UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST

TRUST BOARD

MEETING TO BE HELD ON THURSDAY 26 JUNE 2014 FROM 10AM IN THE C J BOND ROOM, CLINICAL EDUCATION CENTRE, LEICESTER ROYAL INFIRMARY

Public meeting commences at 12noon

AGENDA

Please take papers as read

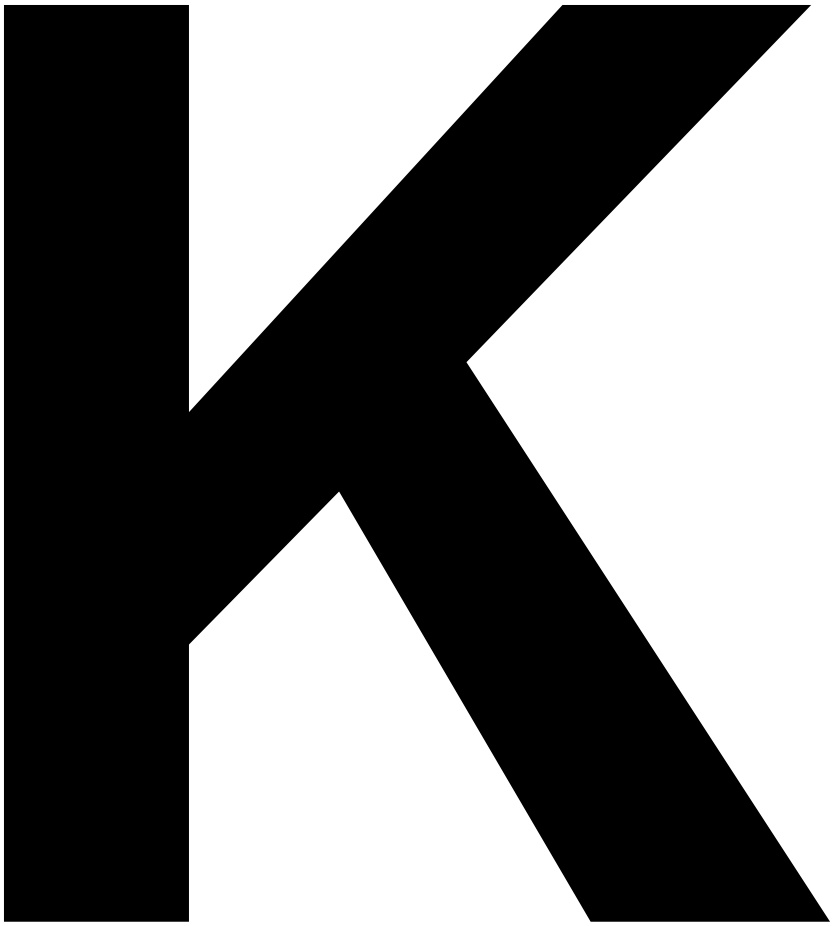
Item no.	Item	Paper ref:	Lead	Discussion time
1.	**EXCLUSION OF THE PRESS AND PUBLIC** It is recommended that, pursuant to the Public Bodies (Admission to Meetings) Act 1960, the press and members of the public be excluded from the following items of business, having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest (items 1-13).			-
2.	**APOLOGIES AND WELCOME** To receive apologies for absence.	**-**	**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**	10am – 10.05
5.	**CONFIDENTIAL MINUTES** Confidential Minutes of the 29 May and 16 June 2014 Trust Board meetings. *For approval*	**A & B**	**Acting Chairman**	10.05 – 10.06am
6.	**MATTERS ARISING** Confidential action log from the 29 May and 16 June 2014 Trust Boards. *For approval*	**C**	**Acting Chairman**	10.06 – 10.25am
7.	**REPORTS BY THE DIRECTOR OF HUMAN RESOURCES** *Prejudicial to the conduct of public affairs and personal data*	**D & E**	**Director of Human Resources**	10.25 – 10.45am
8.	**REPORT BY THE CHIEF NURSE** *Personal data and prejudicial to the conduct of public affairs*	**F**	**Chief Nurse**	10.45 – 10.55am
9.	**REPORT BY THE INTERIM DIRECTOR OF FINANCIAL STRATEGY** *commercial interests*	**G**	**Interim Director of Financial Strategy**	10.55 – 11am
10.	**REPORT BY THE ACTING CHAIRMAN** *Prejudicial to the conduct of public affairs*	**H**	**Acting Trust Chairman**	11 – 11.20am
11.	**REPORTS FROM BOARD COMMITTEES**			11.20 – 11.25am

11.1	**AUDIT COMMITTEE** Confidential Minutes of the 27 May 2014 meeting for noting and endorsement of any recommendations. *Prejudicial to the conduct of public affairs*	**I**	**Audit Committee Chair**	
11.2	**QUALITY ASSURANCE COMMITTEE** Confidential Minutes of the 28 May 2014 meeting for noting and endorsement of any recommendations. *Prejudicial to the conduct of public affairs*	**J**	**QAC Chair**	
12.	**CORPORATE TRUSTEE BUSINESS**			11.25 – 11.29am
12.1	**CHARITABLE FUNDS COMMITTEE** Confidential Minutes of the inquorate 9 June 2014 meeting will be submitted to the July 2014 Trust Board.	**verbal**	**Charitable Funds Committee Chair**	
13.	**ANY OTHER BUSINESS**	**-**	**Acting Chairman**	11.29 – 11.30am
	Comfort break until 12noon			
14.	**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.			
15.	**ACTING CHAIRMAN'S OPENING COMMENTS**	**-**	**Acting Chairman**	12noon – 12.05pm
16.	**MINUTES**			12.05 – 12.06pm
	Minutes of the 29 May 2014 Trust Board meeting. *For approval*	**K**	**Acting Chairman**	
17.	**MATTERS ARISING**			12.06 – 12.20pm
	Action log from the 29 May 2014 meeting. *For approval*	**L**	**Acting Chairman**	
18.	**REPORT BY THE CHIEF EXECUTIVE**			12.20 – 12.25pm
18.1	**MONTHLY UPDATE REPORT – JUNE 2014** *For discussion and assurance*	**M**	**Chief Executive**	
19.	**STRATEGY, FORWARD PLANNING AND RISK**			
19.1	**LLR HEALTH AND SOCIAL CARE 5 YEAR STRATEGY DIRECTIONAL PLAN FOR BETTER CARE TOGETHER PROGRAMME** *For discussion and assurance*	**N (to be tabled)**	**Director of Strategy**	12.25 – 12.50pm
19.2	**UHL 5-YEAR PLAN** *For discussion and assurance*	**O (to be tabled)**	**Director of Strategy**	12.50 – 1.10pm
19.3	**LRI THEATRES RECOVERY AREA BUSINESS CASE** *For approval*	**Additional paper 1**	**Director of Strategy**	1.10 – 1.15pm
19.4	**BOARD ASSURANCE FRAMEWORK**	**P**	**Chief Nurse**	1.15 – 1.30pm

	For discussion and assurance			
20.	**CLINICAL QUALITY AND SAFETY**			
20.1	**PATIENT EXPERIENCE** *For discussion and assurance*	**Q**	**Chief Nurse**	1.30 – 1.50pm
20.2	**UHL QUALITY ACCOUNT 2013-14 AND STATEMENT OF DIRECTORS' RESPONSIBILITIES** *for approval*	**R**	**Chief Nurse**	1.50 – 2.10pm
22.	**STAFFING, EDUCATION AND TRAINING**			
22.1	**MEDICAL EDUCATION QUARTERLY REPORT** *for assurance*	**S**	**Medical Director**	2.10 – 2.20pm
22.2	**WORKFORCE AND ORGANISATIONAL DEVELOPMENT QUARTERLY UPDATE** *For assurance*	**T**	**Director of Human Resources**	2.20 – 2.40pm
22.3	**"HARD TRUTHS" NURSE STAFFING UPDATE** *For assurance*	**U**	**Chief Nurse**	2.40 – 2.50pm
23.	**QUALITY AND PERFORMANCE** *For assurance*			
23.1	**MONTH 2 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 2 position, as considered at the meeting held on 25 June 2014 (the Minutes of which will be presented to the 31 July 2014 Trust Board); (b) **Lead Executive Directors** will then be invited to comment **by exception** on their respective sections of the month 2 report, specifically:- • **Chief Nurse** – patient safety and quality, quality commitment, patient experience; • **Medical Director** – mortality rates; **Finance and Performance** (c) **Acting Trust Chairman** to comment verbally on the month 2 position, as considered at the **Finance and Performance Committee** meeting held on 25 June 2014 (the Minutes of which will be presented to the 31 July 2014 Trust Board). (d) **Lead Executive Directors** will then be invited to comment **by exception** on their respective sections of the month 2 report, specifically:- • **Chief Operating Officer** – operational performance, exception reports, and bed capacity update; • **Director of Human Resources** – staff appraisal, sickness absence and statutory and mandatory training compliance;	**V** **V1**	**QAC Chair** **Chief Nurse** **Medical Director** **Acting Trust Chairman** **Chief Operating Officer** **Director of Human Resources**	2.50 – 3.15pm

	• **Chief Executive** – information management and technology performance, and • **Chief Nurse** – facilities management.		**Chief Executive** **Chief Nurse**	
23.2	**2014-15 MONTH 2 FINANCIAL POSITION** *For assurance*	**W**	**Interim Director of Financial Strategy**	3.15 – 3.20pm
23.3	**EMERGENCY CARE PERFORMANCE AND RECOVERY PLAN** *For discussion and assurance*	**X**	**Chief Operating Officer**	3.20 – 3.30pm
24.	**GOVERNANCE**			
24.1	**NHS TRUST OVER-SIGHT SELF CERTIFICATION** *For discussion and approval*	**Y**	**Director of Corporate and Legal Affairs**	3.30 – 3.35pm
25.	**REPORTS FROM BOARD COMMITTEES**			3.35 – 3.40pm
25.1	**AUDIT COMMITTEE** Minutes of the 27 May 2014 meeting for noting and endorsement of any recommendations.	**Z**	**Audit Committee Chair**	
25.2	**FINANCE AND PERFORMANCE COMMITTEE** Minutes of the 28 May 2014 meeting for noting and endorsement of any recommendations.	**A**	**Acting Chairman**	
25.3	**QUALITY ASSURANCE COMMITTEE** Minutes of the 28 May 2014 meeting for noting and endorsement of any recommendations.	**BB**	**QAC Chair**	
26.	**TRUST BOARD BULLETIN – JUNE 2014**	**CC**	-	-
27.	**CORPORATE TRUSTEE BUSINESS**			3.40 – 3.44pm
27.1	**CHARITABLE FUNDS COMMITTEE** Minutes of the 9 June 2014 inquorate meeting will be submitted to the July 2014 Trust Board. The Charitable Funds Committee Chair will report verbally on 26 June 2014 and invite the Trust Board to approve charitable funds application numbers APP5006 (£497.81) and APP5044 (£11,160).	**verbal**	**Charitable Funds Committee Chair**	
28.	**QUESTIONS FROM THE PUBLIC RELATING TO BUSINESS TRANSACTED AT THIS MEETING**		**Acting Chairman**	3.44 – 3.59pm
29.	**ANY OTHER BUSINESS**		**Acting Chairman**	3.59 -4pm
30.	**DATE OF NEXT MEETING**			
	The next Trust Board meeting will be held on **Thursday 31 July 2014** from **10am** at **Gloucester House, Age UK, Melton.**	**-**		

Helen Stokes
Senior Trust Administrator



UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST

MINUTES OF A MEETING OF THE TRUST BOARD, HELD ON THURSDAY 29 MAY 2014 AT 10AM IN SEMINAR ROOMS 2 & 3, CLINICAL EDUCATION CENTRE, GLENFIELD HOSPITAL

Present:
Mr R Kilner – Acting Trust Chairman
Mr J Adler – Chief Executive
Dr S Dauncey – Non-Executive Director
Dr K Harris – Medical Director (excluding Minute 137/14/2)
Ms K Jenkins – Non-Executive Director
Mr R Mitchell – Chief Operating Officer
Mr P Panchal – Non-Executive Director
Ms J Wilson – Non-Executive Director (up to and including Minute 148/14/1)
Professor D Wynford-Thomas – Non-Executive Director

In attendance:
Dr T Bentley – Leicester City CCG (for Minutes 140/14 – 148/14/1 inclusive)
Ms K Bradley – Director of Human Resources (excluding Minute 135/14)
Ms J Dixon – UHL Senior Site Manager (for Minute 148/14/1)
Mr P Hollinshead – Interim Director of Financial Strategy
Mr B Hyde – Matron, Renal Respiratory and Cardiac Clinical Management Group (for Minute 146/14/1)
Mr K Fananapazir – Associate Specialist, Cardiac Services (for Minute 146/14/1)
Ms C Ribbins – Director of Nursing (in the absence of the Chief Nurse)
Ms K Shields – Director of Strategy (up to and including Minute 139/14)
Ms H Stokes – Senior Trust Administrator
Dr I Sturgess – Interim Consultant (for Minute 148/14/1)
Ms M Thompson – Patient Experience Sister (for Minute 146/14/1)
Mr S Ward – Director of Corporate and Legal Affairs
Mr M Wightman – Director of Marketing and Communications

ACTION

127/14 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 128/14 – 139/14), having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest.

128/14 APOLOGIES

Apologies for absence were received from Colonel (Retired) I Crowe, Non-Executive Director, and Ms R Overfield, Chief Nurse.

129/14 DECLARATIONS OF INTERESTS IN THE CONFIDENTIAL BUSINESS

The Medical Director declared an interest in Minute 137/14/2 and absented himself from the discussion accordingly.

130/14 ACTING CHAIRMAN'S AND CHIEF EXECUTIVE'S OPENING COMMENTS

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

131/14 CONFIDENTIAL MINUTES

Resolved – that the confidential Minutes of 24 April 2014 be confirmed as a correct record and signed accordingly by the Acting Trust Chairman. **CHAIR**

132/14 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.

133/14 REPORT BY THE DIRECTOR OF STRATEGY

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

134/14 JOINT REPORT BY THE CHIEF EXECUTIVE AND THE INTERIM DIRECTOR OF FINANCIAL STRATEGY

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.

135/14 REPORT BY THE DIRECTOR OF HUMAN RESOURCES

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

136/14 REPORT BY THE CHIEF NURSE

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

137/14 REPORTS BY THE DIRECTOR OF CORPORATE AND LEGAL AFFAIRS

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

138/14 REPORTS FROM BOARD COMMITTEES

138/14/1 Audit 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.

138/14/2 Finance and Performance Committee

Resolved – that the confidential Minutes of the 23 April 2014 Finance and Performance Committee be received, and the recommendations and decisions endorsed and noted respectively.

138/14/3 Quality Assurance Committee

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

138/14/4 Remuneration Committee

Resolved – that the confidential Minutes of the 24 April 2014 Remuneration Committee be received, and the recommendations and decisions therein be endorsed and noted respectively.

139/14 PRIVATE TRUST BOARD BULLETIN – MAY 2014

There were no private Bulletin items for noting.

140/14 DECLARATIONS OF INTERESTS IN THE PUBLIC BUSINESS

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

141/14 ACTING CHAIRMAN'S OPENING COMMENTS

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

(a) the sudden death of Mr A Powell, Head of Performance and Quality, NHS Horizons. Mr Powell had been a very longstanding and valued UHL employee, and the Acting Trust Chairman paid detailed tribute to his contribution to the work of the Trust and its predecessor organisations;
(b) the ending of the terms of office for 3 UHL Non-Executive Directors in June 2014. The National Trust Development Authority (NTDA) had asked all 3 to extend their term of office until 1 October 2014 to enable the substantive UHL Chair to be involved in the selection process. Ms K Jenkins had already confirmed that she would not be extending her term of office and would therefore stand down as of 30 June 2014. The Acting Trust Chairman confirmed that UHL would use all available avenues to make the Non-Executive Director recruitment process as inclusive and accessible as possible, engaging with all community sectors;
(c) the process for recruiting a substantive UHL Chair, through NTDA use of an executive search agency. Following a national advertisement, interviews would be held on 21 July 2014 with a view to a postholder being in place from 1 September 2014. In discussion on this issue, Mr P Panchal Non-Executive Director sought assurances that the NTDA would follow appropriate stakeholder engagement procedures as part of that recruitment process, and he also queried what steps had been taken to ensure that the advertisement was accessible to diverse groups. Noting the Birmingham location of the Chair interviews, he also queried whether the Trust could ask for these to be held locally – ie in Leicester. It was agreed to make this request to the NTDA, although noting that more than one post was often recruited for on a single day, and **CHAIR**
(d) the availability of a glossary of useful NHS/UHL acronyms, for the information of public attendees at UHL Trust Board meetings.

Resolved – that the NTDA be asked to consider holding the UHL Chairman interviews in Leicester rather than Birmingham. **CHAIR**

142/14 MINUTES

Resolved – that the Minutes of the 24 April 2014 Trust Board be confirmed as a correct record.

143/14 MATTERS ARISING FROM THE MINUTES

Paper M detailed the status of previous matters arising, particularly noting those without a

specific timescale for resolution. In discussion on the matters arising report, the Board received updated information in respect of the following items:-

(a) **item 1** (Minute 114/14(d) of 24 April 2014) – the Chief Operating Officer confirmed that quarterly review of the Board Assurance Framework risk 2 (failure to transform the emergency care system) would begin from July 2014; **COO**
(b) **item 2** (Minute 114/14(f) of 24 April 2014) – submission of the electronic document records management system (EDRM) was scheduled for June 2014;
(c) **item 7** (Minute 116/14/3 of 24 April 2014) – progress against the CQC action plan would now be monitored through the Quality Assurance Committee, with issues escalated to the Trust Board only by exception;
(d) **item 9** (Minute 117/14/1(b) of 24 April 2014) – the issue of providing further information to the Audit Committee Chair re: the Quality Schedule and CQUIN indicators could now be moved to the Audit Committee matters arising log and deleted from this Trust Board report; **STA/ CN**
(e) **item 19** (Minute 118/14/4 of 24 April 2014) – the Director of Marketing and Communications confirmed that UHL's members favoured holding the Members' Engagement Forum meetings at the Leicester General Hospital site;
(f) **item 23** (Minute 119/14/3(b) of 24 April 2014) – in response to comments from the Acting Trust Chairman, the Director of Human Resources noted that the Delivering Caring at its Best workstream on medical education would also support the CMG workforce leads, together with the newly-established Executive Workforce Board, and
(g) **item 28** (Minute 123/14(c) of 24 April 2014) – it was noted that the 12 June 2014 Trust Board development session would receive a brief verbal update from the Charitable Funds Committee Chair, on that Committee's 9 June 2014 discussions on the preferred investment management approach for the UHL Charity's funds.

Noting any comments above, it was agreed that items 1-27 of 24 April 2014, and items 3 and 4 of 27 February 2014 could now be removed from the Trust Board action log, as either having been completed or being progressed through other avenues. **DCLA/ STA**

Following a comment from Mr P Panchal Non-Executive Director , the Acting Trust Chairman reiterated that it was not acceptable to leave the equality impact assessment and patient/public involvement parts of the Trust Board cover sheet blank – in the absence of specific comments, the equality impact assessment should be completed as follows:- "considered and no implications". **ALL**

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

144/14 REPORT BY THE CHIEF EXECUTIVE – MONTHLY UPDATE REPORT (MAY 2014)

The Chief Executive advised that most of the key issues within his monthly report at paper N were covered on the Trust Board agenda, particularly the Trust's financial position, emergency care performance, and progress in developing the LLR 5-year health and social care plan. The Chief Executive also noted continued 2014-15 acute contract discussions with local Clinical Commissioning Groups, which would need to proceed to formal arbitration if agreement could not be reached. The final issue highlighted within paper N was UHL's 21 May 2014 internal leadership conference, which had been very well attended.

<u>Resolved</u> – that the Chief Executive's May 2014 monthly update be noted.

145/14 STRATEGY, FORWARD PLANNING AND RISK

145/14/1 <u>Caring for the Oldest Old</u>

Paper O from the Director of Marketing and Communications set out the proposed strategic

direction for frail and older people's services at UHL, focusing on changing cultures, practices and the physical environment, and fundamentally upskilling UHL staff to enable them to meet the needs of the oldest old. It was also proposed to position care of older people as UHL 'core business' by appointing an Executive and Non-Executive Director Board lead. Delivery of the strategy would be progressed through the Delivering Caring at its Best framework, and it was agreed that more frequent updates should be received (through that framework) than the proposed 6-monthly interval. The Trust Board welcomed the strategy and the change it represented, supporting the aim of UHL becoming an exemplar for care of older people in hospital. In progressing the strategy, the Trust Board requested that the Director of Marketing and Communications:-

DMC

DMC

(a) reflect appropriate links with carer workstreams;
(b) forge relationships with other relevant community and cultural organisations beyond Age UK;
(c) learn appropriate lessons from UHL's work on teenage cancer services, and
(d) learn appropriate lessons from other Trusts.

<u>Resolved</u> – that (A) UHL's strategy for caring for the oldest old be supported as detailed in paper O;

(B) points (a) – (d) above be taken into account when taking the strategy forward; **DMC**

(C) an Executive and Non-Executive Director lead be nominated to the Director of Marketing and Communications outside the meeting, and **EDs/ NEDs**

(D) updates on the strategy for caring for the oldest old be provided to the Trust Board through Delivering Caring at its Best. **DMC/ CE**

145/14/2 <u>Bed Capacity Plan</u>

Paper P updated the Trust Board on progress in modelling the 'right-sizing' of UHL capacity for 2014-15, noting plans both to provide an additional 45 beds as a short-term measure and to increase community-based activity as the longer-term solution. The modelling was predicated on 3 elements (movement of all suitable elective work to daycase; introduction of surgical triage, and reducing DTOCs to 3.5%) which it was recognised were not all in UHL's sole control. The plan had also been discussed by the Trust's Executive Team and Finance and Performance Committee on 27 and 28 May 2014 respectively, and it was noted that the capital cost of the short-term plan had now fallen to £1.75m (capital programme adjusted as appropriate). Further detail was still required on the scheduling aspects of related revenue costs. In discussion on the plan, the Trust Board:-

(a) sought a view from Dr A Bentley, CCG representative, on the likelihood of achieving a DTOC level of 3.5%. In response, Dr Bentley acknowledged that this issue needed addressing and he commented on the need to understand nursing home issues;
(b) provided assurance (in response to a concern from Dr Bentley) that additional beds would only be opened if safely staffed. Indicative costs were also being explored for accelerating current overseas nurse recruitment;
(c) queried whether wider lessons could be learned from the Renal, Respiratory and Cardiac Clinical Management Group (RRC CMG) review of its bed needs, which had negated the originally-planned need for a further 10 beds. In response, it was not thought that this could be more widely extrapolated to other CMGs;
(d) sought assurance that quality considerations would be safeguarded despite the extra capacity open, and that this was only a short-tem measure. It was also queried whether the impact of moving elective work to daycase would be audited. In receiving assurances on quality, the Trust Board also noted the positive impact of certain planned estates design solutions (eg increase in siderooms), and

(e) noted comments from the Chief Executive on the plan's ring-fencing approach, and on the Executive Performance Board's request that the February 2015 timescale be accelerated as far as possible. Construction of the enabling ward block had already begun. Ms J Wilson, Non-Executive Director and QAC Chair, noted the need to be aware of any downside of ringfencing, and to identify mitigating actions accordingly – it was confirmed in response that an appropriate risk assessment would be undertaken and shared with the Trust Board. A further update on ringfencing would be provided accordingly at the 26 June 2014 Trust Board, including timescales. **COO**

Resolved – that a further update on progress in ringfencing elective beds be provided to the 26 June 2014 Trust Board, including the timescale involved and any risk assessment (plus mitigating actions) of such ringfencing. **COO**

145/14/3 UHL and LLR 5-Year Plans

The Chief Executive advised that he had nothing significant to add to his report at paper N above, and he noted the challenges of developing UHL's internal plan in parallel to the wider LLR 5-year plan. The Trust anticipated having a credible draft to submit by the required deadline of 20 June 2014.

Resolved – that the verbal update be noted.

145/14/4 Delivering Caring at its Best (DCaiB) – Update

Paper Q updated the Trust Board on progress in Delivering Caring at its Best, noting that Executive Director leads were now populating the project initiation documents (PIDs) and would include timescales accordingly. Each DCaiB area was now known as a 'domain', and the programme management discipline was proving useful in reviewing the detail of each workstream and identifying resourcing requirements. In response to a query from the Acting Trust Chairman on when the Board could expect to see more detailed delivery timescales, the Chief Executive agreed to provide headline deliverables for each domain by 30 September 2014 – that update would include an overview of the work programme with the financial implications. The Chief Executive also agreed that the current presentation of the programme could be improved, and he agreed to discuss this further with the Director of Strategy (with a view to clarifying the reporting arrangements for the various threads). **EDs** **CE** **CE**

The Interim Director of Financial Strategy also advised that an overview of the DCaiB programme would be included in UHL's 5-year plan submission on 20 June 2014. The Trust Board was scheduled to receive an update on both the UHL and the LLR 5-year plans at its extraordinary meeting on 16 June 2014.

Resolved – that (A) future updates on the project initiation documents also include reporting timescales; **EDs**

(B) headlines re: an overview of financial and non-financial deliverables for each domain be available by 30 September 2014 and reported to the Trust Board thereafter, and **CE**

(C) the presentation of the various workstreams be clarified in future updates, following discussion with the Director of Strategy. **CE/DS**

145/14/5 Board Assurance Framework (BAF) – Update

In the absence of the Chief Nurse, the Director of Corporate and Legal Affairs presented the latest iteration of UHL's BAF (paper R) and the report was taken as read, noting that all Executive Leads and risk owners would be providing progress reports on any follow-up actions to the Risk and Assurance Manager outside the meeting. Work continued to review

UHL's BAF, which would discussed in its proposed new format at the 12 June 2014 Trust Board development session and formally presented to the 26 June 2014 Trust Board thereafter. Ms K Jenkins Non-Executive Director and Audit Committee Chair emphasised the need for a refreshed BAF and noted that CMGs had been invited to present their risk management plans to the Audit Committee as part of a rolling programme. **CN**

Mr P Panchal Non-Executive Director noted that the 27 May 2014 Audit Committee had queried whether UHL's Non-Executive Director turnover needed to be reflected on its BAF. The Chief Executive advised that a review of strategic objective 1 would probably focus on being a sustainable organisation, which would include issues around the composition and stability of the Trust Board. It was acknowledged that UHL had been in a period of transition for some time, initially with Executive Directors and now with Non-Executive Directors.

In respect of the 3 risks selected for detailed consideration, the Trust Board noted the following information:-

- **risk 9** (*failure to achieve and sustain high standards of operational performance)* – as noted in Minute 145/14/2 above, the additional capacity beds had now been reduced to 45, which needed reflecting on the BAF. Ms J Wilson, Non-Executive Director and QAC Chair, requested that measures to improve productivity also be more fully captured in this risk. It was also agreed to increase the risk score to 25 (5x5); **COO**
- **risk 10** *(inadequate reconfiguration of buildings and services)* – consideration of this risk was deferred in the absence of the Director of Strategy, and
- **risk 11** *(loss of business continuity)* – although this risk had been recently updated, the Chief Operating Officer would also reflect any issues arising from Dr I Sturgess' review of ED (Minute 148/14/1 below refers). Although it was agreed to keep the overall risk score of 12, the Trust Board agreed this should comprise a 4x3 rating rather than the current 3x4 configuration. **COO**

In further discussion on the narrative report accompanying the BAF itself, the Trust Board queried the 25 risk score attributed to the 'risk to patient/staff safety due to security staff not assisting with restraint'. The Director of Nursing clarified that following review, this risk had now been reassessed as 15 or 16, as security staff were in fact assisting with violent patients. The mitigating actions would be notified to the Executive Team through its usual BAF update. **CN**

<u>Resolved</u> – that (A) the revised BAF model be reviewed at the 12 June 2014 Trust Board development session, ahead of formal discussion on 26 June 2014; **CN**

(B) risk 9 be amended to:- **COO**

- **refer to 45 additional beds rather than the initial 55;**
- **cover productivity considerations – eg making the most of existing capacity and capability, and**
- **increase the risk rating to 25 (5x5).**

(C) risk 11 be amended to change the composition of the overall risk rating, from 3x4 to 4x3 (retaining the same overall score), and **COO**

(D) the risk rating for the security staff risk be reduced following appropriate review (to 15 or 16). **CN**

146/14 CLINICAL QUALITY AND SAFETY

146/14/1 <u>Patient Experience – Patient Story Relating to Care Received after Cardiac Surgery</u>

Members watched a patient experience story relating to care received after cardiac surgery, in which the patient had been wrongly labelled as an "anxious patient", and noted both the

personal and potential clinical impact this had had upon that patient. The Renal, Respiratory and Cardiac Clinical Management Group (RRC CMG) staff attending for this item explained how disappointing this patient story had been for all concerned, differing markedly from the usually very positive patient experiences within their services. The RRC CMG took all patient feedback extremely seriously, and had therefore used this particular experience as a key teaching tool for staff, reiterating the need to treat all patients as individuals and listen to them rather than labelling them. The patient experience strategy was also now discussed at the CMG's monthly audit and morbidity and mortality meetings.

In discussion on the patient experience story, the Trust Board:-

(a) welcomed the fact that the RRC CMG was clearly taking all steps to learn from (and prevent a recurrence of) this patient experience, even though patient feedback was usually overwhelmingly positive for the service. The whole team approach being used to learn from the patient story was also commended by the Trust Board, who asked that these comments be passed to all RRC staff; **CN**
(b) sought assurance that the clinicians still had sufficient time to talk to patients on an individual basis, despite service pressures. In response, Mr K Fananapazir reiterated the recognised importance of that contact with patients, and
(c) commented that pathology should not be attributed to anxiety necessarily, as it was perfectly normal for patients to feel anxious in hospital. The Medical Director considered that this was a wider learning point beyond just the RRC CMG.

<u>Resolved</u> – that the Trust Board's congratulations be passed to the Renal, Respiratory and Cardiac CMG for its response to the cardiac surgery care patient experience story. **CN**

147/14 FORMAL ADOPTION OF THE 2013-14 ANNUAL ACCOUNTS

Paper T from the Interim Director of Financial Strategy presented the Trust's annual accounts for 2013-14, and sought the Trust Board's approval to adopt those accounts, to note UHL's management response to External Audit's recommendations (appended to the accounts), to approve the Trust's Annual Governance Statement at paper T1 (updated version now tabled), to approve the Letter of Representation (paper T2 – now tabled) and to authorise the signature of the relevant statements accordingly.

Following External Audit's review of the accounts (which had been submitted and audited on a very tight timescale), an unqualified opinion would be issued on those accounts. External Audit's value for money opinion on the use of resources element would be a qualified opinion however, in light of UHL's significant year end deficit. The Interim Director of Financial Strategy advised the Trust Board that UHL had met 2 of its statutory financial duties (namely the external financing limit and the capital resource limit), although it had not achieved breakeven nor the administrative 'better payments practice code' target.

In tabling an updated version of the Trust's Annual Governance Statement (AGS – paper T1), the Director of Corporate and Legal Affairs confirmed that the new format for expressing Internal Audit's opinion on UHL's internal controls equated to the formerly-used finding of "significant assurance". He also clarified that (as agreed with the Chief Executive) UHL's commitment to equality and diversity was now covered within the Trust's annual report rather than the AGS.

Ms K Jenkins Non-Executive Director and Audit Committee Chair, then advised the Trust Board of the Audit Committee's detailed consideration of the annual accounts on 27 May 2014, and its recommendation of them for approval by the Trust Board. Following a good discussion on UHL's going concern statement, the Interim Director of Financial Strategy had agreed to add wording into the accounts to reflect this position accordingly. The Audit Committee had also received assurance from the process to monitor progress on high risk

actions identified through Internal Audit reports, although the Audit Committee Chair considered that there was still room for improvement on completing actions in a timely manner. The Audit Committee had also endorsed the Letter of Representation for Trust Board approval, appended to which would be UHL's going concern report and a statement on the Trust's 2-year plan in respect of its financial liquidity position. Both of those reports had previously been discussed by the Trust Board.

Resolved – that the 2013-14 annual accounts, Letter of Representation and Annual Governance Statement be approved by the Trust Board as presented, and all relevant statements/certificates/letters be signed accordingly by the appropriate officers, for onward submission as required. **IDFS/ CE**

148/14 QUALITY AND PERFORMANCE

148/14/1 Emergency Care Performance and Recovery Plan

In addition to the standing report on emergency care performance (paper X), Dr I Sturgess, Interim Consultant and Ms J Dixon, UHL Senior Site Manager attended to brief the Trust Board on their review to date of emergency care within LLR. Although their review was initially focusing on in-hospital emergency care, it would necessarily take a system-wide view across LLR as a whole. Key initial thoughts related to:-

(i) LLR's apparent operation of a blame culture, more markedly so than in other healthcare economies;
(ii) the crucial importance of clinical leadership in effecting and delivering change. Clinical leadership was considered to need strengthening across all parts of the LLR emergency care system;
(iii) the further need for alignment of clinical, managerial, and executive teams across all parts of the LLR emergency care system (with appropriate supporting behaviours) in order to deliver change, and
(iv) the welcomed level of openness and receptiveness within UHL, which they hoped would be mirrored across the healthcare economy.

In discussion on the presentation by Dr Sturgess and Ms Dixon, the Trust Board:-

(a) reiterated that the whole healthcare economy was committed to improving LLR emergency care, recognising the crucial importance of a whole system approach;
(b) queried how Dr Sturgess would engage stakeholders;
(c) received confirmation that Dr Sturgess would also review external care pathways (noting engagement planned with the Urgent Care Board). Ms Dixon also commented on the benefits of involving GPs on any clinical engagement group;
(d) noted Dr A Bentley, CCG representative's disappointment at references to a perceived 'blame culture'. He also commented that it would be helpful to have more information on GP practices referring inappropriately (tabled action plan accompanying paper X);
(e) queried how to ensure that clinical leaders actually assumed an appropriate leadership role, and whether UHL was currently in good shape in this regard (compared to the previous ECIST visit some 18 months previously). In response, Dr Sturgess considered that UHL had some very good clinical leaders, but he commented on a perceived system-wide culture of 'learned helplessness' and 'learned hopelessness', which must be addressed. In terms of clinical leadership UHL was considered to be at a 5-6 (out of 10), compared to a 6 18 months previously, as certain solutions had been imposed in the intervening period perhaps without sufficient engagement. The Trust Board commented on the need to measure progress on clinical leadership and engagement;
(f) discussed how to increase the visibility of the ED to other specialties/areas within UHL, to make it feel more connected to the rest of the organisation and less isolated;

(g) asked Dr Sturgess to prioritise the actions needed within UHL as a whole, based on his experience elsewhere. In response, actions included eliminating unnecessary waits across the hospital; one-stop ward rounds on acute assessment units; implementation of a holistic, end-to-end management system, mapping capacity to meet demand; having an appropriate model of clinical decision-making; more rapid requesting of diagnostic tests and same-day receipt of the results to enable safe discharge; timely availability of medication to take home within outpatient areas thus moving away from batch processing of TTOs; a robust wi-fi environment; having an Acute Physician and Geriatrician within ED at peak times to stream patients to appropriate areas; a rapid assessment process within ED and effective shopfloor management reflecting the demand profile, and

(h) voiced concern over patient safety issues prior to addressing the current challenges, given the intense pressure on UHL's ED service. In response to a query from Mr P Panchal, Non-Executive Director re: ED closure, the Medical Director confirmed that appropriate escalation procedures were in place but noted that UHL was a single provider of ED services for a very large catchment area. Ms Dixon echoed this view, noting that closure of UHL's ED was not a viable option in light of the pressure it would place on remaining East Midlands EDs and on East Midlands Ambulance Service. Dr Sturgess added his own view that diversion would increase patient safety risks across the patient pathway as a whole.

The Acting Trust Chairman requested that a further update to the June 2014 Trust Board outline any traction achieved on delivering the changes needed, and on how to ensure appropriate ownership of those changes. **COO**

<u>Resolved</u> – that (A) the update on ED performance and the review of LLR emergency care, be noted, and

(B) a further update in June 2014 include details of traction achieved on the required changes, and on measures to ensure appropriate ownership of those changes. **COO**

148/14/2 <u>Month 1 Quality and Performance Report</u>

The month 1 quality and performance report (paper U - month ending 30 April 2014) advised of red/amber/green (RAG) performance ratings for the Trust, and set out performance exception reports in the accompanying appendices. Discussion at the 28 May 2014 Quality Assurance Committee had highlighted issues relating to fractured neck of femur performance, the backlog of outpatient follow-up appointments, the need for future RTT updates to QAC to include an assessment of the clinical risk of not meeting that target, and the importance of having appropriately triangulated patient feedback (the report on which would be circulated to the Trust Board for information). **STA**

The Director of Nursing advised that there were no additional quality issues to highlight beyond those already flagged within paper U. In terms of clinical issues, the Medical Director responded to QAC concerns re: fractured neck of femur performance, remedial actions on which were being submitted to the June 2014 Executive Performance Board. With regard to outpatient follow-ups, the Medical Director outlined progress in assessing the current scale of the issue and confirmed that additional mechanisms had been introduced to ensure the appropriate use of the Choose and Book system. Ophthalmology remained a particular hotspot on this issue, and an external resource was being used to address backlog capacity.

The Acting Trust Chairman and Finance and Performance Committee Chair then outlined key operational issues discussed by the 28 May 2014 Finance and Performance Committee, including progress on the LLR and UHL 5-year plans (and his view that patient and public involvement on UHL's plan needed strengthening); Consultant recruitment challenges within ENT which should be fed in to the Board Assurance Framework; the significant increase in **MD/CN/ DHR**

2013-14 admissions and the resulting impact on bed capacity, elective activity and RTT performance, and discussions on the need for more efficient use of theatres to aid RTT performance. The Chief Operating Officer advised that improvements to theatre utilisation (which issue extended beyond surgery and anaesthesia) would be monitored by the June 2014 Finance and Performance Committee through the cross-cutting CIP report. **COO**

In response, the Chief Operating Officer noted the very detailed 28 May 2014 meeting with CCGs regarding actions to achieve the November 2014 RTT target (admitted performance), to which all parties remained committed. With regard to other operational issues in the month 1 report, he commented particularly on:-

(i) 3 patients who had exceeded the 52 week wait target. These had initially been Alliance patients and it would have been very challenging for UHL to meet the waiting time target by the time they had transferred;

(ii) the detailed plan appended to paper U for reducing on the day cancellations, and

(iii) unsatisfactory performance in respect of Choose and Book slot availability, which had also been discussed at the 28 May 2014 Finance and Performance Committee.

Lead Directors advised that there were no specific HR nor IM&T issues to report beyond the information within paper U, other than confirming that statutory and mandatory training trajectories were now included in the report as previously requested. Professor D Wynford-Thomas, Non-Executive Director, queried whether the most appropriate performance indicators were being used to monitor Facilities Management performance, noting (in response) that this was currently under review.

Resolved – that (A) the 28 May 2014 QAC report on the triangulation of patient feedback be circulated to Trust Board members for information; **STA**

(B) the 28 May 2014 Finance and Performance Committee discussions on Consultant recruitment difficulties (ENT) be fed in to the Trust Board's June 2014 review of the Board Assurance Framework, and **MD/CN/ DHR**

(C) improvements to theatres utilisation and productivity be monitored through the cross-cutting CIP report being provided to the June 2014 Finance and Performance Committee. **COO**

148/14/3 "Hard Truths Commitments" – Healthcare Staffing Arrangements

Resolved – that this report (paper V) be noted in the absence of the Chief Nurse, and revisited at the June 2014 Trust Board. **CN**

148/14/4 Month 1 Financial Position and Rvised Capital Plan 2014-15

Paper W advised members of UHL's financial position as at month 1 (month ending 30 April 2014), noting that although all key financial duties were currently shown as green the overall year-end position remained a projected deficit of £40.7m. UHL still had no agreed acute contract for 2014-15, and the financial position within paper W did not reflect the impact of any CCG penalties (£1.6m in month 1, if applied). Work also continued to bridge the 2014-15 cost improvement programme shortfall. Section 4.1 of paper W also outlined a number of other potential risks to the financial position and year-end plan. The Interim Director of Financial Strategy advised that a short-term loan had now been agreed with the National Trust Development Authority to March 2015 if needed, to address liquidity issues.

With specific regard to month 1, the Trust Board was encouraged by the reduction in pay expenditure, and noted that an underperformance on income related primarily to the

temporary suspension of the renal transplant service.

Paper W also set out a revised capital plan for 2014-15, noting overcommitments (additional bed capacity and the emergency floor plan now included) and the need to progress certain external funding assumptions.

The Chief Executive advised that the acute contract mediation decision had now been received from the NTDA and NHS England during this Trust Board meeting. Headlines included a cap of 2.5% on penalties and ruling out any carry-forward of recovery action plan penalties. The decision was broadly satisfactory from the Trust's perspective and the Chief Executive noted that all parties were now being exhorted to sign the contract. He noted, however, that the base level of that contract still needed resolving.

Resolved – that the financial position for month 1 be noted and the revised 2014-15 capital programme be approved. **IDFS**

148/14/5 NHS Trust Over-Sight Self Certifications

The Director of Corporate and Legal Affairs introduced UHL's self certification returns for April 2014 (paper Y). In discussion, Mr P Panchal Non-Executive Director queried whether the stated compliance with statement 13 of appendix B was appropriate, given the NTDA's plans not to renew the terms of 3 of UHL's Non-Executive Directors. In response, the Acting Trust Chairman noted his view that the UHL Trust Board was satisfied that all Executive and Non-Executive Directors had the appropriate qualifications, skills and experience to discharge their functions effectively – this was supported by the Board effectiveness review, which had identified no significant skill gaps. Mr Panchal requested that this view be reiterated to the NTDA – in response the Acting Trust Chairman clarified that Non-Executive Director renewal decisions were entirely the remit of the NTDA and should not be seen as a statement on capacity or capability. There was no right to automatic reappointment and it was open to the NTDA to test the market for complex organisations.

Following due consideration, 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 April 2014 be approved for signature by the Chief Executive, and submitted to the NTDA as required. **DCLA/ CE**

149/14 REPORTS FROM BOARD COMMITTEES

149/14/1 Audit Committee

Resolved – that the 15 April 2014 Audit Committee Minutes be received, and the recommendations and decisions therein be endorsed and noted respectively.

149/14/2 Finance and Performance Committee

Resolved – that the 23 April 2014 Finance and Performance Committee Minutes be received, and the recommendations and decisions therein be endorsed and noted.

149/14/3 Quality Assurance Committee (QAC)

Resolved – that the 23 April 2014 QAC Minutes be received, and the recommendations and decisions therein be endorsed and noted respectively.

150/14 TRUST BOARD BULLETIN

Resolved – that the quarter 4 update on progress against UHL's 2013-14 annual operational plan be noted.

151/14 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) appreciation for the glossary of terms and abbreviations, and
(2) welcome for the openness of the emergency care review discussion (Minute 148/14/1 above). The staff member raising this point also considered that this indicated the Trust Board's commitment to reconnect with shopfloor clinicians and staff.

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

152/14 ANY OTHER BUSINESS

152/14/1 R&D Horizon Scanning

Mr P Panchal, Non-Executive Director queried what arrangements were in place to horizon scan the potential impact (on UHL R&D activity) of pharmaceutical company takeovers/ mergers. In response, the Director of Marketing and Communications noted the recent appointment of a Communications and Marketing Manager for R&D, whose remit would also cover horizon scanning. Professor D Wynford-Thomas, Non-Executive Director and Dean of the University of Leicester Medical School suggested it would be helpful for that UHL postholder to liaise with their counterpart at the University of Leicester. **DMC**

Resolved – that the UHL Communications and Marketing Manager for R&D liaise appropriately with their counterpart at the University of Leicester re: horizon scanning. **DMC**

152/14/2 June 2014 Sponsored Walk

The Director of Human Resources encouraged Trust Board members to join her in participarting in a sponsored walk around Leicestershire.

Resolved – that the position be noted.

153/14 DATE OF NEXT MEETING

Resolved – that the next Trust Board meeting be held on Thursday 26 June 2014 in the C J Bond Room, Clinical Education Centre, Leicester Royal Infirmary.

The meeting closed at 3.26pm

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)	2	2	100	R Overfield	2	1	50
J Adler	2	2	100	P Panchal	2	2	100
T Bentley*	2	2	100	K Shields*	2	2	100
K Bradley*	2	2	100	S Ward*	2	2	100
I Crowe	2	1	50	M Wightman*	2	2	100
S Dauncey	2	2	100	J Wilson	2	2	100
K Harris	2	2	100	D Wynford-Thomas	2	1	50
K Jenkins	2	2	100				
R Mitchell	2	2	100				

* non-voting members

University Hospitals of Leicester NHS Trust

Progress of actions arising from the Trust Board meeting held on Thursday 29 May 2014

Item No	Minute Ref:	Action	Lead	By When	Progress Update	RAG status*
1.	141/14	Request to be made to the National Trust Development Authority to hold the UHL Non-Executive Director interviews in Leicester rather than Birmingham.	CHAIR	Immediate	Actioned	5
2.	143/14	***Matters arising*** The following actions to be removed from the action log, as now either completed or appropriate updates provided to this meeting:- • actions 1-8, 10-27 of 24 April 2014; • actions 3 & 4 of 27 February 2014.	STA	Immediate	Actioned.	5
2(a)	143/14	All members to ensure that Trust Board cover sheets are correctly completed, with particular regard to the PPI implications and the equality impact. If there is no equality impact from the report, then its author should state 'considered and no implications' rather than 'N/A'.	ALL	All future TB reports	Actioned	5
3.	145/14/1	***Caring for the Oldest Old Strategy*** In progressing the Strategy, its author to:- • reflect appropriate links with carer workstreams; • forge relationships with other relevant community and cultural organisations beyond Age UK; • learn appropriate lessons from UHL's work on teenage cancer services, and • learn appropriate lessons from other Trusts.	DMC	Ongoing	Actioned via the Older people's strategy board agenda	5
3(a)	145/14/1	An Executive and Non-Executive Director lead for care of older people, to be nominated outside the meeting and notified to the Director of Marketing and Communications.	To DMC	By 26.6.14	Actioned: Richard Kilner and the Chief Nurse	5
3(b)	145/14/1	Future updates on 'caring for the oldest old' to be incorporated into the Delivering Caring at its Best progress reports.	DMC/CE	As required	Will be picked up as the Older people's strategy board work progresses	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***

4.	145/14/2	***Bed capacity plan*** Further update on progress in ringfencing elective beds to be provided to the June 2014 Trust Board, including the timescale involved and any risk assessment (plus mitigating actions) of such ringfencing.	COO	TB 26.6.14	Update featured accordingly on the 26 June 2014 Trust Board agenda	4
5.	145/14/4	***Delivering Caring at its Best*** Future updates on the project initiation documents also to include reporting timescales.	CE/EDs	Ongoing	To be included in future updates	5
5(a)	145/14/4	Headlines re: an overview of financial and non-financial deliverables for each domain to be available by the end of September 2014 and reported to the Trust Board thereafter.	CE	For October 2014 TB	To be scheduled accordingly for the October 2014 Trust Board	4
5(b)	145/14/4	Presentation of the various workstreams to be clarified in future updates, following discussion with the Director of Strategy.	CE/DS	Future TB Updates	To be reflected in future updates commencing the October 2014 Trust Board	5
5(c)	145/14/4	Update on the development of the 5-year LLR health and social care plan and UHL's own 5-year plan, to be provided to the 16 June 2014 Trust Board.	DS/CE	TB 16.6.14	Actioned	5
6.	145/14/5	***Board Assurance Framework (BAF)*** Revised BAF model to be reviewed at the June 2014 Trust Board Development Session, ahead of formal discussion at the end of June Trust Board (see also note 9(a) below).	CN	TBDS 12.6.14 & TB 26.6.14	June 2014 Trust Board development session cancelled. Consideration of the BAF rescheduled for the 17 July 2014 Trust Board development session	3
6(a)	145/14/5	Risk 9 to be amended to:- • refer to 45 additional beds rather than the initial 55; • cover productivity considerations – eg making the most of existing capacity and capability, and • increase the risk rating to 25 (5x5).	COO	For TB 26.6.14	Actioned	5
6(b)	145/14/5	Risk 11 to be amended to change the composition of the overall risk rating, from 3x4 to 4x3 (retaining the overall score).	COO	For TB 26.6.14	Actioned	5
6(c)	145/14/5	Risk rating for the security staff risk to be reduced following appropriate review (to 15 or 16), with the mitigating actions to be notified to the Executive Team through the usual BAF report.	CN	Future ET	Actioned. Risk score reduced	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***

7.	146/14/1	The Trust Board's congratulations be passed to the Renal, Respiratory and Cardiac CMG for its response to the patient experience story shared with the Board today.	CN	Immediate	Actioned	5
8.	147/14	2013-14 annual accounts to be approved by the Trust Board as presented, and all relevant statements/certificates/letters to be signed by the appropriate officers.	IDFS/CE	Immediate	Actioned	5
9.	148/14/1	***Emergency care performance and ED review – update*** Further update in 1 month's time to include details of traction achieved on the required changes, and on measures to ensure appropriate ownership of those changes.	COO	TB 26.6.14	Update featured accordingly on the 26 June 2014 Trust Board agenda	4
10.	148/14/2	***Month 1 quality and performance report*** May 2014 QAC report on the triangulation of patient feedback to be circulated to Trust Board members for information.	STA	By 26.6.14	Actioned	5
10(a)	148/14/2	May 2014 Finance and Performance Committee discussions on Consultant recruitment difficulties (ENT) to be fed in to the Trust Board's June 2014 review of the Board Assurance Framework (see above).	CN/MD/ DHR/ ALL	TBDS 12.6.14	June 2014 Trust Board development session cancelled	3
10(b)	148/14/2	In light of links to RTT performance, improvements to theatres utilisation and productivity to be monitored through the cross-cutting CIP report being provided to the June 2014 Finance and Performance Committee.	COO	FPC 25.6.614	Report scheduled for 25 June 2014 Finance and Performance Committee	4
11.	148/14/3	Any outstanding issues from the 'hard truths' nurse staffing report (paper V) to be covered at the June 2014 Trust Board.	CN	TB 26.6.14 (if required)	Featured on the 26 June 2014 Trust Board agenda accordingly.	4
12.	148/14/4	Revised 2014-15 capital plan to be approved (and progressed accordingly) as presented.	IDFS	Immediate	Actioned	5
13.	148/14/5	Authority be delegated to the Director of Corporate and Legal Affairs to submit the NHS Trust oversight self certification returns to the NTDA by 30 May 2014 as required (last working day).	DCLA	By 30.5.14	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***

Matters arising from previous Trust Board meetings

Item No	Minute Ref:	Action	Lead	By When	Progress Update	RAG status*
24 April 2014						
14.	117/14/1 (b)	Chief Nurse to provide the Audit Committee Chair with supporting additional information on the meaning and the impact of the Quality Schedule and CQUIN indicators.	CN	Immediate	Verbal report to be provided at the 29 May 2014 Trust Board. **Update not available in the absence of the Chief Nurse – to be covered at the June 2014 Trust Board.**	
27 March 2014						
16.	90/14/1	*(2-year operational plan)* • clinical and strategic rationale for the vascular services proposals to be reported to the June 2014 Trust Board. • revised approach to considering business cases to be discussed by the Finance and Performance Committee and Trust Board. • timetable of Trust Board-required approvals for the individual capital schemes, to be developed and advised to Board members.	MD/DS IDFS IDFS	TB 26.6.14 31.5.14 by 24.4.14	Deferred to the July 2014 Trust Board. To be considered as part of the review of the working of the Commercial Executive. Revised process for both Capital and Revenue agreed by Executive Team; paper to be presented to F&P in June 2014 Report to be considered by the 25 June 2014 Finance and Performance Committee.	4
17.	95/14/3	*(any other business)* (subject to recognised exceptions such as the quality finance and performance report, and formal business cases) All future Trust Board papers to be a maximum of 10 pages in length with no appendices, wherever possible.	All EDs	From April 2014 TB	Actioned. **See also item 2(a) above.**	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***

University Hospitals of Leicester NHS
NHS Trust

To:	**Trust Board**
From:	**CHIEF EXECUTIVE**
Date:	**26 JUNE 2014**
CQC regulation:	N/A

Title:	**MONTHLY UPDATE REPORT – JUNE 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: considered and no implications

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: **26 JUNE 2014**

REPORT BY: **CHIEF EXECUTIVE**

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

---

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

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

(a) the Trust's financial position as at month 2 2014/15;

(b) emergency care performance;

(c) the development of an LLR Health and Social Care 5-year Strategy directional plan for the Better Care Together Programme; and the development of the Trust's 5-year Plan;

(d) the new Congenital Heart Disease Review – visit by the NHS England review team to the Trust on 30 May 2014;

(e) the publication on 13 June 2014 by NHS England, the NHS Trust Development Authority and Monitor of a framework to support planning for operational resilience during 2014/15 (including elective as well as urgent care) which heralds the evolution of Urgent Care Working Groups to become 'System Resilience Groups'.

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

19th June 2014

additional paper 1

Additional Trust Board paper 1

To:	**Trust Board**
From:	**Kate Shields, Director of Strategy**
Date:	**26th June 2014**
CQC regulation:	

Title:	**Leicester Royal Infirmary Main Theatres:** **Recovery Area Reconfiguration - Full Business Case (version 2.0)**

Author / Responsible Director: Kate Shields, Director of Strategy, Ian Currie, Project Manager

Purpose of the Report:

Approval sought

This Full Business Case seeks approval to invest £3,675,300* to proceed with the provision, in the main theatres suite at the Leicester Royal Infirmary, of:

- an enlarged and improved post-operative Recovery Area
- a dedicated paediatrics route to theatre and a children's reception area
- an improved staff rest area; and
- the reconfiguration of associated clinical support and office space

This approval is sought at the stage boundary between the Design stage and the Main Build stage of the project.

** Trust approval was previously given to develop a detailed design and Full Business Case and also to undertake some small-scale building works to deliver an Adult Reception Area for patients arriving for surgery from wards. The expenditure to date on these elements of the project has been £297,700. The total forecast project spend is therefore £3,973,000.*

The Report is provided to the Board for:

Decision	⇦	Discussion	
Assurance		Endorsement	

Summary / Key Points:

Context

This is the second phase of the LRI Theatres Improvement Programme. The first phase addressed the flow of adult patients into theatre. It is now complete and has delivered:

- An enlarged and improved Theatre Arrivals Area (for day-of-surgery arrivals);
- Improved changing facilities for theatres staff; and
- A reconfigured Sterile Services Hub (for surgical instruments)

The second phase addresses patient flow out of theatre and also segregates the paediatric and adult patient journeys.

The combined effect is to address both quality of care and capacity and productivity issues.

Quality of Care

The primary driver for this development is to improve the quality of patient care, by remedying various serious deficiencies in the current patient and staff environment. For example, this will:

- Allow adult male/female and paediatric segregation (best practise)
- Reduce infection control risk and promote privacy and dignity, safety and calm
- Assist in the streamlining of the patient journey
- Improve workforce morale and training

Several of the issues above were commented on in the recent CQC audit.

Providing the right capacity to support and optimise surgical activity into the future

Provision of well-designed facilities with the appropriate capacity supports:

- Improved productivity and reduction of cancelled operations, by removing the current bottleneck in post-operative recovery capacity.
- Improved productivity by streamlining the paediatric journey from the wards into theatre
- Flexibility to cater for the likely increase in case mix complexity within the LRI main theatres as day-case moves off-site
- The adequate provision of Critical Care. (Recovery is often used as an overflow or step-down higher dependency area.)

Financial Summary

Financial appraisal of the preferred option shows that:

- The net present value (using the standard Trust discount factor over 20 years) is £4.6m.
- The capital outlay will be paid back in increased volume of patient tariffs (better patient throughput, fewer cancellations and more high-dependency tariffs) within 7.1 years
- The forecast capital expenditure for 2014/15 is within the Capital Programme value for the project.

There is limited impact on revenue costs. With the exception of additional staff to support increased high-dependency activity, the existing Recovery Area staff will be maintained at its current level. (Staff establishment is based on WTE's per operating theatre supported. There are 17 theatres.) Efficiencies will come from the removal of physical capacity constraints and the benefits of a much better designed space.

Procurement and delivery

The scheme is an integral part of the UHL Site Reconfiguration Programme and the build element will be delivered under Lot 2 of the contract between UHL and Interserve FM. The overall project will be managed in accordance with PRINCE2 methodology.

The major part of the project, the build work-stream, will be managed in accordance with the NEC3 design and build methodology.

Proposed completion dates are as follows:

Phase 1: Adult reception (completed)	-	June 2014
Phase 2: Recovery part 1	-	November 2014
Phase 3: Recovery part 2 & staff rest area	-	June 2015
Phase 4: Paediatric reception	-	September 2015

Recommendations:

The recommendation of this business case is to invest £3,675,200 to proceed with the Preferred Option as described in the Full Business Case.

Previously considered at another corporate UHL Committee?

- UHL Capital Group – Approved 19th May 2014
- LRI Recovery Area Reconfiguration Project Board – Approved 5th June 2014

Board Assurance Framework:	**Performance KPIs year to date:**
	n/a

Resource Implications (eg Financial, HR):

The project is part of the Site Reconfiguration Programme and all resources required for delivery are funded via the UHL capital programme.

Assurance Implications:

The PRINCE2 project structure includes a Project Assurance officer who is responsible for assuring that the project is being properly and transparently managed.
Standards for the build itself are governed by compliance with the various NHS published

building regulations. A build quality assurance structure is in place.

Patient and Public Involvement (PPI) Implications:

The relevant patient representative is fully engaged as part of the user group for the project.

There are no aspects of service relocation or significant service redesign visible to the public.

A communications work-stream is in place to maintain the appropriate level of publicity and engagement with the public and other NHS stakeholders.

Stakeholder Engagement Implications:

The main project sponsor is the ITAPS CMG and this CMG is fully represented from a clinical and management perspective both on the Project Board and on the user group. The Women's and Children's Services CMG is also represented.

Other stakeholders, such as Surgical Specialties, Pharmacy, NHS Horizons, Interserve FM, Infection Control, Health & Safety, etc. have been identified and key contacts will be kept informed and consulted as appropriate.

Equality Impact:

A Due Regard assessment has been completed and any relevant impacts were considered throughout the design phase and also as they affect any planned operational process changes.

Information exempt from Disclosure:

n/a

Requirement for further review?

None

Leicester Royal Infirmary Main Theatres: Recovery Area Reconfiguration

Full Business Case (FBC)

Version No: **2.1**

Issue Date: **24th June 2014**

CONTENTS

1. EXECUTIVE SUMMARY 8
1.1. Introduction 8
1.2. Strategic case 10
1.2.1. The strategic context 10
1.2.2. The case for change 12
1.2.3. Project deliverables 17
1.3. Economic case 19
1.3.1. The long list 19
1.3.2. The short list 20
1.3.3. Key findings 20
1.3.4. Overall findings: the preferred option 22
1.4. Commercial case 23
1.4.1. Procurement strategy 23
1.4.2. Required services 23
1.4.3. Potential for risk transfer and potential payment mechanisms 23
1.5. Financial case 24
1.5.1. Financial expenditure 24
1.5.2. Overall affordability and balance sheet treatment 25
1.6. Management case 26
1.6.1. Project management arrangements 26
1.6.2. Timescales 27
1.6.3. Benefits realisation and risk management 28
1.6.4. Post project evaluation arrangements 28
1.7. Recommendation 28

2. THE STRATEGIC CASE 29
2.1. Introduction 29
2.2. Organisational overview 29
2.3. Business strategies 35
2.4. Other organisational strategies 39
2.5. Investment objectives 40
2.6. Existing arrangements 46
2.6.1. Recovery Area 46
2.6.1.1. Main issues with current facilities 46
2.6.1.2. Impact of the above issues 46
2.6.2. Staff rest areas 49
2.6.2.1. Main issues with current facilities 49
2.6.2.2. Impact of the above issues 50
2.6.3. Paediatric routes through theatres (reception, route to theatres, recovery) 50
2.6.3.1. Main issues with current facilities 50
2.6.3.2. Impact of the above issues 50
2.7. Business needs 52
2.8. Potential project scope 53
2.9. Main benefits criteria 56
2.10. Main risks 60
2.11. Constraints 62
2.12. Dependencies 62

3. THE ECONOMIC CASE 64
3.1. Introduction 64
3.2. Critical success factors 64
3.3. The long-listed options 66
3.4. Short-listed options 72
3.5. Economic appraisal 72
3.5.1. Introduction 72
3.5.2. Estimating benefits 72
3.5.3. Estimating income and costs 74
3.5.4. Net present value findings 75
3.5.5. Option ranking 79
3.6. Risk appraisal 79
3.6.1. Methodology 79
3.6.2. Risk scores 80
3.7. The preferred option 80

4. THE COMMERCIAL CASE 81
4.1. Introduction 81
4.2. Procurement Strategy 81
4.3. Key Factors Affecting Outcomes 82
4.3.1. Design, Build and Construction Management 82
4.3.2. Implementation Timescales 82
4.3.3. Building Research Establishment Environmental Assessment Method 82
4.3.4. Potential for Risk Transfer 82
4.3.5. Proposed Charging Mechanisms 82
4.3.6. Proposed Contract Lengths 83
4.3.7. Proposed Key Contractual Clauses 83
4.3.8. Personnel Implications (including TUPE) 83
4.3.9. Procurement Strategy and Implementation Timescales 83
4.3.10. Equipment Strategy 83
4.3.11. FRS 5 accountancy treatment 83

5. THE FINANCIAL CASE 84
5.1. Introduction 84
5.2. Impact on the organisation's income and expenditure account 84
5.3. Impact on the balance sheet 85
5.4. Overall affordability 85

6. THE MANAGEMENT CASE 86
6.1. Introduction 86
6.2. Programme management arrangements 86
6.3. Project management arrangements 86
6.3.1. Project reporting structure 86
6.3.2. Project roles and responsibilities 87
6.3.3. Project plan 88
6.4. Use of special advisers 88
6.5. Outline arrangements for change and contract management 89
6.6. Outline arrangements for benefits realisation 89
6.7. Outline arrangements for risk management 89
6.8. Outline arrangements for post project evaluation 90
6.8.1. Post implementation review (PIR) 90
6.8.2. Project evaluation reviews (PERs) 90
6.9. Gateway review arrangements 90
6.10. Contingency plans 90

7. APPENDICES 91
7.1. Theatre Activity: Analysis by Site 91
7.2. Infection Control Risk assessment: Current Recovery Area 94
7.3. Options Appraisal – non-financial scoring 98
7.4. Financial appraisal – options summaries 99
7.5. Capital costs breakdown 102
7.6. Risk Potential Assessment 104
7.7. Proposed Interserve Build Programme 104
7.8. Capital build phase – risk register 104
7.9. Association of Anaesthetists in Great Britain and Ireland guidelines 104
7.10. Theatre to Recovery times audit summary 105
7.11. Standards for Paediatric Theatre Recovery 105

Document Information

Basic Information

Information	Status
Version	2.1
Release / Issue Date	24th June 2014
Author	Ian Currie
Contributors	Andrew Miller (Consultant Surgeon) Dale Travis (ITAPS CMG Service Manager) Dave Finch (Building Services Manager) Dave Kirkbride (Anaesthetic Head of Service - LRI) Gelder & Kitchen (architects) Interserve Construction Limited Islwyn Jones (Senior Nurse - Infection Control) Karen Dixon (LRI Theatres Matron) Neil Flint (Consultant in Intensive Care and Anaesthesia) Nick Kirk (Service Manager – Paediatrics) Nicky Topham (Project Director – Site Reconfiguration) Paul Gowdridge (Head of Strategic Finance) Paul Spiers (Consultant Anaesthetist – former ITAPS CMG Clinical Director) Simon Martin (Recovery Lead Nurse) Sue Sutton (Project Manager for Ophthalmology) Sutcliffes Mechanical and Electrical Consultants

Review and Authorisation

Name	Role	Review / Authorise	Version	Date reviewed / authorised
Andrew Furlong	Deputy Clinical Director	Review	1.0	
David Kirkbride	ITAPS Head of Service – LRI	Review	1.0	May 2014
Gary Upton	Interim CMG Finance Manager	Review	1.0	May 2014
Helen Seth	Head of Planning and Business Development	Review	1.0	
Liz Collins	Infection Prevention & Control – Lead Nurse	Review	1.0	
Neil Flint	Consultant in Intensive Care and Anaesthesia	Review	1.0	May 2014
Nicky Topham	Project Director: Site Reconfiguration	Review	1.0	13th May 2014
Paul Gowdridge	Head of Strategic Finance	Review	1.0	May 2014
Phil Walmsley	Acting CMG Manager: ITAPS	Review	1.0	15th May 2014
	UHL Capital Group	Authorised	1.1	19th May 2014
	LRI Recovery Area Reconfiguration Project Board members	Review	1.2	3rd June 2014
	LRI Recovery Area Reconfiguration Project Board	Authorised	1.3	5th June 2014
	UHL Trust Board	To be authorised	2.0	

Version Control History

Version	Date	Details
0.1	August 2013	First draft
0.2	30th Oct. 2013	Draft in development – various amendments
0.3	9th May 2014	Draft in development – various amendments
1.0	13th May 2014	First draft for issue to LRI Recovery Area Reconfiguration Project Board, for initial review
1.1	14th May 2014	Amended to take account of comments received from reviewers. Submitted to, and approved by, UHL Capital Group on Monday 19th May
1.2	3rd June 2014	Amended to take account of further review by ITAPS and Paediatrics Services. Submitted for formal approval by Project Board on 5th June 2014. *Sections updated to incorporate results from further detailed financial review:* 1.1 Introduction 1.5 Financial case summary 1.3.3 Key findings 3.5.3 More detail in "Estimating income and costs methodology" 3.5.4 Updated Net Present Value and payback calculations 7.4 Financial appraisal – options summaries 7.5 Capital costs Breakdown *Sections not previously completed:* 5. The Financial Case (affordability) 6. Management case
1.3	4th June 2014	Amendment to NPV calculations following comments by Paul Gowdridge. No effect upon option ranking or financial rationale for the FBC.
2.0	6th June 2014	Section 1 - Minor wording amendments Section 1.2.3 – include key prerequisites and dependencies in Executive Summary
2.1	24th June 2014	Minor amendment to dependencies (Nicky Topham request) - sections 1.2.3 and 2.12.

Related Documents

Document name	Version	Comments
Care Quality Commission: University Hospitals of Leicester NHS Trust Quality report	March 2014	
Immediate Post-anaesthesia Recovery 2013 published by The Association of Anaesthetists of Great Britain and Ireland	March 2013	
Infection Control Risk assessment: Current Recovery Area	18th Dec. 2013	
ITAPS_UtilisationCommentary_20140212_UpdatedDTravis.doc	February 2014	
LRI recovery: Capital Build Risk Register v14	May 2014	
LRI RecoveryAreaReconfig_BusCase_FinancialSum	1.3	
OBC_LRIRecoveryAreaReconfig_v0.4.doc	February 2013	Draft only
PaediatricBenefitsAndGuidelines_v2.doc	Nov. 2013	
6275LRIRecoveryTransfer&WaitingTimes (AnaestheticAudit2013).doc	2013	

1. EXECUTIVE SUMMARY

1.1. Introduction

Approval sought

This Full Business Case seeks approval to invest £3,675,300* to proceed with the provision, in the main theatres suite at the Leicester Royal Infirmary, of:

- an enlarged and improved post-operative Recovery Area
- a dedicated paediatrics route to theatre and reception area
- an improved staff rest area; and
- the reconfiguration of associated clinical support and office space

This approval is sought at the stage boundary between the Design stage and the Main Build stage of the project.

* Trust approval was previously given to develop a detailed design and Full Business Case and also to undertake some small-scale building works to deliver Phase 1 (an Adult Reception Area for patients arriving for surgery from wards). The expenditure to date on these elements of the project has been £297,700. The total forecast project spend is therefore £3,973,000.

Background

This is the second phase of an LRI Theatres Improvement Programme. The business case for the first phase of the Theatres Improvement Programme was approved as part of a combined plan to improve theatre facilities for patients and staff and to remove the obstacles to patient flow through theatres.

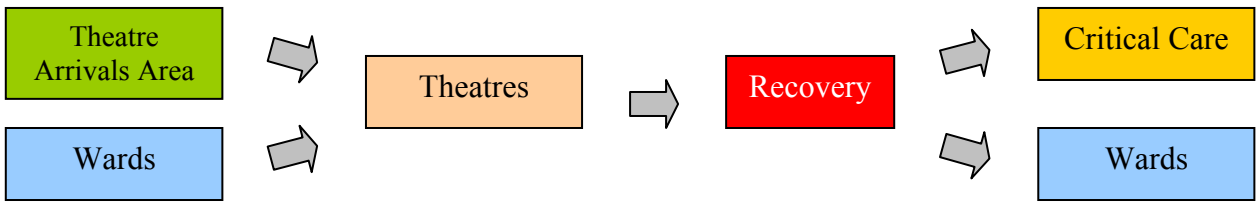
The first phase addressed the flow of adult patients into theatre. It is now complete and has delivered:

- An enlarged and improved Theatre Arrivals Area (for day-of-surgery arrivals);
- Improved changing facilities for theatres staff; and
- A reconfigured Sterile Services Hub (for surgical instruments)

The second phase addresses patient flow out of theatre and also segregates the paediatric and adult patient journeys.

The combined effect is to vastly improve the patient and staff environment and also to remove the capacity issues which are causing log-jams in the patient journey through theatres. The flow of patients is key to increased theatre productivity and utilisation.

High-level patient journey diagram



The Theatres Improvement Programme fits strategically with the plans for the provision of Critical and Emergency care. As stated in the first phase business case:
"UHL's highest operational and strategic plans [are] to improve the Emergency process by revising the clinical model for emergency care and increasing the ICU facilities. It should be noted that, without the additional recovery bays the second stage of this project creates, the ICU expansion may not be able to take place".

Quality of Care

The primary driver for this development is to improve the quality of patient care, through remedying various serious deficiencies in the current infrastructure. Full details of the current issues are given in the section 2.6 Existing arrangements below.

Recovery is a unique area in the hospital environment where patients arrive in the highest state of dependency, similar to the patients on intensive care units and are managed and cared for, enabling them to return to the ward safely and in optimum comfort in a short time. The infrastructure in recovery is vital to facilitate the delivery of this high quality of care by dedicated professionals.

There is a high degree of consensus amongst the internal and external bodies which have carried out assessments of the issues with the current environment and the impacts on surgical services at the LRI. Further details are given in section 1.2.2 Case for Change below. Key bodies involved are:

- Care Quality Commission (March 2014) audit - LRI Surgical Services
- Infection Control Risk Assessment (December 2013) - summary
- Clinical and consultant consensus within theatres
- Paediatric Service review of children's services
- Internal audit evidence of impact on theatre utilisation
- Association of Anaesthetists in Great Britain and Ireland recommendations

All the above bodies have indicated that there are deficiencies in the level of care within theatres caused directly by the current built environment.

Financial Summary

Financial appraisal of the preferred option, which is designed to address the quality of care and productivity issues mentioned above, shows that:

- The capital outlay will be paid back in increased volume of patient tariffs (better patient throughput, fewer cancellations and more high-dependency tariffs) within 7.1 years
- The net present value of the preferred option (using the standard Trust discount factor over 20 years) is £4.6m
- The forecast capital expenditure for 2014/15 is within the Capital Programme value for the project

Structure and content of this document

This FBC has been prepared using the agreed standards and format for business cases, as set out in the guidelines laid down in the HM Treasury's Green Book.

The approved format is the Five Case Model, which comprises the following key components:

- The **strategic case** section.
- The **economic case** section.
- The **commercial case** section.
- The **financial case** section
- The **management case** section

A summary of each of these sections follows.

1.2. Strategic case

1.2.1. The strategic context

There are ten key UHL strategic goals which are all supported by this project. These goals have been summarised in the table in the section 2.3 Business strategies, together with their operational impact on the activity of the main theatres suite at the LRI. The key project deliverables relevant to each goal are also listed.

These goals may be grouped into two main headings as follows:

- **Improve the quality of patient care**
    - Significantly improve the existing poor physical environment for patients and staff. There are many issues of patient experience, safety, infection control, privacy and dignity with the current facilities.
      Please see section 2.6 Existing Arrangements for details of current defects.
    - Allow for adult male/female and paediatric segregation (best practise)
    - Streamline patient journeys
    - Improve workforce morale and training (knock-on effect on retention and recruitment - and patient care)

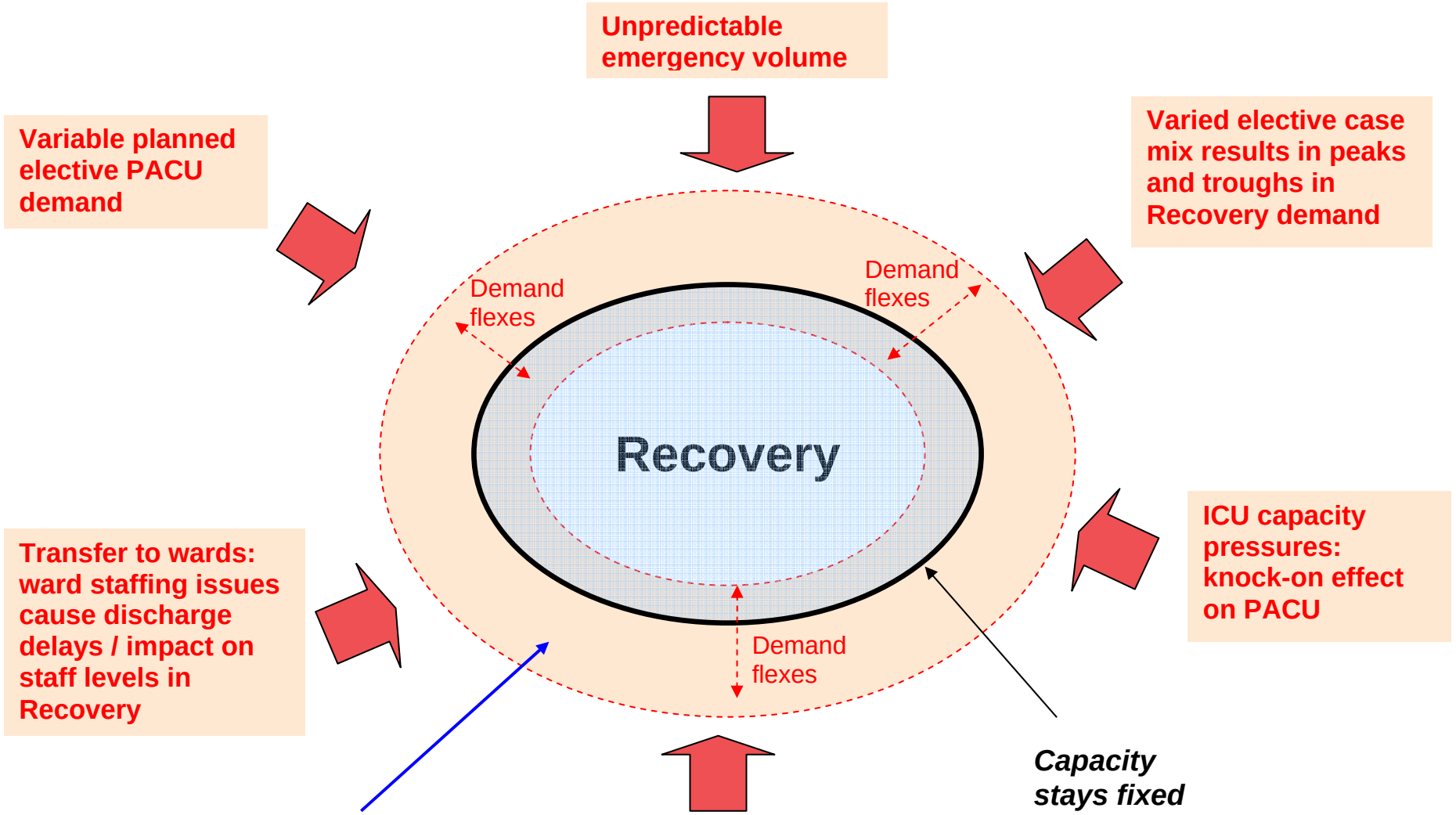
- **Provide the right capacity at the LRI to support and optimise surgical activity into the future**

  This incorporates:
    - Improving productivity and reducing cancelled operations, by removing the current bottleneck in post-operative recovery capacity
    - Catering for the likely increase in case mix complexity within the LRI main theatres as day-case moves off-site
    - Supporting the provision of Critical Care capacity. (Recovery is often used as an 'overflow' higher dependency area.)

Improvements in productivity and in critical care capacity also drive the economic case for the investment in that they enable a significant increase in patient tariffs, both for normal surgical activity and for high dependency tariffs within a Post Anaesthetic Care Unit (PACU).

The diagram below summarises the Demand – Capacity issues being experienced within the LIR main theatres Recovery area.

LRI Recovery Area: varying demand pressures versus a fixed capacity



1.2.2. The case for change

There are six main investment objectives for this project:

1) Improve quality of patient care for those patients undergoing surgery at the LRI
2) Improve support for the current volume and type of theatre activity
3) Segregate children and adult patient pathways, so as to meet best practise
4) Support critical care provision at the LRI
5) Provide flexibility to meet the future demand for surgical activity at the LRI
6) Improve the staff environment

These objectives have all been assessed using the recommended SMART (Specific, Measurable, Achievable, Relevant, Time-constrained) methodology. Further details can be found in section 2.5 Investment objectives.

The case for change, and therefore the need for this investment, is based on the deficiencies in the existing arrangements and their operational impacts. Currently, UHL is significantly failing to meet the objectives above.

1. Surgical activity and capacity – current state

General

- There are 17 operating theatres within the main theatres suite at the LRI, on level 2 of the Balmoral Building.
- There are currently a nominal 17 bed-bays in the main theatres Recovery Area but due to space constraints only about 12 to 14 are actually usable at any one time.
- The AAGBI (Association of Anaesthetists in Great Britain and Ireland) recommend a minimum ratio of two recovery bays to every one theatre. We currently have a less than one-to-one ratio.
- Nearly half of the total number of surgical operations for the Trust as a whole takes place at the LRI and the vast majority of these take place in the main theatres suite.

Emergency activity

- 70% of all UHL emergency surgery takes place at the LRI
- About a third of all the operations at the LRI is emergency surgery (with the three main specialities involved being trauma, general surgery and paediatric)
- 99% of all trauma activity takes place at the LRI.
- There are approximately 2,600 emergency operations a year currently taking place at the LGH. If this was to move to the LRI in future, this represents an increase of about 5% on current total LRI theatre activity.

Productivity

Current activity analysis shows that there is scope for improvement in the levels of utilisation of the LRI theatre estate. A summary report prepared by the ITAPS service manager shows that:

- Both day-case and inpatient elective theatre utilisation at the LRI is consistently below the 86% target and also below the national average
- There are Referral To Treatment (RTT) issues with 5 surgical specialties at UHL
- There are up to 1,300 operations recorded as cancelled on the day of surgery for reasons which are commonly connected with Recovery capacity.

2. Issues with current facilities

There are many and varied issues with the current environment. For details please go to section 2.6 Existing arrangements. Please see highlights below.

A. Recovery Area: current issues

a) Overall size of footprint
- Noisy and cramped environment - gives rise to quality of care, privacy and dignity, infection control and safety issues.
- No opportunity to segregate female and male patients, paediatric patients or high-risk patients nor to allow parents and relatives to visit. This makes it more difficult to deliver the appropriate level of nursing support and observation.

b) Size of bed bays

The allocated space in and around each recovery bay is too small. Impacts:
- There is no space within the bays for emergency or additional equipment and for staff access around the bed.
- If there is a crash call, the lack of space means that staff currently have to physically move other recovering patients out of the way before they can get to the patient in need. This potentially delays urgent assistance reaching the patient and can also be distressing to other patients.
- If additional equipment is needed for a patient (e.g. higher dependency), this means that one or two adjacent bays are put out of action, adding to the capacity bottleneck

c) Inadequate Recovery capacity
- Cancelled operations: The low number of recovery bays means we are unable to efficiently accommodate theatre throughput. A typical situation is that:
  - the first patient on the list is blocking the only available recovery bed
  - therefore, the second patient is being recovered in-theatre
  - the third patient on a list cannot therefore go into theatre for his operation and the list 'times out'
- Low capacity means that any critical incident effectively shuts recovery for normal operations. Transfer of patients from HDU effectively shuts it down also.
- There is no capacity buffer in Recovery which would allow continuing operations in the following situations:
  - Ward beds blocked
  - Surge in demand due to an incident / pandemic (e.g. swine flu)
- The frequent cancelled operations have a negative impact on Referral to Treatment performance and on Length of Stay.

d) Quality and design of built environment
- Generally poor, 30 year-old infrastructure which is viewed as unsuitable for modern practise

B. Staff rest area: current issues

The current staff rest area for staff is cramped and run-down. It is also segregated in line with outdated practise and does not make the best use of space.
The lack of a fit-for-purpose area to rest and to recover from fatigue affects staff morale and impacts staff retention and recruitment. Staff fatigue also affects the quality of patient care.

C. Paediatric routes through theatres (reception, route to theatres, recovery): current issues

There is currently no effective segregation of children from adults on their journey through main theatres at the LRI. This applies to:
- The journey from the wards into theatres reception
- The journey from theatres reception into theatre itself

- Within the Recovery Area itself

The issues noted above for the main Recovery Area all apply here also. In fact, they are even more urgent for children, who are at risk of deteriorating more rapidly than adults. In addition, the current arrangements fail to meet multiple published national guidelines and recommendations relating to the treatment of paediatric patients. (See Appendix Standards for Paediatric Theatre Recovery for details.) For instance:

a) Patient care, patient safety and increased risk
   - There should be observation and care by specialist paediatric nursing recovery staff
   - There is no specific crash-call to a paediatric area, identifying a need for specifically paediatric expertise
   - Increased risk regarding drug dosages: Physical separation from adults improves safety as nursing staff are not dealing with high and low dose regimes simultaneously.

b) Patient experience
   - Care should be delivered in a safe, suitable and child-friendly environment
   - Sharing the reception area and the journey to theatres with adults can be distressing and confusing for a child
   - Parents/carers should be able to be present with their child when they wake up
   - Children should not be exposed to potentially frightening [adult] behaviour; and equally, adults feeling ill should not be disturbed by noisy children

c) Impacts on staff
   - Morale, Recruitment and Retention

3. Reviews and audits

The following are highlights from recent reviews carried out by various internal and external bodies:

a) Care Quality Commission (March 2014) audit - LRI Surgical Services report extracts

Lack of space:
- "The service is fast outgrowing the hospital space within which it is contained."
- "The amount of space around some beds hampered care and could present a safety issue."
- "We found that the care, welfare and dignity of patients could be improved further by an increase in bed spaces in wards and theatres and improvements to the hospital environment."

Cancelled operations:
- "Cancellations of elective surgery on the day are a regular occurrence. On occasions, whole lists are cancelled and then have to be rescheduled."
- "This caused some breaches in Referral To Treatment guidelines."
- Patients' operations were cancelled or delayed due to:
  - lack of theatre time (list over-runs)
  - lack of high dependency unit bed availability
  - ward bed spaces being unavailable.
- There is a relationship with the fluctuating demand for emergency surgery

Critical care capacity
- "Shortages of critical care beds (or beds available for patients with level 2 care needs) resulted in some patients requiring this level of care remaining in the main recovery area of the theatre department or having their surgery delayed."
- "During the inspection we noted that one patient had been in the recovery area for 24 hours while awaiting a high dependency unit bed. Two further patients were still in recovery in the morning having had overnight surgery."

b) Infection Control Risk Assessment (December 2013) - summary

Hazards found (a summary):

- Bed spacing too small
- Lack of isolation facilities
- Poor condition of current infrastructure
- Inadequate hand-washing facilities

Commentary:

- All risk types failed to meet target scores.
- There was a Patients risk scoring of 12, which is at the top of the Moderate Range. It was assessed to be “Likely” that a Moderate injury would occur, “requiring professional intervention or an increase in length of hospital stay by 4-15 days”.

Report action plan

- Increase numbers of sinks on unit
- Improve size of bed spacing
- Provide cubicle facilities to physically separate patients with infections from other patients
- Make good damage to walls and floors
- Provide further storage options

c) Clinical and consultant consensus

There is a universal consensus among clinical staff that low capacity in the current Recovery Area is contributing to poor throughput in theatres.

A properly designed PACU (Post-Anaesthetic Care Unit) is the recommended approach to recovering patients after anaesthesia. It is a key facilitator for an enhanced recovery pathway: the right level of care to the right patient at the right time along the patient pathway

This model is also widely recognised to contribute to reduced LOS (length of stay), reducing cost and getting patients back to their homes quickly.

d) Paediatric service review

The Paediatrics Service Manager carried out a review of published national guidelines and recommendations relating to the treatment of paediatric patients. None of the highlighted guidelines are currently being adequately met within the main theatre suite at the LRI.

e) Audit evidence of impact on theatre utilisation

Key findings:

- Adequate recovery bays coupled with adequate nursing staff would save over 17 hours per week.
- Major delay is in transfer of patient from theatre to recovery. This reflects problems with numbers of recovery bays and possibly also staffing issues
- Cases of anaesthetist recovering patient and patient being recovered in theatre are still occurring

f) Association of Anaesthetists in Great Britain and Ireland

The AAGBI recommend a minimum ratio of two recovery bays to every one theatre. There is currently a less than one-to-one ratio

g) ITAPS Management review: productivity within Theatres - extract

LRI theatre utilisation statistics show that there is significant scope for improvement. For the 10 months to 31st January 2014, both Day-case and Inpatient activity was RAG rated as Red, with performance for the period consistently at 75% percent or less (target utilisation is 86%).

There are up to 1,300 operations a year recorded as cancelled on the day of surgery for reasons which are commonly connected with Recovery capacity.

Increased Recovery capacity would give a buffer which would also tend to alleviate the number of operations cancelled due to lack of ward beds.

Any delay in Recovery has the potential to cause a “log-jam” effect within theatres. For example:

- If beds are slow to come up in the routine wards, patients can be held in Recovery, again causing a log-jam. Surgeons and anaesthetists will cancel if they are not confident of a bed being available.
- The presence of up to 3 to 4 patients in PACU can also slow down the throughput of Recovery. If a bed bay is used for a higher dependency patient this currently uses 2 ‘normal’ bays, further reducing the remaining capacity.

(The financial opportunity this represents is explored in section 1.3 below.)

1.2.3. Project deliverables

The issues described above drive the need for a capital development project which will remedy the deficiencies in the built environment and enable benefits to be derived.

A high-level summary of the main deliverables for the preferred option is given below.

Project Scope and phases

- [Phase 1: Adult reception area - already delivered]
- Phase 2: Recovery part 1 (adult and children's areas)
- Phase 3: Recovery part 2 (reconfigure existing recovery area - plus reconfigure office space and staff rest area)
- Phase 4: Paediatric reception area and direct lift access from 4th floor paediatric ward 10

Key deliverables

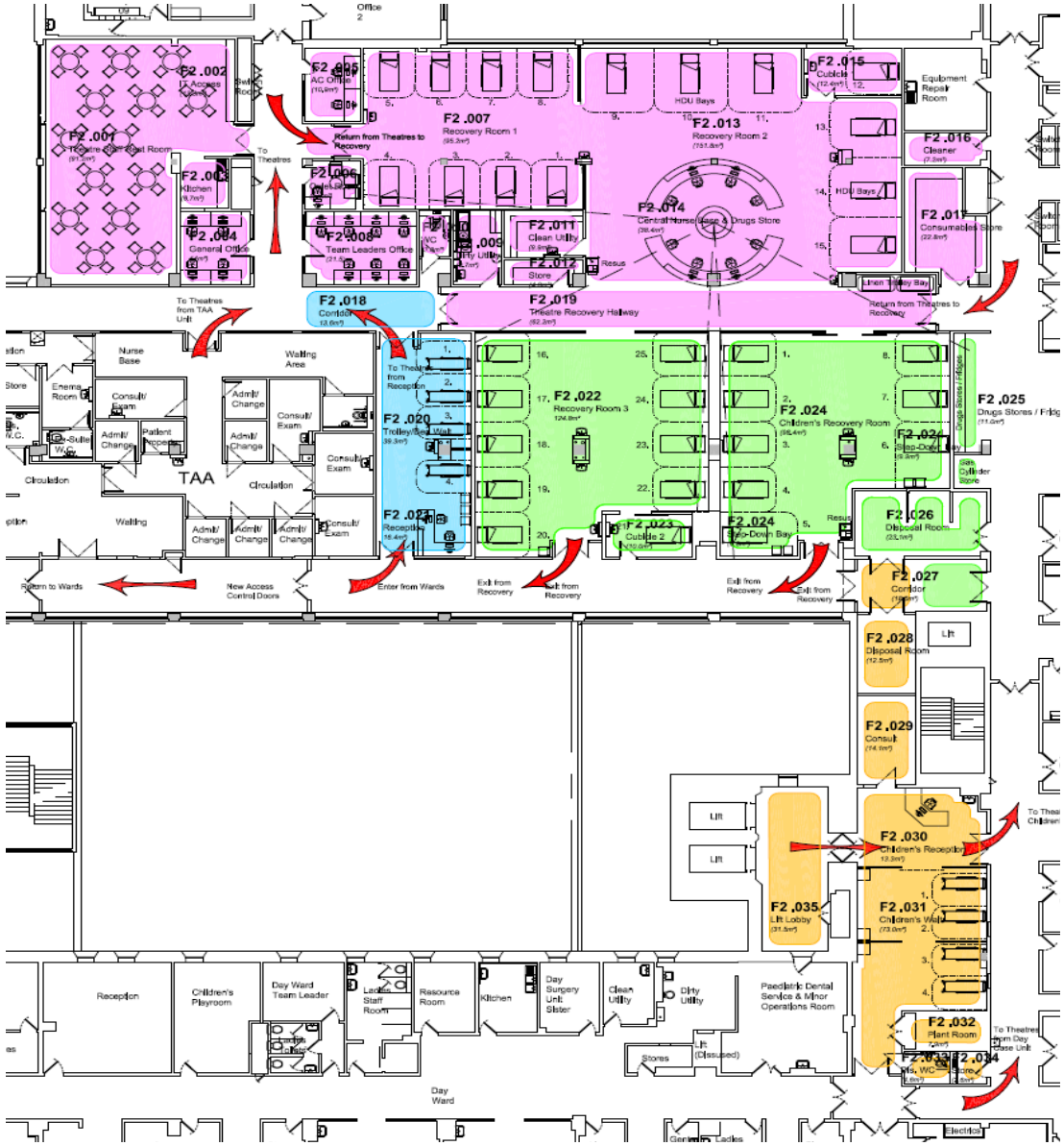
- Compliant recovery facilities (bay spacing, etc.)
- Recovery capacity will increase from 17 bays to 33 bays. The new facility will be divided into four areas and will comprise:
- Two adult areas with a total of 17 standard-sized bays plus one isolation cubicle
- An area with 6 larger bays for higher dependency patients
- A children's area with 8 bays plus an isolation cubicle
- Improved staff rest area
- Segregated and significantly improved route through theatres (and ward transfer route) for children

Key benefits

- Vastly improved patient environment (privacy and dignity, infection control, safety, access to patients, quietness and calm)
- Increased recovery capacity will help to remove 'log-jams', reduce cancellations and increase theatre throughput. Increase in income: more operations from the same estate.
- Increases flexibility and supports Critical Care provision. Increase in HDU income: a threefold increase in high dependency capacity within Recovery.
- Adult and children's routes through theatres segregated leading to a better patient experience and journey. Best practise.
- Enhanced staff rest area, improving staff morale and supporting recruitment and retention

For an overview of the layout and the development phases - see the diagram below.

The final layout and the phases – Level 2 Balmoral Main Theatres



Phase 1: Adult Reception

Phase 2: Recovery part 1

Phase 3: Recovery part 2 + Staff Rest area

Phase 4: Paediatric reception

1.3. Economic case

1.3.1. The long list

Below is a summary of the long list of options explored within the economic case.
(Please see section 3.3 The long-listed options for details.)

Summary of feasible long-listed options

The table below summarises the feasible long-listed options considered.

(Options E and H were excluded after initial consideration as being not feasible.)

Options	Elements included					Option non-financial appraisal ranking
	Recovery capacity - as current	Recovery capacity - expanded	Reconfigured staff rest area	Children's reception area	New children's route to theatre	
A – Do nothing	**No**	**No**	**No**	**No**	**No**	**6**
B - Quality only *Refurbish only – do not increase capacity*	**Yes**	**No**	**No**	**No**	**No**	**5**
C - Quality and capacity *Refurbish only and increase capacity*	**Yes**	**Yes**	**No**	**No**	**No**	**4**
D - Quality, capacity & staff well-being *As above plus staff rest area*	**Yes**	**Yes**	**Yes**	**No**	**No**	**3**
F - Children's reception: version 2 *As above plus children's reception area*	**Yes**	**Yes**	**Yes**	**Yes**	**No**	**2**
G - Children's reception: version 3 *As above plus direct access to children's wards on level 4*	**Yes**	**Yes**	**Yes**	**Yes**	**Yes**	**1**

Assessment of long-listed options: methodology

The six options above were scored and ranked as to how well they met the Critical Success Factors (CSF). The relative weighting of the CSF's was applied so as to reflect the relative importance and relevance of the strategic and investment objectives to this particular project, as directed by the key project and Trust stakeholders and the project user group members.

Summary of results

Options A, D, F and G were included in the short-list of options.

Please see the Appendix Options Appraisal – non-financial scoring for more detail.

1.3.2. The short list

The following short list of options remained after the long-list appraisal:

Options	**Elements included**				
	Recovery capacity - minimum	Recovery capacity - expanded	Staff rest area	Children's reception	New children's route to theatre
A – Do nothing	**No**	**No**	**No**	**No**	**No**
D – Quality, capacity & staff well-being	**Yes**	**Yes**	**Yes**	**No**	**No**
F - Children's reception: version 2	**Yes**	**Yes**	**Yes**	**Yes**	**No**
G - Children's reception: version 3	**Yes**	**Yes**	**Yes**	**Yes**	**Yes**

These options were assessed financially, with the net present value and the payback period being calculated for the base case (predicted outcomes) and then sensitivity analysis on key variables being applied to produce a "best case" and a "worst case" scenario for each option.

1.3.3. Key findings

A summary of the financial analysis is given in the following table. Please see section 3.5 Economic appraisal for details of methodology, assumptions and workings.

Financial summary

	Base case		Best case		Worst case	
	Net present value	Payback	Net present value	Payback	Net present value	Payback
	£'000	years	£'000	years	£'000	years
Option A	0	n/a	0	n/a	0	n/a
Option D	3,775	7.1	7,580	4.9	-75	14.7
Option F	3,431	7.8	7,248	5.4	-436	16.3
Option G	**4,595**	7.1	**8,941**	5.0	**194**	13.8

Commentary

- Options D, F & G all give a positive NPV for the Base case but Option G gives the highest, at £4.6m.
- There is little difference in payback periods between the capex options. (Payback is not applicable to Option A as there is no investment.)
- Option F has the worst NPV and longest payback period.
- When sensitivity is applied, the outcome does not change:
    - Best case: Option G still gives the highest return.
    - Worst case: Option G gives the only positive return and the shortest payback period.

Further analysis:

- The economic assessment boils down to a question of capital outlay versus the resulting net revenue benefit.
- Compared to our baseline of Option A ("Do Nothing"), the main benefit from the investment is the improved productivity in theatres and the increase in higher dependency care tariffs. In addition, Option G gives significant efficiency returns from improvements to the paediatric patient journey.
- The range of capital spend across the investment options (i.e. Option G minus Option D capex) is relatively small i.e. an additional 18.8% (or £573.4k in absolute terms).
- However, this additional capital expenditure for Option G gives a percentage increase in net revenue benefit of 20.4% (or £1,393k in absolute terms). This additional revenue benefit is from efficiencies as a result of the improved paediatric patient journey.

- The key variables where sensitivity analysis was applied were:
    - The capital cost
    - The non-pay costs
    - The cash-releasing benefits

1.3.4. Overall findings: the preferred option

Option G scored highest out of the options on both the non-financial benefits appraisal and the financial analysis and is therefore the preferred option.

1.4. Commercial case

1.4.1. Procurement strategy

In line with Trust capital policy, the scheme will be procured under Lot 2D of the Call-Off Contract for the Provision of Design and Construction Services between University Hospitals Of Leicester NHS Trust and Interserve (Facilities Management) Limited.

The main contractor in this instance will in fact be Interserve Construction Limited. UHL will contract with them and they will manage delivery of the various sub-contractor work packages to deliver the phased build.

Clinical equipment, IT hardware and furniture will be procured directly by the Trust as part of the Equipment work-stream, using authorised UHL suppliers.

1.4.2. Required services

The contract is for the design and build of the preferred option by the main contractor.

1.4.3. Potential for risk transfer and potential payment mechanisms

The risks for the scheme have been assessed in detail and are recorded in the design and build risk register. See appendix for Capital build phase – risk register.

Risks noted in the risk register as owned by the PSCP (Principle Supply Chain Partner) have a risk premium value. This is the payment - included within the Guaranteed Maximum Price (GMP) - which UHL have paid the PSCP in order for them to assume ownership of the risk.

Risks noted in the risk register as owned by the Client (UHL) are retained by UHL and, in the event of the risk materialising, the costs / delay impacts are borne by the Trust. There is a contingency amount within the forecast project costs to cover these items.

1.5. Financial case

1.5.1. Financial expenditure

The following financial appraisal summary for the preferred option is shown in the standard UHL Finance format. For full details of all options, see section 7.4 Financial appraisal – options summaries.

For details of capital expenditure see section 7.5 Capital costs breakdown.

LRI recovery project - Option G - Children's reception: version 3 - Financial summary

Recovery, staff rest area reconfiguration and paediatric reception plus direct access route to paediatric wards

UHL Business Case template		(£'000 unless stated)					
		Year 1 2014/15	**Year 2 2015/16**	**Year 3 2016/17**	**Year 4 2017/18**	**Year 5 2018/19**	**Residual Value** (see note)
Revenue							
Patient episodes	[type]	0	650	912	912	912	
Patient income		£0	£689	£964	£964	£964	
Costs							
Pay costs		£0	£104	£139	£139	£139	
Non-pay		£0	£138	£193	£193	£193	
Indirect costs & overheads		£0	£0	£0	£0	£0	
Total costs		£0	£242	£332	£332	£332	
EBITDA		£0	£447	£632	£632	£632	
Depreciation	0	£121	£187	£187	£187	£187	
Financing costs	0.0%	£0	£0	£0	£0	£0	
Net surplus		-£121	£260	£445	£445	£445	
Cumulative surplus		-£121	£139	£584	£1,029	£1,473	
Average tariff	(£)		£1,059	£1,057	£1,057	£1,057	
Headcount	WTEs	0	4.7	4.7	4.7	4.7	
Average pay cost	(£)		22.4	29.9	29.9	29.9	
EBITDA margin			64.9%	65.6%	65.6%	65.6%	
Net margin			37.7%	46.2%	46.2%	46.2%	
Capital expenditure	(£k)	£2,414	£1,261	£0	£0	£0	
Working capital	(£k)						
Net cashflow (pre funding)		-£2,414	-£814	£632	£632	£632	£7,278
Cumulative cashflow		-£2,414	-£3,229	-£2,597	-£1,965	-£1,333	£5,945
Payback	(Year)						7.1 years
Discounted cashflow	(£k)	-£2,414	-£786	£588	£568	£548	£6,090
Net present value	(£k)	**£4,595**					
Discount rate		**3.5%**					
(based on 3.5% plus risk weighting of:		**0.0%**					
Project IRR		27.9%					
Assumes total project life of		**20**	years				

Note: Residual Value assumes Year 5 cashflows for the remainder of the project life.

Assumes cost of borrowing of	**0.0%**
Surplus cash invested at	**0.0%**

1.5.2. Overall affordability and balance sheet treatment

The capital expenditure is to be funded as part of the UHL Capital Programme. No external funding is required.

The phasing of the proposed capital expenditure for the Preferred Option and the comparison with current UHL Capital Programme values is as follows:

Project forecast capital expenditure:

	2013/14	2014/15	2015/16	Totals
	£'000	£'000	£'000	£'000
Already approved: Design stage	218.2	79.0	0.0	297.2
Requiring approval: Build stage	0.0	2,414.2	1,261.1	3,675.3
Totals	218.2	2,493.2	1,261.1	3,972.5

Impact on Capital Programme values for 2014/15:

	2014/15	2015/16	Totals
	£'000	£'000	£'000
Current capital programme	2,785.0	812.0	3,597.0
Project forecast spend	2,493.2	1,261.1	3,754.3
Variance	291.8	(449.1)	(157.3)

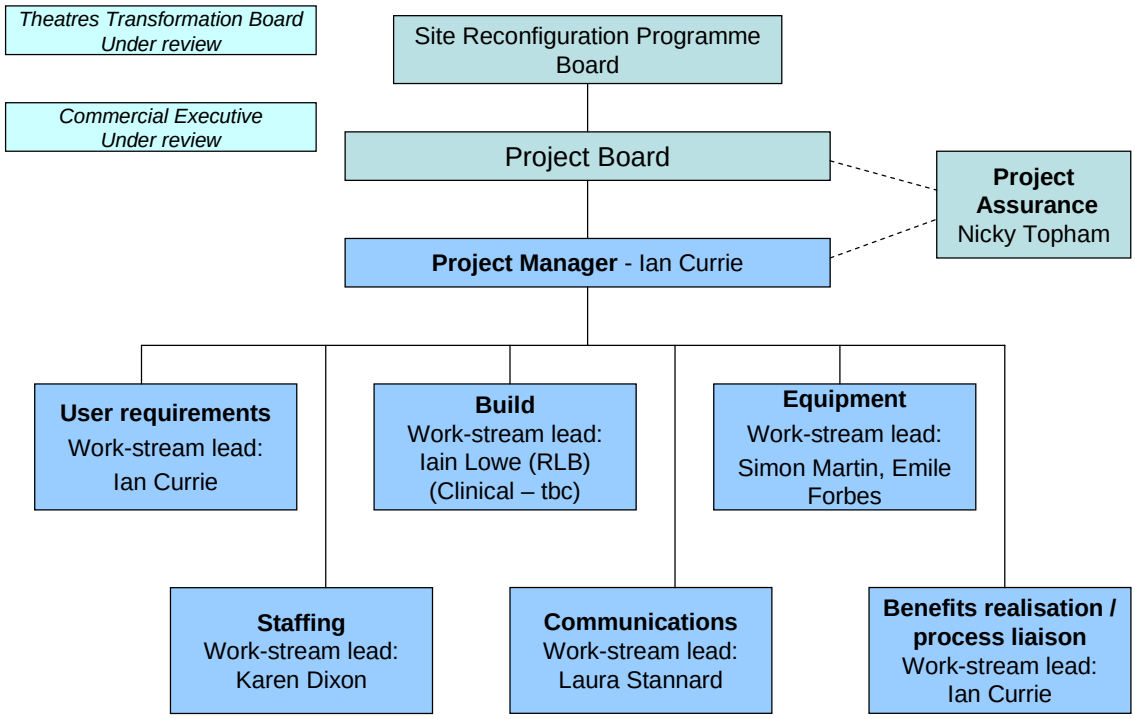
It will be seen that there is a relatively small overall increase in predicted spend as compared to the current Capital Programme values over the two years but that the expenditure in the current year has decreased by £291.8k.

1.6. Management case

1.6.1. Project management arrangements

The project falls under the UHL site Reconfiguration Programme. See summary of UHL project structure below.

LRI Theatre Arrivals Area / Recovery Area - project structure



Project Board membership

There have been various changes in UHL management structure and personnel during the project lifecycle. Where possible, continuity of role and individual has been maintained. The current membership comprises key personal and stakeholders, referencing the recommended PRINCE 2 structure, as shown below:

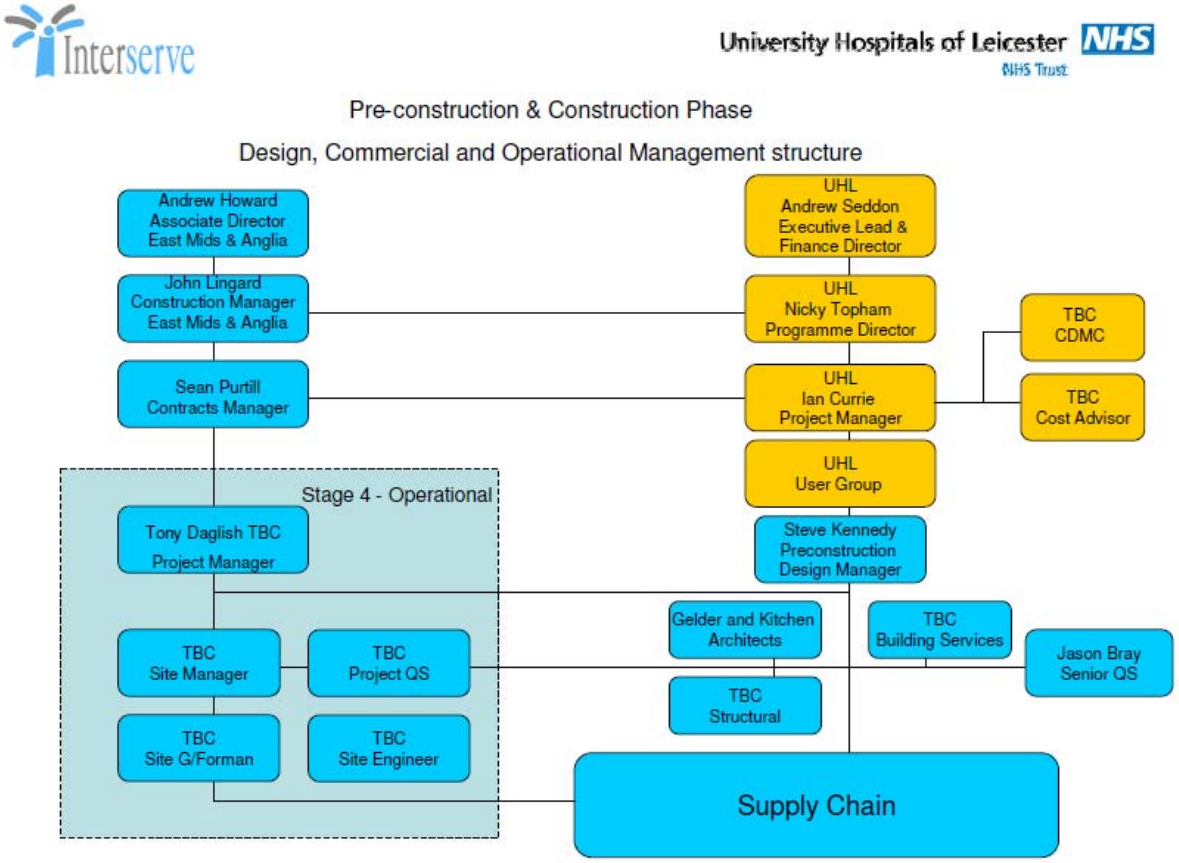
Members and roles:

Chair/ Executive
Nicky Topham Project Director – Site Reconfiguration
Sponsor / Senior User
Andrew Furlong UHL Trust Deputy Medical Director
Phil Walmsley ITAPS CMG General Manager
Helen Brooks ITAPS CMG Deputy Clinical Director
Paul Gowdridge ITAPS CMG Finance & Performance Manager
Customer / Senior User
David Kirkbride Consultant Anaesthetist - Head of Service (LRI)
Neil Flint Consultant Anaesthetist - Recovery Lead & ICU link
Supplier / Senior Supplier
Sean Purtill Interserve Construction Limited

The project manager has delegated authority from the project board to incur expenditure up to the authorised limit for a project Stage.

Contracts (e.g. for the main build) can only be entered into at Trust level.

The build work-stream itself will be managed in conjunction with our Principal Supply Chain Partner, Interserve Construction Limited. The following diagram is correct in terms of role, but named individuals may have changed since it was prepared.



The Trust has engaged Rider Levett Bucknall to act as cost advisors and to provide a CMD coordinator and an NEC3 contract experienced Project Manager for the build phase.

1.6.2. Timescales

Proposed timescales are as follows:

Build phase	**Completion date**
Phase 1: Adult Reception – already in progress	End of May 2014
Full Business Case – Trust Board authorisation	Thursday, 26th June 2014
Phase 2: Recovery part 1	November 2014
Phase 3: Recovery part 2 + Staff Rest area	June 2015
Phase 4: Paediatric reception	September 2015

1.6.3. Benefits realisation and risk management

Risk management
The main tool of risk management during the build phase itself is the Risk Register, which is a document owned jointly by the Client and the PSCP. This tool is constantly updated as the project progresses and regular joint risk reviews and mitigating actions are undertaken.

Benefits realisation
The deliverables of the capital project will be rigorously compared to the user requirements to ensure the project delivers what has been specified.
This capital project is an enabler for Theatres then to realise the revenue benefits described elsewhere in this document.

1.6.4. Post project evaluation arrangements

A post project evaluation will be undertaken with the PSCP, UHL project team, clinical users and stakeholders.

1.7. Recommendation

The recommendation of this business case is to invest £3,675,200 to proceed with the Preferred Option described above and to provide, in the main theatres suite at the Leicester Royal Infirmary:

- an enlarged and improved post-operative Recovery Area
- a dedicated paediatrics route to theatre and reception area
- an improved staff rest area; and
- the reconfiguration of associated clinical support and office space

Signed: Ian Currie, Project Manager

Date: 24th June 2014

Senior Responsible Owner Project
Project Team

2. THE STRATEGIC CASE

2.1. Introduction

In accordance with the Five Case Model, this strategic case section sets out the case for change, together with the supporting investment objectives for the scheme.

Part A: The strategic context

2.2. Organisational overview

Services and population

University Hospitals of Leicester NHS Trust (UHL) is one of the largest NHS Trusts in the country and manages the three NHS hospitals in Leicester:

- Leicester Royal Infirmary
- Leicester General Hospital
- Glenfield Hospital

The Trust provides a range of emergency and elective services, primarily for the one million residents of Leicester, Leicestershire and Rutland. There are also nationally and internationally-renowned specialist services in cardio-respiratory diseases, cancer and renal disorders and these reach a further two to three million patients from the rest of the country.

The range of services is very broad – there are over 40 clinical specialties, plus support services. Key service areas include cardiology, renal, diabetes, vascular surgery, cancer and haematology. The Trust also covers Emergency Medicine (adults and children), maternity, gynaecology, children's services and a range of both medical and surgical specialties.

Organisational structure

The Trust employs over 10,000 staff at its three sites and is organised into seven Clinical Management Groups (CMG's) reporting directly into the Trust Executive. Each of the CMG's is headed by a Clinical Director, a General Manager and a Head of Nursing.

The seven Clinical Management Groups are as follows:

- CHUGS (Cancer, Haematology, Urology, Gastroenterology and Surgery)
- Emergency and Specialist Medicine
- Musculoskeletal and Specialist Surgery
- CSI: (Clinical supporting and Imaging)
- Renal Respiratory and Cardiac: (RRC)
- ITAPS: (Intensive/Critical Care, Theatres, Anaesthetics, Pain and Sleep)
- Women's and Children's

Project sponsors and reporting lines

The Trust has recently (mid-2013) gone through significant organisational change. At the start of this project, the project sponsors were the clinical and management divisional heads for the Planned Care Division. Since then, the organisational re-structuring has removed the divisional management layer and the sponsorship for this business case has therefore devolved to the ITAPS CMG. ITAPS previously fell within the Planned Division and, as the body responsible for managing activity within the LRI theatres suite, was already a key operational customer. The CMGs' management report directly into the Trust Executive team.

There is a Trust-wide capital programme which is responsible for delivering the changes to the estate necessary to support the strategic changes planned for the Trust's service provision and location. This capital programme is called the Site Reconfiguration Programme and this project is one of the projects within its remit. The Site Reconfiguration programme management reports into the Trust Director of Strategy.

Quality

This business case relates to the reconfiguration of facilities which support surgery at the LRI.

There is a significant issue with the quality of the existing recovery facilities, with consequential effects on the quality of patient care, the patient experience, infection control, staff morale and paediatric patient flows.

These are described in detail below in section 2.3.2 "Existing Arrangements".

Activity data (historic)

Surgical activity at University Hospitals of Leicester (UHL) is split between the specialties and across the three sites as shown in the table below.
Further data is shown in the Appendices - Theatre Activity: Analysis by Site.

Key points to note, particularly as it relates to surgical activity at the LRI:

In general

- Nearly half of the total number of operations for the Trust as a whole takes place at the LRI.
- The majority of operations at the LRI take place in the main theatres suite on level 2 of the Balmoral Building. (However, there are other areas of the hospital where specialties such as ophthalmology and obstetrics operate.)

Emergency activity

- 70% of all UHL emergency surgery takes place at the LRI (53% in the main theatres suite and another 17% taking place elsewhere at the LRI).
- About a third of all the operations at the LRI is emergency surgery (with the three main specialities involved being trauma, general surgery and paediatric)
- 99% of all trauma activity takes place at the LRI.
- There are approximately 2,600 emergency operations a year currently taking place at the LGH. If this was to move to the LRI in future, this represents an increase of about 5% on current total LRI theatre activity.

Specialties

- The following specialties are concentrated solely at the LRI:
    - Ear, Nose and Throat
    - Maxillofacial
    - Ophthalmology
    - Plastic surgery
    - Vascular
- Paediatrics are also concentrated solely at the LRI (with the exception of children's cardiac surgery which is included within the GGH cardiac data)

Elective activity

- The two specialties with the most elective activity are ENT and plastic surgery
- Maxillofacial, General and Paediatric also show high volume

Summary of all UHL surgical activity:
Data source: ORMIS. Period: complete year from 1st Sept. 2012 to 31st August 2013
Units: number of distinct operations

UHL - all surgical activity		Percentage spread of activity		
Activity specialty	**Total**	**LGH**	**GGH**	**LRI**
BREAST CARE	1,628		100%	
CARDIAC SURGERY	2,716		100%	
EAR NOSE AND THROAT	3,217			100%
GENERAL SURGERY	7,257	42%	17%	42%
GYNAECOLOGY	4,531	74%	14%	12%
MAXILLOFACIAL	1,992			100%
OBSTETRICS	2,900	41%		59%
OPHTHALMOLOGY	5,082			100%
ORTHOPAEDICS	6,313	100%		
PAEDIATRIC	2,357			100%
PAEDIATRIC ORTHOPAEDICS	415			100%
PAIN MANAGEMENT	1,528	30%	68%	1%
PLASTIC SURGERY	2,867			100%
RENAL ACCESS SURGERY	92	100%		
RENAL SURGERY	681	96%	4%	
THORACIC SURGERY	1,058		100%	
TRAUMA & ORTHOPAEDIC	3,734	1%		99%
UROLOGY	4,990	71%	29%	
VASCULAR SURGERY	873			100%
Grand Total	**54,231**	**34%**	**18%**	**48%**

Please note that expressing the data as the number of distinct operations disguises the differences between minor procedures and major, complex operations. Depending upon the purpose of the analysis, it can sometimes be more appropriate to look at the total time spent in theatre rather than at the number of distinct operations.

Theatre Productivity

Current activity analysis shows that there is scope for improvement in the levels of utilisation of the theatre estate.

A summary report prepared by the ITAPS service manager (Dale Travis) is shown below.

Highlights:

- Both day-case and inpatient elective theatre utilisation at the LRI is consistently below the 86% target and also below the national average
- There are RTT issues with 5 surgical specialties at UHL

ITAPS analysis of the statistics highlights the following key points:

- Even given the incomplete data set available, there are up to 1,300 operations recorded as cancelled on the day of surgery for reasons which are commonly connected with Recovery capacity
- Increased Recovery capacity would give a buffer which would also tend to alleviate the number of operations cancelled due to lack of ward beds

The service manager in her commentary also reiterates the follows points:

- Any delay in Recovery has the potential to cause a “log-jam” effect within theatres

- If beds are slow to come up in the routine wards, patients can be held in Recovery, again causing a log-jam. Surgeons and anaesthetists will cancel if they are not confident of a bed being available.
- If ward staff do not collect patients promptly from Recovery, this can also create a log-jam. In an attempt to alleviate this, the Recovery team can themselves take the patient to the ward thus creating a knock-on effect of too few staff in Recovery to accept new patients.
- The presence of up to 3 / 4 patients in PACU can also slow down the throughput of Recovery. If a bed bay is used for a higher dependency patient this currently uses 2 'normal' bays, further reducing the remaining capacity.

ITAPS Report (April 2014):

Latest YTD theatre utilisation for LRI

Site	Utili Type	Apr 13	May 13	Jun 13	Jul 13	Aug 13	Sep 13	Oct 13	Nov 13	Dec 13	Jan 14	YTD
LRI	Day case	74.36 %	74.65 %	74.97 %	78.87 %	76.71 %	74.85 %	79.00 %	71.69 %	72.66 %	72.08	74.56%
LRI	In patient	72.9 %	71.89 %	73.87 %	73.00 %	72.40 %	68.67 %	70.80 %	72.55 %	69.12 %	71.76	71.69%

Benchmark RTT admitted- exceptions only (target 90%) - December 2013

UNIT	ENT %	Gastro %	Gen surg %	Ophth %	Max fax %	Other (paeds) %	Plastics %	Traum and ortho %	Urol %
Birmingham	90.7	100	89.4	82.7	90.9	91.8	94.1	91.8	88.1
Cov and war	87.3	99.8	87.7	94.1	96.4	99.2	95.2	81.5	96.4
Leeds	79.3	95.3	84.9	98.5	94.7	74.2	81.7	89.6	85.6
Newcastle	93.2	N/A	94.3	97.4	45.6	90.2	92.8	91.9	91.9
Notts	98.6	100	94.1	93.9	98.1	92.2	89.8	70.2	99.4
Sheff	94.3	99.7	89.9	96.6	100	94	90.7	86.4	92.3
UHL	64.1	97.2	73.1	59.3	92.9	81.9	97.1	86.1	92.7
National profile	88.1	98.6	89.7	91.1	86.7	92	90.8	85.6	92.4

LRI Day-Of-Surgery cancellations: 12 months to 31st March 2014

Root cause analysis	Operations cancelled
Unfit patient on the day	1,349
Ward bed unavailable	847
Consultant decision	766
Lack of session time	363
Anaesthetic decision	78
HDU bed unavailable	61
ITU bed unavailable	28
Unrecorded	2,249
Administration errors / miscellaneous	2,278
TOTAL	**8,019**

Commentary

There are obvious issues with the completeness of the data recorded above. However, certain issues are apparent, with the highlighted areas having a potential link / impact with Recovery capacity.

- *Consultant decision*

  Consultants will cancel if there is not a bed or recovery space or Recovery is in back-log. (There may also be equipment issues.)

- *Lack of session time*

  The session time may be caused by a late start but also there is an impact when patients need to be recovered in anaesthetic rooms / theatres due to recovery being full.

- *Anaesthetic decision*

  An anaesthetist will usually cancel because

  - there is no identified ward or ITU bed
  - there is a back-log in recovery so the patient will have to be recovered in theatre

- *HDU bed unavailable / ITU bed unavailable*

  Whilst the need for an ITU bed is highlighted, there is often a will to use PACU if possible rather than cancel. Also, when ITU is full and we cannot discharge to the wards (because the wards are full) we are having transfer level 2 patients out of ITU and back into PACU in order to free up space in ITU for level 3 patients. This exacerbates the capacity issues in Recovery. Also the current non-compliant bay sizes mean that every one level-2 patient takes up two bed spaces. Hence two level-2 patients take out 4 bed-bays, leaving only 13 to support the 17 theatres-worth of activity. This leads directly to patient cancellations.

Current recovery – issues with respect to the through-put of activity

Any delay in Recovery has the potential to cause a “log-jam” effect within theatres - and more so where there is quick, high-turnover day-case mixed in with inpatient higher acuity recovery. Once this occurs, it will mean patients further down the list will be cancelled, with those already in theatre having to be recovered in the theatre itself.

If beds are slow to come up in the routine wards, patients may also be held in Recovery, again causing a log-jam. If surgeons and anaesthetists are not confident of a bed being available, they may not take the risk to proceed and so decide to cancel the patient.

Ward staff may not be released in a timely manner to collect patients from Recovery. This can also create capacity problems and, to prevent further delay, the Recovery team will themselves take the patient to the ward. This is admirable but also has the knock-on effect of delaying the next patient into Recovery, as staff have left the area.

There are also currently 2 notional (non-compliant) PACU bays in the Recovery area but occasionally there may be up to 3 / 4 patients in PACU. This can also slow down the throughput of Recovery until the PACU patients are discharged. If a bed bay is used for a higher dependency patient this currently uses 2 ‘normal’ bays, further reducing the remaining capacity.

Any cancelled operation or element of delay will affect the utilisation of theatres as noted earlier. It is difficult to assign a proportion to Recovery issues because of how data is currently collected.

Potential benefits

Smoother flow due to general increase in Recovery beds / increase in PACU availability - should prevent unnecessary delay due log-jam effect. Therefore we anticipate at least 1 extra case on the underperforming lists. Net result as a minimum 1 extra case per session = 20 per week with utilisation >80%. Value difficult to predict as case mix dependent but as an indication (DC£600, IP £1,500 minimum values) would be in excess of an additional £20k of income per week with a net benefit of reduced waste and improved efficiency.

The requirement to clear all specialty backlogs to recover RTT will exceed this benefit. If we extend the operating day and introduce weekend working, then the Recovery area will assist and support the flow of work coming through as defined in first Para.

Risk

Day case and In-patient bed capacity constraints may reduce the net benefit gained by recovery

Theatre Activity predictions

These are dealt with in section 2.6 below.

2.3. Business strategies

This project fits with, and in most cases positively aims to support, the following organisational strategies.

Sources: *University Hospitals of Leicester Clinical Strategy 2012/13 – 2017/18; and*
University Hospitals of Leicester Strategic Direction …Caring at its best, November 2012

Strategic goal		Impact on LRI main theatres	Inter-relationship with this project
1	Improving quality and safety We will improve quality, safety and the hospital experience for our patients. We will provide safe, high quality, patient-centred healthcare.	We need to ensure we have high-quality and fit-for-purpose facilities which are compliant with national guidelines and which allow for the provision of top quality care. We also need to recruit and retain top-quality staff in the right numbers and to promote good morale.	The main project deliverable is to improve and expand the current sub-standard Recovery Area facility, which is cramped, non-compliant and has too few recovery bays. We are also providing new segregated patient reception areas and improved staff rest facilities. (For details see section 2.6 Existing arrangements.) This will have a major positive impact on patient care, the patient experience and on staff morale.
2	Locations and volume of surgical activity Optimisation and reconfiguration of services across the three different UHL sites. The Leicester Royal Infirmary will be the major provider of acute and emergency services.	There will be continued high demand for theatre activity at the LRI. In all scenarios under consideration, seventeen theatres-worth of activity is anticipated to remain at the LRI. (Even if the drive to close elective theatre lists – working with the Theatres Transformation Programme – is successful, there will be a compensating requirement to increase the number of emergency lists at the LRI.)	The project aims to provide a Recovery Area which is fit for purpose to support 17 operating theatres. Both the Association of Anaesthetists In Great Britain and Ireland and the Healthcare Building Notices state that there should be a **minimum** of two recovery bays for every theatre, in order to support activity, cope with peaks and troughs and ensure proper patient care.

Strategic goal		Impact on LRI main theatres	Inter-relationship with this project
3	<u>Case mix</u> Move outpatient and non-complex elective services away from the Leicester Royal Infirmary and from Glenfield Hospital to a more appropriate clinical setting which provides optimum access for the patient.	This will result in a net increase in complexity of the case mix at the LRI, as non-complex cases are replaced by more complex activity. This will tend to lead to an increase in the average length of stay in recovery. There will also be more high-dependency patients. Discussions with clinicians indicate that the average recovery time could double, which will only be partly accompanied by an associated increase in average theatre time (by about one third). The net effect will be an increase in demand for post-anaesthetic recovery time.	This is another upward pressure on the demand for post-anaesthetic recovery bays in the LRI main theatre suite. We need to deliver sufficient capacity to future-proof this investment.
4	<u>Move adult day-case away from LRI and close current day-case ward at the LRI</u> The development of a dedicated adult day-case and outpatient hub at the Leicester General Hospital.	This leaves paediatric day-case still at the LRI, along with the rest of paediatric activity (see below). The current day-case ward is due to close to allow the expansion of the Critical Care footprint (see below). This reconfiguration increases the length of a day-case paediatric patients' journey to theatre. (They will have to travel from 4th floor wards.) Without putting in place mitigation measures, this will detrimentally affect both the standard of patient care and theatre utilisation (gaps between patients on a list).	A major project deliverable is opening up existing lifts to provide a new direct route from the 4th floor Balmoral paediatric wards straight into a new dedicated paediatric reception and holding area within the main theatres suite - for all paediatric patients, including day-case.

Strategic goal		Impact on LRI main theatres	Inter-relationship with this project
5	Ambulatory arrivals Building a purpose-designed Theatre Arrivals Area (TAA) at Leicester Royal Infirmary. The TAA model takes control of the elective, ambulatory, day-of-surgery patient arrivals journey and brings ownership of the patient and any potential issues back to theatres, by ensuring it is located within the Theatres complex.	Removes the physical bottleneck for day-of-surgery arrivals, with insufficient cubicles for efficient day-of-surgery pre-assessment procedures, thereby enabling increased patient flow into theatres and improved theatre utilisation. The increased capacity also allows for a review and reclassification of patients, some of whom are currently sent via the in-patient route. This will help to reduce demand for ward beds.	Shifts focus onto other physical bottlenecks in the day-of-surgery patient journey, such as the currently inadequate Recovery Area bed-bay provision and environment (see notes above).
6	Recovery Area expansion Expanding facilities for post-operative care in theatre recovery at both Leicester Royal Infirmary and Leicester General Hospital	Removes a physical bottleneck for all surgical activity through main theatres and provides a buffer to cope with surges in demand and with short-term difficulties in discharging to wards. Also remedies the patient care issues around the current non-compliant, sub-standard facilities.	Improved Recovery Area facilities are a project main deliverable
7	Critical Care expansion Changing the current 3-site model for critical care services and providing an integrated Critical Care service across 2 acute sites. Over the next five years, we expect to treat patients with increasingly complex conditions, resulting in an increased demand for critical care beds. Currently we have proportionately fewer critical care beds than many other Trusts, so to meet current and future demands we will increase the number of critical beds at the Leicester Royal Infirmary and Glenfield sites.	Two main impacts: a) During the works to expand the Critical Care footprint at the LRI there will be a need for decant high-dependency capacity. b) There will also be a need for an ongoing inter-relationship between the LRI Critical Care unit and the LRI Recovery Area, with enhanced bays within Recovery being designed so that they can support the surges in demand for level 1, 2 and 3 facilities.	The project will provide increased Recovery capacity (including six larger, enhanced recovery bays) which will provide the capacity and flexibility to support the Critical Care unit in dealing with both of the two main impacts described.

Strategic goal		Impact on LRI main theatres	Inter-relationship with this project
8	<u>Paediatric provision at LRI</u> The strategic goal is to consolidate the hospital care of children onto the Leicester Royal Infirmary site and in due course provide a physical Leicester Children's Hospital on that site with its own unique identity. There will be a need for an increase in provision of paediatric critical care beds. An options appraisal is currently under way to decide on the final location of the children's hospital. In the meantime, there is still a strong need to improve service provision in the short and medium term.	There is likely to be increased demand for paediatric activity within LRI main theatres. Also, this highlights the need for best-practise treatment of children within theatres, such as provision of a segregated route through theatres and of a segregated children's Recovery Area. The current facilities do not allow this, contrary to clinical guidelines from a number of national paediatric bodies (see appendix for details).	The preferred option delivers a segregated route through theatres for children, starting with a direct route from the wards into a Paediatric Reception Area, with an onwards journey to adjacent dedicated paediatric theatres and ending in post-operative care in a physically segregated, dedicated Children's Recovery Area.
9	<u>Upgrading current estate</u> We will save money by no longer supporting old, expensive and under used estate and we will become more productive.	The current recovery facilities are old and not fit for purpose, with much of the plant beyond its recommended useful life. This poses a risk to the continuity of theatre activity. ITAPS CMG also has a plan for a rolling programme of backlog maintenance on the theatres themselves, within the main theatres suite at the LRI.	The Recovery area and associated plant will be brought up to date as a main deliverable of this project. A dependency (which is outside the scope of this project) is that Theatres 0 and 1 also need to be brought up to standard by the end of this project, to enable paediatric surgical activity to be concentrated in the theatres at the end of the theatres suite which is adjacent to the new children's reception area. (There are issues with the heating in these theatres and they are currently not fit for use by paediatrics.) This will allow for the segregation of the adult versus the paediatric patient journeys.

Strategic goal		Impact on LRI main theatres	Inter-relationship with this project
10	Supporting and valuing the workforce Deliver services through a professional, passionate and valued workforce Key developments aims include support for Training and Development	Responses are required to the following current issues (for more details see section 2.6 Existing Arrangements): ▪ There is wide clinical consensus within Theatres that Recovery Area personnel are currently unhappy, in that they feel they cannot provide the desired quality of care in the current facilities. ▪ The facilities are also not well suited to training and development activities. ▪ The current staff rest areas for theatres are inadequate for the number of staff, are segregated (unnecessarily) and are cramped and run-down, contributing to an environment where staff can tend to feel undervalued.	The improved design of the main Recovery Area and Paediatric and Adult Reception areas will provide staff with a much improved working environment. A significant project deliverable is also a refurbished, enlarged and combined staff rest area.

See also section 2.5 Investment objectives below.

2.4. Other organisational strategies

Included above - section 2.3.

Part B: The case for change

2.5. Investment objectives

The investment objectives were arrived at after extensive discussions with key stakeholders within the Trust and with key clinical and management users of the proposed facility. Principle bodies involved were:

1) LRI Recovery Area Reconfiguration Project Board

This body was set up on a Prince2 basis and therefore includes representatives of the Senior User, the Executive and the Senior Supplier. (See Management case section 5 for details.) The ITAPS CMG management, lead clinical users, UHL Trust management and Strategic Site Reconfiguration Programme management are all represented on this board.

2) Project user group

This is the main group for developing the high-level and detailed design, via multiple workshops, assisted by an external architectural consultant and also, where needed, by mechanical and electrical consultants. It includes representation from the following areas:

a) Surgical consultants
b) Anaesthetic consultants
c) Theatres nurses (management and recovery specialists)
d) Paediatrics nurses
e) ITAPS management
f) Paediatrics management
g) Infection Control
h) Patient representative

Other interested parties (such as Trust Fire Safety officer, Health & Safety officer, Buildings maintenance) are also consulted as appropriate.

3) Site Reconfiguration Programme Management

Programme director and other reconfiguration project managers - to ensure strategic and programme fit.

Also consulted were:

- UHL Executive members – in particular the Strategic and Finance directors
- Better Care Together (for Leicester, Leicestershire and Rutland) Programme management

The purpose of this project is to provide a facility which achieves the following investment objectives:

1) Improve quality of patient care A fit-for-purpose post-operative recovery area (and ancillary facilities) which will support improvements in the quality of patient care. *Examples of key deficiencies in current facilities to be remedied are (see section 2.6 Existing arrangements for full details):* *a) Size of bays (too small)* *b) Spaces between the rows too narrow to allow the passage of beds or emergency equipment between recovery bays, if they are occupied* *c) Inadequate segregation between adults and children and between male and female patients* *d) Inadequate segregation of infected cases and inadequate hand-washing facilities* *e) Poor patient environment. Noisy, cluttered and cramped. Lack of confidentiality and privacy and dignity for the patients.* f) *Poor working environment – detrimental to staff morale and team-building and increases stress*	
SMART analysis:	
Specific	A design principles document was drafted by the user group as a touchstone for various aspects of design quality. See appendix for details.
Measurable	Size of each bay to be increased to the following: ▪ HBN dimensions are ideal ▪ However, specific UHL Trust derogations are acceptable (as signed off by user group and UHL Trust Board)
	Spacing between the ends of rows to be sufficient to allow passage of equipment and beds
	Design principles as stated in the design principles document will be used to assess and measure the success of the proposed design as it relates to the other design objectives.
Achievable	Feasibility study and user review indicates that it should be possible to fit facilities required within the footprint available. (See Financial case and Management case sections for appraisal of financial and delivery aspects.)
Relevant	Investment objective relates clearly to several strategic goals (see section 2.2 Business strategies: nos. 1, 3, 4, 5, 7, 8)
Time constrained	The feasibility study indicates a 12 to 15 month delivery timescale for the build itself. This target timescale will be refined by the development of a detailed build programme as part of the FBC and contract negotiation process. (See Management case section below.)

2) Improved support for volume and type of theatre activity A post-operative recovery facility for the following types and volume of theatre activity in the LRI main theatres suite (17 theatres): ▪ adult non- day-case surgical patients, for all surgical specialties ▪ paediatric non- day-case and day-case surgical patients, for all surgical specialties The above may be from any specialty and may be elective, emergency or trauma.	
SMART analysis:	
Specific	Volume of theatre activity (and number and location of theatres) to be supported is clearly specified.
Measurable	Ratio of theatre to recovery bay: ▪ Minimum recommended ratio is 2 bays to each 1 theatre (see national guidelines in Appendices: Association of Anaesthetists in Great Britain and Ireland guidelines) ▪ User group guidance: Must be no less than a ratio of 1 ½ bays to every 1 theatre
Achievable	Feasibility study indicates that it should be possible to fit the number of bays required within the footprint available. (See Financial case and Management case sections for appraisal of financial and delivery aspects.)
Relevant	Investment objective relates clearly to several strategic goals (section 2.2 Business strategies: nos. 2, 3, 4, 5, 6, 7, 8)
Time constrained	The feasibility study indicates a 12 to 15 month delivery timescale for the build itself. This target timescale will be refined by the development of a detailed build programme as part of the FBC and contract negotiation process. (See Management case section below.)

3) Segregate children and adult patient pathways	
To segregate as far as possible the paediatric and adult patient pathways into and out of – and within - the LRI theatres suite. Also to shorten the patient journey from the 4th floor paediatric wards to the theatres suite.	
SMART analysis:	
Specific	Adult and paediatric patient flows can be clearly and separately mapped from arrival on a ward or at the Theatre Arrivals Area, into the theatres suite, then into theatre itself, onwards into a dedicated Recovery area and then back to a ward.
Measurable	The extent of segregation at each stage of the patient journey can be clearly seen. Average patient journey times from calling the paediatric ward to the patient actually arriving in theatre can be audited and reviewed. There is already benchmark data available.
Achievable	Feasibility study indicates that it should be possible to segregate the adult and children's route almost completely and to provide a new and shorter access route directly from the 4th floor ward to the theatres suite.
Relevant	Investment objective relates clearly to several strategic goals (see section 2. 2 Business strategies: nos. 1, 4, 8)
Time constrained	The feasibility study indicates a 12 to 15 month delivery timescale for the build itself. This target timescale will be refined by the development of a detailed build programme as part of the FBC and contract negotiation process. (See Management case section below.)

4) Support critical care provision	
4.1 To provide a potential overflow decant facility to support Intensive Care Unit activity during the disruption caused by the planned refurbishment of the current ICU area (Phase 2 of the ICU facilities development plan). 4.2 To provide the optimal mix of standard, enhanced and isolation recovery bays for the theatre activity	
SMART analysis:	
Specific	Combination of recovery bay numbers (see ratios in investment objective 1) and bay type (see investment objective 2).
Measurable	Included in user design principles document. Design principles are used to assess proposed design.

Achievable	Feasibility study indicates will be able to provide required numbers of bed-bays and also include some wider bed-bays for higher-dependency patients and some isolation cubicles.
Relevant	Investment objective relates clearly to strategic goal no. 7 in section 2.2 Business strategies
Time constrained	The feasibility study indicates a 12 to 15 month delivery timescale for the build itself. This target timescale will be refined by the development of a detailed build programme as part of the FBC and contract negotiation process. (See Management case section below.)

5) Provide future flexibility Given the level of strategic uncertainty as to the future locations of various different types of theatre activity, to provide a facility which is flexible and adaptable such that it will fit as many of the possible future demands as is feasible	
SMART analysis:	
Specific	The design principles document - as drafted by the user group as touchstone for various aspects of design quality – includes flexibility as a key principle. Examples of types of flexibility are: dealing with surges in demand and changes in case mix, with higher-dependency patients, being able to segregate different patient groups, being able to manage the facility easily, both in and out of hours.
Measurable	Included in user design principles document. Design principles are used to assess proposed design. (Actual changes to theatres case mix could take place at any time during the lifetime of the facility.)
Achievable	Feasibility study indicates that the preferred solution will deliver a single large recovery area, divided into 4 separate areas for maximum flexibility.
Relevant	Investment objective relates clearly to strategic goals nos. 2, 3, 4, 7, 8 in section 2.2 Business strategies
Time constrained	The feasibility study indicates a 12 to 15 month delivery timescale for the build itself. This target timescale will be refined by the development of a detailed build programme as part of the FBC and contract negotiation process. (See Management case section below.)

6) Improve staff environment Provide an improved working environment for staff and improved staff rest facilities so as to lead to improved morale and staff well-being.	
SMART analysis:	
Specific	Objective relates clearly to the project deliverables of newly refurbished clinical and staff rest areas.
Measurable	The design principles are used to assess the design, in cooperation with the user group. User feedback on the completed facilities will form part of the post-implementation review.
Achievable	Feasibility study indicated that the preferred solution will be achievable in the available footprint.
Relevant	Investment objective relates clearly to strategic goal no.10 in section 2.2 Business strategies
Time constrained	The feasibility study indicates a 12 to 15 month delivery timescale for the build itself. This target timescale will be refined by the development of a detailed build programme as part of the FBC and contract negotiation process. (See Management case section below.)

2.6. Existing arrangements

This section describes the existing situation with regard to the current facilities which are the subject of the investment. It has been sub-divided into the three main physical areas under consideration for development.

2.6.1. Recovery Area

2.6.1.1. Main issues with current facilities

- Generally poor, 30 year-old infrastructure which is unsuitable for modern practise
- The allocated space for each recovery bay is too narrow and too short
- Insufficient room between the ends of the rows of bed-bays to allow passage of equipment or beds
- Insufficient number of bed bays (only 12 to 14 usable at any one time) for the number of theatres supported
- No opportunity to effectively segregate female and male patients
- No opportunity to effectively segregate paediatric patients
- No opportunity to effectively segregate low-risk and high-risk patients
- The environment is noisy and cramped
- Inadequate emergency call system (does not direct the correct type of care to the correct location)
- There is a very small 'patient environment'
- A lack of confidentiality and privacy and dignity for the patients
- Insufficient space to allow parents and relatives to visit
- Too few wash hand-basins for staff
- No physically separate isolation area (for infectious cases)
- No easy access to toilets for patients
- There is neither the room nor the data and electrical infrastructure to allow the use of electronic patient records
- Limited storage capacity within the recovery area

2.6.1.2. Impact of the above issues

<u>Patient care, patient safety and increased risk</u>

i. Bed-bay size: there is no space within the bays for emergency or additional equipment and for staff access around the bed. This seriously affects the level of proper patient care and increases the risk of errors and accidents.

ii. Bed-bay size: If additional equipment is needed for a patient, this means that one or two adjacent bays are put out of action

iii. The narrow gap between the ends of beds in opposing rows means that staff cannot move equipment without moving existing recovering patients out of the way first.

iv. If there is a crash call, the lack of space means that staff currently have to physically move other recovering patients out of the way before they can get to the patient in need. There is an obvious impact both on the patients being moved (distressing and alarming) and in the delayed access to the patient in need of emergency assistance, increasing the risk of an outcome detrimental to the patient.

v. This issue can be particularly serious in the case of paediatric patients who can deteriorate very quickly and may require rapid intervention in minutes

vi. Infection control risk – for full details of the Infection Control risk assessment see the Appendices Infection Control Risk assessment: Current Recovery Area.
Key points:

- There is a “Patients” risk score of 12 – with a moderate impact on patients’ health being assessed as “Likely”. There is also an Economic risk rating of 9, with a claim between £10,000 and £100,000 being seen as “Possible”. Other risk headings also score higher than the target score.
- Lack of hand hygiene facilities increases the risk of cross infection.
- Sinks that do not meet current regulations for control of pseudomonas increase the risk of a patient acquiring a pseudomonas infection, particularly as this area would be classed as augmented care.
- Damage to floors and walls makes cleaning difficult and allows dirt and dust to be trapped, increasing risk of cross infection.
- Closeness of patients to each other in bed spaces increases the risk of cross infection.
- Patients with known or suspected infections are either recovered in existing bed-spaces or in theatre. Isolation in current bed spaces increases the risk of cross infection to other patients in the same vicinity whilst recovery in theatre takes a theatre out of use for a considerable amount of time.
- Lack of storage for stores and equipment increases the risk that items become contaminated posing a risk of cross infection to patients.

vii. There is clear research that a noisy, crowded environment will tend to lead to staff missing alerts / symptoms that a patient needs assistance (confusion of signals)

viii. The lack of segregation between low- and high-risk patients makes it more difficult to deliver the appropriate level of nursing support and observation

ix. A properly designed PACU (Post-Anaesthetic Care Unit) is the recommended approach to recovering patients after anaesthesia. It is a key facilitator for an enhanced recovery pathway: the right level of care to the right patient at the right time along the patient pathway

x. This model is also widely recognised to contribute to reduced LOS (length of stay), reducing cost and getting patients back to their homes quickly.

xi. The impacts on children of the lack of segregation within Recovery are covered in section 3 below

Patient experience

i. Environment is noisy and cramped meaning a poor patient experience

ii. The closeness to the next bed means a lack of confidentiality and privacy and dignity

iii. The lack of male / female segregation also affects privacy and dignity

iv. The narrow gap between the ends of beds in opposing rows means that staff cannot move beds between the opposing rows without moving existing recovering patients out of the way first.

Theatre utilisation

i. Small capacity: the AAGBI (Association of Anaesthetists in Great Britain and Ireland) recommend a minimum ratio of two recovery bays to every one theatre. We currently have a less than one-to-one ratio.

ii. The low number of recovery bays means we are unable to efficiently accommodate theatre throughput.
It is difficult to get empiric data showing clear and direct causation here, because of the multiple factors affecting theatre throughput (but see audit results below). However, there is a universal consensus among clinical staff that low capacity in the current Recovery Area is contributing to poor throughput in theatres. The built environment is seen as a key factor in poor theatres utilisation – a bottleneck in patient flows.
(Example: A typical situation is that the third patient on a list cannot go into theatre because the second patient is having to be recovered in theatre - because the first patient on the list is taking up the only available recovery bed.)

iii. Low capacity means that:

- any critical incident effectively shuts recovery for normal operations
- transfer of patients from a HDU effectively shuts it down also

iv. A larger capacity would give a buffer which allows continuing operations in the following situations:

- Ward beds blocked
- Surge in demand due to an incident / pandemic (e.g. swine flu)

v. It would also allow the flexible use of space, such as the use of some recovery bed bays as level 1, 2, or 3 critical care beds. This could be on an operational basis or during the planned redevelopment of the nearby ICU area

vi. Poor patients flows lead to poor utilisation of expensive resource (theatres staff – nursing, surgical and anaesthetists)

Audit evidence of impact on theatre utilisation:

An audit carried out by Neil Flint (consultant anaesthetist) reviewed two weeks' activity in LRI main theatres and recorded the transfer times from theatre to recovery and also the time taken to hand over the patient to recovery staff once arrived in the recovery area.

Key findings:

a. Adequate recovery bays coupled with adequate nursing staff would save over 17 hours per week. This represents:
    - 11.5 hours of theatre time (patients ready to leave theatre but awaiting transfer to Recovery); plus
    - 5.75 hours of anaesthetist's time, in effect recovering patients within the recovery area (where this should be done by recovery nursing staff)

b. Major delay is in transfer of patient from theatre to recovery. This reflects problems with numbers of recovery bays and possibly also staffing issues

c. Cases of anaesthetist recovering patient and patient being recovered in theatre are still occurring

Impacts on staff

i. Low morale: There is a high degree of consensus that staff are unhappy as they feel they cannot provide the desired quality of care in the current facilities

ii. A poor working environment and facilities is detrimental to morale, recruitment and retention of staff

iii. Staff working in Recovery have no identity as a group – the chaotic space means staff are just keeping their heads above water and not functioning well as a team

iv. Recruitment and retention: Difficult to recruit. If staff have the choice to go elsewhere with better facilities then they are likely to go there

v. No time for training and development

vi. Expensive use of agency resource to bridge staff shortages

vii. Lack of ownership and pride in facilities leads to loss of engagement by key stakeholders

viii. Lack of training and development: current facilities are not suited to training and development

ix. The use of anaesthetists as recovery nurses leads to a lack of theatre time for other patients

General impacts

i. Currently there is no scope for enhanced recovery (e.g. access to drinks, patient mobilisation)

ii. Limited storage and facilities for near-patient testing

iii. Electronic patient records:

- It will not be possible to introduce this in the current area. We will need one pc per bay – there is neither the room nor the data and electrical infrastructure to allow this.
- Currently we are trialling electronic prescribing within some theatres. It does not work well, as nurses have to leave a patient in order to go and access a pc in another area – effectively temporarily abandoning care of the patient.

2.6.2. Staff rest areas

2.6.2.1. Main issues with current facilities

- Inadequate for the number of staff - very cramped
- Run-down
- Lack of cooking equipment
- Lack of communication means
- Old lockers taking up space
- Hard-working staff have no quiet area
- No place to sit comfortably
- No tables
- No computer access (e.g. internet)
- No microwaves
- Nowhere to keep refrigerated food
- The facilities are segregated into separate areas for medical and for non-medical staff.

2.6.2.2. Impact of the above issues

i. Poor morale – staff feel under-valued

ii. Recruitment - gives poor impression to potential employees. There is a high level of vacancies in nursing teams.

iii. Retention – poor morale will tend to reduce retention rates and increase staff turnover

iv. Additional expense on agency staff + a lack of familiarity with local procedures, required skills and governance can lead to increased risk to the patients

v. Poor physical environment prevents adequate rest – leads to fatigue which in turn leads to:

   a. Increased risks to patients. (Fatigue is a key systemic factor in critical incidents and mistakes.)

   b. A tendency to disengage with initiatives and process improvements, including improvement strategies for clinical pathways

   c. Poor morale

vi. Segregated staff areas: This leads to poor team identity and integration. (Good teamwork is a major factor in how well critical incidents are dealt with.)

2.6.3. Paediatric routes through theatres (reception, route to theatres, recovery)

2.6.3.1. Main issues with current facilities

- Children enter the theatres suite via the same entrance as adults
- Limited space for children to wait. They share the reception area with adults – including sick adults.
- They then have to walk a significant distance to the anaesthetic room, past several working theatres and patients just leaving theatre
- There is no dedicated paediatric recovery area and no effective segregation within Recovery. This leaves children, teenagers and young adults next to critically ill adult patients.
- We are unable to allow parents into recovery area due to confidentiality issues

2.6.3.2. Impact of the above issues

<u>Patient care, patient safety and increased risk</u>

i. The following are published national guidelines and recommendations relating to the treatment of paediatric patients. **None of these guidelines are currently being adequately met within the main theatre suite at the LRI.** (See appendix for full details):

   a. “In the recovery area, there is a physical separation between children and adult patients.”

   b. “Parents/carers are able to be present with their child when they wake up”

   c. “Care should be delivered in a safe, suitable and child-friendly environment”

d. “Using a medicine designed for use in adults may mean that very small amounts must be measured, or the medicine has to be diluted, adding to the potential for error. Physical separation from adults improves safety as staff are not dealing with high and lose dose regimes simultaneously.”

e. “In A&E departments, surgery recovery areas, and outpatient clinics, there should be physical separation between children and adult patients, so that children are not exposed to potentially frightening behaviour; and equally, so that adults feeling ill are not disturbed by noisy children”

ii. Mixed adults and children is against all current (and likely future) national standards

iii. Currently children are recovered behind a partially dividing wall in recovery – poor observation and poor environment for patient

iv. There is currently no specific crash-call identifying a need for specifically paediatric expertise. This is a critical delaying factor. Children can deteriorate much more rapidly than an adult*. (Actual real-time example on day of workshop – a child crash-call occurred – staff responded but initially no paediatric anaesthetist came – staff had to then go and find a specialist paediatric anaesthetist – this led to a potentially risky delay.)*

v. No specialist recovery staff – different mind-set

vi. Adult recovery nurse may feel challenged when required to recover a child. Paediatric recovery staff need specialist skills.

vii. Area should be separate with specialist equipment and local IT access

viii. Different drug dosages from adults

<u>Patient experience</u>

i. Sharing the reception area with adults – including sick adults – is potentially distressing and confusing for a child).

ii. The journey from reception to theatres, past several working theatres and patients just leaving theatre, can again be distressing and confusing

iii. The lack of segregation in Recovery can be distressing for both adults and children. (sick adults, crying children)

iv. There needs to be space for parents to visit children within the PACU.

v. One upset child currently can affect many

vi. Lack of confidentiality, privacy and dignity

vii. Poor care but children have no voice – we have to be their advocates

<u>Impacts on staff</u>

i. Morale - Adult recovery nurse may feel challenged when required to recover a child

ii. Recruitment – Paediatric specialist nurses are potentially put off from applying

iii. Retention – paediatric specialists will look to leave and move somewhere where there are specialist paediatric facilities. Leads to rapid turnover of staff.

iv. Detrimental effect on morale due to inability to deliver good quality care

<u>General</u>

i. Delays do exist with paediatric specialties spread across different theatres

ii. Difficult to plan correct staff ratios with mixed adult and children patients

2.7. Business needs

The issues caused by the deficiencies in the current facilities have been fully described in the preceding section 2.5 Existing arrangements. The business need is to provide solutions to these issues.

As stated in section 2.3 Business strategies above, the underlying assumption of this business case is that there will be a “continued high demand for theatre activity at the LRI. In all scenarios under consideration, 17 theatres-worth of activity is anticipated to remain at the LRI.” As this current level of activity is likely to remain substantially unchanged, the business need will continue for the foreseeable future unless addressed by this project.

2.8. Potential project scope

This section describes the potential scope for the project in relation to the above business needs.

The scope of this capital project is best described by reference to the existing building footprint potentially affected and then to consider the new facilities to be provided within that footprint.

See the "Current layout – 2nd floor Balmoral" diagram below for an overview of the footprint ear-marked for development. The main footprint encompasses the main theatres recovery facility, various associated office and storage spaces, a theatres reception area and a staff rest room. (The areas bounded by dotted lines are areas which are not within the scope of the proposed capital works themselves, but which will be affected by the knock-on effects of the associated operational re-organisation.) The final area to consider is a small, separate day-case recovery facility used for day-case activity in theatres 0 and 1.

The three main elements to be delivered are:

1) **Recovery area plus associated facilities**
   An enlarged, reconfigured and flexible Recovery Area plus associated facilities such as a dirty utility, a clean utility, cleaner's room, disposal facilities, storage space, clinical office space and a new reception area for adults coming from wards.

2) **Staff rest area**
   A single combined, redesigned staff area (with kitchen) in place of the current segregated suite of rest areas and office space.

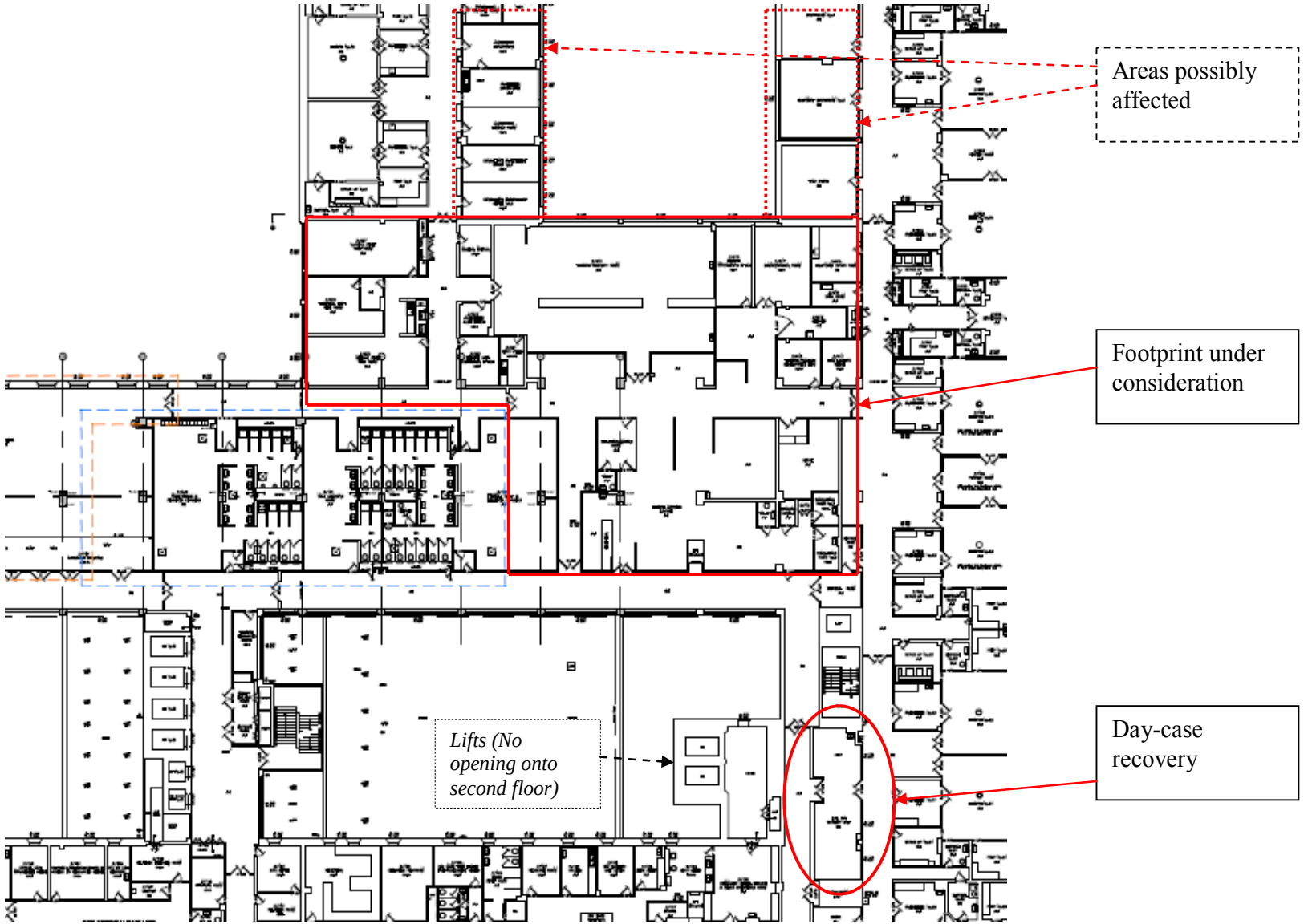
3) **Paediatric route through theatres**
   Comprising an entirely new route from the paediatric wards on the 4th floor, down to a new dedicated reception area on the 2nd floor via new access to an existing lift shaft, thence into the adjacent paediatric theatres and finally into a segregated children's recovery area. This uses the second floor footprint of the current day case recovery and the adjoining corridor.

Please see the diagram "Proposed Layout: 2nd floor Balmoral (showing the phases of development)" for the proposed layout for the completed scheme. The building phases are shown in different colours and are:

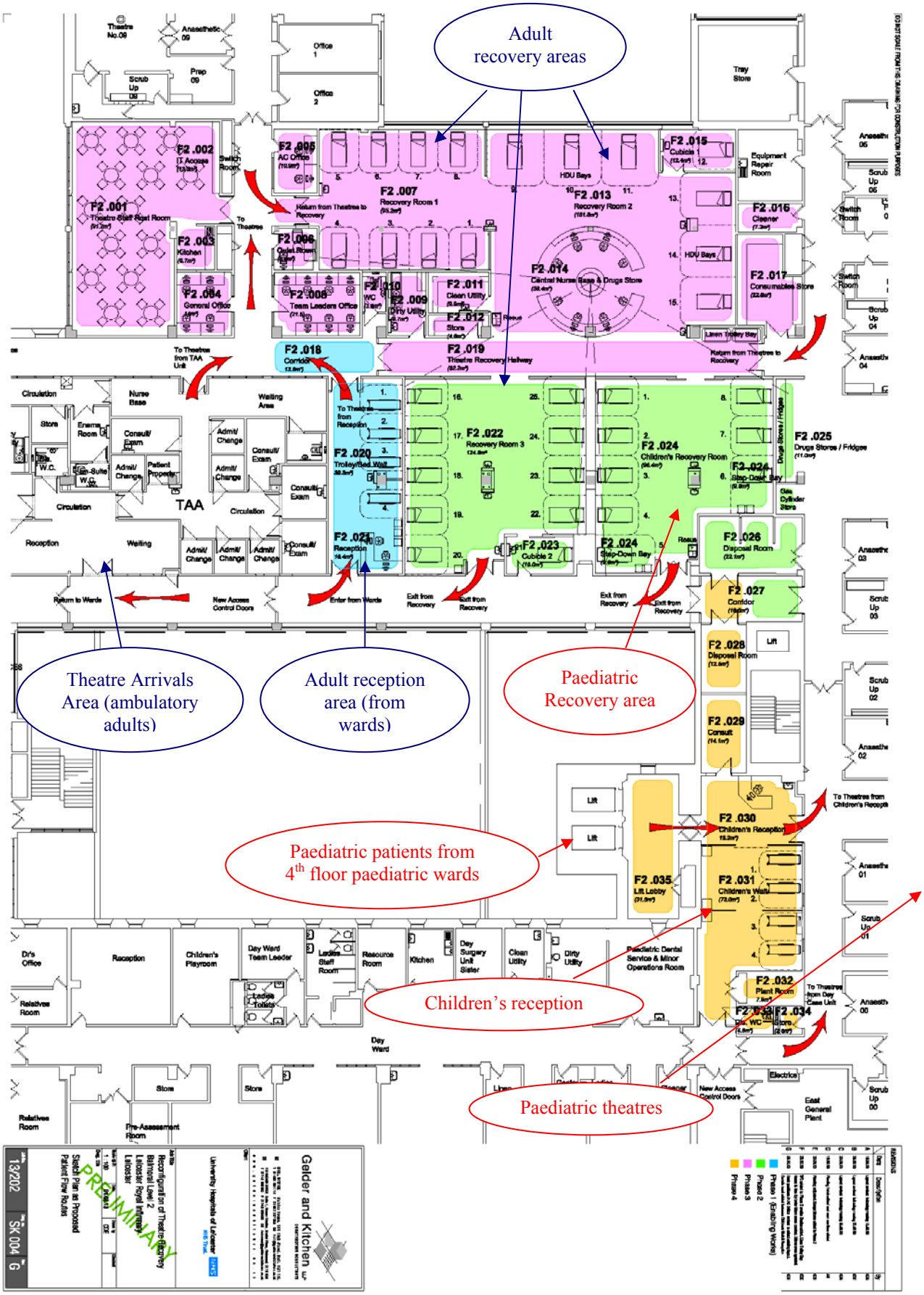
- Phase 1: Adult (non-ambulatory) reception area
- Phase 2: Recovery room 3 and Children's recovery area, plus pharmacy storage and disposal room
- Phase 3: Recovery Room 1 & 2 plus office space and staff rest area
- Phase 4: Paediatric reception area and route from 4th floor paediatric ward

The phasing of the works is largely dictated by the need to continue full operational activity during the build.

Current layout: 2nd floor Balmoral



Proposed Layout: 2nd floor Balmoral (showing the phases of development)



Potential Scope for the capital development

The Options Appraisal is described in detail in section 3 of this document. These options include different scope options for the capital works.

Out of scope

- It was confirmed with the user group stakeholders and with the Project Board that, although there is a need within the Balmoral Theatres suite as a whole for improved and re-organised storage capacity, to meet this need is outside the scope of this project and of the remit set by the initial Trust authorisation.
- Likewise, a wider consideration of office accommodation within Theatres is also outside the scope of this project.
- Any refurbishment of the theatres themselves falls under the general ongoing maintenance and upkeep budget and is not within the scope of this project.

2.9. Main benefits criteria

This section describes the main outcomes and benefits associated with the implementation of the potential scope in relation to business needs.

Satisfying the potential scope for this investment will deliver the following high-level strategic and operational benefits. By investment objective, these are as follows:

Investment objectives	Main benefits criteria by stakeholder group
Investment objective 1 **Improve quality of patient care**	**Patients** Qualitative ▪ *Improved patient experience* ▪ *Improved level of patient care, patient safety and reduced risk* *See section 2.6 Existing arrangements for details* *Note: There is also a reduction in Economic risk, either from preventable infection or from consequences of an incident such (as an arrest)* **Clinicians** Qualitative ▪ *Improved staff morale as their ability to deliver better care in fit-for-purpose facilities increases (see item 6 below)* **Administrators** Non- cash releasing (£s) and Qualitative ▪ *Improvement in patient care feeds through into fewer incidents, complaints, etc. requiring less administrative input*
Investment objective 2 **Improved support for volume and type of theatre activity**	**Patients** Cash releasing (£s) ▪ *Improvements in Theatre utilisation should feed through into increased revenues* ▪ *Increased capacity for higher-dependency patients*

Investment objectives	Main benefits criteria by stakeholder group
	should also lead to increased revenues Qualitative ▪ *Reduction in the numbers of cancellations (due to list over-runs or no recovery capacity) means more patients are treated on time and as scheduled, meaning better patient care* **Clinicians** Qualitative ▪ *More capacity will improve morale as department runs more efficiently, lists are completed to plan and non-ideal workarounds are not required* **Administrators** Non- cash releasing and Qualitative ▪ *Fewer cancellations will ease administrative burden of re-scheduling, etc. – but hard to quantify* ▪ *Easier to plan and schedule theatre activity* ▪ *Supports drive to meet the 18-week referral to treatment (RTT) targets*
Investment objective 3 **Segregate children and adult patient pathways**	**Patients** Qualitative ▪ *Improved patient experience, especially for children* ▪ *Improved level of patient care, patient safety and reduced risk* *See section 2.6.3.2 Main issues with current facilities for details* Cash-releasing (£) ▪ *Reduced ward-to-theatre journey times for all paediatric patients will lead to improvements in theatre utilisation (particularly gaps between patients) meaning more operations and increased revenue* **Clinicians** Qualitative ▪ *Improved staff morale both on paediatric wards and in theatres as they are better able to provide an improved standard of care and implement and follow efficient processes.* **Administrators** Non- cash releasing and Qualitative ▪ *Better quality of care means fewer complaints and lower administrative burden* ▪ *Fewer cancellations should ease administrative burden of re-scheduling etc. – but hard to quantify* ▪ *Easier to schedule theatre activity* ▪ *Supports drive to meet the 18-week referral to treatment (RTT) targets*

Investment objectives	Main benefits criteria by stakeholder group
Investment objective 4 **Support critical care provision**	**Patients** Cash releasing (£s) ▪ *Increased capacity for higher-dependency patients should also lead to increased revenues, as the critical care and post-operative recovery units work together to provide patient care* ▪ *Provision of a decant facility during future works to expand the critical care area will avoid the need for cancelled operations due to lack of critical care capacity* Qualitative ▪ *Enhanced, properly equipped bed bays will replace the current bays which are too small and not really suitable for higher dependency patients (even thought they are being used as such). Will lead to improved patient care and reduced risk.* **Clinicians** Qualitative ▪ *Improved, more flexible facilities empower staff to provide better patient care, which in turn leads to an improvement in staff morale* **Administrators** Non- cash releasing and Qualitative ▪ *Fewer cancellations should ease administrative burden of re-scheduling etc. – but hard to quantify* ▪ *More flexibility makes it easier to schedule theatre activity* ▪ *Supports drive to meet the 18-week referral to treatment (RTT) targets*
Investment objective 5 **Provide future flexibility**	**Patients** Non- cash releasing, cash releasing and qualitative ▪ *A flexible recovery area which can meet the LRI needs for recovery capacity in a variety of future strategic scenarios ensures that all types of benefits, be they financial or qualitative, can be maximised.* **Clinicians** Non- cash releasing and qualitative ▪ *Supports flexible and effective working practises and training needs.* ▪ *Encourages staff retention* **Administrators** Non- cash releasing, cash releasing and qualitative ▪ *Administrative benefits accrue from the ability to cope with a variety of strategic scenarios as the theatre activity changes in the future*

Investment objectives	Main benefits criteria by stakeholder group
<u>Investment objective 6</u> **Improve staff environment**	**Patients** ▪ *Indirect effect of improved staff morale has a major effect on patient care* ▪ *Better rested clinicians reduces risk* **Clinicians** Qualitative ▪ *Improved staff morale. Should become evident with better staff retention and easier recruitment.* ▪ *More opportunities for quality training* ▪ *Better rested clinicians reduces risk* ▪ *Better designed facilities (rest areas and clinical areas) improve team-building and working practises* **Administrators** ▪ *Improved / refurbished offices enhances morale and administrative efficiency* ▪ *Improved retention of clinical staff reduces recruitment effort*

2.10. Main risks

The main business and service risks associated with the potential scope for this project are shown below, together with their counter measures.

Main Risk	Mitigation
Design not fit-for-purpose, leading to intended benefits not being realised	Rigorous design process, with the following characteristics: 1. Full engagement by key stakeholders and end-users throughout the process 2. Clear design principles and objectives set 3. Expert consultancy (architectural, mechanical, electrical, other) accessed as appropriate 4. Sufficient timescale planned to allow for full review and refinement of the design through several iterations 5. Formal sign-off process by user group, project board and other key stakeholders (e.g. fire officer, maintenance officer, patient representative, infection control) 6. Change control process introduced after sign-off, to avoid a 'moving target'
Project costs over-run	1. Consistent implementation of good project management principles and practises 2. Sufficient up-front effort put into detailed costings, specifications and design to ensure no significant omissions or errors surface later and give rise to additional costs 3. Access expert advice (re. contractual issues and design and build cost expertise) 4. Clear and rigorous negotiations leading to the agreed GMP 5. Clear allocation of correctly valued risks between PSCP and Client 6. Continued scrutiny and challenge of claims throughout the build for Compensation Events (additional costs)
Programme over-run	1. Realistic and rigorous planning, in conjunction with all parties responsible for the deliverables 2. Appointment of appropriately skilled project manager 3. Detailed review of submitted project programme, for each stage, to ensure realistic, logical and complete 4. Regular review of progress against programme 5. Full engagement of all project suppliers and

Main Risk	Mitigation
	stakeholders **6.** Continued scrutiny and challenge of claims throughout the build for Compensation Events (time extensions)
Poor quality facilities delivered	1. Engagement of a quality PSCP supplier 2. Check that PSCP has appropriate quality control procedures in place and is adhering to them 3. Detailed and rigorous review of design and specifications prior to agreeing to the GMP 4. Engagement of quality control expert advisor during the build (supervisor / clerk of works – M&E and building) 5. Defined process of snagging, clearing snags and signing off 6. Defined process of documenting defects 7. Review of design and build by key Trust stakeholders
Organisational risk – UHL / CMG sponsor priorities change, affecting support for the project or changing the project remit	1. Continued engagement with key stakeholders 2. Review of Trust and CMG strategic fit 3. Ongoing communications with Site Reconfiguration Programme and Project Board members

For a detailed risk register, compiled in conjunction with the main contractors proposed for the scheme, see appendix: Capital build phase – risk register

2.11. Constraints

The key project constraints identified so far:

1. **Physical constraint**: The available footprint for new facilities is constrained by the boundaries and operational considerations of the existing theatres suite on the second floor of the Balmoral building. There is also a constraint on the limited ward 10 reconfiguration, necessary to give access to the lifts on the 4th floor.

2. **Disruption to theatre activity**: The normal level of theatre activity must continue during the development works.
    a. Must maintain clear routes into and out of theatres
    b. Subsidiary functions (e.g. receptions, stores management, waste, pharmacy, staff circulation, administration) must be able to continue
    c. Recovery capacity must not drop below current levels

3. **Timescale constraint**: The expectation is that the works will begin immediately after the completion of the Theatre Arrivals Area works and will complete by December 2014

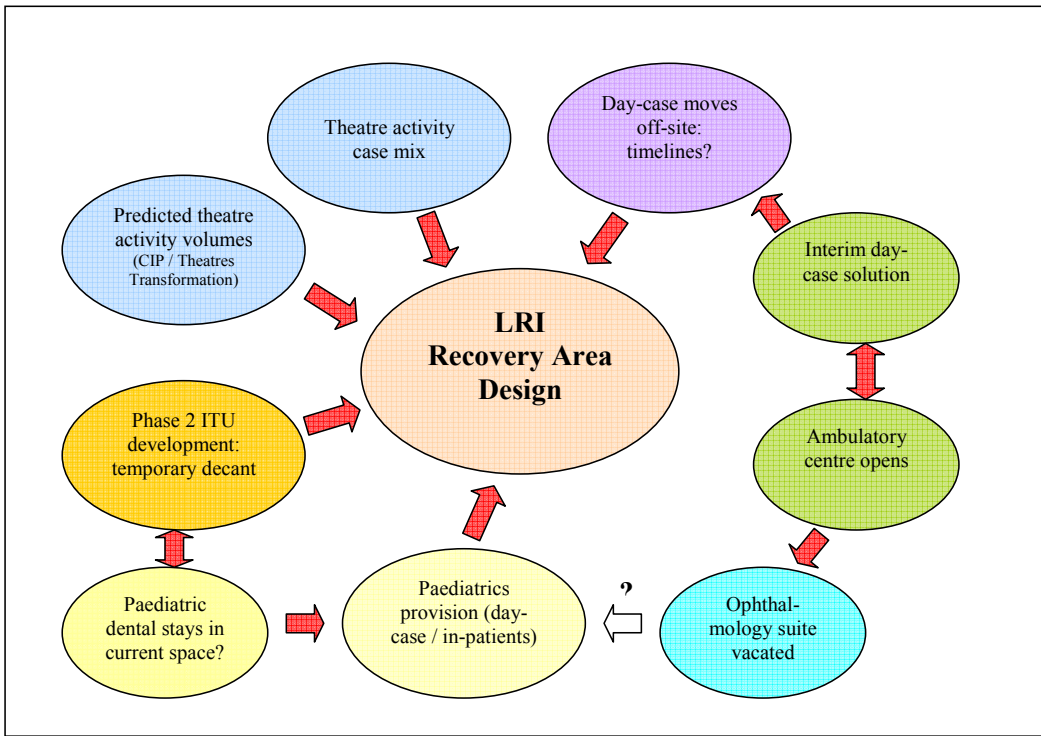
4. **Financial constraint**: There is currently £3.6m included within the Trust capital programme, split roughly 25% in 2013/14 and 75% in 2014/15.

5. **Scope constraint**: The description of the works as authorised within the Trust capital programme is LRI Recovery Area reconfiguration. The scope cannot therefore depart significantly from this description without re-applying for new authorisation.

6. **Procurement method constraint:** The prescribed procurement method for this project is via Lot 2 of the Facilities Management contract between UHL Trust and Interserve Facilities Management.

2.12. Dependencies

The design and successful implementation of the proposed facility project is subject to the following dependencies. They are explained in more detail below *(diagram from LRIRecovery_OptionsAppraisalExtract_v1.1.doc, October 2013).*



Notes to the dependency diagram above:

1. LRI theatre activity volumes

Although the main driver for the project is the poor quality of the existing facilities (with all the attendant risks and negative impacts described in section 2.6 above) the underlying assumption is that there will be 17 fully operational theatres to support within the main theatres suite at the LRI. If this prediction changes then the dependant recovery bay ratios will be re-visited.

2. LRI theatre activity case mix

As stated in the business strategies section above, the Trust plans to move less complex cases away from the LRI. This will result in a net increase in demand for Recovery capacity. If this strategy were to change, then the capacity assumptions would be revisited.

3. Adult day-case move away from the LRI

As part of the Trust strategies around moving less complex cases away from the LRI, adult day-case activity is due to move to the LGH. Paediatric day-case activity is planned to stay at the LRI. Whether this is move occurs after to the establishment of a full ambulatory centre at the LGH or whether there is an interim day-case solution prior to this, the timing of this move affects the activity within LRI main theatres during the proposed period of this build. This will have to be managed accordingly.

4. ITU footprint expansion at the LRI

Closely linked to the move off-site of adult day-case, is the planned expansion of the critical care facilities at the LRI. This is because the area identified for conversion into additional critical care capacity is the current day-case ward. The timing of the closure of the LRI day-case ward, dependent as it is on adult day-case moving to the LGH and on the commencement of the critical care capital development, crucially affects the management of paediatric day-case activity – in particular the journey from the ward to theatres. Mitigation of this impact, via a streamlined route to theatre from the paediatric wards, is a key deliverable of this project.

Another dependency of the ITU footprint expansion is the management of the disruption caused during the ITU works themselves. There will be a temporary reduction in critical care beds during the works and the additional bed-bays provided by the Recovery Area reconfiguration project (including some enhanced bed-bays suitable for higher-dependency patients) will provide a decant facility to support the uninterrupted provision of critical care facilities.

5. Community (paediatric) dental activity

There is a treatment room within the current day-case ward footprint where paediatric dental activity is carried out. If the critical care expansion displaces this activity, it will have to be catered for within the main LRI theatre suite (along with paediatric day-case activity) and patients will be recovered within main recovery.

6. Ophthalmology suite (includes three theatres on level 6)

One of the long-listed options is to convert the ophthalmology suite on the 6th floor of the Balmoral building into a paediatrics theatre suite. This is dependant on the ophthalmology specialist surgery moving elsewhere first.

3. THE ECONOMIC CASE

3.1. Introduction

In accordance with the Capital Investment Manual and requirements of HM Treasury's Green Book (A Guide to Investment Appraisal in the Public Sector), this section of the FBC documents the range of options that have been considered in response to the potential project scope. It also documents the procurement process and provides evidence to show that we have selected the most economically advantageous offer, which best meets our service needs and optimises value for money.

3.2. Critical success factors

The critical success factors (CSFs) used to appraise the long and short-listed options were derived from:

- architectural feasibility
- project constraints
- project investment objectives
- operational considerations for the completed facilities

1) Architectural feasibility

This is purely an assessment of whether a proposed option is feasible and practical, given the constraints of the footprint available. (For example: Can we fit in the facilities we are proposing into the space available? Is it possible to provide the mechanical and electrical infrastructure required? Will the proposed configuration work?)

This CSF is the first hurdle for an option to clear and is a potential 'show-stopper'. If a proposed option is not architecturally feasible, there is no point in continuing to assess it.

2) Project constraints

a) Physical location
The available footprint for the new facilities is constrained by the boundaries of the available area within the existing theatres suite on the second floor of the Balmoral building.

b) Uninterrupted theatre activity during the works
The normal level of theatre activity must continue during the development works. Given the location of the development (right in the middle of the main theatres suite), this is a major challenge and affects the final design itself as well as methods of working. It dictates how the works have to be split into phases. Example considerations:

i) Must maintain clear access routes into and out of theatres throughout

ii) Subsidiary functions (e.g. receptions, stores management, waste, pharmacy, staff circulation, administration) must be able to continue, so decant arrangements have to be made

iii) Recovery capacity must not drop below current levels – so have to deliver in stages

iv) Noise, vibration, dust, site traffic, etc. must be managed so as to allow surgical activity to continue.

Again these constraint CSF's are absolute. The development cannot extend beyond the physical boundaries and cannot interfere with theatres' performance during the build. If

a proposed option does not meet these constraints, there is no point in continuing to assess it.

Once an option has met Critical Success Factors 1 & 2, we can proceed to assess how well the option meets the following CSF's:

3) Investment objectives

Full details of these can be found in section 2.5. For the purposes of brevity, only the short titles are used below.

a) Improve quality of patient care

b) Improved support for volume and type of theatre activity

c) Segregate children and adult patient pathways

d) Support critical care provision

e) Provide future flexibility

f) Improve staff environment

The remaining long-list options were scored as to how well they fulfil these investment objectives.

4) Operational considerations

These include:

a) Staffing of the new areas, both during normal hours and for out-of-hours operations

b) Management of the new areas, both during normal hours and for out-of-hours operations

c) Accessibility of mutual clinical support for the new areas

d) Patient routes and ease of liaison with the wards

The remaining long-list options were scored as to how well they fulfil these operational requirements

3.3. The long-listed options

The following options were considered as part of the initial long-list options appraisal:

A. *The "**Do nothing**" option.*
Do nothing; do not proceed with capital investment in this area.

B. *The **"Quality only"** option.*
Carry out refurbishment and reconfiguration works to address purely some of the issues around quality of the current recovery area facilities. (Do not look to address any issues of capacity, segregation of paediatric and adult patient routes or to improve staff rest facilities.)

C. *The **"Quality and capacity"** option.*
- Carry out refurbishment and reconfiguration works to address both the issues around quality of the current recovery area facilities; and also
- Increase recovery area capacity so as to meet (or be near to) national guidelines. (Look to deliver whatever degree of adult / child segregation is possible within this footprint but do not develop a new route into theatres for children and do not look to improve staff rest facilities.)

D. *The "**Quality, capacity & staff well-being**" option.*
- Carry out refurbishment and reconfiguration works as described in option C; and also
- Improve the adjacent staff rest areas.

E. *The **"Children's reception: version 1"** option.*
- Carry out refurbishment and reconfiguration works as described in option D; and also
- Provide a separate children's reception area in the current day-case recovery footprint. (Do not develop a new route to theatres from the 4th floor paediatric wards. Patients would continue to arrive via the Balmoral main lifts.)

Expert architectural analysis of this option showed that the space available was not sufficient to provide the facilities required. - Fails CSF 1) Architectural Feasibility.
EXCLUDE FROM FURTHER CONSIDERATION

F. – *The **"Children's reception: version 2"** option*
- Carry out refurbishment and reconfiguration works as described in option D; and also
- Provide a separate children's reception area, using both the current day-case recovery footprint and by extending into the adjacent theatres corridor. (Do not look to develop a new route to theatres from the 4th floor paediatric wards. Patients would continue to arrive via the Balmoral main lifts.)

G. *The **"Children's reception: version 3"** option.*
- Carry out refurbishment and reconfiguration works as described in option D; and also
- Provide a separate children's reception area, using both the current day-case recovery footprint and by extending into the adjacent theatres corridor; and also
- Knock through into the existing but unused lift lobbies on both the 2nd and 4th floors, so as to create a new route to theatres directly from the 4th floor paediatric wards.

H. *The **"Ophthalmology suite"** option.*
- Carry out a version of the refurbishment and reconfiguration works as described in option D for use by adults only.
- Convert the theatre suite which is currently occupied by Ophthalmology on the sixth floor of the Balmoral building into a paediatrics theatre suite, incorporating both reception and recovery areas. (The Ophthalmology suite comprises three operating theatres and a clean room.)

Further analysis of this option showed that:

- There are no plans for Ophthalmology to vacate this 6th floor suite.
- This proposal would not work for clinical operational reasons – either in-hours or out-of-hours

EXCLUDE FROM FURTHER CONSIDERATION

Summary of feasible long-listed options

The table below attempts to summarise and clarify the remaining long-listed options (excluding Options E and H for the reasons given above).

Options	Elements included				
	Recovery capacity – as current	Recovery capacity - expanded	Staff rest area	Children's reception	New children's route to theatre
A – Do nothing	**No**	**No**	**No**	**No**	**No**
B - Quality only	**Yes**	**No**	**No**	**No**	**No**
C - Quality and capacity	**Yes**	**Yes**	**No**	**No**	**No**
D - Quality, capacity & staff well-being	**Yes**	**Yes**	**Yes**	**No**	**No**
F - Children's reception: version 2	**Yes**	**Yes**	**Yes**	**Yes**	**No**
G - Children's reception: version 3	**Yes**	**Yes**	**Yes**	**Yes**	**Yes**

Assessment of long-listed options: methodology

The six options above were scored as to how well they met the Critical Success Factors 3 a) - f) and 4 described above. A summary of the results is shown on the next page and a detailed analysis is given in the Appendix Options Appraisal – non-financial scoring.

The relative weighting of the CSF's was applied so as to reflect the relative importance and relevance of the strategic and investment objectives to this particular project, as directed by the key project and Trust stakeholders and the project user group members.

The "Do nothing" option scored very low, but has automatically to be considered in detail as a short-list option, as it is the base-line position, compared to which any change has to be justified

Of the other options, the three top-scoring options were carried forward to the short-list appraisal stage and the bottom two options were rejected.

Recovery Area project: non-financial options appraisal (feasible long-list options)

OPTIONS	Benefit criteria:	Total	1) Improve quality of patient care	2) Improved support for volume and type of theatre activity	3) Segregate children and adult patient pathways	4) Support critical care provision	5) Provide future flexibility	6) Improve staff environment	7) Operational considerations
	CSF weighting:	100	22	10	16	12	14	16	10
	RANKING	Weighted scores							
Option A - Do nothing	6	233	59	45	0	21	42	32	34
Option B - Quality only	5	408	153	45	0	40	56	60	54
Option C - Quality and capacity	4	727	169	80	66	108	140	90	74
Option D - Quality, capacity & staff well-being	3	775	169	80	66	108	140	132	80
Option F - Children's reception: version 2	2	822	176	80	82	108	140	152	84
Option G - Children's reception: version 3	1	920	187	85	160	108	140	152	88

Please see the Appendix Options Appraisal – non-financial scoring for more detail.

Options D, F and G have been included in the short-list of options.

Supplementary notes on the scoring of the long-list options:

Option A – Do nothing

Brief description

Do not proceed with capital investment in this area. Continue to operate in the current facilities.

Score and ranking

Weighted score: 233

Ranking (out of 6): 6

Comments

This has to be considered in detail as a short-list option. It is the base-line position, compared to which any change has to be justified.

Recommendation

INCLUDE IN SHORT LIST

Option B - Quality only

Brief description

Carry out refurbishment and reconfiguration works to address a limited number of issues around quality of the current recovery area facilities. (Do not look to address any issues of capacity, segregation of paediatric and adult patient routes or to improve staff rest facilities.)

Score and ranking

Weighted score: 408

Ranking (out of 6): 5

Comments

This option offers a limited improvement in the care environment within recovery itself but does not score well against any other of the CSF's.

In addition, after further expert review, it was deemed not really feasible to deliver this option and at the same time meet the constraint that the normal level of theatre activity must continue during the development works. (See CSF 2: Project constraints.) This is for the reasons described below.

The existing recovery area has to be closed down before it can be expanded and reconfigured. However, in order to maintain the current level of theatre activity throughout the works, there must be at least equivalent recovery capacity provided elsewhere, before we can close the existing facility so that this phase of works can begin.

There are also architectural constraints around existing structural building elements which cannot be moved.

In effect, the phasing constraint and the architectural feasibility requirements dictate a significant increase in the floor area used for the clinical recovery area, if you are going to carry out the scheme at all. Once you have increased the floor area, the incremental cost of additional recovery bays themselves is small – the main cost is in the building works and the mechanical and electrical infrastructure. It makes no financial or practical sense not to increase recovery bay capacity as well.

Recommendation

EXCLUDE FROM SHORT LIST

Option C - Quality and capacity

Brief description

Carry out refurbishment and reconfiguration works to address both the issues around quality of the current recovery area facilities and also look to increase recovery area capacity so as to meet national guidelines.

Score and ranking

Weighted score: 727

Ranking (out of 6): 4

Comments

This option was deemed architecturally feasible and also possible as part of a phased programme of works which met the constraint of allowing the normal level of theatre activity to continue during the development.

Although it allows for a separate area for children within recovery itself, it scores poorly against the CSF of segregation of children and adult pathways and offers only limited improvements to the staff environment.

Recommendation

EXCLUDE FROM SHORT LIST

Option D - Quality, capacity & staff well-being

Brief description

Carry out refurbishment and reconfiguration works as described in option C but also look to improve the adjacent staff rest areas.

Score and ranking

Weighted score: 775

Ranking (out of 6): 3

Comments

This option scores well as far as quality and capacity improvements to the Recovery Area itself are concerned and it also significantly improves the staff environment. However, it does not provide a segregated route within theatres for children or a streamlined access route from the paediatric wards. However, it scores highly enough to be included in the financial evaluation of short-listed options.

Recommendation

INCLUDE IN SHORT LIST

Option E - Children's route: version 1

Brief description

Carry out refurbishment and reconfiguration works as described in option D but also look to provide a separate children's reception area in the current day-case recovery footprint.

Comments

This was **not feasible**. The space available is too narrow to make a workable children's reception area, which incorporated the requirements of an infant area and a juvenile area (with a total of 4 holding bays), a toilet, a private consulting room and a reception desk. We have to expand into the corridor to make this feasible.

Recommendation

EXCLUDE FROM SHORT LIST

Option F - Children's route: version 2

Brief description

Carry out refurbishment and reconfiguration works as described in option D but also look to provide a separate children's reception area, using both the current day-case recovery footprint and by extending into the adjacent theatres corridor.

Score and ranking

Weighted score: 822

Ranking (out of 6): 2

Comments

This option scored highly in all areas except the provision of a segregated route to theatres from the wards and also the better theatre utilisation stemming from the improved journey from the wards. Patient experience would be improved by these facilites.

Recommendation

INCLUDE IN SHORT LIST

Option G - Children's route: version 3

Brief description

Carry out refurbishment and reconfiguration works, as described in option F, and also knock through into the existing but unused lift lobbies on both the 2nd and 4th floors, so as to create a new route to theatres from the 4th floor paediatric wards

Score and ranking

Weighted score: 920

Ranking (out of 6): 1

Comments

This was the highest scoring option, with all the main investment objectives being met. There is improved quality of patient care throughout the journey to, within and from theatres and also the theatre utilisation benefits that a streamlined journey entails. An improved staff environment is provided in the dedicated rest areas but, equally importantly, within the main clinical working areas affected. The large, centralised recovery area offers a flexible facility which works well operationally and which will support the closely associated provision of critical care.

Recommendation

INCLUDE IN SHORT LIST

3.4. Short-listed options

The short listed options are as follows:

Options	Elements included				
	Recovery capacity - minimum	Recovery capacity - expanded	Staff rest area	Children's reception	New children's route to theatre
A – Do nothing	**No**	**No**	**No**	**No**	**No**
D – Quality, capacity & staff well-being	**Yes**	**Yes**	**Yes**	**No**	**No**
F - Children's reception: version 2	**Yes**	**Yes**	**Yes**	**Yes**	**No**
G - Children's reception: version 3	**Yes**	**Yes**	**Yes**	**Yes**	**Yes**

3.5. Economic appraisal

3.5.1. Introduction

This section provides an overview of the main costs and benefits associated with each of the short-listed options.

More detailed information is shown for each cost and benefit line within the economic appraisals at

3.5.2. Estimating benefits

Methodology

The benefits associated with each option were identified during various workshops with the user group and also during discussions with UHL Finance.

All of the quantifiable, cash-releasing benefits have been estimated using consistent methodology.

The approach taken to the following option appraisals is that of opportunity cost.
The HRG charging structure does not allow us to distinguish purely the theatres portion of the patient journey in terms of income generated. (The HRG codes include an assumed ward stay as part of the tariff.) Therefore, it is not possible to match income and costs into a theatres-only income and expenditure account. (No inter-departmental transfer pricing mechanism exists.)

It has therefore been decided that the most meaningful approach is to quantify the incremental financial changes which may occur as a result of this project - on an opportunity cost basis

The baseline from which the opportunity cost is measured is the "Do nothing" or "As-is" option.

Note:

The Theatres portion of the patient journey incorporates:

1. *Arrival of patient in theatres (reception), whether from a ward or via the Theatre Arrivals Area*
2. *Transfer of patient into the particular anaesthetic room linked to the theatre where the operation will take place*
3. *Anaesthetic and surgical procedures within the anaesthetic room and operating theatre itself*
4. *Transfer out of theatre into recovery*
5. *Recovery time within the recovery area*
6. *Transfer out of recovery and onward to a ward or critical care unit*

Description, sources and assumptions

The benefits identified fell into the following **main** categories. In each case, the sources and assumptions underlying their use are explained.

Type of benefit	**Direct to Organisation**
Cash releasing	1. Increase in revenue due to improved throughput of adult inpatients, paediatric inpatients and paediatric day-case: transfer from theatre into Recovery 2. Increase in revenue due to improved throughput of paediatric inpatients: transfer from ward into theatre 3. Mitigation of negative impact on throughput of paediatric day-case and associated revenue, caused by the planned closure of the day case ward: transfer from ward into theatre 4. Increase in revenue due to improved High Dependency patient throughput: increased capacity within Recovery and enhanced ability to support ICU. *Note: The above are accounted for in the financial case appraisals*
Non-cash releasing	All quantitative benefits with a direct relationship to the options have been treated as having a cash-releasing impact and are listed above. The following items are considered to have possible, or even probable, financial impacts but because multiple factors are involved it is deemed too difficult to quantify and isolate the direct financial cause-and-effect: ▪ Reduction in costs / increases in revenue due to Length of Stay improvements ▪ Cost of clinical negligence claims avoided ▪ Closures of theatres due to old infrastructure failing ▪ CQC audit findings seriously adverse ▪ Reduction in complaints and associated clinical / administrative effort ▪ Reduction in spend on premium rate anaesthetists (paediatric / general) ▪ Reduction in spend on premium rate Recovery nursing

Type of benefit	Direct to Organisation
	staff
Qualitative	Improvements in quality of patient care Improved patient experience Enhanced recruitment and retention of staff

3.5.3. Estimating income and costs

Methodology

Changes in income are the main impact of the options assessed. The only pay expenditure movements anticipated are those related to staffing for the anticipated increase in HDU activity within the expanded Recovery Area. Due to a greater throughput of patients, non-pay costs have been anticipated to increase in all options. This has been calculated based on an average percentage cost of applicable activity.

Non recoverable VAT has been treated as a cost to the organisation. Similarly, capital charges of 3.5% are incurred by the organisation and have therefore also been included as a cost.

Income

There are three key areas of cash-releasing benefit:

a) Transfer delays after operations - from Theatre to Recovery

   Increase in the number of chargeable procedures, due to improved theatre productivity. Estimates of improvements have been based on audit results, which measured actual times versus a target time in the transfer of patients from theatre to recovery. Actual transfer times were significantly greater than target, due to low capacity in recovery and this means that the theatre is blocked unnecessarily. If used productively, this will give rise to fewer patient cancellations within lists.

b) Additional HDU patient income

   Increase in high dependency tariffs. The high dependency capacity within recovery is being more than doubled, from a nominal (non-compliant) 3 bed bays to an actual 6. For reasons of prudence, it has been assumed that the actual average increase in activity over the period considered will be only half of the capacity increase. There are two main sources for additional activity:
   - step-down from critical care, thereby freeing up CC capacity for additional activity
   - unmet demand from HD activity currently taking place on the wards

c) Paediatric elective inpatients and day-case - reducing in-patient transit times between ward and theatre. See the benefits for Phase 2 as described below. The predictions for this income stream are based on results from an audit carried out by the paediatrics CMG. See details in appendix.

   - Phase 1: Additional staff costs (2 personnel) - these are to be incurred as part of a planned CMG CIP initiative, irrespective of the Recovery Area capital project. Benefit: increase throughput of General Surgery/Urology activity.
   - Phase 2: Process changes to coincide with opening of new Children's Reception Area
     Benefit: Incremental increased throughput of all paediatric activity. As a result of the process improvements enabled by the capital development, the same two Phase 1 personnel will be able to manage all the other sub-specialty paediatric surgery, in

addition to the General Surgery/Urology activity. (There will be no additional staff costs associated with this Phase. However, the two Phase 1 staff mentioned above will transfer into the new Reception Area.)

Staff and non-staff costs

- Same number of theatres as currently with no more theatre sessions. (Increased productivity of existing sessions.) Therefore, no increase in theatres staff costs.
- Recovery staff are servicing the same number of theatres as currently and a single combined recovery area is easier to staff and control (currently day case has a separate area). Recovery staff establishment is based on WTE's x number of theatres supported. As there is no increase in the number of theatres, there will be no increase in Recovery staff, even though productivity increases. (Confirmed by ITAPS theatres manager and matron.)
- Paediatric reception staffing. No additional staff required. Paediatrics will transfer 2 existing staff into this area. (Confirmed by Paediatrics service manager.)
- High dependency staffing within Recovery: The cost of staffing a high dependency bed-bay is 3.1 WTE per bay x annual band 5 costs. This has been applied in line with the assumed level of activity increase.
- There is no increase in ward bed-base relating to this case, so therefore no additional pay costs associated with beds.
- Non-pay costs:
  More patients will give rise to a corresponding increase in drugs and consumables. The non-pay percentage of 20% of patient income is an approximation based on historic data for the treatment of surgical patients at the LRI (note: surgical procedures like orthopaedic and cardiac surgery which are high cost in terms of non pay are not performed at the LRI).

Sensitivity analysis

See notes on sensitivity analysis below.

3.5.4. Net present value findings

The detailed economic appraisals for each short-listed option are given in the appendix, together with detailed descriptions for costs and benefits, and their sources and assumptions.

The following table summarises the key results of the economic appraisals for each option:

Option D	**Base case**	**Base case**	**Best case**	**Best case**	**Worst case**	**Worst case**
Recovery and staff rest area reconfiguration	**Undiscounted**	**Net Present Cost**	**Undiscounted**	**Net Present Cost**	**Undiscounted**	**Net Present Cost**
	(£)	**(Value) (£)**	**(£)**	**(Value) (£)**	**(£)**	**(Value) (£)**
Capital	(3,081)	(3,058)	(2,973)	(2,951)	(3,235)	(3,211)
Revenue/current	(5,711)	(3,978)	(4,284)	(2,983)	(7,139)	(4,972)
Risk retained	-	-	-	-	-	-
Optimism bias	-	-	-	-	-	-
Total costs	**(8,792)**	**(7,036)**	**(7,257)**	**(5,934)**	**(10,374)**	**(8,183)**
Less cash releasing benefits	15,522	10,811	19,403	13,514	11,642	8,108
Costs net cash savings	**6,730**	**3,775**	**12,146**	**7,580**	**1,267**	**(75)**
Non-cash releasing benefits	-	-	-	-	-	-
Total	**6,730**	**3,775**	**12,146**	**7,580**	**1,267**	**(75)**

Option F	**Base case**	**Base case**	**Best case**	**Best case**	**Worst case**	**Worst case**
Recovery, staff rest area reconfiguration and paediatric reception	**Undiscounted**	**Net Present Cost**	**Undiscounted**	**Net Present Cost**	**Undiscounted**	**Net Present Cost**
but no direct access route to paediatric wards	**(£)**	**(Value) (£)**	**(£)**	**(Value) (£)**	**(£)**	**(Value) (£)**
Capital	(3,438)	(3,402)	(3,317)	(3,283)	(3,609)	(3,572)
Revenue/current	(5,711)	(3,978)	(4,284)	(2,983)	(7,139)	(4,972)
Risk retained	-	-	-	-	-	-
Optimism bias	-	-	-	-	-	-
Total costs	**(9,149)**	**(7,380)**	**(7,601)**	**(6,266)**	**(10,749)**	**(8,544)**
Less cash releasing benefits	15,522	10,811	19,403	13,514	11,642	8,108
Costs net cash savings	**6,374**	**3,431**	**11,802**	**7,248**	**893**	**(436)**
Non-cash releasing benefits	-	-	-	-	-	-
Total	**6,374**	**3,431**	**11,802**	**7,248**	**893**	**(436)**

Option G	**Base case**	**Base case**	**Best case**	**Best case**	**Worst case**	**Worst case**
Recovery, staff rest area reconfiguration and paediatric reception	**Undiscounted**	**Net Present Cost**	**Undiscounted**	**Net Present Cost**	**Undiscounted**	**Net Present Cost**
plus direct access route to paediatric wards	**(£)**	**(Value) (£)**	**(£)**	**(Value) (£)**	**(£)**	**(Value) (£)**
Capital	(3,675)	(3,631)	(3,547)	(3,504)	(3,859)	(3,813)
Revenue/current	(6,214)	(4,326)	(4,660)	(3,244)	(7,767)	(5,407)
Risk retained	-	-	-	-	-	-
Optimism bias	-	-	-	-	-	-
Total costs	**(9,889)**	**(7,957)**	**(8,207)**	**(6,749)**	**(11,626)**	**(9,220)**
Less cash releasing benefits	18,035	12,552	22,544	15,690	13,526	9,414
Costs net cash savings	**8,146**	**4,595**	**14,337**	**8,941**	**1,900**	**194**
Non-cash releasing benefits	-	-	-	-	-	-
Total	**8,146**	**4,595**	**14,337**	**8,941**	**1,900**	**194**

Assumptions

Discount rate	3.5%	3.5%

Sensitivity

	Best case	Best case	Worst case	Worst case
Capital	(3.5%)	(3.5%)	5.0%	5.0%
Cash releasing benefits	25.0%	25.0%	(25.0%)	(25.0%)
Non-pay costs	(25.0%)	(25.0%)	25.0%	25.0%

Notes on sensitivity:

Capital

Upside: Gain-share mechanism limits main build potential saving to a maximum of 2.5%
Plus may be scope for limited savings elsewhere (equipment, fees, etc.) - an extra 1%

Downside: Gain-share limits main build overspend to agreed GMP + compensation events
Plus may be scope for overspends elsewhere (equipment, fees, etc.)
However, contingency already within budget to account for any overspend

Non-pay costs

Upside: Adjusting the base assumption of 20% of income to 15% recognises that the case mix of additional patients treated will vary and that 20% is a prudent assumption regarding additional costs associated with surgical patients at the LRI

Downside: Adjusting the base assumption of 20% of income to 25% recognises that the case mix of additional patients treated will vary and despite 20% being a prudent assumption it is important to recognise the impact of this increasing

Cash releasing benefits

Upside: The realisation of cash releasing benefits depends on various factors, some of which are outside the scope of this project. The level of risk (and opportunity) is accounted for by the relatively wide sensitivity range considered. However, the audit evidence and the clinicial and the ITAPS and Paediatrics management view is that the opportunity described is reasonable, achievable and prudent.

Downside: See comment above.

A summary of the key outcomes for each option is given below:

Financial appraisal summary:

Discount rate is assumed to be 3.5%

	Base case		Best case		Worst case		Capital expenditure (discounted)	Increments	Net revenue benefit (discounted)
	Net present value	Payback	Net present value	Payback	Net present value	Payback			
	£'000	years	£'000	years	£'000	years	£'000	£'000	£'000
Option A	-	n/a	-	n/a	-	n/a	-		
Option D	3,775	7.1	7,580	4.9	- 75	14.7	- 3,058	- 3,058	6,833
Option F	3,431	7.8	7,248	5.4	- 436	16.3	- 3,402	- 344	6,833
Option G	**4,595**	7.1	**8,941**	5.0	**194**	13.8	- 3,631	- 229	8,226

Commentary

Summary

Options D, F & G all give a positive NPV for the Base case but Option G gives the highest, at £4.6m.
There is little difference in payback periods between the options. (Payback is not applicable to Option A as there is no investment.)
Option F has the worst NPV and longest payback period.
When sensitivity is applied, the outcome does not change:
- Best case: Option G still gives the highest return.
- Worst case: Option G gives the only positive return and the shortest payback period.

Further analysis:

Revenue costs (non-pay) are directly linked to the level of income each option generates.
The only pay costs associated with this project are the additional staff costs to support the increase in HDU activity
Depreciation and finance costs are linked to capital outlay
It therefore becomes a question of capital outlay versus the resulting net revenue benefit.
Compared to our baseline of Option A, the main benefit from the investment is the improved productivity in theatres and the increase in higher dependency care tariffs. Option G also gives us returns from improvements to the paediatric patient journey.
The range of capital spend across the options (i.e. Option G minus Option D capex) is relatively small i.e. an additional 18.8% (or £573.4k in absolute terms).
However, this additional capital spend for Option G gives a percentage increase in net revenue benefit of 20.4% (or £1393k in absolute terms). This additional revenue benefit is from efficiencies as a result of the improved paediatric patient journey.

3.5.5. Option ranking

The results are summarised and shown in the following Table:

Option	Option description	Ranking		
		NPV	Payback period	Net revenue benefit (discounted)
A	Do nothing	4	n/a	4
D	Quality, capacity & staff well-being	2	1	2
F	Children's reception: version 2	3	3	2
G	Paediatric route to theatre	1	1	1

3.6. Risk appraisal

There is no significant difference in risk between the different build options considered. Each involve the possibility of disruption to operational services during the works themselves but the main build area of risk (the expansion of Recovery itself) is common to all short-listed options.

Therefore, the only valid risk assessment is between the baseline "Do Nothing" option and the build options as a group.

3.6.1. Methodology

A detailed appraisal of the design and build risks has been carried out in conjunction with the proposed main contractor (Interserve Construction Limited). A copy of the Risk Register is given in the appendix to this document. (See Appendix Capital build phase – risk register.)

Intrinsic in this methodology is the valuation and allocation of ownership of risk, between the Main contractor (or the Principle Supply Chain Partner - PSCP) and the Client (UHL). Payment to the PSCP for assumption of his risks is included within the Guaranteed Maximum Price. Risk remaining with the Client is provided for within contingency amounts in the project forecast.

Therefore, the risk has been assessed in detail and translated into economic values which have been included in the project forecast expenditure.

The risk appertaining to realisation of the net revenue benefits has been dealt with within the sensitivity analysis within the Economic appraisal.

A Health Gateway Medium / Low Risk Potential Assessment has also been carried out and is shown in Appendix Risk Potential Assessment.

3.6.2. Risk scores

The treatment and valuation of the Design and Build Risks is explained above.

The Health Gateway risk assessment gave an Overall Risk assessment of Low.

Summary comments were:
This is a well-defined capital project with clearly defined deliverables in the form of improvements to the UHL estate at the LRI. There is no significant change to the location or quantity of services (and hence low political or public interest), with the main operational impact anticipated as being an appreciable improvement in the quality of patient care and in the staff working environment.

3.7. The preferred option

The preferred option remains OPTION G.

4. THE COMMERCIAL CASE

4.1. Introduction

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

4.2. Procurement Strategy

The scheme will be procured under Lot 2C & 2D of the Call-Off Contract for the Provision of Design and Construction Services between University Hospitals Of Leicester NHS Trust and Interserve (Facilities Management) Limited. This contract is based on the Procure 21+ (P21+) framework available to NHS organisations in England, which was initiated in July 2012.

Procure 21+ is the Department of Health preferred method of procurement for new builds and refurbishments in the NHS. Procure 21+ and its predecessor Procure 21 have over £5bn worth of schemes registered. The Department of Health has stated that Procure 21+ schemes are providing value for money solutions to over 200 NHS Trusts.

The benefits of the process are that high quality pre-approved supply chains are available for NHS clients without having to go through EU OJEU tendering procedures. This saves an estimated 6 months in procurement time and significant consequential costs. In addition, clients and their supply chain work collaboratively to develop their scheme using common principles and tools that are proven to deliver quality schemes on time and within budget.

P21+ was therefore chosen as the process consistently delivers schemes to time and budget, and enabled risk sharing between clients and contractors. Risk is dealt with openly from the outset of the project and the client, design team and PSCP are encouraged to take an active role in identifying, mitigating and apportioning risk to the party best suited to deal with it. At the point of GMP agreement the joint team will need to allocate residual risks. Detailed discussions are then required in terms of the premium required by the PSCP in order to take on board the risk, and what represents value from the NHS Client viewpoint.

The Trust has appointed Interserve (Facilities Management) Limited (IFM) as the principal supply chain partner (PSCP). However, IFM are assigning the day-to-day management of the design and build provision to Interserve Construction Limited (ICL) – a company which has a base in Leicester (Syston) and which previously successfully delivered the UHL Trust Neo-Natal project. For further details of the project management structure, see section 6 “The Management Case”.

IFM, ICL and UHL have worked together through the full business case (FBC) stage to develop and agree a guaranteed maximum price for delivery of the scheme. This reflects:

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

The Guaranteed Maximum Price (GMP) has been assessed for overall value for money by cost consultants acting for UHL and also by NHS Horizons, the client organisation working on behalf of UHL. This has taken into account elements such as:

- ✓ Prevailing rates for similar works nationally and locally.
- ✓ Published cost indices.

- ✓ Knowledge of the cost of work in the hospital from other recent schemes
- ✓ Prime contractor and client retained risks as identified in the joint risk register

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

4.3. Key Factors Affecting Outcomes

4.3.1. Design, Build and Construction Management

The preferred option requires planning consent in respect of new plant paced on the roof of the Balmoral building. The planning application process with the local planning authority has been completed for this element.
Full building control approval will be sought to current standards.

4.3.2. Implementation Timescales

Section 6 of this business case outlines the implementation programme.

4.3.3. Building Research Establishment Environmental Assessment Method

The Trust is committed to achieving no less than a Very Good rating under BREEAM assessment. The process begins at the design stage and continues right through the build to final certification.

4.3.4. Potential for Risk Transfer

The P21+ Framework has a single comprehensive risk management process, which the Trust will be using. The Project Senior Responsible Officer (SRO) and the PSCP act as joint owners of the joint project Risk Register for this scheme. Responsibility for risks is allocated and identified on the risk register and the risks are valued based on possible value and likelihood.
A list of construction risks associated with the project will be quantified, and then the likely risk-sharing arrangements with the PSCP for all these risks will be agreed.

4.3.5. Proposed Charging Mechanisms

The Trust intends to make payments in relation to works required in accordance with the standard P21+ Framework Agreement. The NEC Option C Form of Contract will be the agreed form of Building Contract for P21+ works. The Building Contract stipulates the payment mechanism, timescales, method of payment calculation, etc.

The approach applied means that the PSCP will be paid a maximum of the GMP for the defined scope of works. If the scope of works changes then the GMP may also change accordingly. There is also a mechanism for a “gain-share”, whereby if the final actual costs are between 95% and 100% of the GMP, then both the Trust and the PSCP will share the savings, on a 50/50 basis. If the final actual cost is less than 95% of the GMP, then the Trust will retain 100% of any savings below the 95% level. If the final cost exceeds the GMP then there is no additional cost to the Trust. This is designed to incentivise efficient working and avoid unnecessary cost.

4.3.6. Proposed Contract Lengths

Contract lengths will be set in relation to the P21+ Framework Agreement. The basis of the LRI Recovery Area Reconfiguration Project Contract will be the NEC Option C contract which contains core clauses and Secondary / Z clauses specific to the P21+ route plus the bespoke requirements of the Client.

4.3.7. Proposed Key Contractual Clauses

Key contractual clauses in relation to works associated with this scheme will be in accordance with standard P21+ Framework contract terms, or existing Trust contracts as appropriate.

4.3.8. Personnel Implications (including TUPE)

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

4.3.9. Procurement Strategy and Implementation Timescales

See the sections above for the procurement strategy.
Full details of the proposed build programme and timescales are given in section 6 below.

4.3.10. Equipment Strategy

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

- ✓ Ownership of the majority of equipment
- ✓ Some Equipment leased depending on UHL Procurement guidance and framework agreements

The equipment work stream will identify all items to be procured by the Trust (group 2 & 3 items).
Guidance on standard framework agreements or preferred suppliers will be sought from theatres Supplies and from the Procurement department.
Price comparisons and value for money assessments will be carried out throughout.
Lead times and the procurement process will be managed so as to fit with the build programme.

4.3.11. FRS 5 accountancy treatment

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

5. THE FINANCIAL CASE

5.1. Introduction

The purpose of this section is to set out the forecast financial implications of the preferred option (as set out in the economic case section) and the proposed deal (as described in the commercial case).

5.2. Impact on the organisation's income and expenditure account

The anticipated payment stream for the project over its intended life span is set out in the following table:

LRI recovery project - Option G - Children's reception: version 3 - Financial summary

Recovery, staff rest area reconfiguration and paediatric reception plus direct access route to paediatric wards

UHL **Business Case template**		(£'000 unless stated) **Year 1** **2014/15**	**Year 2** **2015/16**	**Year 3** **2016/17**	**Year 4** **2017/18**	**Year 5** **2018/19**	**Residual Value** (see note)
Revenue							
Patient episodes	[type]	0	650	912	912	912	
Patient income		£0	£689	£964	£964	£964	
Costs							
Pay costs		£0	£104	£139	£139	£139	
Non-pay		£0	£138	£193	£193	£193	
Indirect costs & overheads		£0	£0	£0	£0	£0	
Total costs		£0	£242	£332	£332	£332	
EBITDA		£0	£447	£632	£632	£632	
Depreciation	0	£121	£187	£187	£187	£187	
Financing costs	0.0%	£0	£0	£0	£0	£0	
Net surplus		-£121	£260	£445	£445	£445	
Cumulative surplus		-£121	£139	£584	£1,029	£1,473	
Average tariff	(£)		£1,059	£1,057	£1,057	£1,057	
Headcount	WTEs	0	4.7	4.7	4.7	4.7	
Average pay cost	(£)		22.4	29.9	29.9	29.9	
EBITDA margin			64.9%	65.6%	65.6%	65.6%	
Net margin			37.7%	46.2%	46.2%	46.2%	
Capital expenditure	(£k)	£2,414	£1,261	£0	£0	£0	
Working capital	(£k)						
Net cashflow (pre funding)		-£2,414	-£814	£632	£632	£632	£7,278
Cumulative cashflow		-£2,414	-£3,229	-£2,597	-£1,965	-£1,333	£5,945
Payback	(Year)						7.1 years
Discounted cashflow	(£k)	-£2,414	-£786	£588	£568	£548	£6,090
Net present value	(£k)	**£4,595**					
Discount rate		**3.5%**					
(based on 3.5% plus risk weighting of:		**0.0%**					
Project IRR		27.9%					
Assumes total project life of		**20**	years				

Note: Residual Value assumes Year 5 cashflows for the remainder of the project life.

Assumes cost of borrowing of	**0.0%**
Surplus cash invested at	**0.0%**

5.3. Impact on the balance sheet

The capital expenditure is to be funded as part of the UHL Capital Programme. No external funding is required.

The phasing of the proposed capital expenditure for the Preferred Option and the comparison with current UHL Capital Programme values is as follows:

Project forecast capital expenditure:

	2013/14	2014/15	2015/16	Totals
	£'000	£'000	£'000	£'000
Already approved: Design stage	218.2	79.0	0.0	297.2
Requiring approval: Build stage	0.0	2,414.2	1,261.1	3,675.3
Totals	218.2	2,493.2	1,261.1	3,972.5

Impact on Capital Programme values for 2014/15:

	2014/15	2015/16	Totals
	£'000	£'000	£'000
Current capital programme	2,785.0	812.0	3,597.0
Project forecast spend	2,493.2	1,261.1	3,754.3
Variance	291.8	(449.1)	(157.3)

It will be seen that there is a relatively small overall increase in predicted spend as compared to the current Capital Programme values over the two years but that the expenditure in the current year has decreased by £291.8k.

5.4. Overall affordability

The UHL Capital Group have reviewed the proposed spend and have confirmed that it falls within the authorised amount for the project in the current UHL Capital Programme.

6. THE MANAGEMENT CASE

6.1. Introduction

This section of the FBC addresses the 'achievability' of the scheme. Its purpose, therefore, is to set out the actions that will be required to ensure the successful delivery of the scheme in accordance with best practice.

6.2. Programme management arrangements

The scheme is an integral part of the UHL Site Reconfiguration Programme, which comprises a portfolio of projects for the delivery of the optimum estate solution to support the planned service delivery by the Trust.

6.3. Project management arrangements

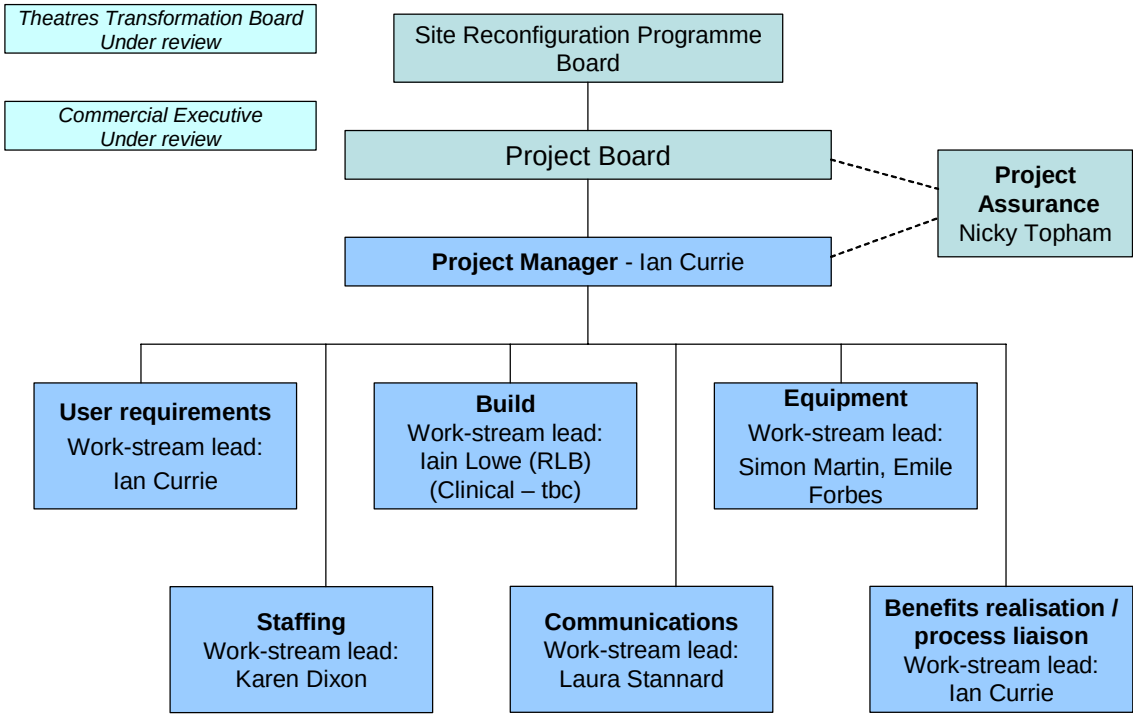
The overall project will be managed in accordance with PRINCE 2 methodology.

The major part of the project, the build work-stream will be managed in accordance with the NEC3 design and build methodology, as described within section 4 above.

6.3.1. Project reporting structure

The reporting organisation and the reporting structure for the project are as follows:

LRI Theatre Arrivals Area / Recovery Area - project structure



6.3.2. Project roles and responsibilities

These are as follows:

Project Board membership

There have been various changes in UHL management structure and personnel during the project lifecycle. Where possible, continuity of role and individual has been maintained. The current membership comprises key personal and stakeholders, referencing the recommended PRINCE 2 structure, as shown below:

Members and roles:

Chair/ Executive
- Nicky Topham Project Director – Site Reconfiguration

Sponsor / Senior User
- Andrew Furlong UHL Trust Deputy Medical Director
- Phil Walmsley ITAPS CMG General Manager
- Helen Brooks ITAPS CMG Deputy Clinical Director
- Paul Gowdridge Head of Strategic Finance (formerly ITAPS CMG Finance manager)

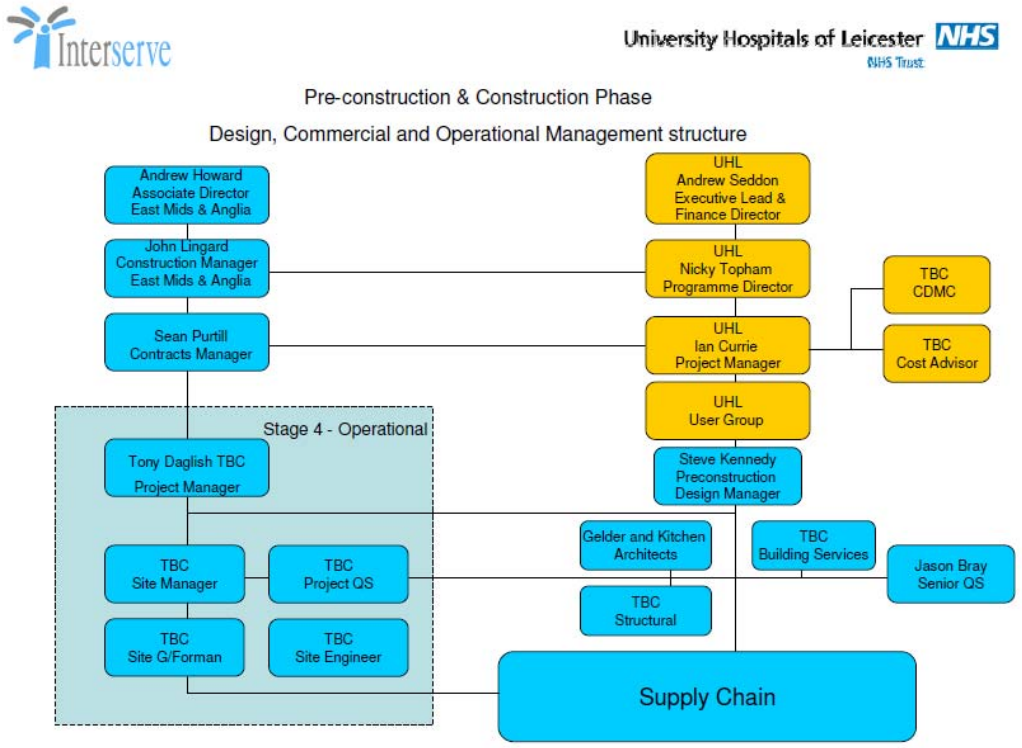
Customer / Senior User
- David Kirkbride Consultant Anaesthetist - Head of Service (LRI)
- Neil Flint Consultant Anaesthetist - Recovery Lead & ICU link

Supplier / Senior Supplier
- Sean Purtill Interserve Construction Limited

The project manager has delegated authority from the project board to incur expenditure up to the authorised limit for a project Stage.

Contracts (e.g. for the main build) can only be entered into at Trust level.

The build work-stream itself will be managed in conjunction with our Principal Supply Chain Partner, Interserve Construction Limited. The following diagram is correct in terms of role, but named individuals may have changed since it was prepared.



The Trust has engaged Rider Levett Bucknall to act as cost advisors and to provide a CMD coordinator and an NEC3 contract experienced Project Manager for the build phase.

6.3.3. Project plan

The outline programme for the build phase (based on the feasibility study draft) is attached the in Appendix Proposed Interserve Build Programme.

The key milestones from the build programmes noted above are summarised in the following table:

Build phase	Completion date
Phase 1: Adult Reception – already in progress	End of May 2014
Full Business Case – Trust Board authorisation	Thursday, 26th June 2014
Phase 2: Recovery part 1	November 2014
Phase 3: Recovery part 2 + Staff Rest area	June 2015
Phase 4: Paediatric reception	September 2015

6.4. Use of special advisers

Special advisers have been, and will be, used in a timely and cost-effective manner in accordance with the Treasury Guidance: Use of Special Advisers**.**

Feasibility study:

Specialist Area	Adviser
Technical	a) Gelder & Kitchen, architects b) Sutcliffes Mechanical and electrical consultants c) NHS Horizons: Nigel Bond, Dave Finch
Procurement and legal	UHL Procurement – Richard Pitt

Detailed design and build stages:

Specialist Area	Adviser
Financial	Rider Levett Bucknall (RLB), Quantity Surveyors
Technical	Expert reviewer (technical design): - NHS Horizons - Richard Kinnersley IDPP CDM coordinator: RLB
Procurement and legal	RLB, Quantity Surveyors
Management	P21+ Project manager: RLB

6.5. Outline arrangements for change and contract management

The strategy, framework and plan for dealing with change and associated contract management is as laid down in the P21+ procurement and contract management guidance.

6.6. Outline arrangements for benefits realisation

There is a benefits realisation and process liaison work-streams part of this project. Its remit is to work with the two operational key customers and project sponsors to plan to deliver the benefits identified in this business case.

Example actions are:

- In the lead up to Phase 3 go-live (increased combined Recovery area), work with surgical specialties and theatre scheduling to recognise and promote the opportunities offered with the removal of the blockages in Recovery. Ensure full lists are planned and staff and processes are ready to deliver them.
- As above, but working with Critical Care and the surgical specialties to plan full utilisation of the increased HDU capacity
- In the lead up to Phase 4 go-live (paediatric holding / reception area), work with Paediatrics service management to ensure the processes and personnel are in place to deliver the predicted benefits for paediatric surgical activity
- Highlight other constraints and dependencies with UHL and ITAPS management, such as ward bed capacity, theatres 0 & 1 refurbishment and re-scheduling of paediatric activity into theatres 0 to 3.

Benefits achieved to be evidenced by:

- Comparison of baseline to future theatre utilisation targets
- Customer satisfaction questionnaires
- Staff questionnaires
- Infection control audit of recovery area & comparison of scores with pre-project audit
- Paediatric service utilisation targets
- Repeat audit of transfer times from Theatres to Recovery
- Repeat audit of transfer times from paediatric ward into theatre
- Review of future CQC audit comments re. standard of current theatre facilities

6.7. Outline arrangements for risk management

The strategy, framework and plan for dealing with the management of risk are as follows:

Each new event / project milestone is assessed by the project manager by reference to the generic project risk categories of cost, programme and quality, as part of normal project management practise. Any predicted exceeding of project tolerances are immediately escalated to the project board by way of an exception report, together with the proposed mitigating actions.

In addition, a risk register is maintained and periodically reviewed for each phase of the project. The NEC / P21+ project management and procurement method ensures design and build risks are identified, costed and included within the agreed GMP. This risk register is kept under constant review throughout the project and adjusted as risks either materialise or are written down.

A copy of the project risk register is attached in the Appendix Capital build phase – risk register

6.8. Outline arrangements for post project evaluation

The outline arrangements for post implementation review (PIR) and project evaluation review (PER) have been established in accordance with best practice and are as follows.

6.8.1. Post implementation review (PIR)

These reviews ascertain whether the anticipated benefits have been delivered and are timed to take place at the following points:

- Quality of facilities provided and improvement in patient care: 3 months after final handover (patient / staff / management questionnaire?) + technical build quality review?
- Benefits to theatre utilisation: 6 months after handover + 12 months after handover (See section 6.6 above)

6.8.2. Project evaluation reviews (PERs)

PERs appraise how well the project was managed and delivered compared with expectations and are timed to take place:

- informal review up to 1 month after end of design and FBC phase
- formal review 1 month after final settlement and project closure
-

6.9. Gateway review arrangements

The impacts / risks associated with the project have been scored against the risk potential assessment (RPA) for projects. The RPA score is Low.

The report is attached at Appendix Risk Potential Assessment

6.10. Contingency plans

In the event that this project fails, the following arrangements are in place for continued delivery of the required services and outputs:

- Continue with current recovery and paediatric reception facilities, attempting to mitigate the inherent problems as much as possible with operational procedures and management strategies
- Re-visit potential estate improvements in this area as soon as feasible within the UHL Trust Capital Programme planning process

Signed: Ian Currie, Project Manager

Date: 24th June 2014

Senior Responsible Owner

Project Team

7. APPENDICES

7.1. Theatre Activity: Analysis by Site

See also section 2.2 Organisational overview

Activity data source: ORMIS. Period: year from 1st Sept. 2012 to 31st August 2013
Units: number of distinct operations

The number of operations by site is shown below. (For simplicity, specialties where the number of operations in a year was less than 10 have been omitted.) The data is sorted in descending order of volume of total operations per specialty and has been split between elective and emergency surgery.

Leicester General Hospital

Commentary:

- Note the predominance of orthopaedics at this site. This is as a result of a previous strategy to consolidate orthopaedic activity at the General.
- The other two significant surgical specialties are urology and gynaecology
- There is currently significant emergency activity which takes place at the General. The majority of this is general surgery, with some obstetrics, urology and gynaecology.

LGH - all theatre activity			
Activity specialty	**Elective**	**Emergency**	**Grand Total**
ORTHOPAEDICS	6,306	7	6,313
UROLOGY	3,138	402	3,540
GYNAECOLOGY	3,222	121	3,343
GENERAL SURGERY	1,926	1,089	3,015
OBSTETRICS	358	843	1,201
RENAL SURGERY	627	25	652
PAIN MANAGEMENT	466		466
RENAL ACCESS SURGERY	6	86	92
TRAUMA & ORTHOPAEDIC	3	28	31
Grand Total	**16,052**	**2,601**	**18,653**
	86%	14%	100%

Glenfield General Hospital

Commentary:

- Glenfield is the centre of excellence for cardiac and thoracic surgery and for breast care
- There is relatively little emergency activity. The vast majority of the emergency activity is cardiac or thoracic.

GGH - all theatre activity			
Activity specialty	**Elective**	**Emergency**	**Grand Total**
CARDIAC SURGERY	2,263	452	2,715
BREAST CARE	1,620	8	1,628
UROLOGY	1,446	4	1,450
GENERAL SURGERY	1,186	12	1,198
THORACIC SURGERY	986	72	1,058
PAIN MANAGEMENT	1,043		1,043
GYNAECOLOGY	651		651
RENAL SURGERY	28	1	29
Grand Total	**9,223**	**549**	**9,772**
	94%	6%	100%

Leicester Royal Infirmary

Commentary:
The majority of operations at the LRI take place in the main theatres suite on level 2 of the Balmoral Building. However, there are other areas in the hospital where specialties such as ophthalmology and obstetrics operate.

LRI - Main theatres suite:

- About one third of operations in the LRI main theatres are classified as emergency operations. In terms of specialties, the key components are trauma and general surgery.
- In terms of elective activity, there are 5 main specialties
- 53% of all UHL emergency activity takes place in the main theatres at the LRI, with another 17% taking place elsewhere at the LRI (see below), making 70% in total

LRI - main theatres only			
Activity specialty	**Elective**	**Emergency**	**Grand Total**
TRAUMA	733	2,929	3,662
EAR NOSE AND THROAT	3,049	160	3,209
GENERAL SURGERY	1,765	1,176	2,941
PLASTIC SURGERY	2,418	213	2,631
PAEDIATRIC	1,711	618	2,329
MAXILLOFACIAL	1,809	174	1,983
VASCULAR SURGERY	600	218	818
PAEDIATRIC ORTHOPAEDICS	379	36	415
ACCIDENT AND EMERGENCY	75	78	153
OPHTHALMOLOGY	79	41	120
TRAUMA & ORTHOPAEDIC	8	25	33
PAIN MANAGEMENT	11	8	19
Grand Total	**12,637**	**5,676**	**18,313**
	69%	31%	100%

LRI - Other theatres or treatment rooms:

Commentary:

- Ophthalmology have a separate suite of 3 theatres on the 6th floor of the Balmoral building
- Obstetrics and gynaecology are carried out in theatres and treatment rooms in the specialist department in the Kensington building

- 24% of the total operations are classified as emergency operations (with the majority being obstetrics – plus some gynaecology and ophthalmology)

LRI surgical activity - not in main theatres suite			
Activity specialty	**Elective**	**Emergency**	**Grand Total**
OPHTHALMOLOGY	4,714	248	4,962
OBSTETRICS	526	1,173	1,699
GYNAECOLOGY	139	397	536
PLASTIC SURGERY	228		228
VASCULAR SURGERY	38	1	39
GENERAL SURGERY	18	1	19
Grand Total	**5,663**	**1,820**	**7,483**
	76%	24%	100%

7.2. Infection Control Risk assessment: Current Recovery Area

(Note: hyperlink to:Main issues with current facilities)

UHL RISK ASSESSMENT FORM				Local Ref. No.	
Title of risk (i.e. There is a risk of/that… resulting in…)	There is a risk of the estate in theatre recovery LRI contributing to cross infection				
CMG/Corporate Directorate	**ITAPS**	**Specialty**	**Theatres**	**Site**	**LRI**
Department/Ward	**Theatre recovery**	**Date of Assessment**	18/12/13	**Assurance Source** (Refer to Datix for reference)	

Description of the risk: List the** causes **and the** consequences **of the risk

Causes (hazard)

- **Lack of adequate hand wash basins in main recovery area. Currently three hand wash basins to 18 bed spaces.**
- **Hand wash basins do not meet current regulations in relation to Pseudomonas prevention guidelines as the drain is not offset and water flows directly into plug hole.**
- **Hand wash basin in sluice too small and doesn't have elbow operated taps.**
- **Flooring in poor state of repair.**
- **Damage to walls**
- **Lack of isolation facilities**
- **Bed spacing loo small**
- **Lack of storage**

Consequences (harm / loss event)

- **Lack of hand hygiene facilities increases the risk of cross infection.**
- **Sinks that do not meet current regulations for control of pseudomonas increase the risk of a patient acquiring a pseudomonas infection particularly as this area would be classed as augmented care.**
- **Damage to floors and walls make cleaning difficult and allows dirt and dust to be trapped increasing risk of cross infection.**
- **Closeness of patients to each other in bed spaces increases the risk of cross infection.**
- **Patients with known or suspected infections are either recovered in existing bed spaces or in theatre. Isolation in current bed spaces increases the risk of cross infection to other patients in the same vicinity whilst recovery in theatre takes a theatre out of use for a considerable amount of time.**
- **Lack of storage for stores and equipment increases the risk that items become contaminated posing a risk of cross infection to patients.**

Controls in place: List what processes are already in place to control the risk (Copy & paste to add rows where necessary)

Hand sanitizer available at each bed space
Patients with infections recovered in theatre

Current Risk Rating (with the controls listed above in place)

Risk subtype: Consequence descriptor: select highest score for Datix (Delete subtype if not applicable)	Consequence (C)	x	Likelihood (L)	=	Risk Rating
Patients	3	x	4	=	12
Injury	3	x	2	=	6
Quality	2	x	3	=	6
Statutory	2	x	4	=	8
Reputation	2	x	3	=	6
Economic	3	x	3	=	9

Action Plan List of 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 £**
Increase numbers of sinks on unit					
Improve size of bed spacing					
Provide cubicle facilities to physically separate patients with infections from other patients					
Make good damage to walls and floors					
Provide further storage options					

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	3	x	2	=	6
Injury	3	x	1	=	3
Quality	2	x	2	=	4
Statutory	2	x	2	=	4
Reputation	2	x	2	=	4
Economic	3	x	2	=	6

Risk Assessment Approval (prior to the entry being input on to Datix)					
Risk Assessor name	Islwyn Jones	Signature		Date	18/12/13
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.	Minor injury or illness, requiring minor intervention Increase in length of hospital stay by 1-3 days	Moderate injury requiring professional intervention Increase in length of hospital stay by 4-15 days RIDDOR/agency reportable incident An event which Consequences on a small number of patients	Mismanagement of patient care with long-term effects Increase in length of hospital stay by >15 days	Incident leading to death Multiple permanent injuries or irreversible health effects An event which Consequences on a large number of patients
INJURY Consequence on the safety of staff or public physical/ psychological harm)	Minimal injury requiring no/minimal intervention or treatment. No time off work	Minor injury or illness, requiring minor intervention Requiring time off work for <3 days	Moderate injury requiring professional intervention Requiring time off work for 4-14 days RIDDOR/agency reportable incident	Major injury leading to long-term incapacity/disability 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 Formal complaint (stage 1) Local resolution Single failure to meet internal standards Minor implications for	Treatment or service has significantly reduced effectiveness Formal complaint (stage 2) complaint Local resolution (with potential to go to independent review) Repeated failure to meet	Non-compliance with national standards with significant risk to patients if unresolved Multiple complaints/ independent review Low performance rating	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

		patient safety if unresolved Reduced performance rating if unresolved	internal standards Major patient safety implications if findings are not acted on	Critical report	national standards
HUMAN RESOURCES (Human resources/ organisational development/ staffing/ competence)	Short-term low staffing level that temporarily reduces service quality (< 1 day)	Low staffing level that reduces the service quality	Late delivery of key objective/ service due to lack of staff Unsafe staffing level or competence (>1 day) Low staff morale Poor staff attendance for mandatory/key 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 No staff attending mandatory/ key training	Non-delivery of key objective/service due to lack of staff Ongoing unsafe staffing levels or competence Loss of several key staff No staff attending mandatory training /key training on an ongoing basis
STATUTORY (Statutory duty/ inspections)	No or minimal Consequence or breech of guidance/ statutory duty	Breech of statutory legislation Reduced performance rating if unresolved	Single breech in statutory duty Challenging external recommendations/ improvement notice	Enforcement action Multiple breeches in statutory duty Improvement notices Low performance rating Critical report	Multiple breeches in statutory duty Prosecution Complete systems change required Zero performance rating Severely critical report
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 objectives/ projects)	Insignificant cost increase/ scheduled slippage	<5 per cent over project budget Scheduled slippage	5–10 per cent over project budget Scheduled slippage	Non-compliance with national 10–25 per cent over project budget Schedule slippage Key objectives not met	Incident leading >25 per cent over project budget Schedule slippage Key objectives not met
ECONOMIC (Finance including claims)	Small loss Risk of claim remote	Loss of 0.1–0.25 per cent of budget Claim less than £10,000	Loss of 0.25–0.5 per cent of budget Claim(s) between £10,000 and £100,000	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	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)	Minimal or no Consequence on the environment	Minor Consequence on environment	Moderate Consequence on environment	Major Consequence on environment	Catastrophic Consequence on environment

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 persisting issue. Or Expected to occur at least weekly. Or Probability: 10-50%	**4**	**8**	**12**	**16**	**20**
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)	Action planned within six months; commenced within 6 months. Review in 3 months. Place on risk register.
High (15 – 20)	Action planned within three months; commenced within 3 months. Review at monthly intervals. Place on risk register.
Extreme (25)	Action planned and implemented ASAP. Review weekly. Place on risk register.

7.3. Options Appraisal – non-financial scoring

Recovery Area project: non-financial options appraisal (feasible long-list options)

Score: 10 = high, 1 = low

Benefit criteria		weight	A - Do nothing		B - Quality only		C - Quality and capacity		D - Quality, capacity & staff well-being		F - Children's reception: version 2		G - Children's reception: version 3	
			score	weight x score	score	weight x score	score	weight x score	score	weight x score	score	weight x score	score	weight x score
1.0	**Improve quality of patient care**	**22**		**59**		**153**		**169**		**169**		**176**		**187**
1.1	Patient care, patient safety and decreased risk	11	2	22	8	88	8	88	8	88	8	88	8	88
1.2	Patient experience	7	3	21	7	49	7	49	7	49	8	56	9	63
1.3	Theatre utilisation - fewer cancelled patients	4	4	16	4	16	8	32	8	32	8	32	9	36
2.0	**Improved support for volume and type of theatre activity**	**10**		**45**		**45**		**80**		**80**		**80**		**85**
2.1	Increased complexity of case mix	5	5	25	5	25	8	40	8	40	8	40	8	40
2.2	Theatre utilisation improvements - increased revenue	5	4	20	4	20	8	40	8	40	8	40	9	45
3.0	**Segregate children and adult patient pathways**	**16**		**0**		**0**		**66**		**66**		**82**		**160**
3.1	Segregated route to theatres from wards	4	0	0	0	0	0	0	0	0	0	0	10	40
3.2	Improved journey from wards - better utilisation - more revenue	3	0	0	0	0	0	0	0	0	0	0	10	30
3.3	Segregated patient journey within theatre suite (reception-theatre-recovery)	4	0	0	0	0	4	16	4	16	8	32	10	40
3.4	Segregated area within recovery facility	5	0	0	0	0	10	50	10	50	10	50	10	50
4.0	**Support critical care provision**	**12**		**21**		**40**		**108**		**108**		**108**		**108**
4.1	Supports ongoing critical care provision and flexibililty	7	3	21	5	35	9	63	9	63	9	63	9	63
4.2	Provides decant facility during ICU expansion works	5	0	0	1	5	9	45	9	45	9	45	9	45
5.0	**Provide future flexibility**	**14**		**42**		**56**		**140**		**140**		**140**		**140**
5.1	Large combined recovery area offers future flexibility of use	14	3	42	4	56	10	140	10	140	10	140	10	140
6.0	**Improve staff environment**	**16**		**32**		**60**		**90**		**132**		**152**		**152**
6.1	Better working conditions within Recovery area	5	2	10	6	30	10	50	10	50	10	50	10	50
6.2	Improved staff facilities	7	2	14	2	14	4	28	10	70	10	70	10	70
6.3	Improved patient reception areas	4	2	8	4	16	3	12	3	12	8	32	8	32
7.0	**Operational considerations**	**10**		**34**		**54**		**74**		**80**		**84**		**88**
7.1	Staffing	2	4	8	5	10	8	16	9	18	9	18	9	18
7.2	Management	2	4	8	5	10	8	16	9	18	9	18	9	18
7.3	Best use of equipment	2	4	8	7	14	8	16	8	16	8	16	8	16
7.4	Clinical support	2	3	6	7	14	7	14	8	16	8	16	8	16
7.5	Patient routes	2	2	4	3	6	6	12	6	12	8	16	10	20
TOTAL WEIGHTED SCORES		**100**		**233**		**408**		**727**		**775**		**822**		**920**
RANKING				**6**		**5**		**4**		**3**		**2**		**1**

7.4. Financial appraisal – options summaries

LRI recovery project - Option A "Do nothing" - Financial summary

It follows from the financial appraisal approach described above that the 'do nothing' option has no capital expenditure (by definiton) and also no related changes to income or expenditure
It has an NPV of Nil.
Payback does not apply

LRI recovery project - Option D - Quality, capacity & staff well-being - Financial summary

Recovery and staff rest area reconfiguration

UHL		**Only populate the green cells**					
Business Case template		(£'000 unless stated)					
		Year 1 2014/15	**Year 2 2015/16**	**Year 3 2016/17**	**Year 4 2017/18**	**Year 5 2018/19**	**Residual Value**
Revenue							(see note)
Patient episodes	[type]	0	583	778	778	778	
Patient income		£0	£621	£828	£828	£828	
Costs							
Pay costs		£0	£104	£139	£139	£139	
Non-pay		£0	£124	£166	£166	£166	
Indirect costs & overheads		£0	£0	£0	£0	£0	
Total costs		£0	£228	£305	£305	£305	
EBITDA		£0	£392	£523	£523	£523	
Depreciation	0	£121	£156	£156	£156	£156	
Financing costs	0.0%	£0	£0	£0	£0	£0	
Net surplus		-£121	£237	£367	£367	£367	
Cumulative surplus		-£121	£116	£483	£851	£1,218	
Average tariff	(£)	#DIV/0!	£1,065	£1,065	£1,065	£1,065	
Headcount	WTEs	0	4.7	4.7	4.7	4.7	
Average pay cost	(£)	#DIV/0!	22.4	29.9	29.9	29.9	
EBITDA margin		#DIV/0!	63.2%	63.2%	63.2%	63.2%	
Net margin		#DIV/0!	38.1%	44.4%	44.4%	44.4%	
Capital expenditure	(£k)	£2,414	£667	£0	£0	£0	
Working capital	(£k)						
Net cashflow (pre funding)		-£2,414	-£274	£523	£523	£523	£6,027
Cumulative cashflow		-£2,414	-£2,689	-£2,165	-£1,642	-£1,119	£4,908
Payback	(Year)						
Discounted cashflow	(£k)	-£2,414	-£265	£487	£470	£454	£5,043
Net present value	(£k)	**£3,775**					
Discount rate		**3.5%**					
(based on 3.5% plus risk weighting of:		**0.0%**					
Project IRR		26.7%					
Assumes total project life of		**20**	years				

Note: RV assumes Year 5 cashflows for the remainder of the project life.

Assumes cost of borrowing of	**0.0%**
Surplus cash invested at	**0.0%**

LRI recovery project - Option F - Children's reception: version 2 - Financial summary

Recovery, staff rest area reconfiguration and paediatric reception but no direct access route to paediatric wards

UHL
Business Case template

Only populate the green cells

(£'000 unless stated)

		Year 1 2014/15	Year 2 2015/16	Year 3 2016/17	Year 4 2017/18	Year 5 2018/19	Residual Value (see note)
Revenue							
Patient episodes	[type]	0	583	778	778	778	
Patient income		£0	£621	£828	£828	£828	
Costs							
Pay costs		£0	£104	£139	£139	£139	
Non-pay		£0	£124	£166	£166	£166	
Indirect costs & overheads		£0	£0	£0	£0	£0	
Total costs		£0	£228	£305	£305	£305	
EBITDA		£0	£392	£523	£523	£523	
Depreciation	0	£121	£175	£175	£175	£175	
Financing costs	0.0%	£0	£0	£0	£0	£0	
Net surplus		-£121	£218	£349	£349	£349	
Cumulative surplus		-£121	£97	£446	£795	£1,143	
Average tariff	(£)	#DIV/0!	£1,065	£1,065	£1,065	£1,065	
Headcount	WTEs	0	4.7	4.7	4.7	4.7	
Average pay cost	(£)	#DIV/0!	22.4	29.9	29.9	29.9	
EBITDA margin		#DIV/0!	63.2%	63.2%	63.2%	63.2%	
Net margin		#DIV/0!	35.1%	42.1%	42.1%	42.1%	
Capital expenditure	(£k)	£2,414	£1,023	£0	£0	£0	
Working capital	(£k)						
Net cashflow (pre funding)		-£2,414	-£631	£523	£523	£523	£6,027
Cumulative cashflow		-£2,414	-£3,045	-£2,522	-£1,999	-£1,475	£4,551
Payback	(Year)						
Discounted cashflow	(£k)	-£2,414	-£609	£487	£470	£454	£5,043
Net present value	(£k)	**£3,431**					
Discount rate		**3.5%**					
(based on 3.5% plus risk weighting of:		**0.0%**					
Project IRR		23.7%					
Assumes total project life of		**20** years					

Note: RV assumes Year 5 cashflows for the remainder of the project life.

Assumes cost of borrowing of	**0.0%**
Surplus cash invested at	**0.0%**

LRI recovery project - Option G - Children's reception: version 3 - Financial summary

Recovery, staff rest area reconfiguration and paediatric reception plus direct access route to paediatric wards

UHL
Business Case template

Only populate the green cells

(£'000 unless stated)

		Year 1 2014/15	Year 2 2015/16	Year 3 2016/17	Year 4 2017/18	Year 5 2018/19	Residual Value (see note)
Revenue							
Patient episodes	[type]	0	650	912	912	912	
Patient income		£0	£689	£964	£964	£964	
Costs							
Pay costs		£0	£104	£139	£139	£139	
Non-pay		£0	£138	£193	£193	£193	
Indirect costs & overheads		£0	£0	£0	£0	£0	
Total costs		£0	£242	£332	£332	£332	
EBITDA		£0	£447	£632	£632	£632	
Depreciation	0	£121	£187	£187	£187	£187	
Financing costs	0.0%	£0	£0	£0	£0	£0	
Net surplus		-£121	£260	£445	£445	£445	
Cumulative surplus		-£121	£139	£584	£1,029	£1,473	
Average tariff	(£)		£1,059	£1,057	£1,057	£1,057	
Headcount	WTEs	0	4.7	4.7	4.7	4.7	
Average pay cost	(£)		22.4	29.9	29.9	29.9	
EBITDA margin			64.9%	65.6%	65.6%	65.6%	
Net margin			37.7%	46.2%	46.2%	46.2%	
Capital expenditure	(£k)	£2,414	£1,261	£0	£0	£0	
Working capital	(£k)						
Net cashflow (pre funding)		-£2,414	-£814	£632	£632	£632	£7,278
Cumulative cashflow		-£2,414	-£3,229	-£2,597	-£1,965	-£1,333	£5,945
Payback	(Year)						7.1 years
Discounted cashflow	(£k)	-£2,414	-£786	£588	£568	£548	£6,090
Net present value	(£k)	**£4,595**					
Discount rate		**3.5%**					
(based on 3.5% plus risk weighting of:		**0.0%**					
Project IRR		27.9%					
Assumes total project life of		**20**	years				

Note: Residual Value assumes Year 5 cashflows for the remainder of the project life.

Assumes cost of borrowing of	**0.0%**
Surplus cash invested at	**0.0%**

7.5. Capital costs breakdown

Phased capital spend - for the short-listed options

(£'000 unless stated)

		Year 1 2013/14	Year 2 2014/15	Year 3 2015/16	Year 4 2016/17	Year 5 2017/18	Totals
Option A	Do nothing	-	-	-	-	-	-
Option D	Quality, capacity & staff well-being Improve Recovery Area quality and increase capacity (to meet national guidelines) plus improve the adjacent staff rest areas	-	2,414.2	666.9	-	-	3,081.1
Option F	Children's route: version 2 As Option D plus provide a separate children's reception area but no new access route from ward.	-	2,414.2	1,023.3	-	-	3,437.5
Option G	Children's route: version 3 As Option F plus create a new route to theatres directly from the 4th floor paediatric ward	-	2,414.2	1,261.1	-	-	3,675.3

WORKINGS:

1 Options Summary

Ignore all sunk costs

Option D	£	£	£	£	£	£
Interserve - Roof works	-	225,591	-	-	-	225,591
Interserve - Phase 2	-	1,049,618	-	-	-	1,049,618
Interserve - Phase 3	-	719,449	496,762	-	-	1,216,211
IM&T and finishing - Phases 2 & 3	-	33,600	-	-	-	33,600
Other costs	-	325,963	155,178	-	-	481,141
General contingency	-	60,000	15,000	-	-	75,000
	-	2,414,221	666,940	-	-	3,081,161
						-

Option F	£	£	£	£	£	£
Interserve - Roof works	-	225,591	-	-	-	225,591
Interserve - Phase 2	-	1,049,618	-	-	-	1,049,618
Interserve - Phase 3	-	719,449	496,762	-	-	1,216,211
IM&T and finishing - Phases 2 & 3	-	33,600	-	-	-	33,600
Interserve - Phase 4a	-	-	352,189	-	-	352,189
IM&T and finishing - Phase 4a	-	-	4,200	-	-	4,200
Other costs	-	325,963	155,178	-	-	481,141
General contingency	-	60,000	15,000	-	-	75,000
	-	2,414,221	1,023,329	-	-	3,437,550

Option G	£	£	£	£	£	£
Interserve - Roof works	-	225,591	-	-	-	225,591
Interserve - Phase 2	-	1,049,618	-	-	-	1,049,618
Interserve - Phase 3	-	719,449	496,762	-	-	1,216,211
IM&T and finishing - Phases 2 & 3	-	33,600	-	-	-	33,600
Interserve - Phase 4a	-	-	352,189	-	-	352,189
IM&T and finishing - Phase 4a	-	-	4,200	-	-	4,200
Direct works - Phase 4b (Ward 10 and lifts)	-	-	237,723	-	-	237,723
Other costs	-	325,963	155,178	-	-	481,141
General contingency	-	60,000	15,000	-	-	75,000
	-	2,414,221	1,261,052	-	-	3,675,273

2 Split of sunk costs versus opportunity cost (for FBC authorisation)

Phasing based on forecast as at 1st May 2014 (assume VAT is recoverable at 20% on build costs and 100% of prof. fees)

See "RecoveryCostSummaryPlusPhasing_v6.xls"

	up to 30/6/2014	01/07/14 to 31/03/15	2015/16	2016/17	2017/18	Totals
	£	£	£	£	£	£
Sunk cost as at FBC submission - Detailed design, Phase 1 and FBC development						
Design						
Detailed design (feasibility + Stage 3)	170,836					170,836
Phase 1 design & build						
Phase 1 direct works	90,708					90,708
Other build-related works (IM&T, finishing, etc.)	4,000					4,000
	94,708	-	-	-	-	94,708
Phase 1 contingency (5%)	4,735					4,735
	99,444	-	-	-	-	99,444
Other costs						
Equipment	-					-
Management and consultancy	27,473					27,473
	27,473	-	-	-	-	27,473
Sunk cost totals	**297,752**	**-**	**-**	**-**	**-**	**297,752**
FBC authority sought: design and build and other costs						
Build stage - Interserve works						
Main build - roof works		188,834	-			188,834
UHL contingency (10%)		18,883	-			18,883
Main build - detailed design (during build phase)		17,873				17,873
Roof works	-	225,591	-	-	-	225,591
Main build - 2		954,198	-			954,198
UHL contingency (10%)		95,420	-			95,420
Phase 2	-	1,049,618	-	-	-	1,049,618
Main build - 3		654,045	451,602			1,105,647
UHL contingency (10%)		65,404	45,160			110,565
Phase 3	-	719,449	496,762	-	-	1,216,211
Main build - 4		-	320,172			320,172
UHL contingency (10%)		-	32,017			32,017
Phase 4a	-	-	352,189	-	-	352,189
Totals for Interserve works	**-**	**1,994,658**	**848,951**	**-**	**-**	**2,843,610**
Build stage - Directly managed works						
IM&T networking and cabling (phases 2 & 3)		24,000				24,000
Finishing (interior design, signage, etc.) - phases 2 & 3		8,000				8,000
	-	32,000	-	-	-	32,000
Contingency (5%)	-	1,600	-	-	-	1,600
	-	33,600	-	-	-	33,600
IM&T networking and cabling (phase 4a)			3,000			3,000
Finishing (interior design, signage, etc.) - phase 4a			1,000			1,000
	-	-	4,000	-	-	4,000
Contingency (5%)	-	-	200	-	-	200
	-	-	4,200	-	-	4,200
Phase 4b Ward 10 direct works (including design)			170,723			170,723
Phase 4b Lifts direct works			55,680			55,680
	-	-	226,403	-	-	226,403
Contingency (5%)	-	-	11,320	-	-	11,320
	-	-	237,723	-	-	237,723
Totals for Direct build works	**-**	**33,600**	**241,923**	**-**	**-**	**275,523**
Design and build totals	***270,279***	***2,028,258***	***1,090,874***	***-***	***-***	***3,389,412***
Other costs						
Equipment		216,071	141,441			357,512
Management and consultancy		109,892	13,737			123,629
Totals for other costs	-	325,963	155,178	-	-	481,141
General contingency	-	60,000	15,000			75,000
FBC totals	**-**	**2,414,221**	**1,261,052**	**-**	**-**	**3,675,273**
Project totals (total expenditure)	***297,752***	***2,414,221***	***1,261,052***	***-***	***-***	***3,973,026***

7.6. Risk Potential Assessment

RPA-LRIRecoveryAr
eaReconfiguration.dc

7.7. Proposed Interserve Build Programme

LRIRecoveryProgram
meRevC.pdf

7.8. Capital build phase – risk register

RiskRegister_v14_Dr
aft.xls

7.9. Association of Anaesthetists in Great Britain and Ireland guidelines

A copy of the guidelines relating to Immediate Post-anaesthesia Recovery is attached. Of particular note are the sections on "The PACU Facility" (pages 3 – 5) and on "Children" (pages 11 & 12).

AAGBI_ImmediatePo
st-AnaesthesiaRecov

7.10. Theatre to Recovery times audit summary

Theatre to Recovery Transfer and Handover Times audit

Author:	Neil Flint
Date:	tbc
Sample period	2 weeks
Number of cases:	
adults	203
children	43
emergency theatres	22
	268

Day-case activity was not included in the sample
Normal working hours only

Times recorded (minutes):

1 Contacting recovery to arrival in recovery

Target time 2 minutes

Actual times					
<= 2	2 - 5	6 - 10	11 - 15	16 - 20	> 20
12%	26%	33%	13%	5%	11%

Total time in 2 weeks over the target 2 minutes per transfer 23 hours 12 mins
Time wasted per week **11 hours 36 mins**

2 Arrival in recovery to handover of patient to recovery staff

Target time 0 minutes

Actual times		
0	1 - 5	> 6
42%	42%	16%

Total time in 2 weeks over the target 0 minutes per handover 11 hours 29 mins
Time wasted per week **5 hours 45 mins**

Key findings:

1. **Adequate recovery bays coupled with adequate nursing staff would save over 17 hours per week.**
2. **Major delay is in transfer of patient from theatre to recovery. This reflects problems with numbers of recovery bays and possibly also staffing issues**
3. **Cases of anaesthetist recovering patient and patient being recovered in theatre are still occurring**

7.11. Standards for Paediatric Theatre Recovery

1. GUIDELINES

a. *"Standards for Childrens Surgery" PLUS "Childrens Surgical Forum"*

State the following: (Standard 9.10)
"In the recovery area, there is a physical separation between children and adult patients." "Parents/carers are able to be present with their child when they wake up"

Endorsed by:

- The Association of paediatric Anaesthetists of Great Britain and Ireland
- The Association of Surgeons of Great Britain and Ireland
- The British Association of Paediatric Surgeons
- The British Association of Paediatric Otorhinolaryngology
- The British Association of Paediatric Urologists
- The British Association of Urological Surgeons
- The British Orthopaedic Association
- ENT UK

- The Patient Liaison Group at the Royal College of Surgeons of England
- The Royal College of Anaesthetists
- The Royal College of nursing
- The Royal College of Obstetricians and Gynaecologists
- The Royal College of Paediatrics and Child Health
- The Royal College of Surgeons of England
- The Society for Cardiothoracic Surgery in Great Britain and Ireland

b. Getting the right start: "National Service Framework for Children" and "Standard for Hospital Services (April 2003)"

State the following:
"Child-friendly hospitals recognise that children are not the same as adults". (forward, page 1)
"Childrens physiology differs from that of adults and changes as they grow and develop". (section 2.8 – line 2)
"Care should be delivered in a safe, suitable and child-friendly environment". (Section2.21)
"Using a medicine designed for use in adults may mean that very small amounts must be measured, or the medicine has to be diluted, adding to the potential for error". (section 4.19), Physical separation from adults improves safety as staff are not dealing with high and lose dose regimes simultaneously."
"In A&E departments, surgery recovery areas, and outpatient clinics, there should be physical separation between children and adult patients, so that children are not exposed to potentially frightening behaviour; and equally, so that adults feeling ill are not disturbed by noisy children". (section 5.5)

2. ACTIVITY ISSUES

Moving children from the Current Surgical Day Ward on Level 2 where there is direct access to theatres will increase the transfer time to and from theatre/wards.

Audit: Summer 2013
- Average time between cases, where child went from an in-patient ward to theatre = 15 minutes
- Average time between cases where chid was on day ward prior to theatre = 8mins

    - Potential lost time in one year equates to 160 hours, assuming a 7 minute difference between each model.

    - At an average of 40 minutes per procedure, this equated to 245 procedures a year that may be lost to additional inefficiency.

    - This does not take into account additional efficiency gains that may be made by improving transit times for in-patients via direct lift access. Over 4,000 patients per year have surgery from locations other than the Day Ward. There is a potential to reduce time between these cases by 7 mins each, based on average times. This equates to 460 plus hours or 700 procedures per year.

(That however is of course only part of the picture. In order to realise the benefits of this, better patient flow, and patient throughput will be required to ensure that beds are available to facilitate additional cases.)

P

Trust Board paper P

To:	**Trust Board**
From:	**Rachel Overfield - Chief Nurse**
Date:	**26 June 2014**
CQC regulation:	Outcome 16 – Assessing and Monitoring the Quality of Service Provision

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

Author/Responsible Director: Chief Nurse

Purpose of the Report:

The report provides the Board with an updated BAF and oversight of any new extreme and high risks opened within the Trust during the reporting period. The report includes:-

a) A copy of the BAF as of 31 May 2014.
b) An action tracker to monitor progress of BAF actions
c) New extreme and/ or high risks opened during the reporting period.
d) An update of progress with the review and development of a 2014/15 BAF.

The Report is provided to the Board for:

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

Summary :

- This 'interim' 2014/15 BAF provides a continuation of the previous 2013/14 BAF until such time that a full review of the contents is completed.
- The TB is asked to note the following points :

  a. In relation to action 1.24; the question as to whether it will be possible to complete the IBP and SOC at the same time.

  b. In relation to action 1.30; the change from a green to an amber rating due to delays caused by the lack of agreement on the consequences of fines and penalties.

  c. In relation to action 9.15 the reduction in the total number of additional beds to be opened from 44 to 18.

  d. In relation to action 13.8 the further slippages of the completion date to November 2014 due to delays in the tendering process for works.

  e. Updates to actions under the ownership of the CIO have not been possible due to annual leave of the CIO.
- The following three BAF entries are suggested for review.
  Risk 1 – Failure to achieve financial sustainability
  Risk 12 – Failure to exploit the potential of IM&T
  Risk 13 – Failure to enhance education and training culture
- The production of a fully revised 2014/15 BAF is delayed pending agreement of the principal risks for inclusion. It is anticipated that this will be produced for the July 2014 TB meeting.
- Three new high risks have been opened on the UHL register during May 2014.

Trust Board paper P

Recommendations:

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

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

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

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

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

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

(f) Note the requirement for principal risks to be identified by the TB before further work on the revised 2014/15 BAF can commence.

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

Resource Implications (eg Financial, HR)
N/A

Assurance Implications:
Yes

Patient and Public Involvement (PPI) Implications:
Yes

Equality Impact
N/A

Information exempt from Disclosure:
No

Requirement for further review?
Yes. Monthly review by the Board

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST

REPORT TO: **TRUST BOARD**

DATE: **26th JUNE 2014**

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

SUBJECT: **UHL RISK REPORT INCORPORATING THE BOARD ASSURANCE FRAMEWORK (BAF) 2014/15**

---

1. INTRODUCTION

1.1 This report provides the Trust Board (TB) with:-

a) A copy of the interim BAF as of 31 May 2014.
b) An action tracker to monitor progress of BAF actions.
c) Notification of any new extreme or high risks opened during the reporting period.
d) An update of progress with the review and development of a 2014/15 BAF

2. BAF POSITION AS OF 31 MAY 2014

2.1 A copy of the 2014/15 'interim' BAF is attached at appendix one with changes since the previous version highlighted in red text. A copy of the action tracker is attached at appendix two. Actions completed prior to May 2014 have been removed from the tracker and a full audit trail of these is available by reference to previous documents.

2.2 The 'interim' 2014/15 BAF provides a continuation of the previous 2013/14 BAF until such time that a full review of the content for 2014/15 is performed.

2.3 The TB is asked to note the following points :

a. In relation to action 1.24; the question as to whether it will be possible to complete the IBP and SOC at the same time.

b. In relation to action 1.30; the change from a green to an amber rating due to delays caused by the lack of agreement on the consequences of fines and penalties. Following intervention by NHSE/TDA regarding the application of local fines and penalties the Trust is in a position to agree a contract and a proposal is now awaited from the CCG.

c. In relation to action 9.15 the reduction in the total number of additional beds to be opened from 44 to 18.

d. In relation to action 13.8 the further slippages of the completion date to November 2014 due to delays in the tendering process for works.

e. Updates to actions under the ownership of the CIO have not been possible due to annual leave of the CIO therefore updates to actions due for completion in May will be presented in the July BAF report to the TB

2.4 To provide an opportunity for more detailed scrutiny the following three BAF entries are suggested for review against the parameters listed in appendix three.

- Risk 1 – Failure to achieve financial sustainability
- Risk 12 – Failure to exploit the potential of IM&T
- Risk 13 – Failure to enhance education and training culture

3 REVIEW OF PROGRESS IN THE DEVELOPMENT OFTHE 2014/15 BAF

3.1 To develop a BAF there are a number of key steps that must be taken in sequence:

- Establish strategic objectives (and their owners).
- Identify the principal risks to the achievement of the objectives (and, in addition, identifying the risk owners).
- Identify the key controls that are at our disposal to achieve the objective and control the principal risks.
- Identify the mechanisms by which the Board receives assurance (positive or negative) that the controls are effective.
- Identify any gaps in control or gaps in assurance
- Put in place plans to address any gaps

3.2 Best practice dictates that the TB *'must be appropriately engaged in developing and monitoring the BAF'* (ref. Board Assurance Frameworks – Good Governance Institute 2009). This includes involvement in the identification of principal risks (ref. Building an Assurance framework – A Practical guide for NHS Boards – Dept. of Health 2003).

3.3 Principal risks should wherever possible be aligned with the UHL 5 year integrated business plan (IBP) that sets out the road map of how our strategic objectives will be achieved. To do otherwise would mean that the TB may not be seeking assurance in relation to the correct risks. It was therefore felt prudent to delay the complete revision of the 2014/15 BAF until the IBP was approved in principle by the TB at the meeting on 16 June 2014. It is important for the TB to be engaged in the identification of the principal risks (see 3.2) and further work will be required to distil the 50 - 60 risks contained in the IBP into a set of principal risks for inclusion in the BAF. It must be noted that the identification of appropriate principal risks is the key to an accurate BAF and further work on the BAF will not be able to commence until this is complete.

3.4 Taking into account section 3.3 it is not possible to provide the Board with a fully revised 2014/15 BAF and it is now anticipated that this will be produced for the July 2014 TB meeting.

4. EXTREME AND HIGH RISK REPORT.

4.1 Three new high risks have opened during May 2014 as described below. The details of these risks are included at appendix four for information

.

Risk ID	Risk Title	Risk Score	CMG/Corporate Directorate
2339	Potential risk to Renal transplant patients as a result of deterioration of team working & deviation from policy	20	RRC

	and procedures		
2338	There is a risk of patients not receiving medication and patients receiving the incorrect medication due to an unstable homecare	16	Medical Directorate
2341	Long term follow up outpatient appointments not made	16	Operations

5. RECOMMENDATIONS

5.1 Taking into account the contents of this report and its appendices the TB is invited to:

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

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

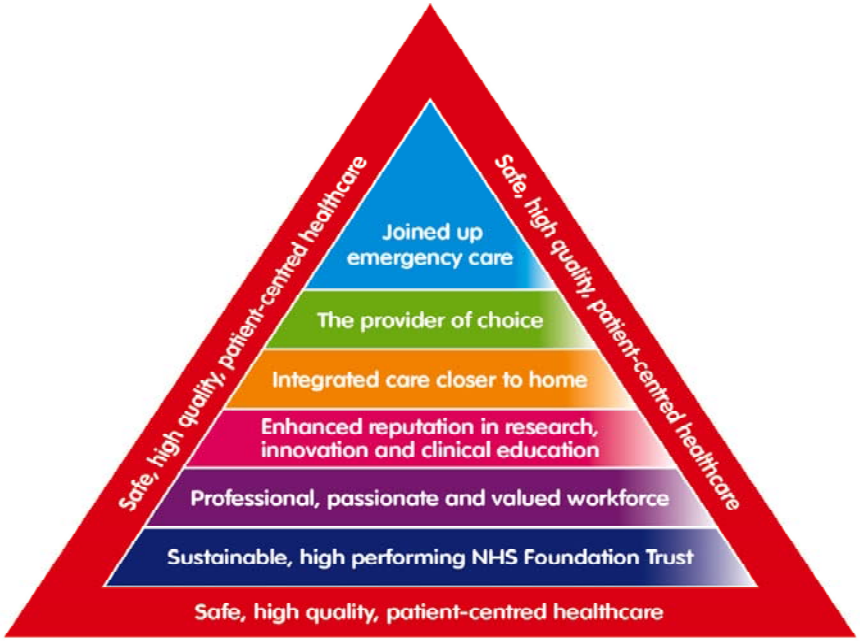
(c) identify any areas which it feels that the Trust's controls are inadequate and do not, therefore, effectively manage the principal risks to the organisation achieving its objectives;

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

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

(f) Note the requirement for principal risks to be identified by the TB before further work on the revised 2014/15 BAF can commence.

Peter Cleaver,
Risk and Assurance Manager,
19 June 2014.


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

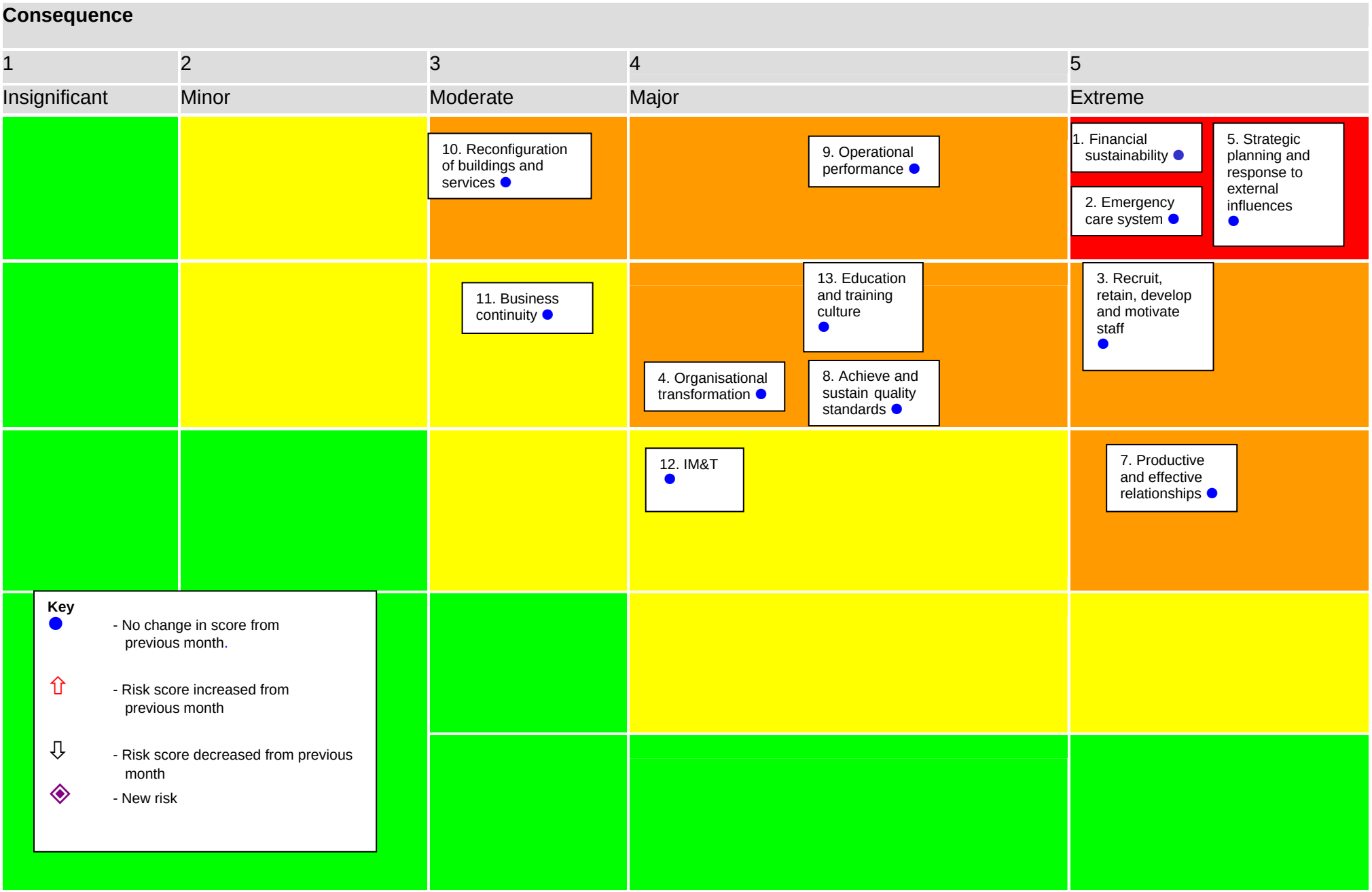
UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST – BOARD ASSURANCE FRAMEWORK (INTERIM) MAY 2014

PERIOD: MAY 2014

RISK TITLE	STRATEGIC OBJECTIVE	CURRENT SCORE	TARGET SCORE
Risk 1 – Failure to achieve financial sustainability	g - To be a sustainable, high performing NHS Foundation Trust	25	20
Risk 2 – Failure to transform the emergency care system	b - To enable joined up emergency care	25	12
Risk 3 – Inability to recruit, retain, develop and motivate staff	f - To maintain a professional, passionate and valued workforce e - To enjoy an enhanced reputation in research, innovation and clinical education.	20	12
Risk 4 – Ineffective organisational transformation	a - To provide safe, high quality patient-centred health care c - To be the provider of choice d - To enable integrated care closer to home	16	12
Risk 5 – Ineffective strategic planning and response to external influences	a - To provide safe, high quality patient-centred health care c - To be the provider of choice g - To be a sustainable, high performing NHS Foundation Trust	25	12
Risk 6 – **Risk deleted from BAF following approval of Trust Board**	**Not applicable**	**N/A**	**N/A**
Risk 7 – Failure to maintain productive and effective relationships	c - To be the provider of choice d - To enable integrated care closer to home f - To maintain a professional, passionate and valued workforce	15	10
Risk 8 – Failure to achieve and sustain quality standards	a - To provide safe, high quality patient-centred health care c - To be the provider of choice	16	12
Risk 9 – Failure to achieve and sustain high standards of operational performance	a - To provide safe, high quality patient-centred health care	20	12
Risk 10 – Inadequate reconfiguration of buildings and services	a - To provide safe, high quality patient-centred health care	15	9
Risk 11– Loss of business continuity	g - To be a sustainable, high performing NHS Foundation Trust	12	6
Risk 12 – Failure to exploit the potential of IM&T	a - To provide safe, high quality patient-centred health care d - To enable integrated care closer to home	12	6
Risk 13 - Failure to enhance education and training culture	e – To enjoy an enhanced reputation in research, innovation and clinical education	16	6

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

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST – BOARD ASSURANCE FRAMEWORK (INTERIM) MAY 2014



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

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST – BOARD ASSURANCE FRAMEWORK (INTERIM) MAY 2014

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

Principal Risk (What could prevent the objective(s) being achieved)	**What are we doing about it?** **(Key Controls)** What control measures or systems we have in place to assist secure delivery of the objective (describe process rather than management group)	**Current Score I x L**	**How do we know we are doing it?** **(Key Assurances of controls)** Provide examples of recent reports considered by Board or committee where delivery of the objectives is discussed and where the board can gain evidence that controls are effective.	**What are we not doing?** **(Gaps in Controls C) / Assurance (A)** What gaps in systems, controls and assurance have been identified?	**How can we fill the gaps or manage the risk better?** **(Actions to address gaps)**	**Target Score I x L**	**Timescale** When will the action be completed?
Failure to deliver recurrent balance	Standing Financial Instructions & Standing Orders Overarching Financial Governance Processes	5x5=25	Monthly progress reports to F&P Committee, Executive Board, & Trust Board Development Sessions TDA Monthly Meetings Chief Officers meeting CCGs/Trusts TDA/NHSE meetings Trust Board Monthly Reporting UHL Programme Board, F&P Committee, Executive Board & Trust Board	(c) Varying level of financial understanding/ control within the organisation. (c) Lack of supporting service strategies to deliver recurrent balance	Finance Training Programme (1.21) Production of a FRP to deliver recurrent balance within five years (1.22) Health System External Review to define the scale of the financial challenge and possible solutions (1.23) Production of UHL Service & Financial Strategy including Reconfiguration/SOC (1.24)	5x4=20	Jun 2014 IDFS Jun 2014 IDFS Jun 2014 IDFS Jun 2014 IDFS

Failure to achieve CIPs	Establishment of Weekly CIP Meetings Executive ownership of cross CIP cutting themes Engagement of Ernst & Young to provide external support to the delivery of the programme Executive Sign off of Plans Establishment of CIP Board Establishment of Project Management Office Short Term Expenditure Reserves CIP Performance Management as part of Integrated Performance Management		Weekly Progress meetings with CEO, COO, FD Monthly Reports to F&P Committee Trust Board Development Sessions Formal sign off documents with CMGs as part of agreement of IBPs Weekly meetings Briefings to Trust Board, F&P Committee, Executive Board regarding establishment of PMO Weekly meeting with Ernst & Young to formalise progress	(c) CIP Quality Impact Assessments not yet agreed internally or with CCGs (c) PMO structure not yet in place to ensure continuity of function following departure of Ernst & Young	Expedite agreement of CIP quality impact assessments both internally and with CCGs. (1.25) PMO Arrangements need to be finalised (1.26)		This is a continuous process therefore review July 2014 IDFS Jun 2014 IDFS
Failure to effectively manage financial performance	Monthly CMG Performance Reviews Escalation meetings at FD/COO level Internal Contracts Management Group Revised Integrated Performance Management Process Revised financial reporting to Trust Board, Executive Performance Board and F&P Committee 2014/15 'budget book/ financial plan		Formal documentation for sign off Report to Trust Board, F&P Committee and Executive Board Formal approval of process by Executive Board Agenda, action notes and supporting papers for meetings Schedule of meetings	(c) The organisation has not effectively identified its service model. (c) Varying level of financial understanding/ control within the organisation. (c) Finance department having difficulties in recruiting to finance posts leading to temporary staff being employed. (	Finance Training Programme (1.21) Restructuring of financial management via MoC (1.28)		Jun 2014 Jul 2014
Failure to agree financially and operationally deliverable contracts	Contract Arbitration & TDA Mediation Internal Contracts Group -		Agreed contracts document through the dispute resolution process/arbitration Regular updates to F&P Committee, Executive Board, Escalation meeting between CEOs/CCG Accountable Officers	(c) Failure to agree appropriate levels of financial impact for QIPP, fines and penalties and MRET. (c) Failure to agree levels of operational performance in relation to the above.	Negotiate realistic contracts with CCGs and Specialised Commissioning - QIPP - Fines & Penalties - MRET rebase - Counting & Coding - CCG Non Recurring Funding (1.30)		Jun 2014 IDFS

Failure to receive capital funding	Capital Group Established TDA Monthly IDM Meeting IBM Commercial Sub Group to Joint Governance Board Link to Strategy & SOC Assessment of affordability of Business Cases and consistency with financial recovery Link to Health Systems Review and Service Strategy		UHL Programme Board, Trust Board, F&P Committee and Capital Group Agreement through Commercial Executive (or it's replacement), F&P Committee and Trust Board Health Economy Steering Group, FD's Sub-Group Regular reports to F&P Committee, Trust Board and Executive Board	(c) Lack of clear strategy for reconfiguration of services.	Production of Business Cases to support Reconfiguration and Service Strategy (1.31)		Jun 2014 IDFS

Failure to obtain sufficient cash resources	Agreeing short term borrowing requirements with TDA Short Term borrowing applications Formalised arrangements with TDA/CCGS Escalation to TDA Rolling cash-flow forecasts Cash-flow Monitoring/Reporting		Board reporting and F&P Committee review of cash flow Integral to Service & Financial Strategy UHL Programme Board, F&P Committee, Executive Board and Trust Board Reports to F&P Committee Trust Board and F&P Committee reporting	**(c)** Lack of service strategy to deliver recurrent balance	Agreeing long term loans as part of June Service & Financial Plan (1.32)		Jun 2014 IDFS

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST – BOARD ASSURANCE FRAMEWORK (INTERIM) MAY 2014

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

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

	Formation of an EFU and AFU to meet increased demand of elderly patients.		'Time to see consultant' metric included in National ED quarterly indicator.	No gaps	No actions		
	Maintenance of AMU discharge rate above 40%.		Reported to Operational Board twice monthly and will be included in Emergency Care Update report in Q&P Report.	No gaps	No actions		
	New daily MDT Board Rounds on all medical wards and medical plans within 24hrs of admission.		Reported to Operational Board twice monthly and will be included in Emergency Care Update report in Q&P Report.	No gaps	No actions		
	EDDs to be available on all patients within 24 hours of admission. Review built in to daily discharge meetings to check accuracy of EDDs (from 2/09/13).		Monitored and reported to Operational Board twice monthly and will be included in Emergency Care Update report in Q&P report.	No gaps	No actions		
	Maintain winter capacity in place to allow new process to embed.		All winter capacity beds are to be kept open until the target is consistently met.	No gaps	No actions		
	DTOCs to be kept to a minimal level by increasing bed capacity. 24 Additional beds available from December 2013.		Forms part of the Report on Emergency Access in the Q&P Report.	No gaps	No actions		

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST – BOARD ASSURANCE FRAMEWORK (INTERIM) MAY 2014

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

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

	Appraisal and objective setting in line with UHL strategic direction. Local actions and appraisal performance recovery plans/ trajectories agreed with CMGs and Directorates Boards.		Appraisal rates reported monthly to Board via Quality and Performance report. Appraisal performance features on CMG / Directorate Board Meetings to monitor the implementation of agreed local actions.				
	Summary of quality findings communicated across the Trust; to identify how to improve the quality of the appraisal experience for the individual and the quality of appraisal meeting recording.		Results of quality audits to ensure adequacy of appraisals reported to the Board via the quarterly workforce and OD report.	No gaps identified.	No actions required.		
			Appraisal Quality Assurance Findings reported to Trust Board via OD Update Report June 2013 Quality Assurance Framework to monitor appraisals on an annual cycle (next due March 2014).	No gaps identified.	No actions required.		
	Workforce plans to identify effective methods to recruit to 'difficult to fill areas). CMG and Directorates 2013/14 Workforce Plans. Active recruitment strategy including implementation of a dedicated nursing recruitment team. Programme of induction and adaptation for international pool of nurses.		Nursing Workforce Plan reported to the Board in September 2013 highlighting demand and initiatives to reduce gap between supply and demand. The use of locum staff in 'difficult to fill' areas is reported to the Board on a monthly basis via the Q&P report. Reduction in the use of such staff would be an assurance of our success in recruiting substantive staff.	(c) Risks with employing high number from an International Pool in terms of ensuring competence	Develop an employer brand and maximise use of social media (3.9).		Jul 2014 DHR
	Reward /recognition strategy and programmes (e.g. salary sacrifice, staff awards, etc). Recruitment and Retention Premia for ED medical and nursing staff.				Development of Pay Progression Policy for Agenda for Change staff (3.3).		Sep 2014 DHR
	UHL Branding – to attract a wider and more capable workforce. Includes development of recruitment literature and website, recruitment events, international recruitment. Recruitment progress is measured now there is a structured plan for bulk recruitment. Leads have been identified to develop and encourage the production of fresh and up to date recruitment material. Reporting and monitoring of posts with 5 or less applicants.		Evaluate recruitment events and numbers of applicants. Reports issued to Nursing Workforce Group. Reporting will be to the Board via the quarterly workforce an OD report. Quarterly report to senior HR team and to Board via quarterly workforce and OD report.	(a) Better baselining of information to be able to measure improvement. (c) Lack of engagement in production of website material.			

	Statutory and mandatory training programme (e-learning) for 10 key subject areas in line with National Core Skills Framework.		Monthly monitoring of statutory and mandatory training attendance data from e-UHL via reports to TB and ESB against 9 key subject areas (				

RISK NUMBER/ TITLE:	**RISK 4 – INEFFECTIVE ORGANISATIONAL TRANSFORMATION**						
LINK TO STRATEGIC OBJECTIVE(S)	**a. - To provide safe, high quality patient-centred health care.** **c. - To be the provider of choice.** **d. - To enable integrated care closer to home**						
EXECUTIVE LEAD:	Director of Strategy						
Principal Risk (What could prevent the objective(s) being achieved)	**What are we doing about it?** **(Key Controls)** What control measures or systems we have in place to assist secure delivery of the objective (describe process rather than management group)	**Current Score I x L**	**How do we know we are doing it?** **(Key Assurances of controls)** Provide examples of recent reports considered by Board or committee where delivery of the objectives is discussed and where the board can gain evidence that controls are effective.	**What are we not doing?** **(Gaps in Controls C) / Assurance (A)** What gaps in systems, controls and assurance have been identified?	**How can we fill the gaps or manage the risk better?** **(Actions to address gaps)**	**Target Score I x L**	**Timescale** When will the action be completed?

Failure to put in place a robust approach to organisational transformation, adequately linked to related initiatives and financial planning/outputs.	Developing an integrated business plan based upon an overarching strategy for UHL supported by service based strategies. Ensuring that the 2 year operating plan and the 5 year strategy describe the outputs of the clinical strategy and workforce strategy and reflect the estates and financial consequences Engaging in the BCT 2014 programme to ensure cross LLR alignment and ensuring that, allowing for appropriate transition our 2 year and 5 year plans reflect direction of travel in respect of system wide clinical service (and wider social care transformation e.g. more care, closer to home where it is safe and cost effective to do so. Implementing the 'Delivering Caring at its Best' work programmes and put the clear governance arrangements in place Cross LLR capacity and activity plan. Capacity planning workshop with all CMGs to build internal capacity and capability	4x4=16	Delivery of 'Delivering Caring at its Best' work programmes will be formally reported through sub-committees of the Board. This requires alignment with the whole local Health Economy change programme Better Care Together 2014 Track delivery against key programme metrics and CMG based delivery targets through ESB, EPB and Trust Board Monitored through the LLR Better Care Together 2014 programme	(c) Gaps are evident in the alignment of transformational process between UHL and principle partners – this is being raised through the Better Care Together Programme structures. (c) Gaps are evident in medium term capacity planning across the Trust and LLR	Review outputs from Chief Officers Group and strategic Planning Group to ensure gaps in current processes are being addressed (4.1). The LLR BCT 2014 planning process will support and facilitate the development and agreement of an LLR wide capacity plan in May/June 2014 (4.3)	4x3=12	Jun 2014 DS Jun 2014 DS

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

Principal Risk (What could prevent the objective(s) being achieved)	**What are we doing about it?** **(Key Controls)** What control measures or systems we have in place to assist secure delivery of the objective (describe process rather than management group)	**Current Score I x L**	**How do we know we are doing it?** **(Key assurances of controls)** Provide examples of recent reports considered by Board or committee where delivery of the objectives is discussed and where the board can gain evidence that controls are effective.	**What are we not doing?** **(Gaps in Controls C) / Assurance (A)** What gaps in systems, controls and assurance have been identified?	**How can we fill the gaps or manage the risk better?** **(Actions to address gaps)**	**Target Score I x L**	**Timescale** When will the action be completed?

Failure to put in place appropriate systems to horizon scan and respond appropriately to external drivers. Failure to proactively develop whole organisation and service line clinical strategies.	Integrated business planning processes in place across CMGs. Forward programme developed. CMG Strategy Leads now engaged in the Business and Strategy Support Teams (BSST) meetings to improve engagement, alignment and teamwork. ESB forward plan to reflect a 12 month programme aligned with: • the development of the IBP/LTFM • the reconfiguration programme • the development of the next AOP • The TB Development Programme. The TB formal agenda Processes now in place to deliver a rolling 2 year operational plan based upon a 5 year strategic plan.	5x5=25	Weekly strategic planning meetings in place – cross CMG and corporate team attendance with delivery led through the Strategy Directorate. Progress reported through reports to ESB and Trust Board Development of a clear, clinically based 5 year strategic for Trust Board sign off in June 2014 and subsequent TDA sign off by the TDA will provide assurance that strategic planning is taking place. Reports to ESB. Regular reports to TB reflecting progress against 12 month rolling programme.	.(c) No high level plan yet developed	High level plan for the Trust to be developed. (5.16)	4x3=12	Jun 2014

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

Principal Risk (What could prevent the objective(s) being achieved)	**What are we doing about it?** **(Key Controls)** What control measures or systems we have in place to assist secure delivery of the objective (describe process rather than management group)	**Current Score I x L**	**How do we know we are doing it?** **(Key Assurances of controls)** Provide examples of recent reports considered by Board or committee where delivery of the objectives is discussed and where the board can gain evidence that controls are effective.	**What are we not doing?** **(Gaps in Controls C) / Assurance (A)** What gaps in systems, controls and assurance have been identified?	**How can we fill the gaps or manage the risk better?** **(Actions to address gaps)**	**Target Score I x L**	**Timescale** When will the action be completed?

Failure to maintain productive relationships with external partners/ stakeholders leading to potential loss of activity and income, poor reputation and failure to retain/ reconfigure clinical services.	Stakeholder Engagement Strategy including engagement with the Trust's Commissioners	5X3=15	Twice yearly GP surveys with results reported to UHL Executive Team. Latest survey results discussed at the April 2013 Board and showed increasing levels of satisfaction… a trend which has now continued for 18 months. Annual Reputation / Relationship survey to key professional and public stakeholders Nov 13.	(c) No external and 'dispassionate' professional view of stakeholder / relationship management activity.	Invite PWC (Trust's Auditors) to offer opinion on the plan / talk to a selection of stakeholders. (7.3)	5X2=10	Jul 2014 DCM
	Regular meetings with external stakeholders and Director of Communications and member of Executive Team to identify and resolve concerns.						
	Regular stakeholder briefing provided by an e-newsletter to inform stakeholders of UHL news.						
	Leicester, Leicestershire and Rutland (LLR) health and social care partners have committed to a collaborative programme of change ('Better Care Together').						
	The Board to meet 3 times per year in external venues hosted by stakeholders						
	The Chairman, with CCG colleagues hosts regular meetings with CCG lay members to improve dialogue and understanding and foster a culture of teamwork between providers and commissioners.						
	A joint report by local Healthwatch organisations to be included in Trust Board papers as a means of bringing community and stakeholder views to the Board's attention.						

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

Principal Risk (What could prevent the objective(s) being achieved)	**What are we doing about it?** **(Key Controls)** What control measures or systems we have in place to assist secure delivery of the objective (describe process rather than management group)	Current Score I x L	**How do we know we are doing it?** **(Key Assurances of controls)** Provide examples of recent reports considered by Board or committee where delivery of the objectives is discussed and where the board can gain evidence that controls are effective.	**What are we not doing?** **(Gaps in Controls C) / Assurance (A)** What gaps in systems, controls and assurance have been identified?	**How can we fill the gaps or manage the risk better?** **(Actions to address gaps)**	Target Score I x L	**Timescale** When will the action be completed?

Failure to achieve and sustain quality standards leading to failure to reduce patient harm with subsequent deterioration in patient experience/ satisfaction/ outcomes, loss of reputation and deterioration of 'friends and family test' score.	Standardised M&M meetings in each speciality.	4x4=16	Routine analysis and monitoring of out of hours/weekend mortality at CMG Boards.	No gaps.	No action needed.	4x3=12	
	Systematic speciality review of "alerts" of deterioration to address cause and agree remedial action by Mortality Review Committee. All deaths in low risk groups identified. Working with DFI to ensure data has been recorded accurately.		Quality and Performance Report and National Quality dashboard presented to ET and TB. Currently SMHI "within expected" (i.e. 107 based on HSCIC data from July 12 to June 13). UHL subscribes to the Hospital Evaluation Dataset (HED) which is similar to the Dr Foster Intelligence clinical benchmarking system but also includes a 'SHMI analysis tool'. Independent analysis of mortality review performed by Public Health. Results reported at November 2013 TB meeting.	(a) UHL risk adjusted perinatal mortality rate above regional and national average.			
	Agreed patient centred care priorities for 2013-14: - Older people's care - Dementia care - Discharge Planning		Quality Action Group meets monthly. Achievement against key objectives and milestones report to Trust board on a monthly basis. A moderate improvement in the older people survey scores has been recorded.	No gaps identified.	No action needed.		
	Multi-professional training in older peoples care and dementia care in line with LLR dementia strategy.		Quality Action Group monitoring of training numbers and location.	No gaps identified.	No action needed.		
	Protected time for matrons and ward sisters to lead on key outcomes.		CMG/ specialty reporting on matron activity and implementation or supervisory practice.	(c) Present vacancy levels prevent adoption of supervisory practice.	Active recruitment to ward nursing establishment so releasing ward sister –for supervisory practice (8.5).		Sep 2014 CN
	Promote and support older people's champion's network and new dementia champion's network.		Monthly monitoring of numbers and activity.	No gaps identified.	No action needed.		
	Targeted development activities for key performance indicators - answering call bells - assistance to toilet - involved in care - discharge information		Monthly monitoring and tracking of patient feedback results. Monthly monitoring of Friends and Family Test reported to the Board				

	Quality Commitment 2013 – 2016: • Save 1000 extra lives • Avoid 5000 harm events • Provide patient centred care so that we consistently achieve a 75 point patient recommendation score.		Quality Action Groups monitoring action plans and progress against annual priority improvements. A Quality Commitment dashboard has been developed to present updates to the TB on the 3 core metrics for tracking performance against our 3 goals. These metrics will be tracked up to 2015. Impressive drops in fall numbers have been observed in Datix reports and in the Safety Thermometer audit. Quality commitment has been refreshed and aligned with the components of quality (experience, safety, effectiveness) that the Trust is undertaking				
	Relentless attention to 5 Critical Safety Actions (CSA) initiatives to lower mortality.		Q&P report to TB showing outcomes for 5 CSAs. 4CSAs form part of local CQUIN monitoring and there is full compliance against agreed action plans. Full CQUIN funding received	(c) Lack of a unified IT system in relation to ordering and receiving results means that many differing processes are being used to acknowledge/respond to results. Potential risk of results not being acted upon in a timely fashion.	Implementation of Electronic Patient Record (EPR). (8.10)		2015 CIO

	NHS Safety thermometer utilised to measure the prevalence of harm and how many patients remain 'harm free' (Monthly point prevalence for '4 Harms'). Monthly meetings with operational/clinical and managerial leads for each harm in place.		Monthly outcome report of '4 Harms' is reported to Trust board via Q&P report. There are no areas of concern in relation to the prevalence of New Harms.	(a) There is some concern that the revised DH monitoring tool is still not an effective measure to produce accurate information. Local actions to resolve this are not practicable.			

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST – BOARD ASSURANCE FRAMEWORK (INTERIM) MAY 2014

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

Principal Risk (What could prevent the objective(s) being achieved)	**What are we doing about it?** **(Key Controls)** What control measures or systems we have in place to assist secure delivery of the objective (describe process rather than management group)	**Current Score I x L**	**How do we know we are doing it?** **(Key Assurances of controls)** Provide examples of recent reports considered by Board or committee where delivery of the objectives is discussed and where the board can gain evidence that controls are effective.	**What are we not doing?** **(Gaps in Controls C) / Assurance (A)** What gaps in systems, controls and assurance have been identified?	**How can we fill the gaps or manage the risk better?** **(Actions to address gaps)**	**Target Score I x L**	**Timescale** When will the action be completed?
Failure to achieve and sustain operational targets leading to contractual penalties, patient dissatisfaction and poor reputation.	Referral to treatment (RTT) backlog plans (patients over 18 weeks) and operational performance of 90% (for admitted) and 95 % (for non-admitted). Further recovery plans for RTT performance agreed by Commissioners Use of independent sector for key specialties. Reissue across UHL of cancelled operations policy UHL action plan signed off by Commissioners (to reduce cancellations on the day for non-clinical reasons to <0.8%and rebook within 28days)	4x5=20	Key specialities in weekly performance meetings with COO to implement plans. Monthly monitoring of RTT performance recovery plans Daily RTT performance and prospective reports to inform decision making. Weekly patient level reporting meeting for all key specialties. Monthly Q&P report to Trust Board showing 18 week RTT performance. Operational group meeting alternate weeks Operational improvement plan in place Weekly monitoring and actioning 28 day rebooking via access meeting Monthly report to Trust Board and commissioners	(c) Inadequate elective capacity. (c) Not creating ring-fenced elective capacity to prevent cancellations due to no beds on the day	To open an additional 18 beds (9.15)	4x3=12	COO Aug 2014
	Transformational theatre project to improve theatre efficiency to 80 -90%.		Monthly theatre utilisation rates. Theatre Transformation monthly meeting. Transformation update to Board.	No gaps identified.	No actions required.		

	Emergency Care process redesign (phase 1) implemented 18 February 2013 to improve and sustain ED performance.		Monthly report to Trust Board in relation to Emergency Dept (ED) flow (including 4 hour breaches).	See risk number 2.	See risk number 2.		
	Cancer 62 day performance - Tumour site improvement trajectory agreed and each tumour site has developed action plans to achieve targets. Senior Cancer Manager appointed. Lead Cancer Clinician appointed. Action plan to resolve Imaging issues implemented.		Cancer action board established and weekly meetings with all tumour sites represented. Monthly trajectory agreed and Cancer action plan agreed with CCGs and reported and monitored at Executive Performance board. Chief Operating Officer receives reports from Cancer Manager and 62 day performance included within Monthly Q&P report to Trust Board. The ongoing management of cancer performance is carried out by a weekly cancer action board to provide operational assurance. Performance against 62 day standard has been achieved for the past 6 months. Commissioners have formally removed the contract performance notice in relation to 62 day standard.	No gaps identified.	No actions required.		

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST – BOARD ASSURANCE FRAMEWORK (INTERIM) MAY 2014

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

Principal Risk (What could prevent the objective(s) being achieved)	**What are we doing about it?** **(Key Controls)** What control measures or systems we have in place to assist secure delivery of the objective (describe process rather than management group)	**Current Score I x L**	**How do we know we are doing it?** **(Key Assurances of controls)** Provide examples of recent reports considered by Board or committee where delivery of the objectives is discussed and where the board can gain evidence that controls are effective.	**What are we not doing?** **(Gaps in Controls C) / Assurance (A)** What gaps in systems, controls and assurance have been identified?	**How can we fill the gaps or manage the risk better?** **(Actions to address gaps)**	**Target Score I x L**	**Timescale** When will the action be completed?
Inadequate reconfiguration of buildings and services leading to less effective use of estate and services.	Reviewing and refreshing our Clinical Strategy. LLR Better Care Together 2014 Strategy	3x5=15	Trust Board development session on development of approach to strategic planning and development of strategic case for change. On-going monitoring of service outcomes by MRC to ensure outcomes improve. Improvement in health outcomes and effective Infection Prevention and Control practices monitored by Executive Quality Board (Q+P report) with escalation to ET, QAC and TB as required.	(a) Service specific KPIs not yet identified for all services.	Iterative development of operational and strategic plans (10.5)	3X3=9	Jun 2014 DS
	Review and refresh of our current Estates Strategy to ensure that it will support the delivery of an Estates solution that will be a key enabler for our clinical strategy. Reconfiguration Programme working with clinicians to develop a 'preferred' way forward' completed.		Trust Board development sessions and Board reports in respect of estate related developments over a 2 year and 5 year time horizon. Facilities Management Collaborative (FMC) monitors operational estate delivery against agreed KPIs to provide assurance of successful outsourced service.	(c) Estates plans not fully developed to achieve the strategy.	Reconfiguration programme to develop a strategic outline case which will inform the future estate strategy (10.6)		Jun 2014 DS
				The success of the plans will be dependent upon capital funding beyond our own capital resources and successful approval by the NTDA.	Deliver our financial plan, activity plans (10.7)		Jun 2014 IDFS/COO
				Access to discretionary capital will be dependent on delivery of our agreed financial plan	Secure capital funding (10.3).		Jun 2014 IDFS/COO

	CMG service development strategies and plans to deliver key developments.		Progress on CMG development plans reported to Development Meetings with execs	No gaps identified.	No actions required.		
	Executive Strategy Board - Reconfiguration		Monthly ESB to provide oversight of reconfiguration.	No gaps identified.	No actions required.		Jun 2014 DS
	Capital expenditure programme to fund developments. Capital Board to oversee in year performance management		Capital expenditure reports reported to the Board via F&P Committee. Capital Board re-established	Require financial strategy by the end of Q1 to reflect how the Trust anticipates sourcing external capital for strategic business cases.	Develop and secure TDA approval for access to strategic capital. (10.8)		Jun 2014 IDFS
	Managed Business Partner for IM&T services to deliver IT that will be a key enabler for our clinical strategy. IM&T incorporated into Improvement and Innovation Framework.		IM&T Board in place.	No gaps identified.	No actions required.		

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST – BOARD ASSURANCE FRAMEWORK (INTERIM) MAY 2014

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

Principal Risk (What could prevent the objective(s) being achieved)	**What are we doing about it?** **(Key Controls)** What control measures or systems we have in place to assist secure delivery of the objective (describe process rather than management group)	**Current Score I x L**	**How do we know we are doing it?** **(Key Assurances of controls)** Provide examples of recent reports considered by Board or committee where delivery of the objectives is discussed and where the board can gain evidence that controls are effective.	**What are we not doing?** **(Gaps in Controls C) / Assurance (A)** What gaps in systems, controls and assurance have been identified?	**How can we fill the gaps or manage the risk better?** **(Actions to address gaps)**	**Target Score I x L**	**Timescale** When will the action be completed?
Inability to react /recover from events that threaten business continuity leading to sustained downtime and inability to provide full range of services.	Major incident/business continuity/ disaster recovery and Pandemic plans developed and tested for UHL/ wider health community. This includes UHL staff training in major incident planning/ coordination and multi agency involvement across Leicestershire to effectively manage and recover from any event threatening business continuity. Tailored training packages for service area based staff. Contingency plans developed to manage loss of critical supplier and how we will monitor and respond to incidents affecting delivery of critical supplies.	3x4=12	Annual Emergency planning Report Training Needs Analysis developed to identify training requirements for staff External auditing and assurances to SHA, Business Continuity Self-Assessment, Completion of the National Capabilities Survey, November 2013 Results included in the annual report on Emergency Planning and Business Continuity to the QAC. Audit by PwC Jan 2013. Completed Jan 2014. Documented evidence from key critical suppliers has been collected to ensure that contracts include business continuity arrangements.	(c) On-going continual training of staff to deal with an incident. (a) Lack of coordination of plans between different service areas and across the specialties. c) Not all the critical suppliers questioned provided responses. (c) Contracts aren't assessed for their potential BC risk on the Trust.	Training and Exercising events to involve multiple specialties/CMGs to validate plans to ensure consistency and coordination (11.13). Finance and procurement staff to be trained how to assess the BC risk to a contract and utilise the tools developed. (11.14)	2x3=6	Aug 2014 COO Aug 2014 COO

	Emergency Planning Officer appointed to oversee the development of business continuity within the Trust.		Outcomes from PwC LLP audit identified that there is a programme management system in place through the Emergency Planning Officer to oversee. A year plan for Emergency Planning developed and updated annually. Production/updates of documents/plans relating to Emergency Planning and Business Continuity aligned with national guidance have begun. Including Business Impact Assessments for all specialties. Plan templates for specialties now include details/input from Interserve. 2014/2015 work plan based on priority tasks to undertake and plans to review	(c) Local plans for loss of critical services not completed due to change over of facilities provider. (c) Plans have not been provided by Interserve as to how they would respond or escalate issues to the Trust. (c) A number of plans are out of date and risk being inadequate for a response due to operational changes. (c)Call out system designed to notify staff of a major incident and activate the plan is not suitable.	Further work required to develop escalation plans and response plans for Interserve. (11.11) Review and consider options for an automated system to reduce time and resources required to initiate a staff call out (11.16).		Jun 2014 COO Sep 2014 COO
			Minutes/action plans from Emergency Planning and Business Continuity Committee. Any outstanding risks/issues will be raised through the COO.	No gaps identified.	No actions required.		
			New Policy on InSite Emergency Planning and Business Continuity Committee ensures that processes outlined in the Policy are followed, including the production of documents relating to business continuity within the service areas. Incidents within the Trust are investigated and debrief reports written, which include recommendations and actions to consider. Issues/lessons feed into the development of local plans and training and exercising events.	No gaps identified.	No actions required.		

			Head of Operations and Emergency Planning Officer are consulted on the implementation of new IM&T projects that will disrupt user's access to IM&T systems.	(c) Do not always consider the impact on business continuity and resilience when implementing new systems and processes. (c) End users aren't always consulted adequately prior to downtime of a system.	Further processes require development, particularly with the new Facilities and IM&T providers to ensure resilience is considered/ developed when implementing new systems, infrastructure and processes. (11.8)		Review Jun 2014 COO
	All priority IT systems have disaster recovery testing completed as part of the change approvals for major upgrades or at least once per year if no upgrade is planned within a financial year.			(a) Lack of clarity around how the trust receives assurance that disaster recovery testing for IT systems takes place	Develop an assurance process (11.17)		May 2014 CIO

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST – BOARD ASSURANCE FRAMEWORK (INTERIM) MAY 2014

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

Principal Risk (What could prevent the objective(s) being achieved)	**What are we doing about it?** **(Key Controls)** What control measures or systems we have in place to assist secure delivery of the objective (describe process rather than management group)	**Current Score I x L**	**How do we know we are doing it?** **(Key Assurances of controls)** Provide examples of recent reports considered by Board or committee where delivery of the objectives is discussed and where the board can gain evidence that controls are effective.	**What are we not doing?** **(Gaps in Controls C) / Assurance (A)** What gaps in systems, controls and assurance have been identified?	**How can we fill the gaps or manage the risk better?** **(Actions to address gaps)**	**Target Score I x L**	**Timescale** When will the action be completed?
Failure to integrate the IM&T programme into mainstream activities.	IM&T is required to be part of the short/medium and long term planning processes	4x3=12	Strategic IM&T Board in place. Quarterly reports to Trust Board IM&T represented on key groups such as ESB, capital planning etc…	(c) late notice of significant changes that have a material impact on M&T provision (c) lack of uptake of IM&T opportunities within the planning processes	Ensure that there is further integration of IM&T within planning groups (12.9) Ensure that there are no unforeseen IM&T requirements coming out of the 2014-2016 planning phase. (12.10)	3x2=6	May 2014 CIO Review Jun 2014 CIO
	Creation of an exciting portfolio of opportunities for UHL to use within its delivery and reporting activities		A clear plan for 2014/15 exists, within the IM&T strategic framework. Work with directly affected areas has commenced	(c) lack of a fully signed off five year plan for IMT (c) a clear communications and engagement plan to inform all stakeholders of these opportunities	Work with the DOF and the capital group to ensure a coherent 5 year plan is in place for the delivery of the core IM&T components (12.11) Work with specialists from UHL and IBM to better define the communications and engagement strategy. (12.12) Review and reissue the IM&T strategy (12.13)		May 2014 CIO May 2014 CIO Jun 2014 CIO
	Engagement with the wider clinical communities (internal) including formal meetings of the newly created advisory groups/ clinical IT. Improved communications plan incorporating process for feedback of information.		CMIO(s) now in place, and active members of the IM&T meetings The joint governance board monitors the level of communications with the organisation.				

	Engagement with the wider clinical communities (External). UHL CMIOs are added as invitees to the meetings, as are the clinical (IM&T) leads from each of the CCGs.		UHL membership of the wider LLR IM&T board	(c) no involvement of external stakeholders on our significant internal projects	Review any relevant groups and engage our external stakeholders for membership (12.15)		May 2014 CIO/CMIO
Benefits are not well defined or delivered	Appointment of IBM to assist in the development of an incentivised, benefit driven, programme of activities to get the most out of our existing and future IM&T investments. Initial engagement with key members of the TDA to ensure there is sufficient understanding of technology roadmap and their involvement. The development of a strategy to ensure we have a consistent approach to delivering benefits. Increased engagement and communications with departments to ensure that we capture requirements and communicate benefits. Standard benefits reporting methodology in line with trust expectations. Paperwork and processes have be re-modelled and issued to all IM&T project staff to ensure they work to required standards.		Minutes of the joint governance board, the transformation board and the service delivery board. Benefits are part of all the projects that are signed off by the relevant groups.	. (c) Ownership of benefits delivery is being overlooked when a project, from IM&T's perspective, is finished. (c) Requirements within projects are moving significantly from the time a project specification is signed off.	Post project benefit realisation plans and ownership is identified at pre-commencement phase to ensure the total work is identified. (12.17) Requirements and benefits are fully signed off prior to any work commencing (12.18)		Jul 2014 CIO Jul 2014 CIO
Major programmes of work do not deliver on time and budget	A joint Programme and project methodology is in place between UHL and IBM for managing and tracking activities. Monthly meetings with a nominated lead to discuss projects and overall performance with the CMGs. Enhanced communications with the CMGs to include new opportunities that they could consider within their planning processes going forward		Weekly and Monthly reports are in place to track both at a programme level and at an individual project level	(c) sufficient feedback to individual CMGs on both the progress, benefits and further opportunities from their IM&T projects	Monitor the meetings and review for effectiveness (12.23)		Jul 14 CIO

	External factors such as CCG alignment and NTDA approval are in place to ensure smooth passage of approvals		Bi monthly LLR meetings are in place to ensure alignment across all healthcare stakeholders in Leicestershire	(c) Agree LLR joint priorities for 2014	Invite key external parties to be part of the significant projects. The first of these will be the EPR project (12.24) Further work through the IM&T strategy board is required to refine the large set of requirements into a realistic deliverable plan (12.22)		Jul 14 CIO May 2014 CIO

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST – BOARD ASSURANCE FRAMEWORK (INTERIM) MAY 2014

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

Principal Risk (What could prevent the objective(s) being achieved)	**What are we doing about it?** **(Key Controls)** What control measures or systems we have in place to assist secure delivery of the objective (describe process rather than management group)	**Current Score I x L**	**How do we know we are doing it?** **(Key Assurances of controls)** Provide examples of recent reports considered by Board or committee where delivery of the objectives is discussed and where the board can gain evidence that controls are effective.	**What are we not doing?** **(Gaps in Controls C) / Assurance (A)** What gaps in systems, controls and assurance have been identified?	**How can we fill the gaps or manage the risk better?** **(Actions to address gaps)**	**Target Score I x L**	**Timescale** When will the action be completed?
Failure to implement and embed an effective medical training and education culture with subsequent critical reports from commissioners, loss of medical students and junior doctors, impact on reputation and potential loss of teaching status.	Medical Education Strategy and Action Plan.	4x4=16	Strategy approved by the Trust Board. Strategy monitored by Operations Manager and reviewed monthly in Full team Meetings. Favourable Deanery visit in relation to ED Drs training.	(c) Lack of engagement/awareness of the Strategy with CMGs.	Meetings to discuss strategy with CMGs (13.1).	3x2 = 6	Jun 2014 MD
	UHL Education Committee. 'Doctors in Training' Committee established. Education and Patient Safety. Links with LEG/ QAC and EQB		Professor Carr reports to the Trust Board. Reports submitted to the Education Committee. Terms of reference and minutes of meetings.	(c) Attendance at the Committee could be improved. (c) Improved trainee representation on Trust wide committees. (c) Improve engagement with other patient safety activities/groups.	Relevance of the committee to be discussed at specialty/ CMG meetings (13.2).		Jun 2014 MD
	Quality Monitoring. Engagement with specialties to share findings from education and training dashboards		Quality dashboard for education and training (including feedback from GMC and LETB visits) monitored monthly by Operations Manager, Quality Manager and Education Committee. Education Quality Visits to specialties. Exit surveys for trainees. Monitor progress against the Education Strategy and GMC Training Survey results.	(a) Do not currently ensure progress against strategic and national benchmarks. (c) Inadequate educational resources.	Monitor UHL position against other trusts nationally. (13.7) New Library/learning facilities to be developed at the LRI .(13.8)		Review Jun 2014 MD Nov 2014 MD

	Educational project teams to lead on education transformation projects.		Project team meets monthly. Favourable outcome from Deanery visit in relation to ED Drs training.				
	Financial Monitoring.		SIFT monitoring plan in place.	(c) Poor engagement with specialties in relation to implication of SIFT.	Need to engage with the specialties to help them understand the implication of SIFT and their funding streams. (13.10)		Jun 2014 MD

Appendix two

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST

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

Monitoring body (Internal and/or External):	Executive Team
Reason for action plan:	Board Assurance Framework
Date of this review	**May 2014**
Frequency of review:	Monthly
Date of last review:	April 2014

REF	ACTION	SENIOR LEAD	OPS LEAD	COMPLETION DATE	PROGRESS UPDATE	STATUS
1	**Failure to achieve financial sustainability**					
1.21	Implementation of financial training programme to address variability of financial knowledge and control across UHL.	IDFS		June 2014	On track	4
1.22	Production of a FRP to deliver recurrent balance within five years. (*Note: It is highly likely that recurrent balance will be within 5 years and not 3 years. The LTFM is a five year model*	IDFS		June 2014	On track, but reliant on and overlap with the delivery of outputs from the Challenged Health economy (LLR) work (1.23)	4
1.23	Health System External Review to define the scale of the financial challenge and possible solutions.	IDFS		June 2014	On track	4
1.24	Production of UHL Service & Financial Strategy including Reconfiguration SOC. (	IDFS		June 2014	On track however there is a question whether it will be possible to complete the IBP and SOC at the same time	4
1.25	Expedite agreement of CIP quality impact assessments both internally and with CCGs.	IDFS		~~April~~ ~~May 2014~~ Continuous process therefor further review July 2014	The balance of the QIA cannot be completed until red CIP schemes have been defined. 11/06 – process for approval of QIA of additional CIP schemes as they are developed through the Contract Performance review process	4
1.26	PMO Arrangements need to be finalised to ensure continuity following departure of Ernst & Young.	IDFS/ COO/ DS		~~May 2014~~ Review June 2014	PMO arrangements to be finalised as part of Delivering Care at Its Best arrangements	3

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

1.27	Production of 2014/15 'budget book'/ financial plan *(NB this action reworded in June 2014 following discussion with IDFS)*	IDFS		June 2014	**Complete** – April Trust Board approval	5
1.28	Restructuring of financial management via MoC.	IDFS		July 2014	On track	4
1.30	Negotiate realistic contracts with CCGs and Specialised Commissioning	IDFS		~~April~~ ~~May~~ Review June 2014	Discussions at CEO level continue but the Trust is unable to reach agreement on the consequences of fines and penalties. The Specialised services contract is ready to sign but national issues prevent progress. Situation is being escalated with TDA and NHSE 11/06 – following intervention by NHSE/TDA re the application of local fines and penalties the Trust is in a position to agree a contract. Proposal awaited from CCG	3
1.31	Production of Business Cases to support Reconfiguration and Service Strategy	IDFS		June 2014		4
1.32	Agreeing long term loans as part of June Service & Financial Plan	IDFS		June 2014		
2	**Failure to transform the emergency care system**					
2.7	Continue with substantive appts until funded establishment within ED is achieved.	COO	HO	Review ~~Sept~~ ~~Nov 2013~~ ~~Jan 2014~~ June 2014	Still on track to recruit to funded establishment. International recruitment has been successful. Continued review of progress.	4

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

3	**Inability to recruit, retain, develop and motivate staff**					
3.3	Development of Pay Progression Policy for Agenda for Change staff.	DHR	DDHR	~~October~~ ~~November~~ ~~December 2013~~ ~~February 2014~~ Review ~~April~~ September 2014	Confirmation has been received from Unison that they intend to ballot members in relation to one element of the proposed pay progression criteria from 21.06.14. Other Unions are still consulting. Indicative timescales are that this will be completed by September 2014.	3
3.9	Develop an employer brand and maximise use of social media to describe benefits of working at UHL	DHR		~~April~~ July 2014	Action plan in development, focused on three elements of employment cycle. A focused piece of work will take place on the development of the work for us area. Best nursing practice in relation to values based recruitment will be shared with other staff groups. Linkedin to be used to promote upcoming recruitment campaigns. There has been an extension to timescales for completion due as UHL needs to acquire a credit card in order to register for Linkedin for advertising and we need to find a way to progress this. The Employer Brand task and finish has been re-established to progress this work.	4
4	**Ineffective organisational transformation**					

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

4.1	Review outputs from Chief Officers Group and strategic Planning Group to ensure gaps in current processes are being addressed	DS		~~Review~~ ~~February~~ ~~May~~ June 2014	The Trust is fully engaged in the LLR BCT 5 year planning process and is actively working with E&Y to ensure that our processes and plans are aligned. An LLR 5-year plan will be submitted on 20 June as will UHLs. Between June and September there will be a further period of reconciliation for the UHL and LLR plan.	3
4.2	Capacity planning workshop with all CMGs in April/May to build internal capacity and capability and to scope and develop our internal planning assumptions	DS		May 2014	**Complete**	5
4.3	The LLR BCT 2014 planning process will support and facilitate the development and agreement of an LLR wide capacity plan in May/June			June 2014	On track- Submission of LLR and UHL plan to NHS England and the NTDA on 20 June	4
5	**Ineffective strategic planning and response to external influences**					
5.16	High level plan for the Trust to be developed	DS		June 2014	CMG planning and strategy workshops undertaken January – June 2014. Forward programme developed.	4
7	**Failure to maintain productive and effective relationships**					
7.3	Invite PWC (Trust's Auditors) to offer opinion on the plan / talk to a selection of stakeholders.	DMC		~~January 2014~~ ~~March~~ ~~May~~ Review July 2014	PWC conducting phone and F2F interviews with stake holders currently. Review progress in July 2014	4
8	**Failure to achieve and sustain quality standards**					
8.5	Active recruitment to ward nursing establishment so releasing ward sister for supervisory practice.	CN		September 2014	On going recruitment process in place and is likely to take 12 -18months. Deadline extended to reflect this.	4

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

8.10	Implementation of Electronic Patient Record (EPR)	CIO		2015	On track. Procurement has commenced - ITT issued to 11 vendors	4
9	**Failure to achieve and sustain high standards of operational performance**					
9.15	To open an additional 18 beds	COO		~~Feb 2015~~ August 2014	On track. This has now been reduced to opening an additional 18 beds (10 less in respiratory due to their request, 28 less in medicine due to staffing issues) Agreed at ET 10.6.14	4
10	**Inadequate reconfiguration of buildings and services**					
10.3	Secure capital funding to implement Estates Strategy.	IDFS		~~May 2013~~ ~~December 2013~~ ~~March~~ ~~Review April~~ June 2014	Capital funding requirements will be reflected in the LTFM for additional PDC as part of the Service and Financial plan (see 1.24)	3
10.5	Iterative development of operational and strategic plans with specialities.	MD		~~March~~ June 2014	Iterative development of operational and strategic plans with specialities to be reflected in our 5 year Integrated Business Plan by June 2014 – including proposed configuration to best meet the clinical and financial sustainability challenges faced by the Trust and the local health and care community. This is monitored by CMG and Executive Boards. Operational plans due April 2014 and strategic plans by June 2014	4
10.6	Reconfiguration programme to develop a strategic outline case which will inform the future estate strategy	DS		June 2014	A decision was made at the Reconfiguration Board that, we need to refresh the programme structure, work stream ownership and governance arrangements. We are developing clinical and service based strategies that will inform all aspects of our IBP This will inform the future estate strategy and associated reconfiguration programme.	4

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

10.7	Deliver our financial plan, activity plans	IDFS/ COO		June 2014	On track.	4
10.8	Develop and secure TDA approval for access to strategic capital.	IDFS		June 2014	On track. Capital funding requirements will be reflected in the LTFM for additional PDC as part of the Service and Financial plan (see 1.24)	4
11	**Loss of business continuity**					
11.8	Further processes require development, particularly with the new Facilities and IM&T providers to ensure resilience is considered/ developed when implementing new systems, infrastructure and processes.	COO	EPO	~~July~~ ~~August~~ Review ~~October~~ ~~November 2013~~ ~~December 2013~~ ~~March~~ June 2014	Lack of progress with Interserve escalated via Chief Nurse and NHS Horizons; however still no formal assurance from Interserve of the BCM policy/process/plans. Meeting scheduled (19/05/2014) to review process and determine an appropriate process. Deadline extended to reflect this.	3
11.11	Further work required to develop escalation plans and response plans for Interserve.	COO	EPO	~~October~~ ~~December 2013~~ ~~March~~ ~~April~~ ~~May 2014~~ June 2014	Draft escalation plan received 1st May. Plan reviewed and updated based on feedback. To be implemented within UHL and Interserve within the revised deadline	3
11.13	Training and Exercising events to involve multiple CMGs/ specialties to validate plans to ensure consistency and coordination	COO	EPO	August 2014	BCM training and exercising programme has been developed. Training sessions for bleep holders in cardiology and MSK and Specialist Surgery undertaken with more to be planned. New exercises planned for May and July with more to follow.	4
11.14	Finance and procurement staff to be trained how to assess the BC risk to a contract and utilise the tools developed.	COO	EPO	~~March~~ ~~May~~ August 2014	Materials developed awaiting availability to run training session. Propose to include in the routine training and exercise timetable.	3

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

11.16	Review and consider options for an automated system to reduce time and resources required to initiate a staff call out	COO	EPO	~~April~~ ~~June~~ September 2014	A number of solutions considered but high costs and integration with current trust systems are not ideal. IBM considering a design specification further discussions are on-going.	3
11.17	Develop an assurance process for IT disaster recovery testing in order to provide the Trust with confidence that testing is being performed.	CIO		May 2014	We have achieved the ISO 27001 accreditation which has been externally validated. Awaiting update from CIO	4
12	**Failure to exploit the potential of IM&T**					
12.9	Ensure that there is further integration of IM&T within planning groups (12.9)	CIO		May 2014	On track Awaiting update from CIO	4
12.10	Ensure that there are no unforeseen IM&T requirements coming out of the 2014-2016 planning phase.	CIO		Review June 2014	Significant work still needed to assess the 2016 planning horizon and what all the elements of UH:\CMG\LLR plans mean with regards to IM&T	2
12.11	Work with the DOF and the capital group to ensure a coherent 5 year plan is in place for the delivery of the core IM&T components	CIO		May 2014	On track Awaiting update from CIO	4
12.12	Work with specialists from UHL and IBM to better define the communications and engagement strategy.	CIO		May 2014	On track Awaiting update from CIO	4
12.13	Review and reissue the IM&T strategy	CIO		June 2014	On track	4
12.15	Review any relevant groups and engage our external stakeholders for membership	CIO/ CMIO		May 2014	On track Awaiting update from CIO	4
12.17	Post project benefit realisation plans and ownership is identified at pre-commencement phase to ensure the total work is identified.	TBA		July 2014	Paperwork and processes have be re-modelled and issued to all IM&T project staff. Further work required to test the output from this work	4

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

12.18	Requirements and benefits are fully signed off prior to any work commencing	TBA		July 2014	Paperwork and processes have be re-modelled and issued to all IM&T project staff. Further work required to test the output from this work	4
12.22	Further work through the IM&T strategy board is required to refine the large set of requirements into a realistic deliverable plan	CIO		May 2014	On track. Awaiting update from CIO	4
12.23	Monitor the monthly meetings with nominated leads and review for effectiveness	CIO		July 2014	On track	4
12.24	Invite key external parties to be part of the significant projects. The first of these will be the EPR project	CIO		July 2014	On track	4
13	**Failure to enhance education and training culture**					
13.1	To improve CMG engagement facilitate meetings to discuss Medical Education Strategy and Action Plans with CMGs.	MD	AMD	~~December 2013/January 2014 March April~~ June 2014	Meetings held with CMGs other than RRC. Previous meeting with Cardiac Services had to be postponed. New meeting date 6/6/14.	4
13.2	Relevance of the UHL Education Committee to be discussed at CMG Meetings in an effort to improve attendance.	MD	AMD	~~December 2013/January 2014 March April~~ June 2014	Meetings held with CMGs other than RRC. Previous meeting with Cardiac Services had to be postponed. New meeting date 6/6/14... Previous meeting with Cardiac Services had to be postponed. New meeting date 6/6/14.	4
13.7	Monitor UHL position against other trusts nationally to ensure progress against strategic and national benchmarks.	MD	AMD	Review ~~October 2013 March~~ June 2014	Following further discussions with the LETB this data is not readily available. LETB to investigate how we can acquire this data.	2

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

13.8	New Library/learning facilities to be developed at the LRI to help resolve inadequate educational resources.	MD	AMD	~~October 2013~~ ~~April~~ November 2014	Delay in the tendering process means that this project will not start until July and should end in November 2014.	2
13.10	Need to engage with the CMGs to help them understand the implication of SIFT and their funding streams.	MD	AMD	~~December 2013/January 2014~~ ~~March~~ ~~April~~ June 2014	Meetings held with CMGs other than RRC. Previous meeting with Cardiac Services had to be postponed. New meeting date 6/6/14.Previous meeting with Cardiac Services had to be postponed. New meeting date 6/6/14.	4

Key

CEO	Chief Executive Officer
IDFBS	Interim Director of Financial Strategy
MD	Medical Director
AMD	Assistant Medical Director
COO	Chief Operating Officer
DHR	Director of Human Resources
DDHR	Deputy Director of Human Resources
DS	Director of Strategy
ADLOD	Asst Director of Learning and Organisational Development
DMC	Director of Marketing and Communications
CIO	Chief Information Officer
CMIO	Chief Medical Information Officer
EPO	Emergency Planning Officer
HPO	Head of Performance Improvement
HO	Head of Operations
CD	Clinical Director
CMGM	Clinical Management Group Manager
DDF&P	Deputy Director Finance and Procurement
FTPM	Foundation Trust Programme Manager
HTCIP	Head of Trust Cost Improvement Programme
ADI	Assistant Director of Information
FC	Financial Controller
ADP&S	Assistant Director of Procurement and Supplies
HoN	Head of Nursing

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

TT	Transformation Team
CN	Chief Nurse

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

Appendix three

University Hospitals of Leicester NHS Trust

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

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

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

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

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

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

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

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

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

8) Are the assigned risk scores realistic?

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

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST

OPERATIONAL RISKS SCORING 15 OR ABOVE FOR THE PERIOD ENDING 31/05/14

REPORT PRODUCED BY: UHL CORPORATE RISK MANAGEMENT TEAM

Key

Red	Extreme risk (risk score 25)
Orange	High risk (risk score 15 - 20)
Yellow	Moderate risk (risk score 8 - 12)
Green	Low risk (risk score below 8)
⮝	Risk score increased from initial risk score
⮟	Risk score decreased from initial risk score
★	New risk since previous reporting period
⇔	No Change in risk score since previous reporting period

Risk ID	CMG	Specialty	Risk Title	Opened	Review Date	Description of Risk	Risk subtype	Controls in place	Impact	Likelihood	Current Risk Score	Action summary	Target Risk Score	Risk Owner
2339	RRC	Renal Transplant	Potential risk to Renal transplant patients as a result of deterioration of team working & deviation from policy and procedures	02/05/2014	30/06/2014	Causes Poor lines of communication Poor interpersonal relationships Lack of clarity of procedures and policies Consequences Potential for patient harm Suboptimal transplant outcomes Potential for morbidity and mortality related to transplant process.	Targets	Clear lines of communication have been defined The 4 surgical consultants have agreed significantly improved ways of working and are demonstrating significantly improved team working skills and attitudes. Appointment of an external clinical lead (Chris Rudge) who will be working with the team 2 days a week for 3 - 6 months Policies / guidelines have been written for ward rounds, OPD and kidney acceptance MDT's and M&M's will be in place for the restart of the process	Extreme	Likely	20	Confirming the unit director - TBC Completion and ratification of ward policies and protocols document - 31/5/14 Establishment of multidisciplinary governance meetings overseeing all aspects of practice - 20/05/14	5	SLEA

Risk ID	CMG	Specialty	Risk Title	Opened	Review Date	Description of Risk	Risk subtype	Controls in place	Impact	Likelihood	Current Risk Score	Action summary	Target Risk Score	Risk Owner
2338	Medical Directorate	Medical Directorate	There is a risk of patients not receiving medication and patients receiving the incorrect medication due to an unstable homecare	01/05/2014	30/06/2014	Causes A major homecare company has left the Homecare market requiring remaining companies to take on large numbers of patients. These companies are now experiencing difficulties in maintaining their current levels of service. UHL patients are now being affected. One homecare supplier has changed their compounding to Bath ASU causing concerns about UHL supply of chemotherapy drugs over the next few weeks. Healthcare at Home (H@H) 1)H@H have changed their logistics provider (to Movianto). There are IT incompatibilities between both providers resulting in a large number of failed deliveries. 2) H@H no longer accepting new referrals for CF, respiratory and haemophilia patients who need to be repatriated to UHL urgently. There are also patients in whom homecare has been agreed and they are now referring back 3) H@H have changed their compounding to Bath ASU. This has resulted in Bath ASU not having enough capacity to carry out their routine production. UHL is a large user of dose banded chemotherapy. Currently we do not have the facility to compound all of our dose banded chemotherapy, a Alcura 1)Experiencing difficulties that have resulted in failed deliveri 2)There are on-going issues with invoicing. No invoices for A Consequences	Quality	UHL Homecare team liaising with homecare companies to try and resolve issues of which they are made aware. H@H high risk patients currently being repatriated to UHL. UHL procurement pharmacist in discussion with NHS England (statement due out soon - timeframe unsure), and with the CMU. Patient groups and peer group discussions also been held to support patient education and support during this uncertain period. Reviewing which medicines can be done through UHL out-patient provider or through UHL Discussions with Medical Director and CMG (CSI) and clinical specialty teams to ensure that any necessary clinical pathway changes are supported	Major	Likely	16	Long term review or all homecare products and understand business continuity. - 30/6/14 Financial risk associated with repatriation and highlight this to commissioners - 30/6/14 Healthcare at Home currently addressing IT issues with logistics provider - 26/5/14 UHL Pharmacy procurement team investigating the procurement of drugs which are currently only available through a homecare provider - 5/5/14	9	CELL

Risk ID	CMG	Specialty	Risk Title	Opened	Review Date	Description of Risk	Risk subtype	Controls in place	Impact	Likelihood	Current Risk Score	Action summary	Target Risk Score	Risk Owner
2341	Operations		Long term follow up outpatient appointments not made	06/05/2014	30/06/2014	As the result of one specialty (rheumatology) finding they were not managing long term follow up appointments in accordance with clinical requirements, the Trust has undertaken a further assessment across all specialties of the risk of the same occurring. Initial assessment indicates that there are 24, 582 patient records on HISS / PAS where follow up appointments are not being managed in a timely way. These fall into 4 categories: 1) Patients with outcomes of waiting reports , but they have no follow up appointment booked 2)Outcome of long term follow up not made and patients are not on a waiting list and do not have a future appointment 3) Those on an outpatient waiting list but they are overdue their date to be seen 4)Outcome of future appointment but no appointment has been made. Full validation of patient level records is required to determine the size of the real risk in particular to patient care. Each CMG is required to make this assessment and report back to the Governance group on a weekly basis.(this is part of the action plan) Causes: The root cause for this failure has not yet been established a Potential consequences: (NB: until validation of all patient re Adverse impact on patient safety / care, potential for irrevers	Patients	-A Governance group, chaired by the Chief Operating Officer and Medical Director set up 23rd April , meeting weekly, terms of reference agreed and reporting to Executive Quality Board - Trust wide action plan written , updated weekly. Including clear instructions to CMG management teams - From 6th May patient level validation at specialty level underway , with weekly monitoring of progress	Major	Likely	16	Establish weekly Governance meeting to manage Trust wide approach - Complete Communicate required actions to all CMGs - Weekly Issue specialty level patient reports for validation to all CMGs - Complete Issue corporate guidance on validation process to all CMGs - Complete Collate weekly returns to monitor validation progress - Weekly Run weekly Trust wide report to monitor progress of validation - Weekly CMGs to provide weekly update action plans on progress - Weekly Undertake Root Cause Analysis incident investigation - 15/07/14 Arrange standard external communication to patients - on track	2	KHAR

Trust Board paper Q

To:	**Trust Board**
From:	Rachel Overfield, Chief Nurse
Date:	26th June 2014
CQC regulation:	Outcomes: 1, 4, 16

Title:	Carer Experience Feedback - Transition for Patients with Learning Disabilities from Children to Adult Services

Author/Responsible Director:
Katrina Dickens, Learning Disability Acute Liaison Lead Nurse Practitioner

Purpose of the Report:
To describe for the Trust Board, the impact of transition from paediatric to adult care for a patient with a learning disability

The Report is provided to the Board for:

Decision		Discussion	X
Assurance		Endorsement	

Summary / Key Points:

The Learning Disability Nurses distribute patient feedback diaries in an easy read format to patients with learning disabilities who access hospital. A general overview of the feedback received from the diaries is included in the team's annual report.

During the team's time working within the hospital they have encountered patients who have transferred from children to adult services who have experienced concerns.

It was decided to have a face to face conversation with one of the patient's carers to identify the issues that they have encountered within the transition process. The patient had been admitted to hospital with chest infections and vomiting and required management of the infection and maintenance of their oxygen saturation levels.

<u>Carer's Feedback of the Transition Process</u>

- The carer experiences were a feeling of isolation and being alone. Within paediatrics there is one doctor that co-ordinates all the care, but this changes when you go into adult services dependent on the reason the patient is admitted to hospital.
- The carer found on one occasion the handover between paediatric and adult services was an ineffective exchange of information. The handover was undertaken via a letter.
- Staff not trained in the use of the Portacath when emergency admissions occur. A Portacath is placed under the skin, with the catheter inserted into a vein. It can be used by clinicians for the delivery of fluids and medications as well as for obtaining blood samples.
- Lack of bathroom facilities for the patient's to have a shower or bath due to their body posture. The individual is not able to sit on a standard shower chair.
- Limited support for family members who stay with their child/family member.
- Limited involvement of family members in discussions to ensure the care is given in accordance with the patient's needs.

Actions in response to Feedback

- A DVD called Freddie's story is on the hospital e-learning site for the staff to see. It gives insight into a patient's journey through hospital. The patient has learning disabilities.
- Transitions Team in City Children's Community Service – CQUIN initiative. The team will visit all year 9 pupils. If they feel a person coming up to 16 years of age has a learning disability they will inform the Learning Disability Acute Liaison Nurse Team (LDALN). To date the LDALN team have had three referrals with home visits planned this month.
- The team is currently promoting within the hospital the use of the Emergency Grabsheet, the Traffic Light Hospital Booklet and the DisDAT Tool for patients with learning disability. The forms can also be found on the Betterlives website at http://www.betterlives.org.uk/learning-disability-acute-liaison-nursing-team/

The Future

To look at ways of increasing awareness of the needs of patients with a learning disability.

What carers and the LDALN team would like to happen:

- Joint handover appointments required between Consultants within child and adult services prior to discharge from child services as a priority.
- To involve the learning disability acute liaison nurse team in the transition process.
- To promote the use of the dependency scale for patients with learning disabilities to assess the level of risk/support needed.
- To develop a rolling plan of learning disability awareness sessions for Trust personnel/ clinical teams and to develop an e-learning package.
- All hospital clinical personnel to undertake the above learning disability awareness sessions and e-learning package when devised.
- All clinical areas to refer to the learning disability acute liaison nurse team when someone with a learning disability is admitted.
- To continue to disseminate the patient feedback diary.

Recommendations:
The Trust Board is asked to :

- Receive and listen to this carer's story
- Support the improvements/recommendations identified in response to the feedback.

Previously considered at another corporate UHL Committee? No	
Strategic Risk Register: N/A	**Performance KPIs year to date:** N/A
Resource Implications (eg Financial, HR): N/A	
Assurance Implications: This paper provides assurance that the Learning Disabilities Team are listening and acting upon patient / carer feedback to improve patient's experience of care	
Patient and Public Involvement (PPI) Implications: Carer has been encouraged to share story at the Trust Board	
Stakeholder Engagement Implications: N/A	
Equality Impact: Feedback taken from a carer who cares for a person with learning disabilities	
Information exempt from Disclosure: N/A	
Requirement for further review? None	