UHL remains an accredited centre for training based on the experiences of trainees
- Working in partnership with the University develop a programme for improving the quality and capacity of education provision
- Capitalise on our reputation in relation to research and development
- Developing learning programmes which incorporate community and acute experiences
- Develop multiprofessional approaches to education based on the model developed in the Emergency Department
- Fully utilise technology such as Moodle to enhance the learning experience

What steps will we take to achieve this?

WORK STREAM 3. Develop	
2014/15 Initiatives	**Consultant** • **Utilise the outputs of consultant selection assessment centres to develop bespoke programmes of learning and development for individuals** • **Ensure all new consultants are supported by a mentor and systematic talent management processes are put in place** • **Fully develop the induction programme to ensure appropriate orientation to the Trust and introduction to lifelong learning**

- **Proactively promote available leadership development programmes particularly those relating to leadership across boundaries**
- **Promote the new Consultant Forum which provides quarterly developmental updates for new consultants in post**
- **Leadership and management development programmes particularly those relating to leadership across boundaries:**
    - **Access to suite of Leadership Academy Programmes (including Team leadership)**
    - **Internal aspiring leadership programmes for future Heads of Service**
    - **Knowing the Business programmes to support Service Line Management**
    - **Mentoring training with HEEM**
    - **Appraiser training and refresher training**

Trainees

- **Utilise the Tariff to create a transformative approach to education and training in the future**
- **Develop community and acute rotations to enhance learning experiences**
- **Build on existing programmes of development relating to:**
    - **developing your career**
    - **preparing for consultant positions**
    - **preparing for the consultant interview**

Specialty Doctors

- **Assign Clinical Supervisors to support ongoing development of this workforce**
- **Develop bespoke training modules which enable retention and promote opportunities to return to training programmes, adoption of ED model**

DRAFT

Longer Term Initiatives	• **Review learning models and approaches in the context of the 'Shape of Training' Review** • **Identify specialties to adopt credentialing approaches** • **Implement estates strategy for the improvement of education and training facilities**
Measures	• **Staff Survey** • **Evaluation of Learning Experiences**

DRAFT

9 Work Stream 4: Establish a Culture of Engagement and Innovation

Desired Outcomes

We will systematically engage Doctors in decisions that affect them and enable a culture of innovation in order that, as leaders of their clinical services, they have the opportunity to develop and enhance their services

We will create opportunities to develop service improvement techniques and encourage a culture of testing and trying new initiatives in partnership with the wider health and social care community where it is safe and appropriate to do so.

What steps will we take to achieve this?

WORK STREAM 4. ESTABLISH A CULTURE OF ENGAGEMENT AND INNOVATION	
2014/15 Initiatives	• **Continue to promote the Clinical Senate as a confirm and challenge to significant Trust strategic decisions** • **Continue to promote the Doctors in Training Committee particularly to use as Sounding Board for initiatives to improve the Drs experience** • **Build on success of recent Joint Consultant and GP Leadership Conference to further embed integrated models of care** • **Build on early intervention for junior and senior trainee doctors to enable a business/patient focused approach to service delivery eg Knowing the Business courses including financial awareness** • **Embed LiA as an approach to drive service innovation through listening and engagement** • **Further enhance CMG service development interventions to optimise improvement**

DRAFT

Longer Term Initiatives	• **Create a Improvement and Innovation Centre in collaboration with local health and academic partners to focus on**
	  ○ **Service improvement**
	  ○ **Research**
	  ○ **Innovation**
	  ○ **Education**

Measures	• **Staff Survey Results** • **New Initiatives** • **LiA Pulse Check Results**

Conclusion

This strategy pulls together a number of cross cutting workstreams to develop a vision for the medical workforce. Although it has been written as a professional specific approach, it describes a number of multiprofessional and cross organisational initiatives which will be key to the sustainability of affordable and high quality patient care in the LLR community.

DRAFT

Appendix 1B OUTLINE WORKFORCE ACTION PLAN 2014 – 2015 (YEAR ONE OF MEDICALWORKFORCE PLAN)

Monitoring body (Internal and/or External):	Delivering Caring at its Best Programme Board
Executive Sponsor:	Kevin Harris
Operational Lead:	Pete Rabey/Louise Gallagher
Frequency of review:	Monthly
Date of last review:	

This plan is a high level summary of actions identified in across the four mainstreams

REF	ACTION	SENIOR LEAD	OPS LEAD	COMPLETION DATE	PROGRESS UPDATE	STATUS
1	Recruit and Retain a High Quality Medical Workforce					
	Complete review of Consultant appointments process	Kate Bradley/ Kevin Harris	Emma Stevens	Sept 2014	Reviews of documentation complete and require refinement. Process review complete and new panel infrastructure implemented. Assessment centre proposal developed	4
	In conjunction with evolution of Five Year LLR and UHL strategies, develop innovative and potential strategic alliance role to support development of specialised services for example		Clinical Directors and CMG Management	Ongoing	Some work commenced eg cancer services, geriatrics	4
	Closer monitoring of likely trainee doctor posts gaps and more proactive management of vacancies	Kevin Harris	Louise Gallagher /Leena Patel		Better and more timely communication from Health Education East Midlands in order to develop rotas for known staffing	4
	Development of innovative trust grade/ training posts to attract trainees	Heads of Service/ TPDs	Service and Operational Managers		Posts in place in Emergency Department and Emergency Medicine offering OOPE and OOPTEs	4
	Review recruitment strategies and identify where there is scope to introduce incentives to attract high calibre applicants in difficult to recruit areas eg research and development	CMG Directors		Ongoing		4

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

	Workstream Two Shape a Medical Workforce to be Efficient and Effective and Focused on Quality adopting non medical solutions where appropriate					
	Rescope roles where there are ongoing recruitment challenges or there is a strong likelihood of disinvestment and identify competencies required for post, deliver non medical solutions	Kate Bradley, Kevin Harris, Rachel Overfield	New roles development group members	March 2015	New roles group and terms of reference currently being established and new roles summit being planned for Sept	4
	Revised process in place for authorisation of non contracted payment and revised definitions of Waiting Lists Initiative Payments	Pete Rabey	Locum Bookers and Clinical Directors	June 2014 and ongoing	Revised processes in place	4
	Define productivity measures for consultant workforce and implement	Pete Rabey	Medical Productivity Board	March 2015	Progress being made in defining measures	4
	Implement processes and systems for ensuring the medical workforce can translate operational procedures into workforce models	Clinical Directors	CMG Managers, Heads of service	March 2015	Commencing with workforce plans for the Emergency Floor	4
	Review rota template development to ensure maximum efficiency and understanding by service and HR leads	Kate Bradley	Vidya Patel		Plan to be drafted for end June 2014	1
	Develop conversion strategy for all non contracted payments and develop into job plan review sessions	Pete Rabey	Louise Gallagher	End Nov 2014	Job plan review process underway	4

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

	Ensure delivery of targets in relation to appraisal and revalidation	Peter Furness	CMG Directors	Ongoing		4

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

3	Pillar three Develop a Learning Organisation Approach to Education and Training					
	Review mechanisms for supporting the development and mentorship arrangements for new consultants including using the outputs of assessment centres	Sanjay Agrawal	Helen Mancini	March 2015	Assessment Centre approach developed. proposal in place for revised induction programme including mentorship	4
	Proactive promotion of leadership and other development programmes	Bina Kotecha	Helen Mancini	Ongoing	Already in progress	4
	Develop training programme and support for Specialty and Trust Grade Drs	Sue Carr	CMG Mgt	March 2015	Programme to assign Clinical Supervisors already underway	4
	Develop community and acute rotation to enhance learning experiences	Heads of School/ Service	TPDs	March 2015	Already in place in emergency medicine	4
	Support increased intake of ED specific trainees and innovative OOPE and OOPTE programmes	Richard Wright		August 2014 and ongoing	Workforce numbers agreed and appointed to. In long term will deliver viable model of senior training grades	4
	Pillar Four Establish a Culture of Engagement and Innovation					
	Continue to promote Clinical Senate as a confirm and challenge to significant Trust changes	Kevin Harris	Sanjay Agrawal	Ongoing	Clinical Senate in place	4
	Continue to promote the Drs in Training Committee as a mechanism for engagement	Sue Carr	Drs in training committe e	March 2015	Already adding value to such initiatives as Junior Drs Induction Portal	4
	Further develop Knowing your Business Development Programmes	Sanjay Agrawal	Helen Mancini	November 2014 and ongoing	Face to face delivery in place, Funding sought for developing on line training programmes to support development	4

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

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

Trust Board Paper X

To:	**Trust Board**
From:	**Chief Nurse**
Date:	**31 July 2014**
CQC regulation:	**Outcome 16 – Assessing and Monitoring the Quality of Service Provision**

Title:	**UHL RISK MANAGEMENT POLICY**

Author/Responsible Director: CHIEF NURSE

Purpose of the Report: To provide the Board with an overview of changes to the UHL Risk Management Policy for endorsement.

The Report is provided to the Board for:

Decision		Discussion	
Assurance		Endorsement	X

Summary / Key Points:

- The Risk Management Policy has been updated to reflect changes in organisational structure. A list of changes from the previous version is provided on page 3 of the policy (attached).
- As a 'category A' document this requires ratification by the Board prior to uploading onto the hospital's document management system (InSite).

Recommendations:
The Trust Board is invited to:

a. Receive and note the contents of the UHL Risk Management Policy.
b. Ratify the changes outlined on page 3 of the policy.

Previously considered at another corporate UHL Committee?
Yes – UHL Policy and Guidelines Committee 18 July 2014

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

Resource Implications (eg Financial, HR):
N/A

Assurance Implications:
N/A

Patient and Public Involvement (PPI) Implications:
Yes

Stakeholder Engagement Implications: No

Equality Impact: Assessment completed – no impact
Information exempt from Disclosure: No
Requirement for further review? Next review due June 2017

University Hospitals of Leicester NHS
NHS Trust

RISK MANAGEMENT POLICY

Approved By:	**Trust Board**
Date Approved:	**31 July 2014**
Trust Reference:	**A12/2002**
Version:	**5.0 (July 2014)**
Supersedes:	**Version 4**
Author / Originator(s):	**Corporate Risk Management Team**
Name of Responsible Committee/Individual:	**Peter Cleaver / Richard Manton**
Review Date:	**May 2017**

CONTENTS

REVIEW DATE AND DETAILS OF CHANGES MADE DURING REVIEW

Document reviewed and revised March 2014 to reflect changes in organisational structure (including committee structures).
Risk scores referred to as a numerical value rather than low, moderate, high and extreme throughout the whole document.
Change of terminology from 'division' or 'divisional' to CMG throughout whole document.
Change in terminology from 'Clinical Business Unit' (CBU) to 'specialty' throughout whole document.
Change in terminology from 'Divisional Directors' to 'Clinical Directors' throughout whole document.
Change in terminology from 'strategic risk' to 'principal risk throughout whole document.
Removal of reference to 'Medical Leads' throughout whole document.
Section 3 inclusion of reference to LLR Elective Care Alliance.
Section 5.2.2 amendment to Medical Director and Chief Nurse portfolios.
Section 5.2.3 change from Director of Communications and External Relations to Director of Communications and Marketing.
Section 5.2.4 (n) addition of CAS responsibility.
Section 5.2.6 removal of 'Quality and Safety Manager', CBU Managers, and CBU Medical Leads
Section 5.2.9 Addition of 'Risk and Safety Manager' and change from 'Senior Health and Safety Manager' to 'Health and Safety Services Manager'
Section 5.3 removal of reference to Quality and Performance management Group (QPMG).
Section 6.3.5 addition of text to read 'In cases where a risk has been entered directly on to the risk register it would be acceptable to have some other form of correspondence from the relevant director to demonstrate that the risk has been approved (i.e. an email, a signed print out of the Datix risk entry, a copy of minutes/notes etc)'.
Section 6.7.1 and 6.7.2 addition of text to read 'When the implementation of risk control measures is beyond the authority or resources available to the CMG/ directorates then the Clinical Director/ General Manager are responsible for escalating this to the relevant executive director and / or Trust committee so a decision can be reached as to whether the risk will be accepted at this level or whether resources will be made available to treat the risk.
Section 6.7.5 and 6.7.6 addition of text to read 'The assessment must be reviewed by the relevant manager and monitored by the CMG board at least quarterly to ensure the content is still valid and that any associated actions have been implemented within timescales. Reviews will continue until the target risk score is achieved and the risk is closed'.
6.7.7 New section
Section 6.9.3 text amended to read 'National Reporting and Learning System (NRLS)'.
Section 6.9.5, 7.1.2 and section 11 addition of document reference numbers

Appendices
Appendix one: Previous appendix removed and appendices renumbered to reflect this.
Appendix two: Addition of new section 4 to appendix.

Keywords Risk, risk management, Risk management process, Risk Assessment, strategic risks, operational risks, risk register, Board Assurance Framework, BAF.

1 INTRODUCTION

1.1 This document sets out the University Hospitals of Leicester (UHL) NHS Trust (hereafter referred to as "the Trust") policy to manage risks arising from all types of activity including governance (incorporating Information Governance and Research Governance), finance and mandatory services, clinical, human resource, safety, environmental, service development and business. The document also sets out the Trust's procedure for risk assessment to comply with the general duties of the Health and Safety at Work etc Act and more specific duties in various Acts and Regulations, including the Management Regulations.

1.2 Effective risk management requires a culture where all staff are involved in reducing risks and improving quality and safety. Risk management is not solely the responsibility of the Trust's Risk and Safety Managers but a responsibility for all members of staff and must be part of objective setting in every business and management planning cycle and of every service development. It relies on all members of staff identifying and minimising risks within a progressive, honest, learning and open environment.

1.3 It is important that risk management is a systematic process, using existing expertise and structures along with clear direction, guidance and support from the Trust's senior management teams. This policy and its supporting documents set out the Trust's framework for risk management.

1.4 The policy recognises that there is a requirement for an annual Governance Statement, informed by an embedded system of assurance via the Board Assurance Framework (BAF) and joined by a clear public declaration on compliance with the Care Quality Commission's (CQC) registration standards, which require the Trust Board and nominated committees to consider the whole system of internal control.

2 POLICY AIMS / STATEMENT OF INTENT

2.1 The Trust Board of Directors (hereafter known as the 'Trust Board') is committed to ensuring the implementation of risk management and ensuring that risk management is embedded into the culture of the organisation to enable an environment which minimises risks and promotes the health, safety and well being of all those who enter or use the premises whether as staff, patients or visitors.

To that end this policy shall ensure:

a. Compliance with all appropriate legislative and statutory requirements.
b. That risk management is embedded in the Trust's business processes.
c. Selective, regular and systematic audit/ review of activities is undertaken in order to identify and, minimise risk in line with statutory requirements and as far as is reasonably practicable.
d. Action is taken on recommendations from inspecting bodies.
e. Full co-operation of all Trust staff in identifying and managing risk.
f. Business and financial opportunities are pursued within a managed, risk based framework.
g. An environment where all members of staff are encouraged to report risks, incidents and 'near misses' and raise concerns about matters that affect the quality of care.
h. To secure optimum levels of investment (staffing and other resources) in the management of risk.
i. Strategic and operational objectives (i.e. organisational, Clinical Management Group (CMG)/ directorate and Specialty/ department) and the risks to their achievement are described.

2.2 The aim of this document is to ensure that all risks associated with the delivery of the Trust's objectives and the provision of the Trust's services are minimised in line with statutory requirements and as far as is reasonably practicable. The broad objectives of this policy are to:

a. Describe a co-ordinated approach for the management of risk across all Trust activities including risks arising from significant partnerships and other external factors.
b. Promote safe working practices aimed at the reduction of risk, as far as is reasonably practicable;

c. Describe responsibilities and accountabilities for risk management at every level of the Trust
d. Raise awareness of risk management through a programme of communication, education and training.
e. Promote continuous improvement through internal and external audit and assessment.
f. Maintain a pro-active, forward-looking approach.
g. Ensure a systematic and consistent approach to risk assessments.
h. Manage risks to an acceptable level ensuring action plans for further controls are fully completed.
i. Integrate risk management with quality and performance management arrangements to become an integral part of the business planning and objective setting processes of clinical CMGs and corporate directorates and the Trust as a whole.
j. Enable staff to be empowered to report risks and register concerns about unsafe practice.
k. Enable all aspects of risk management to be approached in a structured manner, in line with the CQC registration standards and Foundation Trust Compliance framework,
l. Provide guidance on the risk management process and the benefits of how effective risk management will enable the Trust to contribute to a wider risk network within the health community.

3 POLICY SCOPE

3.1 This policy applies to members of staff directly employed by the Trust for whom the Trust has legal responsibility and includes the Leicester, Leicestershire and Rutland (LLR) Elective Alliance. For those staff covered by a letter of authority / honorary contract or work experience, this policy is also applicable whilst undertaking duties on behalf of the Trust or working on Trust premises including those covered by the Research Passport Scheme.

3.2 This policy forms an integral part of the Trust's Health and Safety process.

4 DEFINITIONS

Risk: The chance that something will happen to have an impact on achievement of the Trust's aims and objectives or exposure to a chance of loss or damage. It is usually measured in terms of likelihood (frequency or probability of the risk occurring) and consequence (impact on the organisation if the risk occurs).

Cause (Hazard): Something with the potential to cause harm.

Consequence: The potential harm or loss caused by the risk.

Risk management: The culture, processes and structures that are directed towards the effective management of potential opportunities and adverse effects.

Risk management process: The systematic application of management policies, procedures and practices to the tasks of establishing the context, identifying, and analysing, evaluating, treating, monitoring and communicating risk.

Risk Assessment: The systematic collection of information to determine the likelihood and severity of harm and identify where additional controls are needed to reduce the risk to an acceptable level.

Strategic Risks: Risks to the achievement of the Trust's strategic objectives. They are contained within the Trust's Board Assurance Framework (BAF).

Operational Risks: Risks identified at CMG/ directorate or specialty/ department level.
Risk Register (Datix): The Trust's database of CMG, specialty, directorate or department risks.

Risk Appetite: The amount and type of risks that an organisation is willing to pursue to secure the achievement of its objectives.

Board Assurance Framework (BAF): A Board developed and managed document identifying the Trust's strategic objectives, the principal risks to the achievement of these, the controls required to mitigate these risks, the assurance sources to prove that controls are effective, gaps in controls and assurances, and actions to remedy these.

5 ROLES AND RESPONSIBILITIES

5.1 Organisational Structure

5.1.1 The Trust Board (TB) holds ultimate responsibility for ensuring that the Trust has effective risk management processes in place.

5.1.2 The Chief Executive has overall responsibility for risk management and discharges this through the designated accountability of other executive directors for different aspects of risk management.

5.1.3 Executive and corporate directors are collectively and individually responsible for the management of risk, and in particular for the areas included in their portfolios and as reflected in their individual job descriptions. These responsibilities will be discharged through CMG directors and managers and directorate managers.

5.1.4 The discharge of these responsibilities is overseen and supported by a number of Trust committees that are ultimately accountable to the TB (see section 5.3). Each committee is formally constituted, and has approved terms of reference.

5.2 Roles and Responsibilities

5.2.1 Chief Executive

Is responsible for establishing and maintaining an effective risk management system within the Trust to meet all statutory requirements and adhere to guidance issued by Monitor and the Department of Health in respect of governance. The Chief Executive is the Accountable Officer responsible for ensuring an effective system of internal control is maintained to support the achievement of the Trust's strategic goals and objectives. This will include the identification and management of risk and oversight of progress against the BAF. The Chief Executive is supported in the role by the executive and corporate directors below:

5.2.2 **Executive Board Directors:**

Chief Nurse

Is responsible for driving the quality, safety and risk agenda in the Trust. This will include being accountable for the processes to enable the Trust to comply with the CQC registration standards and leading on the Trust's fulfilment of its clinical governance and risk management responsibilities (clinical and non-clinical health and safety management, patient safety and complaints management, infection prevention, safeguarding adults and children, information governance.

Medical Director

Is responsible for minimising risks to clinical effectiveness, research and development, clinical education, clinical quality and improvement, medical appraisal and revalidation. This portfolio is discharged via Deputy. Associate and Assistant Medical Directors

Director of Finance and Business Services

Is responsible for financial risk management. The Director of Finance and Business Services is also the Trust's Senior Information Risk Owner (SIRO).

Director of Human Resources

Is responsible for minimising risks relating to workforce and service equality.

5.2.3 **Corporate Directors:**

Director of Marketing and Communications
Is responsible for minimising risks to UHL reputation.

Director of Nursing (Accountable to the Chief Nurse)
Is responsible for minimising operational risks in relation to 'safeguarding' issues.

Director of Corporate and Legal Affairs
Is responsible for minimising risks to corporate governance.

Director of Research and Development
Is responsible for minimising risks to research and development governance.

Director of Strategy
Is responsible for minimising risks to business development.

Director of Safety and Risk (Accountable to the Chief Nurse)
Is responsible for corporate risk and safety; including development and maintenance of the Trust's risk management and assurance framework. This role also incorporates that of Patient and Employee Safety Lead reporting to the Chief Nurse and with a direct link to the Chief Executive.

Director of Clinical Quality (Accountable to the Chief Nurse)
Is responsible for minimising risks in relation to compliance and external accreditation.

Chief Operating Officer
Is responsible for minimising the risks to the delivery of all operational targets, emergency preparedness and business continuity.

Managing Director of LLR FMC
Is responsible for minimising risks to the estate, environment, security, water, quality and fire.

Director of IM&T
Is the Trust's Chief Information Officer with responsibility for controlling risks to information, management and technology within the Trust.

5.2.4 C**linical Directors** shall discharge their responsibilities for clinical risk management by:

a. Agreeing levels of competence with medical/dental staff in line with national and professional guidelines.
b. Ensuring induction and on-going training of medical staff to the desired levels of competence.
c. Ensuring monitoring and maintenance of the quality of clinical records;
d. Ensuring planned introduction of new clinical procedures.
e. Ensuring the development, dissemination, implementation and review of local clinical policies, procedures and guidelines.
f. Ensuring local dissemination and implementation of Trust wide clinical policies;
g. Actively managing clinical risk.
h. Ensuring evidence exists for all clinical risk management activity.
i. Implementing, supporting and co-ordinating risk management processes in line with this policy.
J Ensuring new risk assessments are considered by CMG/ directorate boards and 'signed-off' as approved prior to entry onto the risk register.

5.2.5 **Corporate Directors** / **Managers, CMG General Managers and Heads of Nursing** shall discharge their responsibilities for risk management by:

a. Ensuring risks to the achievement of CMG/ directorate objectives are identified, assessed and effectively managed to minimise those risks as far as practicable.
b. Ensuring adequate resources and expertise are made available to effectively manage risks within their areas of responsibility

c. Ensuring risk management is incorporated into all clinical and non-clinical processes (including business processes).
d. Ensuring that this policy and other information related to risk management is disseminated to and upheld by all staff.
e. Identifying staff responsible for championing risk management and making their roles, responsibilities and accountabilities clear to them and to other staff.
f. Identifying the risk management training needs of CMG/ directorate managers and ensuring their attendance at relevant training events.
g. Ensuring all Trust / local policies are implemented and that compliance with these policies is regularly reviewed/ audited.
h. Ensuring all staff have received corporate induction and specific local induction and are aware of their personal responsibility within the risk management process.
i. Act upon aggregated information from incident reports, complaints and claims to identify risks, and, where necessary, update working practice;
j. Providing feedback from Trust committees and/or CMG/ directorate boards to staff on the outcome of incidents, complaints, claims and risk reporting.
k Ensuring new risk assessments are considered by CMG/ directorate boards and 'signed-off' as approved prior to entry onto the risk register.
l. Ensuring that existing risks are reviewed by CMG/ directorate boards.
m. Ensuring that evidence exists for all risk management activity to demonstrate that Trust standards and legal and statutory requirements are being met.
n. Being accountable for the CMG or corporate directorate management of the Central Alerting System (CAS) broadcasts.

5.2.6 **Specialty Managers** shall discharge their responsibilities for risk management by:
a. Ensuring that risks to the achievement of specialty or department objectives and all significant hazards inherent within work processes are identified, assessed, effectively managed and risk assessments submitted to CMG/ directorate boards for approval prior to entry onto the risk register.
b. Analysing and investigating incidents, complaints, risks and claims and subsequent implementation of improvement strategies.
c. Ensuring accurate risk register entries are maintained and that risks and mitigating actions are implemented and regularly reviewed in line with this document.
d. Ensuring health and safety, incidents, complaints, claims and risk management processes are embedded within specialties / departments.
e. Ensuring there are sufficient competent people to perform risk assessments.
f. Ensuring that the results of risk assessments are brought to the attention of their staff group.
g. Seeking advice and guidance from the corporate risk team on any aspects of risk management that are beyond their knowledge and skills.
h. Identifying the risk management training needs of staff, monitoring and ensuring their attendance at relevant training events.
i. Providing advice and support to staff in relation to incidents, inquests, claims, and complaints.
j. Ensuring that there are suitable arrangements in place for the review and control of serious and imminent danger, where this potential is identified during the risk assessment process.

5.2.7 **All Staff** are accountable for their own working practice and behaviour and this shall be implicit in contracts of employment and reflected in individual job descriptions, objective setting and performance review.

All staff must:-
a. Be aware of risk assessment findings and control measures appropriate to their work area.
b. Co-operate with and engage in the risk assessment process including using and complying with control measures implemented to ensure the health and safety of themselves and others.
c. Understand their accountability for individual risks and how their actions can enable continuous improvement of risk management.

d. Report systematically and promptly any perceived hazards, new risks or failures of existing control measures to their line manager.
e. Comply with any measures in place for dealing with a situation of serious and imminent danger.
f. Understand that risk management and risk awareness are a key part of the organisation's culture.

5.2.8 **Risk Assessors** will:-

a. Carry out risk assessments, within the context of their own competency and in consultation with others, as situations arise and seek advice where unforeseen situations arise.
b. Identify and attend appropriate risk assessment training programmes.
c. Support managers in the identification and assessment of risks.
d. Ensure new risk assessments are 'signed off' by their line manager, reviewed by specialty/ department managers at specialty boards and presented at CMG/ directorate boards for consideration and approval prior to entry onto the risk register.
e. Contribute to CMG/ directorate training programmes for risk assessment and risk awareness.

5.2.9 **Corporate Safety and Risk Management Team**

There are specialist officers within this team with Trust wide roles relative to specific risk areas. These are: -

- Director of Safety and Risk
- Risk and Assurance Manager
- Risk and Safety Manager
- Senior Safety Manager (clinical risk and complaints)
- Health and Safety Services Manager
- Head of Privacy (Information Governance)
- Local Security Management Specialists (LSMS)

5.2.10 The Trust employs other **specialist advisors** as listed below:

- Claims & Inquest Advisers
- Fire Safety Advisers
- Security Officers
- Radiation Protection Officer
- Occupational Health Physicians and Nurses
- Infection Prevention Team.
- Research & Development Manager

5.2.11 Roles described in sections 5.2.9 and 5.2.10 shall co-ordinate and support risk management activity within the Trust by:

a. Providing CMGs and directorates with relevant advice, guidance and information.
b. Participating in the activities of Trust committees / groups as required.
c. Facilitating corporate risk management training and contributing to CMG and corporate directorate risk management training programmes.
d. Producing information materials on risk management within the Trust for staff, patients, stakeholders and the public.
e. Maintaining and developing the Trust risk register.
f. Advising the TB on risk management strategies for the Trust and CMGs / corporate directorates; auditing achievement in line with those objectives.
g. Developing corporate risk management tools.
h. Producing reports on risk management activities for relevant Trust committees and local boards.
i. Regularly auditing compliance against relevant policies.

5.2.12 In addition to the roles listed in the previous sections there are other specialist groups within the Trust, who play a role in risk management who have formal links with, and reporting systems to, the corporate committees with risk management responsibilities.

5.3 Committee Structures and Reporting Arrangements

5.3.1 The risk reporting framework shall integrate across all established committees within the Trust that have responsibility for risk in order to create a culture of risk reporting and feedback. A reporting framework is attached at appendix one. Overarching committees with responsibility for risk are the Board Committees listed in 5.3.3 and 5.3.4 below, which report directly into the TB.

5.3.2 **Trust Board (TB)**

Will seek assurance of the implementation of risk management processes within the Trust and will be responsible for the identification of the Trust's strategic objectives, principal risks, the assessment and subsequent review of the Trust's BAF. On a day-to-day basis executive responsibility for clinical and non-clinical risk management shall be delegated in accordance with the portfolios set out in sections 5.2.2 and 5.2.3.

No less than four times per year the TB will receive an updated BAF.

The TB will also receive a monthly report to show all risks scoring 15 or above opened within the reporting period and this will be supplemented with a quarterly report of all risks scoring 15 or above on the UHL risk register.

The function of the TB within the risk management process is to;

a. Develop, review and comment upon the BAF, as it deems appropriate;
b. Note the actions identified within the BAF to address any gaps in either controls or assurances (or both);
c. Identify any areas in respect of which it feels that the Trust's controls are inadequate and do not effectively manage the strategic risks to the organisation meeting its objectives;
d. Identify any gaps in assurances of the effectiveness of the controls in place to manage the strategic 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 that the Trust is meeting its strategic objectives.
f. Be aware of risk trends developing within the organisation and the strategies adopted for their control.
g. Agree the levels of risk appetite and tolerance that the Trust is prepared to accept in the pursuit of its strategic objectives

5.3.3 **Audit Committee (AC)**

Is a committee of the TB and has responsibility for monitoring implementation of the risk framework. Its duties include:

a. Reviewing the BAF at each meeting, to ensure that there is an appropriate range of strategic objectives and that the principal risks to these objectives have been identified.
b. Seeking assurance that the process undertaken to populate the BAF is appropriate, in that the necessary directors and managers have been involved and take responsibility for their entries, and that there are no major omissions from the list of controls.
c. Seeking assurance that actions have been identified and implemented to address gaps in controls and assurances in the BAF.
d. Considering, in particular, the "audit needs" of the organisation in terms of the sources of assurance, both independent and from line management, and ensure that there is a plan for these assurances to be received.
e. Reviewing the results of assurances, either in whole or specific to a risk or objective, and the implications that these have on the achievement of objectives.
f. Reviewing the risk process to monitor that the assurance framework is effective and there is a robust system in place for the identification, assessment and prioritisation of risk including a means of escalating significant risks to relevant Trust committees and providing a line of sight for risks from 'ward to Board'.
g. Holding CMGs to account for the effectiveness of local risk frameworks.

At each meeting it will receive an updated BAF and risk report to show all risks scoring 15 or above. In this way the AC provides assurance to the TB regarding its controls systems and supports the annual Governance Statement.

5.3.4 **Executive Team (ET)**

This is an executive level group led by the Chief Executive that meets weekly. Membership includes executive and corporate directors, and clinical directors.

The ET will receive monthly an update of the BAF and a report showing all risks scoring 15 or above and, twice yearly, a report of all risks scoring 8 to 12.

The function of the ET in relation to risk management is to;

a. Develop, review and update the contents of the BAF prior to submission to the TB.
b. Identify whether any risks from the UHL risk register are of strategic significance and decide whether the risk(s) are already linked to themes within the BAF or whether there is a requirement for a new principal risk to be entered.
c. Ensure that clinical directors, corporate directors and CMG general managers are held to account in relation to the effective management of local risks and their mitigations. This will include monitoring of risks scoring 15 or above on the risk register where there is a risk with one or more elapsed action due date and / or elapsed risk review dates.

5.3.6 **CMG/ directorate Boards**

On a monthly basis will receive a report from the corporate risk management team identifying risks scoring from 8 to 25.

On a monthly basis will receive new risk assessments from their specialties for consideration and approval prior to entry on the risk register (see appendix five).

The function of the CMG/ directorate boards will be to:-

i. Approve risks for entry onto CMG/ directorate risk registers.
ii. Ensure relevant personnel are held to account for those risks within CMGs / directorates.
iii. Ensure appropriate quality in relation to the content of the risk register. This will include challenge and confirmation to assure:
    a. The risk has a descriptive title.
    b. The risk description lists the causes and consequences of the risk.
    c. The documented controls are currently in place and are not future actions.
    d. The risk rating scores are robust and accurate (current and target).
    e. The risk review date is current.
    f. Where a risk can be treated an action plan is included with explicit actions, realistic and achievable timeframes and responsible persons identified.
    g. The risk owner details are correct.
    h. Monitor action plans to ensure that actions are completed within specified timeframes and where an action due date has elapsed challenge will be made to the risk owner about the reason why.
iv. Analyse risk themes across the CMG/ directorate in order to identify trends.
v. Report any confirmed risks scoring 25 to the ET and corporate risk management team at the earliest possible opportunity.

The review of risk assessments and the risk register must be a standing agenda item at each CMG/ directorate board and the notes of the meeting shall evidence involvement in approving assessments and reviewing open risk register entries including seeking assurance of current control measures, challenging risk ratings and monitoring progress of action plans.

5.3.7 **Specialty boards (where applicable)**

Will be responsible for:-

a. Submitting new risk assessments to the CMG/ directorate board for consideration and approval.

b. Monitoring that all actions to reduce risks are being implemented in line with the specified timeframes.

5.3.8 **Reporting to Commissioners**
All new risks scoring 15 or above are reported to our commissioners each week as a requirement of the Quality Schedule.

6 POLICY STATEMENTS AND ASSOCIATED DOCUMENTS

6.1 Risk Appetite

6.1.1 The Trust will aim for a zero appetite for undue risks to the health and/or safety of its staff and others.

6.1.2 The Trust will aim for a zero appetite for undue clinical risks, i.e. a level of risk that is greater than that accepted as consistent with safe clinical practice.

6.1.3 The Trust has a zero appetite for undue risks relating to failure to meet national targets and /or registration requirements from regulators, except where this would conflict with 6.1.1 and/or 6.1.2 above.

6.1.4 The Trust may decide to accept risks in developing innovative pathways to improve patient care where this is in line with its clinical quality strategy. This level of risk will be no more than accepted as consistent with safe clinical practice.

6.1.5 The Trust may decide to accept financial risks and will use its financial capabilities to enable change in support of its ambitions.

6.1.6 The Trust may decide to take calculated reputational risks where it deems the outcomes will be beneficial to its stakeholders.

6.2 Risk Identification

6.2.1 The Trust is committed to reducing healthcare risks by undertaking risk management at every level of the organisation.

6.2.2 An important part of minimising risk involves reporting incidents. Any incident that *'has given or may result in actual or possible personal injury; to patient dissatisfaction; or to property loss or damage'* must be reported following the UHL incident, complaint or claim procedures. A robust system of reporting allows the Trust to monitor incidents, complaints and claims; to review practice; and to identify trends and patterns. It also allows for the quick detection and resolution of any problems resulting from inadequate procedures, lack of training, or pressure of work.

6.2.3 Risk identification and assessment systems are vital to the success of the Trust's risk management process and there are a number of internal and external sources of risk identification that can be used. These are listed in sections 6.4.2 and 6.4.3.

6.2.4 Risks identified from these sources must be assessed to predict their likelihood to affect the organisation and the consequences on the organisation should they occur.

6.3 The Process for Assessing Risk:

6.3.1 The risk assessment process provides a systematic examination of clinical and non-clinical processes and allows a Trust-wide risk profile to be developed subsequently enabling informed decisions to be taken about the management of the risks identified. The responsibility for ensuring suitable and sufficient risk assessments lies with managers with support as necessary from the specialists within the Trust. It is expected that all risks will be reduced to the level required by law and/or as far as is reasonably practicable.

6.3.2 Risk assessments are essential components of the Trust's risk management programme and must not be solely an annual 'snapshot' but rather an embedded and cyclic process to ensure that risks

are regularly identified, assessed, managed, monitored and reviewed. Assessments must take account of all types of risk and the following list illustrates the risk domains that are of key importance to the Trust and must form the basis of the risk identification and assessment process:

- Safety and health of patients (physical / psychological harm) – Patient domain
- Safety and health of staff, public or others (physical / psychological harm) – Injury domain
- Business objectives, targets, projects, etc – Business domain
- Quality / complaints / audit – Quality domain
- Human resources (e.g. organisational development, staffing levels, competence to practice, etc) – Human resources domain
- Statutory duty/ inspections – Statutory domain
- Adverse publicity/ reputation – Reputation domain
- Finance (including claims), organisational economy, property loss, etc – Economic domain
- Service / business interruption – Target domain
- Environment – damage to the environment – Environmental domain

6.3.3 All aspects of a risk must be considered. Some risks may cross more than one domain and in those instances all relevant domains must be assigned a separate risk score. The domain with the highest risk score should be selected when entering the risk on to the risk register. Risks will normally link to UHL or CMG/ directorate objectives.

6.3.4 Risk assessments are performed using a standard UHL risk assessment form (see appendix four) and all fields of the form must be completed to ensure a minimum dataset for entry onto the risk register. As part of the risk assessment each risk identified must be scored using the Trust's risk scoring matrix.

6.3.5 The risk assessment must be approved by the appropriate CMG/ directorate board prior to entry onto the risk register. A scanned copy of the original risk assessment form with approval authorisation must be attached to the risk register entry. In cases where a risk has been entered directly on to the risk register it would be acceptable to have some other form of correspondence from the relevant director to demonstrate that the risk has been approved (i.e. an email, a signed print out of the Datix risk entry, a copy of minutes/notes etc).

6.3.6 Each risk must be reviewed at a frequency based on the severity of the risk score (see section 6.7.3 to 6.7.6). The risk owner must perform the review along with others who were involved in the initial assessment in order to provide consistency in risk scoring. Following review the owner must ensure the risk register is updated to reflect any changes to the assessment.

6.3.7 Managers will set out a programme for risk assessments to be performed by identifying the various work processes and producing a prioritised list based on information from sources listed in sections 6.4.2 and 6.4.3.

6.4. Requirements of a Risk Assessment

6.4.1 Identify the causes of the risk (i.e. **Hazard Identification)**
This involves examining all causes of risk from the perspective of all stakeholders, both internal and external. Causes of risks (hazards) can be systematically identified from a number of proactive and reactive processes/sources including but not limited to:-

6.4.2 **Internal Sources**

- Organisational key performance indicators (e.g. Quality and Performance reports, etc)
- Risk, incident, complaints and claims reporting and analysis
- Work activities/ processes
- Internal audits/ reviews
- Self-assessments
- Process analysis, including compliance with Trust / dept strategies, policies, plans & procedures
- Internal safety alerts
- Post event analysis

- Surveys (e.g. patient and staff satisfaction surveys)
- Training evaluations
- Unions
- Whistle blowing

6.4.3 **External Sources**

- Coroner reports
- Media
- National standards, guidance and new/updated legislation
- Horizon scanning of the external healthcare environment and learning from others
- Central Alerting System broadcasts
- External Audits
- Corporate Health and Safety Performance Index (CHaSPI) score
- Reports from assessments, inspections from external bodies, e.g., CQC, Health and Safety Executive, External Audit, etc.

When assessing risks, evidence must be examined from internal and external sources and processes within the organisation to identify what could reasonably be expected to cause harm. It is important to concentrate on significant risks that could result in harm to individuals or the organisation.

6.4.4 **Decide What or Who may be Harmed and How (i.e. the consequences of the risk)**

Health and Safety issues must always be considered e.g. are there risks to the safety and well-being of patients, staff and others? This may include people who might not be in the workplace all the time for example, domestics, contractors, delivery personnel, etc. Consideration must also be given to risks affecting the business of the Trust, for example risks to quality, finance, business objectives, reputation of the Trust, or continuity of service, etc.

6.4.5 **Identify Current Controls in Place**

Consider how the causes are already being controlled to reduce the likelihood of the risk occurring and how consequences are being mitigated should the risk event occur.

6.4.6 **Evaluate the Risk**

The likelihood of the risk occurring and the consequence of the risk must be measured.

6.4.7 In this context, consequence is defined as the potential harm or loss if the risk occurs and must be scored using the risk consequence table in appendix four. Score the risk against the most appropriate domain(s) from the left hand column of the table and work along the appropriate row until the most relevant definition of the risk consequence is found. The consequence score is assigned a number from 1 – 5 dependant upon the severity and can be found at the top of the columns.

6.4.8 The likelihood score is a reflection of how likely it is that the risk will occur with the current controls in place and can be identified by using the likelihood scoring table included within appendix four where definitions of descriptors used to score the likelihood of a risk being realised are provided. The likelihood is assigned a number from '1' to '5': the higher the number the more likely it is the risk will occur. Frequency may not be useful in scoring certain risks associated with time-limited or one-off projects and for these risks the likelihood score must be based on the probability of the risk occurring in a given time period.

6.5 Risk Scoring

6.5.1 Once a cause (hazard) is identified the severity of risk is measured using a matrix giving a numerical value to the consequence and the likelihood of the risk occurring to produce a single risk severity score. The Trust uses a 5 x 5 risk scoring matrix to assign a risk rating (i.e. a level of low to extreme) dependent upon the risk score (i.e. 1 – 25). The risk score is calculated by multiplying the consequence score by the likelihood score. The risk scoring matrix is included in appendix four.

6.5.2 When assessing a risk there are two risk severity scores that need to be recorded, these are:

- Current score – i.e. the level of the risk at present time taking into account any current controls. The current score may alter following periodic review of the risk if further controls have since been put into place (i.e. actions to mitigate the risk have been implemented) or withdrawn and this must be reflected in an altered score within the risk register entry.
- Target score – i.e. the level of the risk expected following the implementation of an action plan.

NB: Where the current risk score equals or is less than the target risk score the risk should have been treated as far as is reasonably practicable and the risk can be closed.

6.6 Risk Treatment

Risks may be:-

6.6.1 ***Tolerated (accepted):*** Low risks can normally be accepted as requiring no further action, however always consider whether further action is appropriate to control low scoring risks that have an consequence score of 4 or 5.

6.6.2 ***Transferred:*** The Trust is a member of the Liabilities to Third Parties Scheme (LTPS), Property Expenses Scheme (PES), and the National Health Service Litigation Authority (NHSLA) risk pooling schemes. This membership transfers some financial risk to these scheme providers.

6.6.3 ***Treated***: In many cases further controls can be implemented to reduce the risks. If so these should be recorded on the risk assessment document as future actions and should include timescales for completion and details of the individual accountable for implementing the actions.

6.6.4 ***Terminated:*** In some cases risks cannot be tolerated, transferred or treated. In these cases the Trust may decide a particular risk should be avoided altogether and this may involve ceasing the activity that gives rise to the risk.

6.7 Local Accountability for Risk, Review & Escalation

6.7.1 Risk assessments must be reviewed by CMG/ directorate boards at a frequency determined by the risk score. Regular review will ensure that when actions have been implemented they are reassigned as control measures with a subsequent revision of the risk score in the risk register entry. When the implementation of risk control measures is beyond the authority or resources available to the CMG/ directorates then the Clinical Director/ General Manager are responsible for escalating this to the relevant executive director and / or Trust committee so a decision can be reached as to whether the risk will be accepted at this level or whether resources will be made available to treat the risk.

6.7.2 Line managers are responsible for agreeing, implementing and monitoring appropriate risk control measures within their designated areas. Where the implementation of risk control measures is beyond the authority or resources available to the manager then this should be brought to the attention of the CMG/ directorate board so a decision can be reached as to whether the risk will be accepted at this level or whether resources will be made available to treat the risk

6.7.3 <u>Risk Score 1 – 6 (Low Risks)</u>

Can be accepted without further treatment and in these instances the risk does not need to be entered on to the risk register, however a copy of the assessment must be maintained at local level. Always consider whether further action is required to control any low risks with a consequence score of 4 or 5. Where it is decided to treat a low risk the risk shall be entered onto the risk register following approval by the appropriate CMG/ directorate board and reviewed on an annual basis until the target risk score is achieved.

6.7.4 <u>Risk Score 8 - 12 (Moderate Risks)</u>

Risk assessment details must be entered onto the risk register following approval by the appropriate CMG/ directorate board, along with a scanned copy of the original risk assessment form. The assessment must be reviewed by the relevant manager and monitored by the CMG

board at least quarterly to ensure the content is still valid and that any associated actions have been implemented within timescales. Reviews will continue until the target risk score is achieved and the risk is closed. In instances where the risk is accepted at a moderate level (i.e. no actions can be taken to reduce risk) then it must still be approved and recorded on the risk register.

6.7.5 Risk Score 15 – 20 (High Risks)
Risk assessment details must be entered onto the risk register following approval by the appropriate CMG/ directorate board, along with a scanned copy of the original risk assessment form. The assessment must be reviewed by the relevant manager and monitored by the CMG board at least monthly to ensure the content is still valid and that any associated actions have been implemented within timescales. Reviews will continue until the target risk score is achieved and the risk is closed. In instances where the risk is accepted at a high level (i.e. no actions can be taken to reduce risk) then it must still be approved and recorded on the risk register.

6.7.6 Risk Score 25 (Extreme Risks)
Must be brought to the immediate attention of the Clinical Director /Manager, or corporate director as appropriate who will subsequently contact the corporate risk management team to provide independent advice in relation to the accuracy of scoring. Risks that are downgraded following this exercise shall follow the process outlined in sections 6.7.3 – 6.7.5. Risk assessment details must be entered onto the risk register following approval by the appropriate CMG/ directorate Board, along with a scanned copy of the original risk assessment form. The assessment must be reviewed by the relevant manager and monitored by the CMG board at least weekly to ensure the content is still valid and that any associated actions have been implemented within timescales. Reviews will continue until the target risk score is achieved and the risk is closed. All risks scoring 25 will be reported at the earliest opportunity to the ET meeting by the relevant director. The table below summarises the risk escalation process described in sections 6.7.3 to 6.7.6.

6.7.7 Following consideration and approval of new risks by the CMG/ directorate board (Quality and Safety Board or equivalent) the risk assessment form must be 'signed-off (electronic signature is acceptable) by the appropriate Corporate/ CMG Director, CMG General Manager or Head of Nursing prior to entry onto the risk register. In circumstances where a risk needs to be entered onto the risk register as a matter of urgency where it cannot wait until the next scheduled board meeting then the risk assessment must be considered and approved by the appropriate Corporate/ CMG Director, CMG General Manager or Head of Nursing.

Risk Escalation

Risk Rating / Score	Risk Owned by	Reviewed by	Reported to/ Monitored by
1 – 6 (Low)	Dept Manager	Dept manager	Dept manager
8 – 12 (Moderate)	Dept Manager	Dept manager	CMG/ directorate board (quarterly), ET (twice yearly)
15 – 20 (High)	Dept Manager	Dept manager	CMG/ directorate board (monthly), ET (monthly), TB (Quarterly), AC.
25 (Extreme)	Dept Manager	Specialty/ Dept Manager, CMG/ directorate board, relevant exec director, ET, TB	ET(ASAP), TB (monthly)., AC.

6.7.8 Where the risk rating for an open risk has either increased or reduced the risk must be presented to the CMG/ directorate board for approval. This process should provide either assurance that actions have been taken to control the risk or identify where there are gaps in control and the proposed action plan including due dates and responsible personnel.

6.8 Risk Recording:

6.8.1 BAF

NHS Chief Executive Officers are required to sign an Annual Governance Statement as part of the statutory accounts and annual report. The TB must be able to demonstrate they have been properly informed about the totality of risks within the Trust, both clinical and non-clinical (including business risks). The TB shall assure itself that strategic objectives have been systematically identified and the principal risks to achieving them are adequately managed. The BAF fulfils this purpose.

The application of the Trust's risk scoring criteria shall assist in the rating of these risks.

The minutes of the TB shall evidence that it identifies, records, assesses and analyses the Trust's principal risks via the BAF and that it is involved in taking decisions on risk treatment options.

6.8.2 Risk Register (Datix)

The risk register is an electronic database (Datix) and provides a dynamic risk profile of the Trust. It is used in conjunction with the Trust's BAF to provide an overall view of the Trust's risk profile.

The register provides a mechanism for risks and risk treatments to be recorded and accessed by individuals, teams, and CMGs/ directorates to assist in informing clinical, non-clinical and business decisions.

As a minimum the risk register will hold details as specified in the *'UHL Datix Risk Register User Guide'* (appendix two).

CMGs and directorates shall maintain accurate risk register entries and risks shall be entered in line with the process described section 6.7 of this document.

The Trust's corporate risk management team is responsible for producing regular and ad-hoc risk reports for Trust committees and CMG/ directorate boards.

6.9 Learning

6.9.1 Learning from incidents, complaints and claims and other such events is key to developing a culture within the Trust that welcomes investigation of such cases to provide opportunities to improve patient care, the services offered within the Trust, the working environment and the safety of staff, visitors and contractors.

6.9.2 A well established and active internal reporting culture provides the Trust with detail about actual and potential harm and associated risks for incidents, complaints and claims. Data from incidents, complaints, claims, and inquest activity, are managed, monitored and investigated in conjunction with CMGs and directorates by the:-

- Patient Safety/ Patient Information and Liaison (PILS) team
- Litigation (Claims) team
- Health and Safety Services team

6.9.3 Clinical incident data is uploaded to the National Reporting and Learning System (NRLS) as part of the external reporting requirement.

6.9.4 Learning lessons from internal incidents, complaints, claims and inquests is an important factor in the Trust's approach to managing risk. Following investigation, presentation of the final report and action plan will be monitored via the appropriate CMG and relevant Trust-wide groups.

6.9.5 More detailed information regarding the management of incidents, complaints and claims can be found in the following Trust policies:

- Policy for the Support of Staff Involved in Incidents, Inquests, Complaints and Claims. B28/2007
- UHL Policy for Reporting and Management of Incidents (including the investigation of serious incidents. B57/2011
- Claims Handling Policy and Procedure. B24/2008
- Management of Complaints Policy. A11/2002

6.10 Embedding Risk Management

6.10.1 The effective implementation of this risk management policy will facilitate the delivery of a quality service and alongside staff training and support will provide an improved awareness of the measures needed to prevent, control and contain risks. To this end the Trust will:

a. Ensure appropriate levels of resources are available to develop and maintain effective risk management processes;
b. Ensure all staff have access to a copy of this policy;
c. Maintain a risk register that is subject to regular review;
d. Communicate to staff any actions to be taken in respect of risk issues;
e. Deliver risk management training and evaluate and monitor its effectiveness;
f. Ensure that training programmes raise and sustain awareness throughout the Trust about the importance of managing risk;
g. Monitor and review the performance of the Trust in relation to the management of risk and the continuing suitability and effectiveness of the systems and processes in place to manage risk.

7 EDUCATION AND TRAINING REQUIREMENTS

7.1 Risk Management Training

7.1.1 The Trust is committed to the provision of training and education to ensure the workforce is informed, competent, prepared and possesses the necessary skills and knowledge to perform and respond appropriately to the demands of clinical care and service delivery.

7.1.2 Staff will be offered risk management training (including risk awareness training for senior managers) commensurate with their duties and responsibilities.

7.1.3 TB members will receive risk awareness training, commensurate with their roles and responsibilities.

7.1.4 The Trust employs advisers in specialist areas (see section 5.2.9 and 5.2.10) to ensure that a link is provided for information, advice and training in these specialist areas.

8 PROCESS FOR MONITORING COMPLIANCE

8.1 Systems for Monitoring the Effectiveness of the Policy

8.1.1 An annual report on risk management in the Trust, based on all available relevant information, shall be produced in the first quarter following the end of the financial year. To ensure compliance with this policy the report, together with performance against the key performance indicators (KPIs), shall be reviewed annually by the ET and the AC and used to inform the development of action plans to remedy deficiencies and to inform future strategies. Existing audit / review mechanisms shall be used wherever possible to avoid duplication.

8.1.2 Regular self assessment of compliance against the Care Quality Commission 'essential standards' of quality and safety' is a requirement of registration and the Trust must demonstrate that it meets these across all its services.

8.1.3 Systematic review of the risk management process is a key responsibility of the AC and the ET.

8.1.4 Other internal and external audits shall take place as required by the Department of Health, Monitor, Audit Commission and other external bodies.

8.2 Key Performance Indicators

8.2.1 Systems shall be in place to monitor and report performance against KPIs with findings reported to the AC, ET and other Trust committees as required.

8.2.2 KPIs and audit requirements are described in appendix three.

9 EQUALITY IMPACT ASSESSMENT

9.1 The Trust recognises the diversity of the local community it serves. Our aim therefore is to provide a safe environment free from discrimination and treat all individuals fairly with dignity and appropriately according to their needs.

9.2 As part of its development, this policy and its impact on equality have been reviewed and no detriment was identified.

10 LEGAL LIABILITY

10.1 The Trust will generally assume vicarious liability for the acts of its staff, including those on honorary contract. However, it is incumbent on staff to ensure that they:

- Have undergone any suitable training identified as necessary under the terms of this policy or otherwise.
- Have been fully authorised by their line manager and their CMG/ directorate to undertake the activity.
- Fully comply with the terms of any relevant Trust policies and/or procedures at all times.
- Only depart from any relevant Trust guidelines providing always that such departure is confined to the specific needs of individual circumstances. In healthcare delivery such departure shall only be undertaken where, in the judgement of the responsible clinician it is fully appropriate and justifiable - such decision to be fully recorded in the patient's notes.

10.2 It is recommended that staff have Professional Indemnity Insurance cover in place for their own protection in respect of those circumstances where the Trust does not automatically assume vicarious liability and where Trust support is not generally available. Such circumstances will include Samaritan acts and criminal investigations against the staff member concerned.

10.3 Suitable Professional Indemnity Insurance Cover is generally available from the various Royal Colleges and Professional Institutions and Bodies.

For advice please contact: Assistant Director - Head of Legal Services on Ext 8585.

11 SUPPORTING REFERENCES, EVIDENCE BASE AND RELATED POLICIES

11.1 References

[1] Australian/New Zealand standard AS/NZS 4360:2004.

[2] ISO 31000 – Guide 73

11.2 Related Policies

- UHL Health and Safety Policy. A17/2002
- UHL Safer Handling Policy – Risk Assessment. B65/2011
- UHL Policy for Reporting and Management of Incidents (including the investigation of serious incidents. B57/2011
- UHL Information Governance Policy. B4/2004
- UHL Statutory and Mandatory Training Policy. B21/2005
- UHL Corporate and Local Induction Policy for Permanent Staff. B4/2003
- Management of Complaints Policy. A11/2002
- UHL Claims Handling Policy and Procedure. B24/2008
- UHL Central Alerting System (CAS) Policy. B1/2005
- Datix Risk Register User Guide
- UHL Maternity Risk Management Strategy. C22/2011

- Policy for the Support of Staff Involved in Incidents, Inquests, Complaints and Claims. B28/2007.

12 PROCESS FOR VERSION CONTROL, DOCUMENT ARCHIVING AND REVIEW

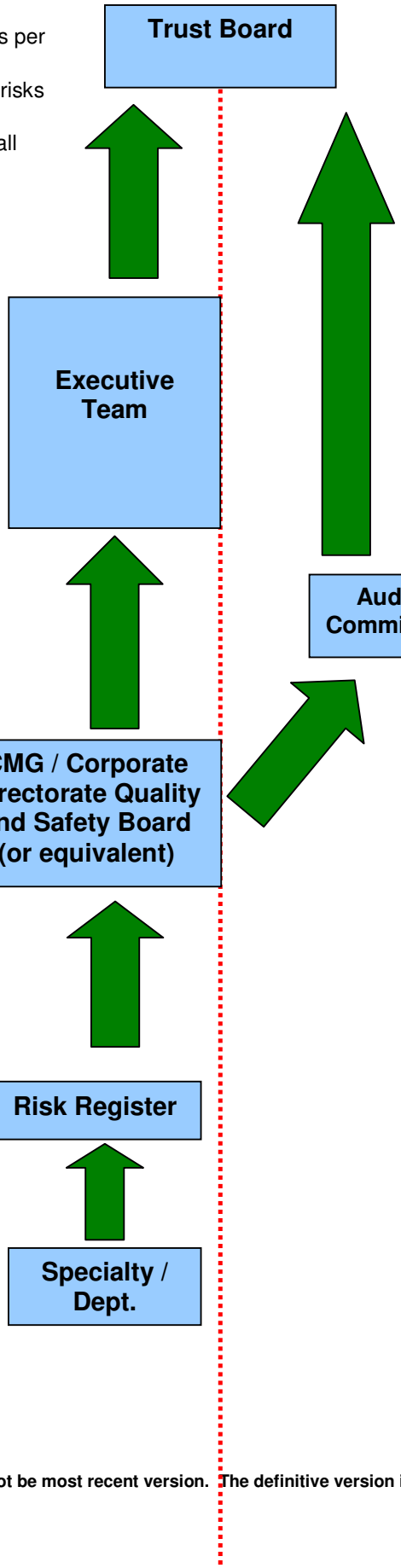
12.1 Following ratification by the TB and UHL Policy and Guidelines Committee new versions of this document will be uploaded onto SharePoint by Trust Administration and previous versions will be archived automatically through this system. Access for staff to this document is available through UHL 'InSite'.

12.2 This document will be reviewed on a three yearly basis unless earlier revision is required following internal audits and/ or external guidance. The UHL Risk and Assurance Manager will be responsible for initiating the regular review of this policy.

Appendix: One

UHL RISK REPORTING FRAMEWORK

Executive Function | **Assurance Function**



- Will review the BAF no less than 4 times per year.
- Will receive monthly notification of new risks scoring 15 or above
- Will receive a quarterly report showing all risks scoring 15 or above.

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

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

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

- Approved risks entered on to risk register.

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

1. Introduction

1.1 This guidance is intended to provide support to Datix users in relation to data entry and searching for risks on the UHL risk register.

2. Scope

2.1 All staff having responsibility for data entry and searching for data within the UHL risk register.

3. Recommendations, Standards and Procedural Statements

3.1 When risk assessments have been performed the information must be transferred to the 'Datix' Risk Register in line with the Trust's Risk Management Policy. A fully completed action plan to reduce the risk must accompany each risk register entry (see section 3.3). Actions must be specific, measurable, achievable, realistic and timely (SMART).

3.2 Adding a Risk to the Risk Register

3.2.1 Following login to Datix click on the yellow risk triangle at the top of the screen, ⚠ then click on the '***NEW'*** tab (symbolised by a pencil and paper along the same tab/row).

3.2.2 Complete the risk register fields as required. A number of these are mandatory (identified by a red outline) and must be completed to allow the record to be saved. Many fields incorporate drop down menus that can be accessed by using the arrow at the right hand side of the field. The following table provides further detail on how to complete the risk register module. **Please note that fields indicated by an asterisk (*) are mandatory.**

Field	Information required
Title*	Provide a clear and concise description of the risk issue. Consider prefacing the risk title with '*there is a risk of* 'or *'there is a risk to'* in order to try and ensure a descriptive title (e.g. '*There is a risk of unavailability of syringe pumps, there is a risk to the achievement of CIP, etc).*
Ref No	This field can be left blank, unless you have a local referencing system within your department that you wish to refer to.
ID	A Datix generated reference number. Users cannot enter data into this field.
Site*	Select from the drop-down list the site or sites that are affected by the risk.
CMG*	Select from the drop-down list the CMG or directorate affected by the risk.
Specialty	Select from the drop-down list the specialties within specific directorates affected by the risk (**NB:** if you require additional specialties to be added please contact the Datix Administration Manager on ext 8562).
Location (type)	Select the type of location affected by the risk (if applicable) (**NB:** if you require additional specialties to be added please contact the Datix Administration Manager on ext 8562).
Location (exact)	Select the exact location that is affected by the risk (if applicable).
Risk Type	**THIS FIELD IS NOT CURRENTLY USED**
Risk Subtype*	Select from the drop-down list the risk subtype (domain) that scores highest on the risk assessment.
Objectives	Users need not enter data into this field. The corporate risk team will link risks to the Trust's objectives.
Assurance Sources*	Identify either **Internal** or **External** sources of risk information (i.e. how have you identified that a risk is evident). This may relate to inspections / reports from sources such as HSE, Care Quality Commission, internal /external audits, internal policies and procedures, etc. Select from the multi-pick field.
Handler	This field is populated automatically with the name of the person who is logged in to record the risk. (Please note if you require additional names to be added to this list please contact the Datix Administration Manager on ext

	8562)
Manager*	Select a name from the drop-down list of the person that will be responsible for managing the risk. (Please note if you require additional names to be added to this list please contact the Datix Administration Manager on ext 8562).
Description*	**NB: The field can be expanded for easier viewing by pressing 'Ctrl' and 'E'.** Enter a concise description of the risk, outlining, in brief, both the **causes** and the **consequences** of the risk. Descriptions should avoid abbreviations that may not be understood by people external to the organisation. The use of bullet points is encouraged wherever possible to avoid lengthy narrative.
Controls in place*	**NB: The field can be expanded for easier viewing by pressing 'Ctrl' and 'E'.** Describe the measures that are already in place to control the risk.
Approval Status	**THIS FIELD IS NOT CURRENTLY USED.**
Risk rating*	Enter the consequence and likelihood descriptors from the drop-down menus The risk rating will be entered in three fields as follows: - **Initial*:** The consequence and likelihood descriptors at the time of assessment. **Current***:At first this field will reflect the 'initial' consequence and likelihood descriptors however this field should be revised following periodic reviews of the risk action plan to reflect the level of risk at the time of the review. When all actions have been implemented it is expected that the rating will be the same as the 'target'. **Target*:** The consequence and likelihood descriptors applicable if the actions to mitigate the risk are fully implemented**.**
Rating	Automatically populated by Datix once the risk consequence and likelihood descriptors have been entered.
Level	As above.
Cost of risk	An estimate of costs to the Trust if the risk came to fruition (if known)
Investment	Automatically populated from any figures entered in the 'Cost' column of the action plan.
Type	If costs have been identified please specify whether the costs are actual or estimated.
Adequacy of Controls	Specify whether these are Adequate, Inadequate or Uncontrolled.

Field	Information required
Cost/Benefit	Automatically populated by Datix if costs are entered on the action plan. The cost benefit is the cost per risk point between the initial and target score and is calculated by dividing the investment cost by the difference between the initial score and the target score.
Review Date*	A future date must be entered when the risk will be reviewed (in line with review frequency outlined in the UHL Risk Management Policy). **NB:** When an action has been completed it should be entered as a 'control' and the current score should be revised if appropriate to reflect the lower risk.

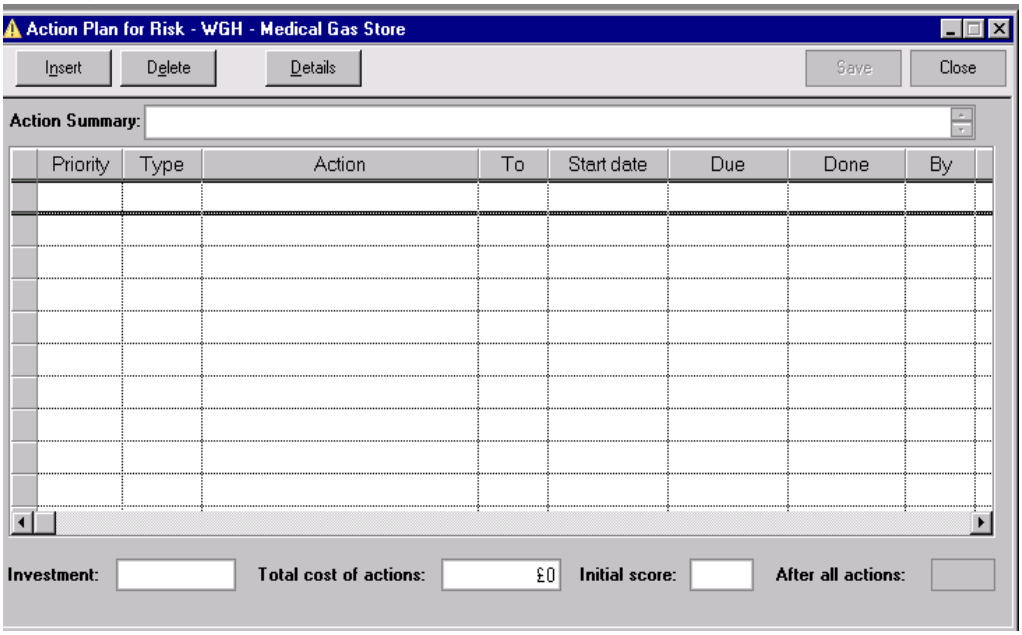
3.2.3 When all information is entered, click '***SAVE'***. This will generate a risk ID.

3.2.4 A scanned copy of the risk assessment form signed off by the Divisional / Directorate Board must be attached to the entry on the risk register. See section 3.4 for attaching documents.

3.3 Completing a Risk Action Plan

3.3.1 After saving the risk the ***'ACTION'*** function button (tab) at the right of the risk register screen will become active (i.e. not greyed out).

3.3.2 Click on the ***ACTIONS*** tab, located on the right hand side of the main risk register screen and you will be presented with this screen:



3.3.3 Fields within the action plan must be completed as follows:

3.3.4 **Action Summary**

NB: To more easily visualise content this field can be expanded by pressing 'Ctrl' and 'E'.

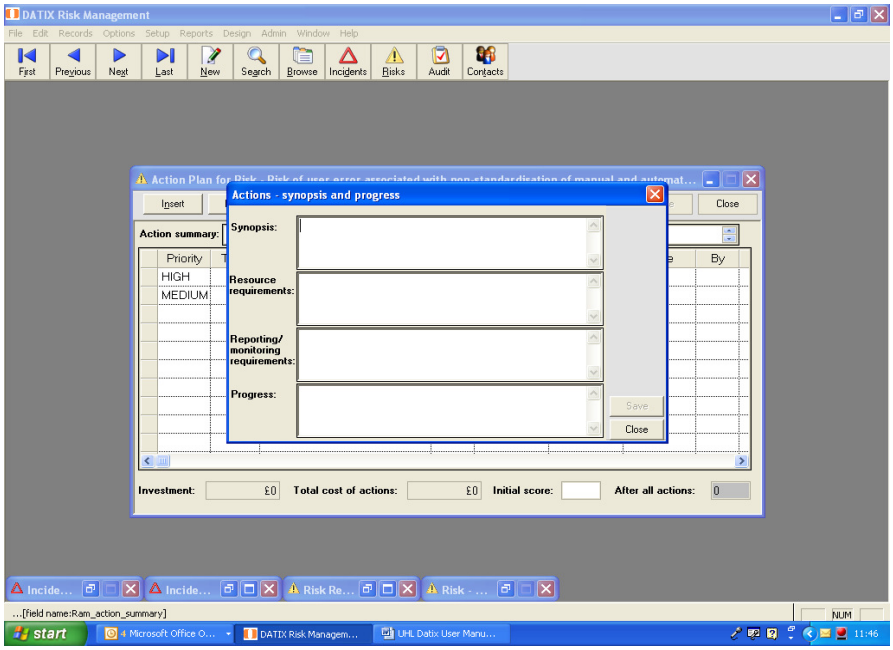
A list of actions to further control (reduce) the risk must be added in this section. An estimated completion date must be entered alongside each action in the ***'Due'*** field. Actions listed in the ***'ACTION'*** field in the main body of the screen must also be copied into the ***'ACTION SUMMARY'*** above.

3.3.5 Below the action summary field is the main body of the action screen. This allows further details about the actions to be entered (e.g. date that action is due to start, date the action is due to be completed, accountable person/s, etc). Click '***INSERT'*** and a single line will be highlighted in the screen. For the highlighted line the following information is required.

Field	Information required
Priority (optional)	Assign a priority of high, medium or low if relevant.
Type	**Field not currently in use.**
Action (mandatory)	Copy each action from the *'Action Summary'* field using a separate line for each action.
To (mandatory)	Insert the initials of the person the action is assigned to.
Start (mandatory)	Insert the date the action is due to start.
Due (mandatory)	Insert the date the action is due to be completed. This field must be updated when necessary to reflect any changes to timescales.
Done (mandatory)	Insert the date the action is completed.
By (mandatory)	Insert the initials of the person who has completed the action(s).
Cost (optional)	Insert any cost associated with each action (if known). These will automatically populate the 'investment' field and will enable Datix to calculate a cost/ benefit analysis
Cost Type (optional)	Specify whether the costs are capital or revenue or charitable funds (i.e. non-exchequer funded).

3.3.6 In instances where multiple actions are required, click ***INSERT*** to highlight a specific line for each of the actions. **IMPORTANT:** When an action is complete the ***'Done'*** field within the action plan must have a date inserted and in addition the word *'COMPLETED'* must replace the date alongside the relevant action in the *'ACTION SUMMARY'* field.

3.3.7 Additional information can be added to each action (if required) by accessing the fields shown below.

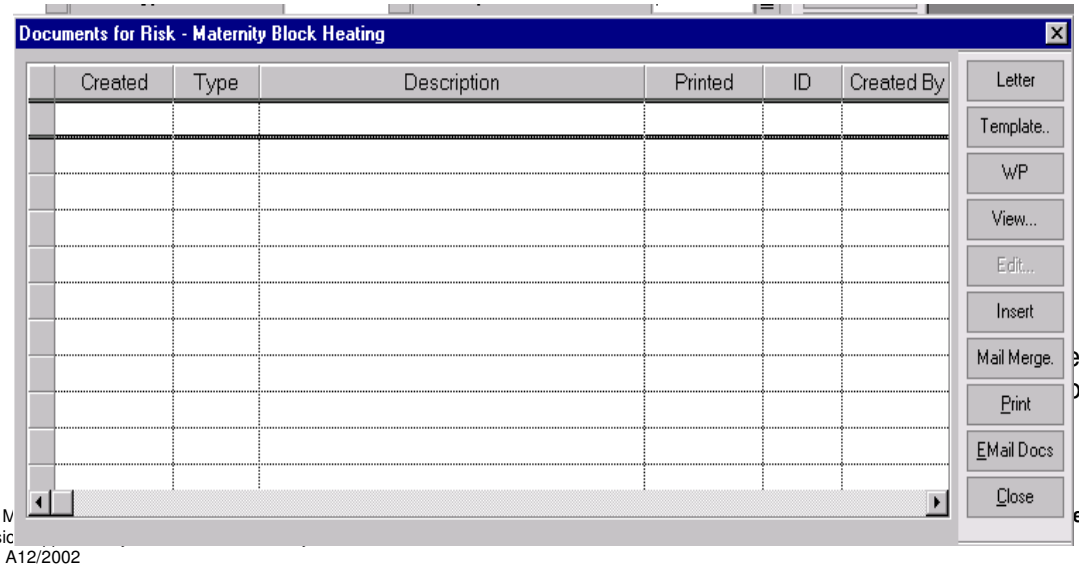


3.3.8 The fields shown in the screen shot above are accessed by clicking on '***DETAILS'*** (above the action summary field). If information has been entered, click '***SAVE'*** then '***CLOSE'*** **to** return to the action plan screen.

3.3.9 Following completion of the action plan click '***SAVE' then 'CLOSE'*** and you will return to the main risk screen.

3.4 Attaching Documents

3.4.1 To attach documents (e.g. an electronic copy of the original risk assessment form, etc) click on the '***DOCUMENTS'*** tab, located to the right of the main risk screen and the screen below will be displayed.



3.4.2 elected a tion. Please

As a minimum a copy of the completed risk assessment form must be attached or where the assessment has been entered directly on to the risk register there should be some form of correspondence to demonstrate approval of the risk assessment.

Click '***SAVE'*** and the document will now be attached to the risk entry.
Repeat the process for any additional documents.

3.5 Using Notepad

This facility can be used to make short notes (e.g. notes of discussions, telephone calls, etc) and is accessed by clicking 'NOTEPAD' on the main risk register screen.

Note: Details entered in the ***NOTEPAD*** field will not be included within Datix generated reports.

4. Searching for a Risk on the Risk Register

4.1 Following login to Datix click on the yellow risk triangle at the top of the screen, ⚠ then click on the '***SEARCH'*** tab (symbolised by a magnifying glass along the same tab/row).

4.2 If the risk register reference number is known then this should be input in to the ***'ID'*** box on the main risk assessment (NEW QUERY) screen. Click ***'START'*** to search for the risk.

4.3 If the risk register reference number is not known, the table below describes how to perform a new search:

Search symbol	Fields to search	Information required
*	Title / description / controls	The asterisk is used to tell Datix that your search criteria include a number of unknown characters. e.g. A search under BROWN* will retrieve all risks beginning with BROWN, i.e. BROWN, BROWNE, BROWNING etc. The asterisk can also be used for key word or phrase searches, e.g. *infusion* will retrieve all risks with the word infusion in the specific search field chosen. Type the 'word' with the asterisk/s and then select the Start button.
:	Opened date / reviewed date / closed date	The colon allows you to search for a range of variables by specifying start and end dates. e.g. 01/01/13:31/03/13 will retrieve risks for the first quarter of 2013.
<	Opened date / reviewed date / closed date / risk ratings (rating field)	The 'less than' symbol enables you to search for value less than a specified amount, or dates before a specified date. e.g. <01/01/14 will retrieve risks for before 1st January 2014.
>	Opened date / reviewed date / closed date / risk ratings (rating field)	The 'more than' symbol enables you to search for values greater than a specified amount, or dates after a specified date. e.g. >01/01/14 will retrieve risks after 1st January 2014.

Search code	Fields to be used	Information required
'Is null' or '=0'	Closed date	If this is entered in the closed date field, it will retrieve all records which do not have data entered in that field. For example if 'is null' is entered in the 'Closed date' field, only cases where there is no date in this field will be identified, i.e. records that are 'open'. This can be entered in upper or lower case.

5. Education and Training

5.1 Datix risk register training is strongly recommended prior to entering data onto the risk register. This training can be accessed by contacting the UHL Corporate Risk Management Team for further detail (ext 3479 or 3441).

6. Monitoring and Audit Criteria

Key Performance Indicator	Method of Assessment	Frequency	Lead
Correct completion of risk register entries	Risk register review of: • Extreme/ high risks • Moderate risks	• Monthly. • Twice per year	Corporate Risk Management Team

7. Legal Liability Guideline Statement

Guidelines or Procedures issued and approved by the Trust are considered to represent best practice. Staff may only exceptionally depart from any relevant Trust guidelines or Procedures and always only providing that such departure is confined to the specific needs of individual circumstances. In healthcare delivery such departure shall only be undertaken where, in the judgement of the responsible healthcare professional' it is fully appropriate and justifiable - such decision to be fully recorded in the patient's notes

8. Supporting Documents and Key References

UHL Risk Management Policy.

9. Key Words

Datix, risk register, guidelines, user guide, search

DEVELOPMENT AND APPROVAL RECORD FOR THIS DOCUMENT			
Author / Lead Officer:	Peter Cleaver		**Job Title:** Risk and Assurance Manager
Reviewed by:	Richard Manton		
Approved by:	**PGC**		**Date Approved:**

REVIEW RECORD			
Date	**Issue Number**	**Reviewed By**	**Description Of Changes (If Any)**
13/2/14	3	P Cleaver	Addition of 'search' instructions.

DISTRIBUTION RECORD:			
Date	**Name**	**Dept**	**Received**

Appendix: Three

Element to be monitored	Lead	Tool	Frequency	Reporting arrangements	Acting on recommendations and lead(s)	Change in practice and lessons to be shared
UHL Risk Management Structure	Risk and Assurance Manager	Risk reports to TB, ET, and AC in line with reporting framework	Annually	Risk management annual report to ET and AC. Report will be scrutinised to identify deficiencies in the risk management system and make recommendations for improvement	Action plans will be developed by UHL corporate risk management team and implemented at a corporate or local level as necessary	Required changes will be actioned within time frame and lessons learned will be shared with all relevant stakeholders via ET, AC and CMG/ directorate boards.
	Risk and Assurance Manager	Risk reports to CMG/ directorate boards in line with reporting framework	Annually	As above	As above	As above
	Risk and Assurance Manager	Review of risk register to show risk movement.	Annually	As above	As above	As above
	Health and Safety Manager	No. of risk assessors per CMG /directorate	Annually	As above	As above	As above
High level review of risk register	Risk and Assurance Manager	Risk reports to ET and AC in line with reporting framework.	Annually	As above	As above	As above
Board Assurance framework	Risk and Assurance Manager	BAF reports to TB, ET, and AC in line with reporting framework	Annually	As above	As above	As above
Local management of risk	CMG/ Corporate Directors and Managers	Risk reports to CMG/ directorate boards in line with reporting framework	Annually	As above	As above	As above
	CMG/ Corporate	Actions to mitigate risks being taken within	Annually	As above	As above	As above

	Directors and Managers	timescales				
	CMG/ Corporate Directors and Managers	Risks being reviewed at local level at the frequencies defined within Risk Management Policy	Annually	As above	As above	As above
Risk Reports	Risk and Assurance Manager	Risk reports showing involvement of key individuals in risk management	Annually	As above	As above	As above

Appendix Four

UHL RISK ASSESSMENT FORM				Local Ref. No.	
Title of risk (i.e. There is a risk of/that… resulting in…)					
CMG/Corporate Directorate		Specialty		Site	
Department/Ward		Date of Assessment		Assurance Source (Refer to Datix for reference)	

*Description of the risk: List the **causes** and the **consequences** of the risk*

Causes of the risk (hazard)

Consequences of the risk (harm / loss event)

Controls in place: What processes are already in place to control the risk? (Copy & paste to add rows where necessary)

Current Risk Rating: (with the current controls, listed above, in place)

Risk subtype: Consequence descriptor: select highest risk subtype score to enter on to Datix risk register (Delete risk subtype if not applicable to the risk in question)	Consequence (C)	x	Likelihood (L)	=	Current Risk Rating
Patients		x		=	
Injury		x		=	
Quality		x		=	
Human Resources		x		=	
Statutory		x		=	
Reputation		x		=	
Business		x		=	
Economic		x		=	
Targets		x		=	
Environment		x		=	

Action Plan: What actions that can be taken to further control the risk? *(Copy & paste to add rows where necessary)*

Action Plan	Assigned to	Start date	Due date	Completed date	Cost £

Target Risk Rating: (with the proposed actions, listed above, in place)

Risk subtype: Consequence descriptor (Delete subtype if not applicable)	Consequence (C)	x	Likelihood (L)	=	Target Risk Rating
Patients		x		=	
Injury		x		=	
Quality		x		=	
Human Resources		x		=	
Statutory		x		=	
Reputation		x		=	
Business		x		=	
Economic		x		=	
Targets		x		=	
Environment		x		=	

Risk Assessment Approval (All risk assessments must be approved prior to being entered on to Datix)

Risk Assessor name		**Signature**		Date	
Line Manager name		**Signature**		Date	
NOTE: This Risk Assessment form must be approved by the CMG / corporate directorate board prior to being entered on to the Datix risk register					
Approved by CMG / Director: name		**Signature**		Date	

Risk Review Details

1st Review Date	

Scoring Guidance:

Consequence score (impact of cause / hazard) and example of descriptors

Risk Subtype	1	2	3	4	5
	Insignificant	**Minor**	**Moderate**	**Major**	**Extreme**
PATIENTS (Consequence on the safety of patients physical/ psychological harm)	Minimal injury requiring no/minimal intervention or treatment. Not requiring first aid	Minor injury or illness, requiring minor intervention (including first aid, additional therapy and/ or medication) Increase in length of hospital stay by 1-3 days An event that consequences on 1 – 2	Moderate increase in treatment defined as a return to surgery, unplanned readmission, prolonged episode of care (4-15 days), extra time as an outpatient, cancellation of treatment or transfer into hospital as a result of the incident. Moderate injury requiring	Mismanagement of patient care with long-term effects Prolonged episode of care by >15 days An event that consequences on 16 – 50 patients	Incident leading to death Multiple permanent injuries or irreversible health effects An event which Consequences on a large number of patients (i.e. > 50)

		patients	professional intervention RIDDOR/agency reportable incident An event which Consequences on 3 -15 patients		
INJURY Consequence on the safety of staff or public physical/ psychological harm)	Minimal injury requiring no/minimal intervention or treatment. Not requiring first aid No time off work	Minor injury or illness, requiring minor intervention. Requiring first aid. Requiring time off work for <3 days	Moderate injury requiring professional intervention and / or counseling Requiring time off work for 4-14 days RIDDOR/agency reportable incident	Major injury leading to long-term incapacity/disability and / or counseling Requiring time off work for >14 days	Incident leading to death Multiple permanent injuries or irreversible health effects
QUALITY Quality/ complaints/ audit	Peripheral element of treatment or service suboptimal Informal complaint/ inquiry	Overall treatment or service suboptimal verbal complaint Local resolution Single failure to meet internal standards Minor implications for patient safety if unresolved Reduced performance rating if unresolved	Treatment or service has significantly reduced effectiveness (written) complaint Local resolution (with potential to go to independent review) Repeated failure to meet internal standards Major patient safety implications if findings are not acted on	Non-compliance with national standards with significant risk to patients if unresolved Multiple, repeated complaints/ independent review Critical report	Totally unacceptable level or quality of treatment/ service Gross failure of patient safety if findings not acted on Inquest/ombudsman inquiry Gross failure to meet national standards
HUMAN RESOURCES (Human resources/ organisational development/ staffing/ competence)	Short-term low staffing level that temporarily reduces service quality (< 1 day)	Ongoing low staffing level that reduces the service quality 75% – 95% staff attendance at mandatory training	Late delivery of key objective/ service due to lack of staff Unsafe staffing level or competence 2-5 days) Low staff morale Moderate / minor error due to poor staff attendance for mandatory/key training 50% -75% staff attendance at mandatory training	Uncertain delivery of key objective/service due to lack of staff Unsafe staffing level or competence (>5 days) Loss of key staff Very low staff morale Major/ serious error due to no staff attending mandatory/ key training 25%-50% staff attendance at mandatory training	Non-delivery of key objective/service due to lack of staff Ongoing unsafe staffing levels or competence Loss of several key staff Critical error due to no staff attending mandatory training /key training on an ongoing basis Less than 25% staff attendance at mandatory training
STATUTORY (Statutory duty/ inspections)	No or minimal consequence or breech of guidance/ statutory duty. Small number of recommendations that focus on quality and safety improvement issues	Single breech of statutory duty Reduced performance rating if unresolved Minor recommendations that can be implemented by low level of management action	multiple breeches in statutory duty Challenging external recommendations/ improvement notice that can be addressed with appropriate action plan	Multiple breeches in statutory duty with subsequent enforcement action Improvement notices Critical report	Multiple breeches in statutory duty with subsequent prosecution Complete systems change required Severely critical report and subsequent prosecution
REPUTATION (Adverse publicity/ reputation)	Rumors Potential for public concern	Local media coverage – short-term reduction in public confidence Elements of public expectation not being met	Local media coverage – long-term reduction in public confidence	National media coverage with <3 days service well below reasonable public expectation	National media coverage with >3 days service well below reasonable public expectation. MP concerned (questions in the House) Total loss of public confidence
BUSINESS (Business	Insignificant cost increase/ or	<5 per cent over project budget	5–10 per cent over project budget	Non-compliance with national 10–25	Incident leading >25 per cent over project budget

objectives/ projects)	slippage of project but recoverable to original timescale	Slippage of project with uncertain recovery to original timescale	Slippage of project affecting original timescale but within contingency plans	per cent over project budget Slippage of project affecting original timescale with uncertain recovery within contingency plans Key objectives not met	Late delivery of project (outside of contingency limits). Key objectives not met
ECONOMIC (Finance including claims)	Loss of £1 - £999 Risk of claim remote	Loss of £1,000 - £9,999 Overspend or 0.1–0.25 per cent of budget Claim less than £10,000	Loss £10,000 – 50,000 Overspend of 0.25–0.5 per cent of budget Claim(s) between £10,000 and £100,000	Loss of £100,000 - £1 million Uncertain delivery of key objective/Loss of 0.5–1.0 per cent of budget Claim(s) between £100,000 and £1 million Purchasers failing to pay on time	Loss > £1 million Non-delivery of key objective/ Loss of >1 per cent of budget Failure to meet specification/ slippage Loss of contract / payment by results Claim(s) >£1 million
TARGETS (Service/ business interruption)	Loss/interruption to service of >1 hour	Loss/interruption to service of >8 hours	Loss/interruption to service of >1 day	Loss/interruption to service of >1 week	Permanent loss of service or facility
ENVIRONMENT (Environmental Consequence)	Minor on-sit release of substance No direct contact with patients, staff, members of the public.	On-site release of substance contained. Minor damage to Trust property <£10,000	On-site release with no detrimental effect Moderate damage to Trust property £10,000 – £50,000	Off-site release/ on-site release with potential for detrimental effect. Major damage to Trust property >£50,000	On-site/ off-site release with realised detrimental/ catastrophic effects Loss of building

How to assess likelihood:
When assessing 'likelihood' it is important to take into consideration the controls already in place. The likelihood score is a reflection of how likely it is that the risk described will occur with the current controls. Likelihood can be scored by considering:

- The frequency (i.e. how many times will the adverse consequence being assessed actually be realised?) or
- The probability (i.e. what is the chance the adverse consequence will occur in a given reference period?)

Likelihood and Risk score
The risk score is calculated by multiplying the consequence score by the likelihood score.

	← Consequence →				
Likelihood	**1**	**2**	**3**	**4**	**5**
↓	**Insignificant**	**Minor**	**Moderate**	**Major**	**Extreme**
1 Rare This will probably never happen/recur. Or Not expected to occur for years. Or Probability: <0.1%	**1**	**2**	**3**	**4**	**5**
2 Unlikely Do not expect it to happen/recur but it is possible it may do so. Or Expected to occur at least annually. Or Probability: 0.1-1%	**2**	**4**	**6**	**8**	**10**
3 Possible Might happen or recur occasionally. Or Expected to occur at least monthly. Or Probability: 1-10%	**3**	**6**	**9**	**12**	**15**
4 Likely Will probably happen/recur but it is not a	**4**	**8**	**12**	**16**	**20**

persisting issue. Or Expected to occur at least weekly. Or Probability: 10-50%					
5 Almost certain Will undoubtedly happen/recur, possibly frequently. Or Expected to occur at least daily. Probability: >50%	**5**	**10**	**15**	**20**	**25**

RISK RATING (SCORE)	**ACTION REQUIRED**
Low (1 – 6)	Acceptable risk requiring no immediate action. Review annually.
Moderate (8 – 12)	Review at least quarterly. Place on risk register.
High (15 – 20)	Review at least monthly. Place on risk register.
Extreme (25)	Review weekly. Place on risk register.

Appendix: Five

RISK ASSESSMENT ESCALATION PROCESS