University Hospitals of Leicester NHS
NHS Trust

Cover report to the Trust Board meeting to be held on 5 December 2019

	Trust Board paper I
Report Title:	**People, Process and Performance Committee – Chair's Report** (formal Minutes will be presented to the next Trust Board meeting)
Author:	Gill Belton – Corporate and Committee Services Officer

Reporting Committee:	**People, Process and Performance Committee (PPPC)**
Chaired by:	Andrew Johnson – PPPC Chair and Non-Executive Director
Lead Executive Director(s):	Rebecca Brown – Chief Operating Officer Hazel Wyton – Director of People and Organisational Development (OD)
Date of last meeting:	28 November 2019
Summary of key public matters considered by the Committee and any related decisions made:	

This report provides a summary of the following key public issues considered at the People, Process and Performance Committee on 28 November 2019:-

- **Becoming the Best (Culture, Leadership and QI Elements) –** an update was provided on progress with the cultural, leadership and QI elements of the Trust's Quality Strategy – Becoming the Best. The design mapping had been completed and interventions worked through with the Improvement Agents and Subject Matter Leads. A selection of these were being tested/ reviewed as part of the design phase (reflecting gaps identified). Ideas from the Leadership Conference / Expert Reference Group had also been shared with Improvement Agents for exploring / testing during the design phase. Mission brief sessions continued to be run with Improvement Agents and design activity was being monitored and tracked centrally via INsite. A number of Design Focus Groups would be run during December 2019 ensuring Improvement Agent input in developing interventions in a small number of key areas, working with Subject Matter Experts and reflecting People Strategy / Interim People Plan priorities. Work would be undertaken in clarifying the role of Improvement Agents reflecting decisions taken at a recent Executive Planning Meeting. Dedicated Organisational Development Specialists had been appointed and were initially focusing efforts on supporting Improvement Agents with progressing design / service improvement initiatives. This team would also support the QI Collaborative work planned for December 2019, aligned to Trust priorities. In discussion, the PPPC noted that the Trust Board Thinking Day to be held in February 2020 would focus on design synthesis. In reference to particular discussion which arose relating to the large number of Improvement Agents in corporate areas in comparison to those in Clinical Management Groups, this was considered to be appropriate for the current stage of the process. Specific note was made of the need to take into account clinical staff (albeit not specifically Improvement Agents) working on QI initiatives and it was agreed helpful to have a matrix presented at a future PPPC meeting which captured QI work being undertaken across the Trust and also on an individual site basis. In response to a query raised, it was anticipated that recruitment to the QI Team would have been completed by April 2020. Specific note was made of the importance of communications, specifically in disseminating positive impact, and it was agreed to invite the Head of Communications to the December 2019 meeting of the PPPC in order to discuss the communications strategy.

- **Approach to Improve our People Practices –** this report sought to outline a refreshed approach to case work management, centred much more around creating an environment which created supportive rather than punitive policies and process, compassionate leadership and a 'just culture' ethos. It also provided an update on the national guidance, work progress made to date in this area and provided recommendations / next steps to improve service provision aligned to the people strategy deliverables / Becoming the Best work programmes. The PPPC was requested to note the contents of this report and endorse the action plan contained in appendix B of the report (specifically supporting the 'Just Culture' approach and associated actions and commenting on any gaps for further development or focus). The PPPC was supportive of the approach described within the report and emphasised the importance of ensuring adequate resource for this work, an aspect which they considered was not currently reflected sufficiently within the action plan. Also emphasised by the PPPC was the need to recognise the different cultures of staff due to the Trust's diverse workforce and take account of this accordingly. It was confirmed that on-going scoping work continued to be undertaken by HR colleagues and that a further update

report would be presented to the Executive Culture and People Board, and thereafter the PPPC, in February 2020.

- **Freedom to Speak Up, encompassing:-**
  - **Guidance for Boards on Freedom to Speak Up in NHS Trusts –** this report set out four recently published reports / letters regarding Freedom to Speak Up (F2SU) arrangements in NHS Trusts as follows: (1) Freedom to Speak Up Guidance for Boards (July 2019) (2) Letter from National F2SU Guardian to Chief Executives / Chairs on 'Supporting your Freedom to Speak Up Guardian' (July 2019) (3) Letter from National F2SU Guardian to Chief Executives regarding planned Phase 2 F2SU case reviews (September 2019) and (4) National Freedom to Speak Up Index (October 2019). Following the Executive Culture and People Board meeting on 29 October 2019, further discussions on this paper have been held with the Director of Safety and Risk, Freedom to Speak up Guardian, Director of People and Organisational Development, Deputy Director of Human Resources and Deputy Director of Organisational Development. It was agreed that all suggested actions should be integrated with the Culture and Leadership Programme and the Becoming the Best initiative. Proposed actions include (i) a staff story around speaking up to be taken to Trust Board in the New Year – now scheduled for February 2020 (b) Exit interview data to be reviewed by CMGs and discussed further at the Performance Review Meetings (c) Freedom to Speak up Guardian and Equality Lead to link up to discuss Civility Saves Lives and the Bystander Programme to encourage further culture change (d) consider Improvement Agents to be Freedom to Speak up Champions to further embed the Speaking Up agenda and signpost and encourage staff to raise concerns (e) Audit the F2SU policy in 2020 and (f) consider implementing pre-leaving exit interviews. The PPPC received and noted the contents of this work. Particular discussion took place regarding the importance of initiatives being visible to staff through posters / other communication aids, e.g./ social media posts etc. Discussion also took place regarding how best to support clinical staff who were dealing with constant workload pressure, and it was noted that this matter was currently under consideration at the Health and Well-Being Board. Note was also made of the leadership role for the Trust Board in supporting its staff.
  - **Freedom to Speak Up (Quarter 1 and 2 of 2018/19) –** this report detailed data relating to concerns raised through various mechanisms for Freedom to Speak Up in quarters 1 and 2 of 2018/19, the contents of which were received and noted and ***recommended onto the Trust Board accordingly (copy attached to this summary).*** The report noted that, currently, the learning from the themes was not shared trust-wide and this was an area for consideration in future. Highlighting the themes from staff speaking up would further embed an open and transparent culture.

- **Performance Management and Accountability Framework – *the PPPC endorsed and recommended for Trust Board approval an updated copy (as attached) of the UHL Performance Management and Accountability Framework.*** The updated Framework codified the Trust's approach to performance management, and documented the Trust's accountability arrangements. It complemented, and formed an important component of, the Trust's overall Governance Framework. The Framework had been updated to reflect the implementation of the new NHS Oversight Framework; and reference was made also to the Quality Strategy and how, in time, this may change the way the Framework was designed and operated. In parallel, the Chief Operating Officer, Director of Corporate and Legal Affairs and Deputy Director of Quality Assurance were working with the Clinical Management Groups to standardise CMG Board governance arrangements and arranging/providing training for CMG staff to support them in this regard. It was noted that this Framework would be reviewed again formally in two years' time, albeit updates would potentially be required earlier and would be incorporated as required. Specific discussion took place regarding means of driving improvement in CMGs through specific focus on individual KPIs and the Director of Corporate and Legal Affairs undertook to discuss this with the incoming Acting Chief Financial Officer and CMG colleagues when discussing the plans for the forthcoming year.

- **Urgent and Emergency Care Performance Report Month 7 -** one of the Trust's current priorities was to streamline emergency care pathways. The Trust's quality approach was being utilised to ensure that actions and improvements were linked to the drivers in performance. The Trust's internal transformation plan sat alongside the LLR action plan to give a whole system approach to improving urgent and emergency care. The A&E Delivery Board had system wide oversight and was chaired by the Trust's Chief Executive. The highlights from Month 7 were as follows: (1) overall demand into ED had continued (with a continued increase in ED attendances and a 5.3% increase in emergency admissions) (2) ambulance demand continued to increase (3) there continued to be an imbalance between capacity and demand for Medicine within LRI which was being addressed through the Winter Plan (4) progress on the plan was being made and further actions were being developed and (5) a system wide approach had been escalated as agreed with the Trust's Regulators. Key completed actions were as follows (i) GPAU opened overnight to provide 8 additional spaces (ii) Majors Ambulatory capacity had increased from 10 to 15 (iii) Perfect Day initiative undertaken, the outputs of which would be disseminated (iv) improved consultant advice and guidance to GPs to reduce admission requests (v)

early opening of 28 additional beds across the LRI and Glenfield and (vi) the planned placement of a pod outside ED to release EMAS crews. The report also documented the outcome of a recent GIRFT (Getting It Right First Time) visit to ED. All of the outcomes from the visit were being reviewed in order to form a detailed action plan. The PPPC received and noted the contents of this report. Specific discussion took place regarding work being undertaken around the TTO process as a whole, the outputs of which would be reported at a future PPPC meeting (potentially in January 2020). In discussion, it was agreed that future Emergency and Urgent Care reports to the Committee would differentiate between the reasons patients were designated as 'super stranded' (i.e. had a hospital stay of over 21 days) as this could be for legitimate reasons such as that they continued to be medically unwell. It was also agreed, in discussion, that the Deputy Chief Operating Officer would feed back to CCG / LPT colleagues the need to involve Further Education colleges, as well as the University, in matters concerning wider issues relating to student mental health. Specific discussion also took place regarding operational plans in place across LLR over the Christmas / New Year period and the Trust Chairman indicated his wish for the Chief Executive / Chief Operating Officer to cover these arrangements in a high-level summary format at the December 2019 public Trust Board meeting (noting that these would also be subject to discussion at the ESB meeting due to be held the following week). Particular discussion took place regarding how lessons were learnt from day to day, as well as from wider initiatives such as the Perfect Day for discussion at a future PPPC meeting – it was agreed that discussions would be held between the Deputy Chief Operating Officer, Chief Operating Officer and Chairman and Chief Executive to determine the most appropriate format for this item to be scheduled for a future PPPC meeting. Under the circumstances the Committee was not assured that the Trust is able to meet its targets for Emergency Care.

- **Bed Capacity and Bridge Report –** this report described the predicted bed gap; how this had been calculated and the efficiencies by CMG to manage the gap or decrease occupancy. This was an iterative process and schemes and numbers of beds released would be updated following each meeting with the CMG's. A review of Q2 activity had shown very little change in the predictions compared to Q1 and therefore further changes had not been made to the modelling prospectively. Three strands of work were on-going in relation to this – short-term, medium-term and long-term. As noted in the discussion above, it was agreed to consider relevant issues further in terms of winter capacity at the December 2019 Trust Board meeting.

- **Safe Staffing Allied Health Professionals** - this paper, the contents of which were received and noted, considered national and local issues arising out of the significant workforce agenda for clinical staff groups outside of medical and nursing staff groups. It detailed how the themes across the non-medical/non nursing professions from the developing workforce safeguards gap analysis could be addressed and aimed to promote discussion about how UHL could promote professional diversity at a senior leadership level in line with the expectations of a 'Well-led' trust and as a response to some of the challenges arising from the gap analysis. Additionally, it considered the governance arrangements required to ensure other professional staff groups were visible and represented at a senior level visible to the Trust Board in line with other staff groups and the national guidance on developing allied health professional leaders.

- **Model Employer WRES Targets -** the Trust Workforce Race Equality Standards (WRES) action plan which incorporated the nine WRES key performance indicators was approved by the Equality, Diversity and Inclusion Board in September 2019 (as detailed within the report presented to PPPC) and work would be undertaken by the EDI Board and national WRES Team (dedicated expert support would be provided to UHL) to update the action plan reflecting the areas of best practice set out in the WRES Model for improving BME representation across the NHS workforce, comprising four elements (1) Leadership and culture transformation (2) Positive action and practical support (3) Accountability and assurance and (4) Monitoring progress and benchmarking. PPPC's input and support was sought in increasing BME representation at senior levels across the Trust and strengthening accountability and assurance, in order to meet UHL aspirational targets set (10 year ambition). The PPPC received and noted the contents of this report and noted that a revised version of the action plan would be worked up and presented at the February 2020 Trust Board Thinking Day.

Items for Information

The following reports were noted:-

- **Trust-wide Medical E-Rostering Project**
- **IR35 Quarterly Update**
- **Workforce and Organisational Development data set (month 7)** – the PPPC Non-Executive Director Chair made specific note of the rise in sickness absence,
- **Executive Performance Board action notes from 22.10.19**
- **Executive People and Culture Board actions from 29.10.19.**

Joint PPPC and QOC session

- **Cancer Performance Monthly Report -** the cancer referral rate remained higher than last year and continued to increase; performance remained relatively stable despite the growing demand. In September 2019 UHL achieved 3 standards against the national targets and 3 standards against UHL's trajectory. The 62 day standard remained the Trust's biggest challenge; this was a National challenge with UHL ranked 9/18 against peers and 97/142 against all acute Trusts. The paper showed a breakdown of performance against all targets and performance by tumour site for the 62 day target. A detailed action plan was included within the paper presented to PPPC which showed the actions that were being undertaken by the CMG's in order to improve performance. 104 Day Clinical Harm Review Quarter 1 2019/20 demonstrated no physical harm during the quarter (details in October board report). The Trust had received positive feedback from EMCA, NHSE and the CCG on its transformational programme which was being delivered and would support improved quality and performance.

- **Quality and Performance Report – Month 7** - members received and noted the contents of the monthly Quality and Performance report. The report provided a high level summary of the Trust's performance against the key quality and performance metrics, together with a brief commentary. Specific discussion took place regarding the reference to 'TBC' against specific targets detailed within the report and a request was made as to when this information would be available. In response, it was noted that this data had not been included as there was not currently a national target against these areas. It was agreed to amend future reports to read 'no national target' rather than 'tbc'. It was the case that local standards might be set in the absence of national standards and the data presented would reflect this, where relevant.

- **CMG performance review data** – the report summarised the outputs from the September 2019 performance review meetings (PRMs) with CMGs, the contents of which were received and noted.

Matters requiring Trust Board consideration and/or approval:

Recommendations for approval:-

1. Freedom to Speak Up (Q1 and Q2) – as attached.
2. Performance Management and Accountability Framework (attached for approval)

Items highlighted to the Trust Board for information:

1. Approach to Improve our People Practices
2. Urgent and Emergency Care Performance Report – Month 7
3. Bed Capacity and Bridge Report

Matters referred to other Committees:

Feedback Fortnight – deferred to the PPPC meeting in December 2019.

Date of Next Meeting:	19 December 2019

FREEDOM TO SPEAK UP Q1 AND 2 REPORTS

Paper E2

Purpose of report:

This paper is for:	Description	Select (X)
Decision	To formally receive a report and approve its recommendations OR a particular course of action	
Discussion	To discuss, in depth, a report noting its implications without formally approving a recommendation or action	X
Assurance	To assure the Board that systems and processes are in place, or to advise a gap along with treatment plan	
Noting	For noting without the need for discussion	

Previous consideration:

Meeting	Date	Please clarify the purpose of the paper to that meeting using the categories above
CMG Board (specify which CMG)		
Executive Board	Quarterly	Discussion and approval of recommendations
Trust Board Committee		
Trust Board		

Executive Summary

Context

The purpose of this report is to provide the ECPB with information relating to concerns raised through various mechanisms for F2SU **Quarters 1** and **2**.

Questions

i. Are we taking sufficient actions on the key themes raised?
ii. Does ECPB support the 'You said, we did' approach to share the learning and themes from staff speaking up to the wider Trust?

Conclusion

These two reports clearly highlight the various mechanisms that staff use to speak up and concerns are demonstrated in the main themes captured below for quarters 1 and 2. The main themes are:-

- Medical staffing within CHUGGS has been a notable theme.
- Medical staffing highlighting concerns around not receiving their payslips.
- We have seen an increase in Junior Doctors Gripes this quarter
- Medical Outliers on ward 18.
- Medical staffing on Ward 16 Glenfield was a notable theme.
- High number of concerns rose due issues with junior doctors' pay.
- Car parking for our twilight shift workers within ED continues to be a theme.

- Cultures and behaviours within departments continue to be escalated and an increase in requests to undertake Drop-ins within departments has increased this quarter.

We currently do not share the learning from the themes Trust wide and this is something we need to consider going forward. Highlighting the themes from staff speaking up will further embed an open and transparent learning culture.

Input Sought

The People, Process and Performance Committee is invited to consider the content of these four reports and:-

- Consider whether we are taking sufficient action on the key themes raised.
- Consider how we feedback to the wider trust on concerns raised and share the learning from staff speaking up.
- Consider whether exit questionnaires are being monitored, as these can be another mechanism to monitor themes within a department.
- Consider whether we are taking sufficient action on the key themes raised.
- Consider the "You said, we did" approach to share the learning and themes from staff speaking up.
- Consider whether exit questionnaires are being monitored, as these can be another mechanism to monitor themes within a department and taking action on this could improve retention within the Trust.

For Reference

This report relates to the following UHL quality and supporting priorities:

1. Quality priorities

Safe, surgery and procedures	[No]
Safely and timely discharge	[No]
Improved Cancer pathways	[No]
Streamlined emergency care	[No]
Better care pathways	[No]
Ward accreditation	[No]

2. Supporting priorities:

People strategy implementation	[Yes]
Estate investment and reconfiguration	[Not applicable]
e-Hospital	[Not applicable]
More embedded research	[Not applicable]
Better corporate services	[Yes]
Quality strategy development	[Yes]

3. Equality Impact Assessment and Patient and Public Involvement considerations:

- What was the outcome of your Equality Impact Assessment (EIA)? None undertaken
- Briefly describe the Patient and Public Involvement (PPI) activities undertaken in relation to this report, or confirm that none were required. None required.
- How did the outcome of the EIA influence your Patient and Public Involvement? N/A
- If an EIA was not carried out, what was the rationale for this decision? N/A

4. Risk and Assurance

Risk Reference:

Does this paper reference a risk event?	**Select (X)**	**Risk Description:**
Strategic: Does this link to a ***Principal Risk*** on the BAF?	No	
Organisational: Does this link to an ***Operational/Corporate Risk*** on Datix Register	No	
New Risk identified in paper: What ***type*** and ***description***?		
None	x	

5. Scheduled date for the **next paper** on this topic: January 2020

6. Executive Summaries should not exceed **5 sides** [My paper does comply]

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST

REPORT TO: **PEOPLE, PROCESS AND PERFORMANCE COMMITTEE**

DATE: **28TH NOVEMBER 2019**

REPORT BY: **DIRECTOR OF SAFETY AND RISK / FREEDOM TO SPEAK UP GUARDIAN**

SUBJECT: **FREEDOM TO SPEAK UP REPORT QUARTER 1 DATA**

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1. INTRODUCTION

1.1 The purpose of this report is to provide the People, Process and Performance Committee with information relating to concerns raised through various mechanisms, including:

- CQC.
- Anti-Bullying and Harassment Advice service.
- Junior Doctor Gripe Tool.
- Counter Fraud Management Services.
- 3636 Staff Concerns Reporting Line.
- Freedom to Speak Up Guardian.
- Junior Doctors Gripe Tool.

1.2 In addition to the work plan the Freedom to Speak up Guardian is currently involved in:

- National Guardian Office news rollout
- Trust Culture and Leadership work, especially with the Improvement Agents
- Preparations for World Patient Safety Day and 'Speaking up Safely'.

2. STAFF RAISING CONCERNS 1st QUARTER 2019/20 (APR/JUN)

2.1 There has been **1** concern raised to CQC. The CQC received a letter from an anonymous whistle-blower in May 2019, regarding endoscopy at the LGH. The concerns were:

- Deputies having long periods of time off work, coming in late and going early without senior managers asking any questions.
- Deputies covering for friends who have taken too much time on sick leave.
- Endoscopy doctors and nurses do what they want.
- The department is unsafe with very little communication.
- Matron and managers know the situation but cannot cope and turn a blind eye.
- There is an aggressive member of staff which affects patients.

2.2. HUMAN RESOURCES

There have been **6** cases referred to HR. All these cases relate to Bullying and Harassment allegations.

2.3 COUNTER FRAUD MANAGEMENT SERVICES

Counter Fraud management have received **8** cases:

- Patient treatment fraud = 1
- Staff working whilst on sick = 1
- False representation = 1
- Time sheet fraud = 2
- Supplier potentially overcharging = 1
- Staff potentially working elsewhere = 2

- Total = 8 referrals.

2.4 **BULLYING AND HARASSMENT SERVICES**

The Bullying and Harassment Service has reported that **13** staff members have accessed the service.

- CSI=3
- E&F=1
- MSK=2
- CHUGGS=1
- Finance and Procurement= 1
- Corporate Nursing=1
- Unknown=4

3. JUNIOR DOCTOR GRIPES TOOL

3.1 I continue to support the Junior Doctors Gripe as a mechanism dedicated for our junior doctors to raise concerns.

3.2 I meet on a six weekly basis with the Director of Medical Education, Consultant Physician, Chief Registrar, and a number of junior doctors. This is to discuss the Gripes we have received, and encourages an open and learning culture. We will introduce the new Director of Medical Education to this once the post has been appointed to.

3.3 In the first Quarter 45 Junior Doctor Gripes were received. These break down as follows:-

Subjects of Gripes received in 2019/20 Quarter 1	Total
Lack of staffing resource	23
IT issues	7
Equipment and ward environment	5
Pay Issues	4
Quality and safety of care	2
Training / supervision	2
Teamwork and communication	2
Grand Total:	**45**

3.4 The themes of the Gripes received are as followed:-

3.5 We received a high number of Gripes for Ward 39, 40, 41 due to medical staffing and lack of support from phlebotomy services. Due to the number of Gripes, a meeting was arranged with the Education Lead for CHUGGS, myself, the Director of Education and the Junior Doctors on rotation on the ward. From this meeting an open discussion was held to share with the junior doctors the challenges within the department. They were also advised that further support will be arranged from the phlebotomy service.

3.6 Car parking continues to be an issue. A number of medical staff have raised a Gripe due to working twilight shifts within ED as they are expected to move their cars mid shift (due to the car park they are allocated to closes whilst they are working on shift). This creates a huge challenge for the staff within the department.

3.7 A Gripe has been received around referrals to specialist services such as Fracture Clinic as junior doctors claim that there is not a clear process to refer the patients. The department, together with IT colleagues are looking into this.

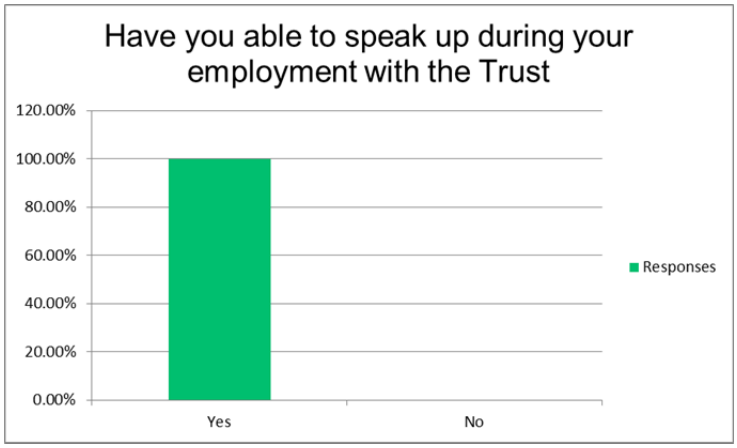
3.8 We have received a number of gripe reports relating to incorrect junior doctor pay (no pay, underpayment, no payslips, no overtime payment). Each of these concerns has been escalated to the medical workforce, CMG or payroll teams for comment and resolution.

3.9 Below are the links to the Junior Doctors Gripes Newsletter cascaded:-
December 2018
March 2019
August 2019

4. EXIT INTERVIEW DATA

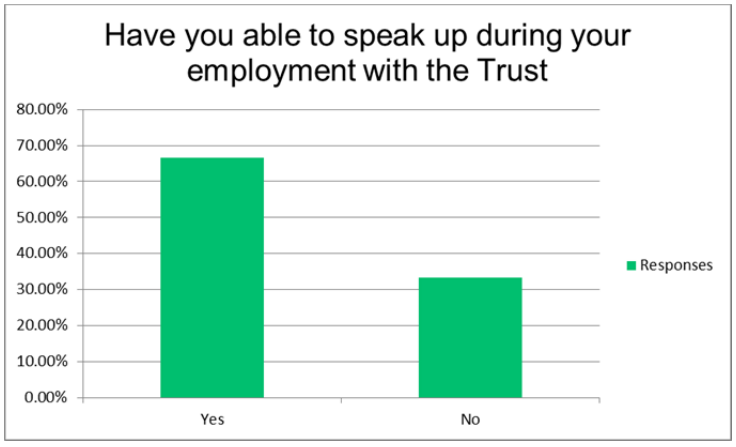
4.1 Key questions have been added to Exit Interviews as suggested from the National Guardian Office. The aim of this is to provide another avenue for staff to highlight concerns.

4.2 For Quarter 1 I have broken this down into CMGs:-
W&Cs: An example of comments from the Exit Questionnaire:-
Comments added:-
""Staff shortages - as a team we spoke up but due to staff shortages we could not be listened to"



Answer Choices	Responses	
Yes	100.00%	5
No	0.00%	0
	Answered	**5**
	Skipped	**2**

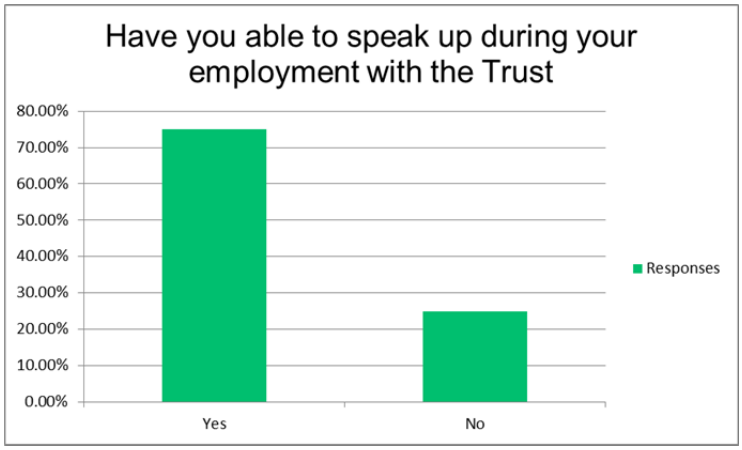
4.3 **ALLIANCE**: An example of comments from the Exit Questionnaire :-
Comments added:-
No comments added.



Answer Choices	Responses	
Yes	66.67%	2
No	33.33%	1
	Answered	**3**
	Skipped	**0**

4.4 **CHUGGS**: An example of comments from the Exit Questionnaire:-

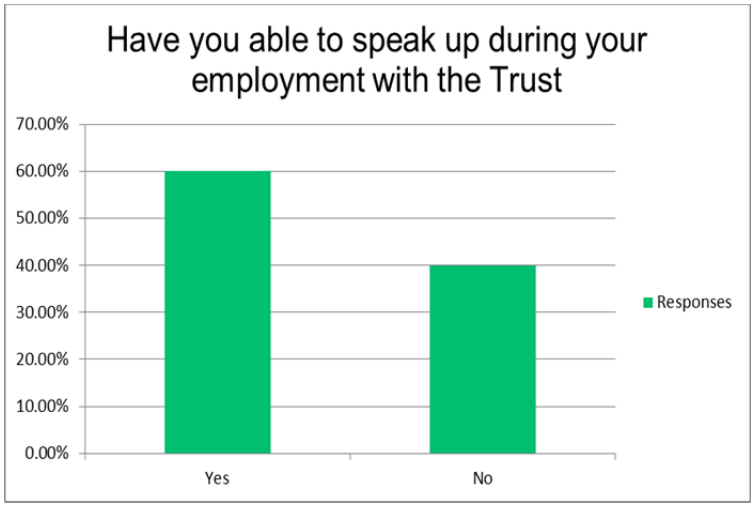
Comments added: - *"Trust, the feeling that I wasn't being listened to and if I did put my matters across nothing would have been done about it. Line managers were way too busy to ever listen"*



Answer Choices	Responses	
Yes	75.00%	6
No	25.00%	2
	Answered	**8**
	Skipped	**1**

4.5 **CORPORATE:** An example of comments from the Exit Questionnaire:-

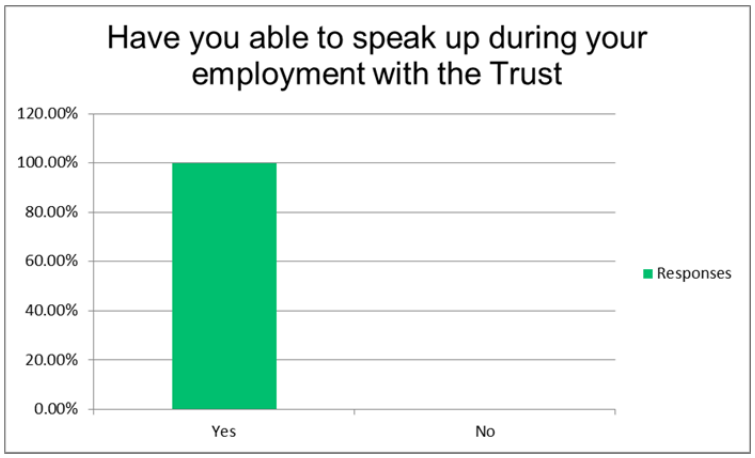
Comments added: - "*Resistance from senior management for making necessary changes to culture and career progression in office - used excuse of budget constraints - yet promotions for management were given and new posts were funded elsewhere"*



Answer Choices	Responses	
Yes	60.00%	3
No	40.00%	2
	Answered	**5**
	Skipped	**2**

4.6 **CSI**: An example of comments from the Exit Questionnaire:-

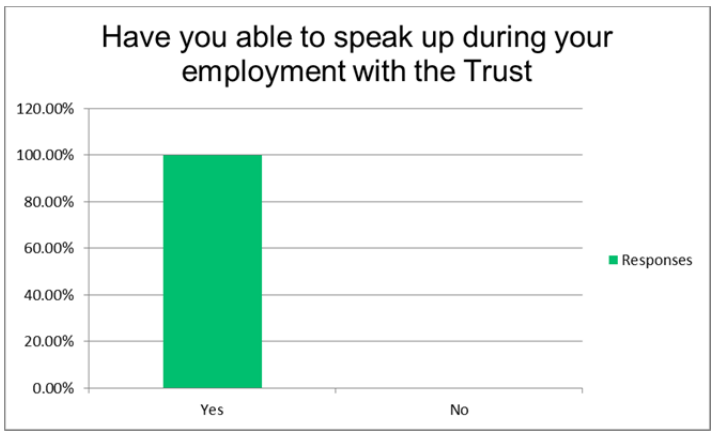
Comments added: - ""ease of conversation with supportive management team"



Answer Choices	Responses	
Yes	100.00%	6
No	0.00%	0
	Answered	**6**
	Skipped	**2**

4.7 **ESM**: An example of comments from the Exit Questionnaire:-

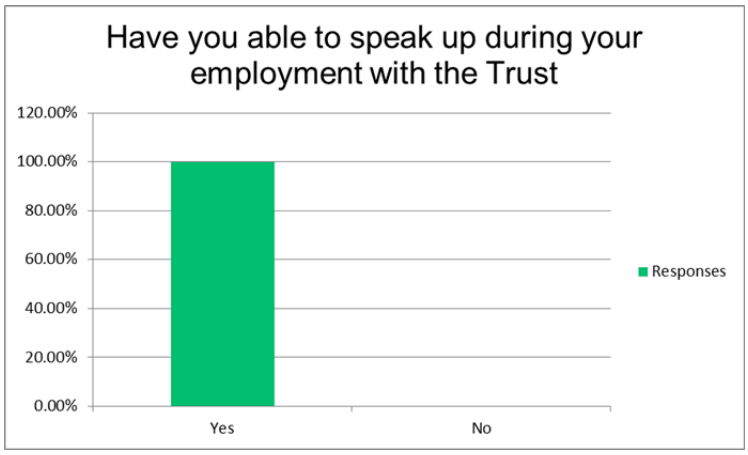
No Comments added



Answer Choices	Responses	
Yes	100.00%	2
No	0.00%	0
	Answered	**2**
	Skipped	**3**

4.8 **ITAPS:** An example of comments from the Exit Questionnaire:

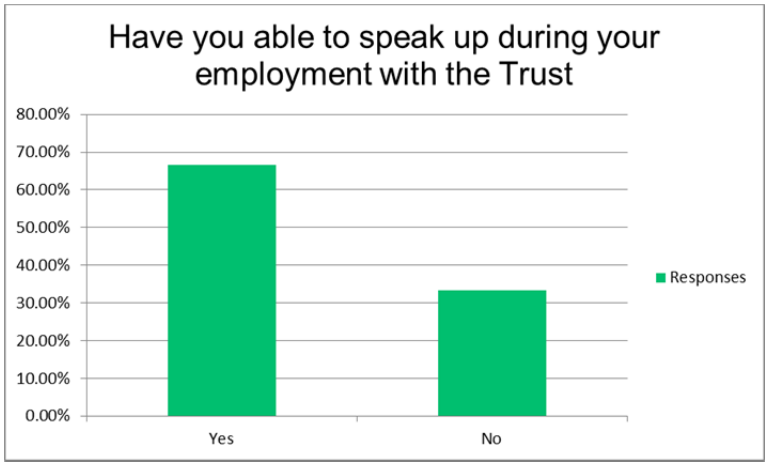
Comments added: *"Support of other team members"*



Answer Choices	Responses	
Yes	100.00%	4
No	0.00%	0
	Answered	**4**
	Skipped	**0**

4.9 **RRCV:** An example of comments from the Exit Questionnaire:

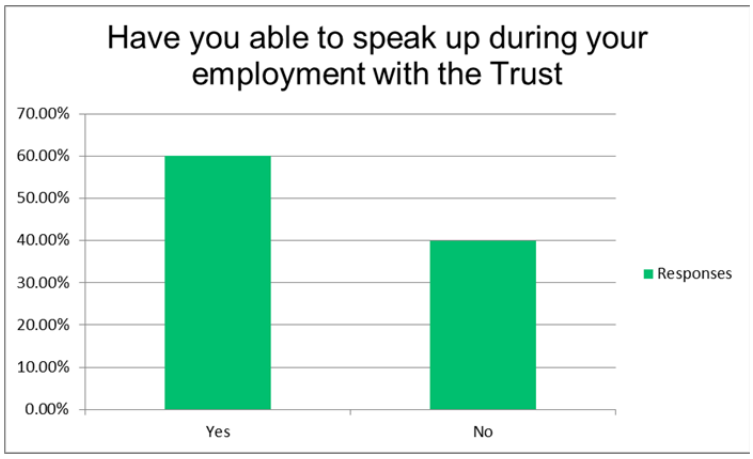
Comments added *"Did not feel comfortable enough talking about mental health and wellbeing"*



Answer Choices	Responses	
Yes	66.67%	6
No	33.33%	3
	Answered	**9**
	Skipped	**1**

4.10 **E&F:** An example of comments from the Exit Questionnaire:

Comments added: *"Barriers for Speaking up-"Management making decisions"*



Answer Choices	Responses	
Yes	60.00%	3
No	40.00%	2
	Answered	**5**
	Skipped	**0**

4.11 I would like to continue to urge all CMGs to review exit interview data as it is can be a helpful resource to hear staff views within their departments.

5. FREEDOM TO SPEAK UP GUARDIAN/3636 STAFF CONCERNS

5.1 I have received **18** concerns directly to me and **10** concerns raised through the 3636 staff reporting line.

5.2 I have received two 3636 staff concerns through the reporting line from ward 18 at LRI. This is due to medical outliers and reports that patients are being moved in the early hours of the morning. This has been reported to be very distressing for the patients and the staff. The Director on Call on the day and the Head of Patient Flow kindly visited the ward to thank the staff for their dedication to the patients and share the trust wide challenges at present. The issue out outlying has been further picked up by the Director of Safety and Risk and presented at the Executive Quality Board.

5.3 I have received a number of concerns around Estates at the LRI; we have received two 3636 staff concerns around the lifts not working in the Balmoral Building. These were escalated in the normal way and the issues have been resolved.

5.4 Behaviour and cultures in departments continue to be the theme from staff when they raise concerns with me. I continue to work closely with the Better Teams and Organisational Development who offer support with teams to improve cultures in departments.

5.5 I continue to see an increase in requests for Drop-in sessions in departments to provide an opportunity for staff to share their views on the wards/departments to continually improve cultures throughout the Trust.

5.6 The F2SU Annual Report has been shared at the August Trust Board and communicated widely to our staff through the communications team as we recognise the importance of promoting the guardian role and for all staff to feel confident to raise concerns.

5.7 National ‘Speaking up month’ is happening again in October, and plans are in place to promote this at UHL.

6. NATIONAL GUARDIAN OFFICE NEWS

6.1 The Guidance for Boards on Freedom to Speak up in NHS trusts and NHS foundation Trusts has recently been published. The Director of Safety and Risk will present details of this and proposed actions at a future Executive People and Culture Board.

6.2 On reflection to this my thoughts are:-

- The Trust has shown a strong commitment to the Freedom to Speak agenda. We have robust process for when we receive a staff concern, however if we do not have the staff members details we do not have a process to feedback to the wider trust. I acknowledge this can be challenging, especially with the sensitivity of the cases however this will a priority to focus on in 2019/2020 as communicating the learning from staff speaking up will further embed a culture change.

- We offer essential to role training through the Patient Safety team which covers a variety of patient safety topics however we do not offer dedicated training sessions on Freedom to Speak up agenda this however can be reviewed and discussed as to the best possible steps to further embed the Speaking up agenda.

7. DATA

Quarter	Raising Concerns Notifications						Junior Doctors Gripe Tool
	Calls to the 3636 staff concerns line	Cases raised with Freedom to Speak up Guardian	CQC whistleblowing notifications	Notifications of whistleblowing to Human Resources	Cases reported to Counter Fraud Management Services	Reported cases of Bullying and Harassment	
Q3 2015/16	9	-	0	0	4	0	Unavailable
Q4 2015/16	7	-	4	0	1	8	40
Q1 2016/17	6	-	3	0	7	8	44
Q2 2016/17	13	-	0	0	12	12	31
Q3 2016/17	6	-	0	0	7	8	20
Q4 2016/17	6	-	3	1	8	8	20
Q1 2017/18	13	20	2	0	10	5	39
Q2 2017/18	23	17	2	0	6	7	23
Q3 2017/18	8	17	1	0	6	14	20
Q4 2017/18	14	23	2	1	3	9	27
Q1 2018/19	9	15	0	0	5	13	14
Q2 2018/19	8	30	1	0	22	12	37
Q3 2018/19	9	26	0	0	42	17	26
Q4 2018/19	12	22	1	15	65	19	23
Q1 2019/20	10	18	1	6	8	13	45

8. CONCLUSION

8.1 On review of all the data included within this report, staff are continuing to use a number of avenues to raise their concerns.

8.2 Reading across all the themes, the notable issues are:-

- Medical staffing within CHUGGS have been a notable theme.
- Medical staffing highlighting concerns around not receiving their payslips.
- We have seen an increase in Junior Doctors Gripes this quarter.
- Medical Outliers on Ward 18.

9. RECOMMENDATIONS

9.1 The People, Process and Performance Committee is invited to note the contents of this report and the following recommendations:-

- Consider whether we are taking sufficient action on the key themes raised.
- Consider how we feedback to the wider trust on concerns raised and share the learning from staff speaking up.
- Consider whether exit questionnaires are being monitored, as these can be another mechanism to monitor themes within a department.

Jo Dawson,
Freedom to Speak Up Guardian,
October 2019

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST

REPORT TO: **PEOPLE, PROCESS AND PERFORMANCE COMMITTEE**

DATE: **28TH NOVEMBER 2019**

REPORT BY: **DIRECTOR OF SAFETY AND RISK**

SUBJECT: **FREEDOM TO SPEAK UP REPORT QUARTER 2 DATA**

---

1. INTRODUCTION

1.1 The purpose of this report is to provide the People, Process and Performance Committee with information relating to concerns raised through various mechanisms, including:

- CQC
- Anti-Bullying and Harassment Advice service
- Junior Doctor Gripe Tool
- Counter Fraud Management Services
- 3636 Staff Concerns Reporting Line
- Freedom to Speak Up Guardian
- Junior Doctors Gripe Tool

1.2 To update on the initiatives the Freedom to Speak up Guardian is currently involved in and future plans:

- National Guardian Office news
- Speaking up Month

2. STAFF RAISING CONCERNS 2nd QUARTER 2019/20 (JUL/SEPT)

2.1 There has been **1** concern raised to the CQC. The CQC received a concern in Endoscopy at the LGH. Please note this is the second CQC referral from Endoscopy at the LGH. The staff member raised concerns about bullying, staff leaving, not following procedures in the decontamination room, cleaning fluids for machines are not changed and are out of date. A full response was provided to the CQC in the previous quarter due to very similar concerns regarding Endoscopy at the LGH, therefore no further action was taken / response given.

2.2. HUMAN RESOURCES

There have been **5** cases referred to HR; all these cases were allegations of bullying and harassment.

2.3 COUNTER FRAUD MANAGEMENT SERVICES

Counter Fraud management have received **18** cases:

- Phishing emails = 8
- Patient identity fraud = 1
- Staff working whilst on sick = 1
- False representation = 2
- Time sheet fraud = 2
- Staff potentially working elsewhere = 2
- Medicine theft = 1
- Staff with false qualification/certificates = 1
- Total = 18 referrals.

2.4 **BULLYING AND HARASSMENT SERVICES**

The Bullying and Harassment Service have reported that **9** staff members have accessed the service. 7 contacted the service directly and 2 completed an online form to raise their concerns.

- Unknown=4
- RRCV= 3
- ITAPS=1
- CORPORATE=1

3. JUNIOR DOCTOR GRIPES TOOL

3.1 I continue to support the Junior Doctors Gripe as a mechanism dedicated for our junior doctors to raise concerns.

3.2 I meet on a six weekly basis with the Director of Medical Education, Consultant Physician, Chief Registrar, and a number of junior doctors. This is to discuss the Gripes we have received, and encourages an open and learning culture. We will introduce the new Director of Medical Education to this once the post has been appointed to.

3.3 In the 2nd Quarter 45 Junior Doctor Gripes were received.

Subjects of Gripes received in 2019/20 Quarter 2	Total
Lack of staffing resource	19
Equipment and ward environment	13
Teamwork and communication	7
IT issues	5
Quality and safety of care	1
Pay Issues	0
Training / supervision	0
Grand Total:	45

3.4 The themes of the Gripes received are as followed:-

3.5 We have received 6 Gripes around the working environment in the Sandringham Building for the Junior Doctors, and generator testing impacting on the workload of medical staff. The Head of Operations is aware of the concerns with the working environment and Estates and Facilities have provided a timetable which will be shared with the Junior Doctors to minimise the risk of the testing impacting on their workload.

3.6 Car parking for our Junior Doctors, who work twilight shifts within ED continues to be an issue, this is an recurring theme however I appreciate the challenge relating to car parking.

3.7 We have received 3 Gripes with regards to medical staffing on Ward 16; the Gripes were escalated to Clinical Director. As a result of this, more staff were rostered in to support medical staffing gap.

3.8 Below are the links to the Junior Doctors Gripes Newsletter cascaded:-
December 2018
March 2019
August 2019

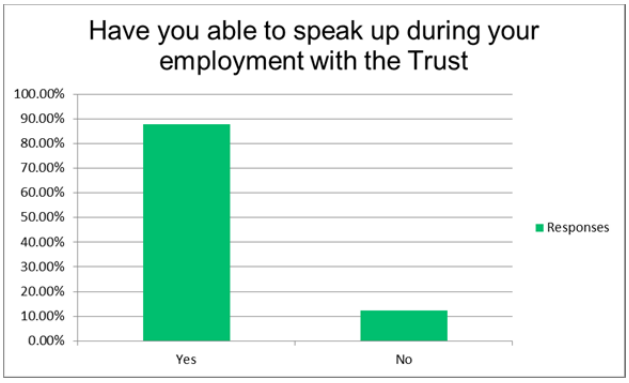
4. EXIT INTERVIEWS DATA

4.1 Key questions have been added to Exit Interviews as suggested from the National Guardian Office. The aim of this is to provide another avenue for staff to highlight concerns.

4.2 For Quarter 2 I have broken this down into CMGs:-

W&Cs: An example of comments from the Exit Questionnaire:-

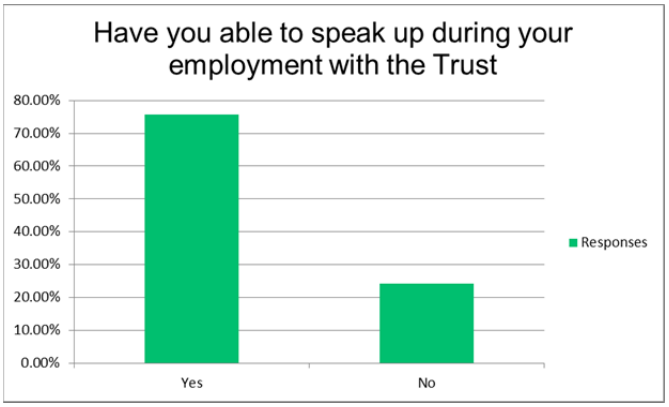
Comments added:- “Not being listened to, met with hostility when trying to speak to senior staff”



Answer Choices	Responses	
Yes	87.80%	36
No	12.20%	5
	Answered	**41**
	Skipped	**10**

4.3 **CHUGGS**: An example of comments from the Exit Questionnaire:-

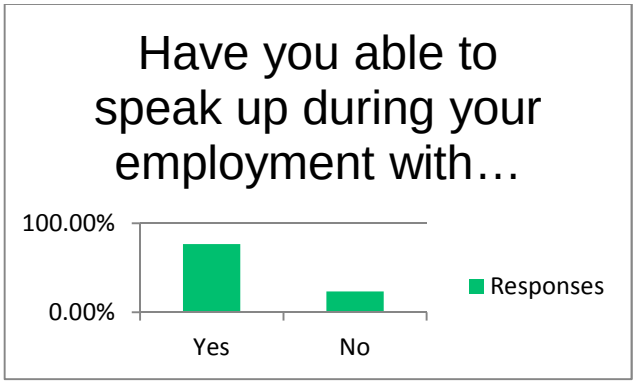
Comments added:- “Management- When i made a complaint or voiced a concern no further action was taken despite the protocols put in place.”



Answer Choices	Responses	
Yes	75.68%	28
No	24.32%	9
	Answered	**37**
	Skipped	**3**

4.4 **CORPORATE:** An example of comments from the Exit Questionnaire:-

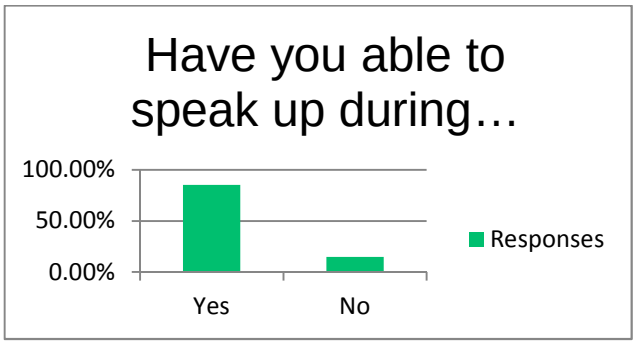
Comments added:- “In the few team meetings we have had in the last 18 months, discussion was not expected and it was to tell us what is happening not for our input”



Answer Choices	Responses	
Yes	76.74%	33
No	23.26%	10
	Answered	**43**
	Skipped	**12**

4.5 **CSI**: An example of comments from the Exit Questionnaire:-

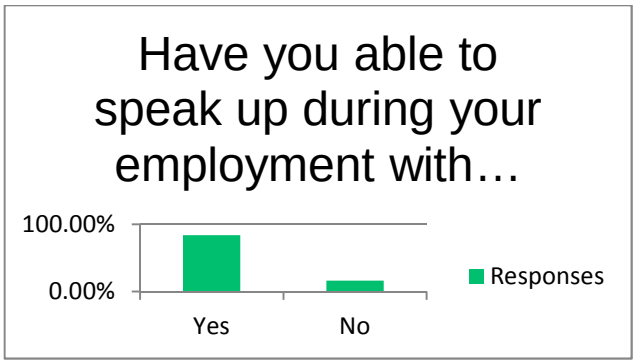
Comments added “previous concerns not listened too, felt like future comment wouldn't be listened to”



Answer Choices	Responses	
Yes	85.25%	52
No	14.75%	9
	Answered	**61**
	Skipped	**17**

4.6 **ESM**: An example of comments from the Exit Questionnaire:-

No Comments added “No formal barriers but very little ever came from speaking up. Often seen as 'whinging' when trying to offer service improvement/better ways of working.”



Answer Choices	Responses	
Yes	83.87%	26
No	16.13%	5
	Answered	**31**
	Skipped	**6**

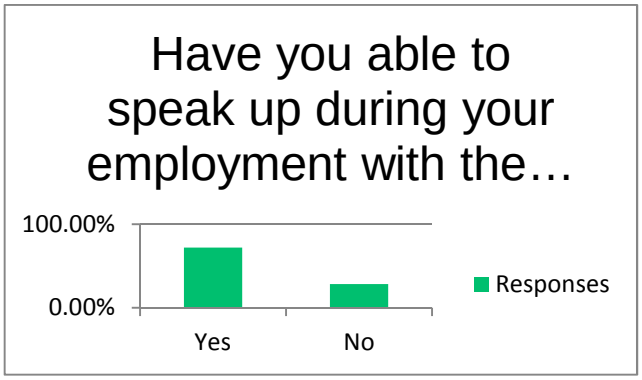
4.7 **ITAPS:** An example of comments from the Exit Questionnaire:

Comments added: “The feeling of why speak to someone in the trust as in the end, nothing happens”

Answer Choices	Responses	
Yes	68.75%	22
No	31.25%	10
	Answered	**32**
	Skipped	**4**

4.8 **RRCV:** An example of comments from the Exit Questionnaire:

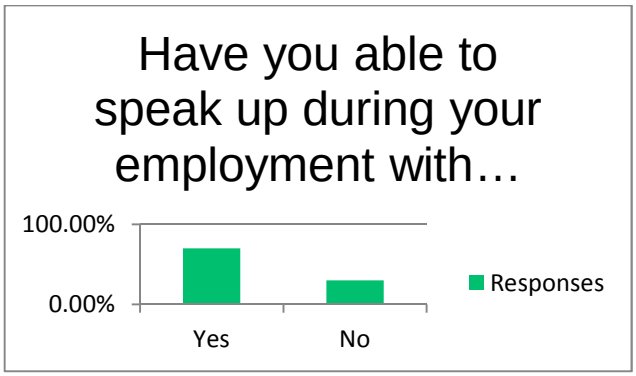
Comments added: “Did not feel comfortable enough talking about mental health and wellbeing”



Answer Choices	Responses	
Yes	71.88%	23
No	28.13%	9
	Answered	**32**
	Skipped	**8**

4.9 **E&F:** An example of comments from the Exit Questionnaire:

Comments added: “Not supported by line managers”



Answer Choices	Responses	
Yes	70.00%	7
No	30.00%	3
	Answered	**10**
	Skipped	**3**

4.10 I would like to continue to highlight that all CMGs review exit interviews data as it is a valuable source of staff views within their departments.

4.11 Within the Exit Questionnaires, there were a number of worrying comments which merit further investigation. I would be keen to know the local action taken on these comments which could improve staff morale and staff retention.

5. FREEDOM TO SPEAK UP GUARDIAN/3636 STAFF CONCERNS

5.1 I have received **27** concerns directly to me and **8** concerns raised through the 3636 staff reporting line.

5.2 I have received a concern due to staff being moved on a night shift and the language used by colleagues. Following this, I have discussed the concern with the Deputy Head of Patient Flow and we will be arranging a time out day with the Duty Management Team with support from Organisational Development. The aim of the session is to encourage and promote the importance of positive behaviours but to also recognise the challenges they face on a daily basis.

5.3 Car parking unfortunately continues to be an issue, especially for medical staff who are rotated to work a twilight shift within ED. This has been escalated to the car parking team however, due to challenges within car parking; there are not any options to change their permits.

5.4 There have been a number of Gripes and F2SU concerns raised due to 9 medical staff not being paid. Each case has been looked into individually and all the Junior Doctors have been paid, however it is important to recognise that this has created a lot of unnecessary distress and upset to the Junior Doctors.

5.5 I continue to receive a number of concerns around the culture and behaviours in departments. It is encouraging that staff feel able to raise these concerns but important that the Trust takes decisive action when behaviours fall below our stated values. I continue to work with

Organisational Development and the Better Teams to work with teams in supporting positive cultures within departments.

5.6 I have received a 3636 staff concern due to staffing within the maternity services at the LGH; as per process, the concern was escalated to Head of Midwifery who sent a response to all staff to thank them for raising the concern and to share that new midwives will be starting in post in November 2019.

5.7 In previous reports I have highlighted my concerns on how we report to the wider Trust on themes raised through the various mechanisms. To encourage a positive learning culture, it is important to share the good news stories from staff raising concerns, however this will need to be sensitive to the individuals involved and the departments this may impact. In the next quarter I would like to focus on a "You said, we did" approach where quarterly there is a section in the CEO briefing which highlights the themes and sharing good news stories, I welcome your thoughts on this.

6. NATIONAL GUARDIAN OFFICE NEWS

6.1 It is "Speaking up" month in October; I have arranged for lunch time stalls to he held across the 3 main sites. To also celebrate "Speaking Up" month I have arranged for the Victoria Building to be lit up green for the month in support/empower our staff to speak up and raise their concerns.

6.2 As some staff may not be able to attend the lunch time events, I have asked all leaders to show their support in their own department, and share how they encourage the Freedom to Speak up Agenda within their own teams. This could be from simple drop-in events or a lunch time event in their own department with leaders inviting their team to come and talk to them.

6.3 The National Guardian's Office has produced their Autumn newsletter

7. DATA

Quarter	Raising Concerns Notifications						Junior Doctors Gripe Tool
	Calls to the 3636 staff concerns line	Cases raised with Freedom to Speak up Guardian	CQC whistleblowing notifications	Notifications of whistleblowing to Human Resources	Cases reported to Counter Fraud Management Services	Reported cases of Bullying and Harassment	
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Q4 2016/17	6	-	3	1	8	8	20
Q1 2017/18	13	20	2	0	10	5	39
Q2 2017/18	23	17	2	0	6	7	23
Q3 2017/18	8	17	1	0	6	14	20

Q4 2017/18	14	23	2	1	3	9	27
Q1 2018/19	9	15	0	0	5	13	14
Q2 2018/19	8	30	1	0	22	12	37
Q3 2018/19	9	26	0	0	42	17	26
Q4 2018/19	12	22	1	15	65	19	23
Q1 2019/20	10	18	1	6	8	13	45
Q1 2019/20	8	27	1	5	18	9	45

8. CONCLUSION

8.1 On review of all the data included within this report, staff continue to use a number of avenues to raise their concerns.

8.2 Reading across all the themes, the notable issues are:-

- Medical staffing on Ward 16 Glenfield were a notable theme.
- High number of concerns raised due issues with junior doctors' pay.
- Car parking for our twilight shift workers within ED continues to be a theme.
- Cultures and behaviours within departments continue to be escalated and an increase in requests to undertake Drop-.ins within departments has increased this quarter.

9. RECOMMENDATIONS

9.1 The People, Process and Performance Board is invited to note the contents of this report and the following recommendations:-

- Consider whether we are taking sufficient action on the key themes raised.
- Consider the "You said, We did" approach to share the learning and themes from staff speaking up.
- Consider whether exit questionnaires are being monitored, as these can be another mechanism to monitor themes within a department and taking action on this could improve retention within the Trust.

Jo Dawson,
Freedom to Speak Up Guardian,
October 2019

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST

PERFORMANCE MANAGEMENT AND ACCOUNTABILITY FRAMEWORK

Version:	2
This version issued:	November 2019
Review date:	November 2021
Authors:	Stephen Ward, Director of Corporate and Legal Affairs, Rebecca Brown, Chief Operating Officer and Deputy Chief Executive

The Trust Board of University Hospitals of Leicester has agreed a set of values and the expectation is that these values are reflected in the behaviours of all staff at all times.

The values were created with the input of staff and they are in line with, and support, the NHS Constitution.

The Trust's values and associated behaviours are set out below:

CONTENTS

1. Introduction

1.1 Effective NHS Boards demonstrate leadership by undertaking three key roles:

- formulating strategy for the organisation,
- ensuring accountability by holding the organisation to account for the delivery of the strategy and through seeking assurance that systems of control are robust and reliable, and
- shaping a positive culture for the Board and for the organisation.

1.2 To underpin its work in ensuring accountability, the Trust Board has approved this performance management and accountability framework.

1.3 It is the aim of the Trust Board to ensure that, as a result of the application of this performance management and accountability framework, the Trust will be able to evidence that there is a performance management system for quality, operations and finance across all departments, which comprises:

- appropriate performance measures relating to relevant goals and targets,
- reporting lines within which these will be managed, including how this will happen across teams (for example finance and operations)
- policies for managing/responding to deteriorating performance across all activities, at individual, team, service-line and organisational levels, with clear processes for re-forecasting performance trajectories,
- a programme or portfolio management approach that allows the co-ordination of initiatives across the organisation, and with external partners as required,
- a clear process for identifying lessons from performance issues and sharing these across the organisation on a regular, timely basis,
- clear processes for reviewing and updating policies regularly to take account of organisational learning, and changes in the operating environment and national policy.

1.4 Furthermore, the implementation of this framework will ensure that there are clear processes for:

- escalating quality, operational and financial performance issues through the organisation to the relevant Committees as part of and outside the regular meeting cycle as required, linked to the organisation's risk matrix and consistent with the organisation's risk appetite,
- creating robust action plans, with clear ownership, timeframes and dependencies, all of which are monitored and followed up at subsequent meetings until they are resolved.

1.5 Finally, senior leaders will be able to further evidence that:

- these processes are effective,
- the appropriate individuals/management levels are aware of the issues and are managing them through to resolution,

- themes arising from the most frequent risks and issues are analysed to identify barriers that need to be removed to drive improvement.

2. The NHS Oversight Framework

2.1 NHS Improvement and NHS England have aligned their operating models to review performance and identify support needs across Sustainability and Transformation Partnerships and Integrated Care Systems.

2.2 The joint approach is documented in the NHS Oversight Framework.

2.3 The purposes of the NHS Oversight Framework are to identify and address both:

- performance issues in organisations directly affecting system delivery; and
- developmental issues which may, if not addressed, threaten future performance.

2.4 Reginal Directors and their teams lead on system oversight, working closely with organisations and systems and drawing on the expertise and advice of national colleagues. Oversight incorporates:

- system review meetings: discussions between the Regional Team and system leaders, informed by a shared set of information covering (a) performance against a core set of national requirements at system and/or organisational level a set monitoring Providers' performance; (b) any emerging organisational health issues that may need addressing; and (c) implementation of transformation objectives in the NHS Long Term Plan,
- identifying the scale and nature of Providers' support needs,
- co-ordinating support activity so that it is targeted where it is most needed.

2.5 The full list of the NHS Oversight Framework metrics for Providers is set out in appendix 1.

3. Ensuring Accountability

The role of the Trust Board

3.1 There are two main aspects to the role of the Trust Board in ensuring accountability:

- holding the organisation to account for the delivery of the strategy;
- seeking assurance that the systems of control are robust and reliable.

3.2 The fundamentals for the Board in holding the organisation to account for performance include:

- drawing on Board 'intelligence', the Board monitors the performance of the organisation in an effective way and satisfies itself that appropriate action is taken to remedy problems as they arise,
- looking beyond written intelligence to develop an understanding of the daily reality for patients and staff, to make data more meaningful,
- seeking assurance where remedial action has been required to address performance concerns,
- offering appreciation and encouragement where performance is excellent,
- taking account of independent scrutiny and performance, including from regulators and overview and scrutiny committees,
- rigorous but constructive challenge from all Board members, Executive and Non-Executive as corporate Board members.

Seeking assurance that the systems of control are robust and reliable

3.3 This second aspect of accountability has seven elements:

- quality assurance and clinical governance,
- financial stewardship,
- risk management,
- legality,
- decision-making,
- probity,
- corporate trustee.

Quality assurance and clinical governance

3.4 The Board has a key role in safeguarding quality, and therefore needs to give appropriate scrutiny to the three key facets of quality:

- clinical effectiveness
- patient safety
- patient experience

3.5 Effective scrutiny relies primarily on the provision of clear comprehensive summary information to the Board and its Committees, particularly the Quality and Outcomes Committee, set out for everyone to see, for example, in the form of quality accounts.

3.6 The Board has a statutory duty of quality. In support of this, good practice suggests that:

- all Board members need to understand their ultimate accountability for quality,
- there is a clear organisational structure that clarifies responsibility for delivering quality performance from the Board to the point of care back to the Board,
- quality is a core part of main Board meetings both as a standing agenda item and as an integrated element of all major discussions and decisions,
- quality performance is discussed in more detail regularly by a quality committee with a stable, regularly attending membership, hence the Trust Board has established the Quality and Outcomes Committee,
- the Board becomes a driving force for continuous quality improvement across the full range of services.

Financial stewardship

3.7 The exercise of effective financial stewardship requires that the Board assures itself that the organisation is operating effectively, efficiently, economically and with probity in the use of resources. The Board has a statutory duty to balance the books. It is also required to ensure that financial reporting and internal control principles are applied, and appropriate relationships with the Trust's internal and external auditors are maintained.

Risk Management

3.8 The role of the Board in risk management is twofold:

- firstly, within the Board itself an informed consideration of risk should underpin organisational strategy, decision-making and the allocation of resources,
- secondly, the Board is responsible for ensuring that the organisation has appropriate risk management processes in place to deliver the annual plan/commissioning plan and comply with the registration requirements of the quality regulator, the Care Quality Commission. This includes systematically assessing and managing its risks. These include financial, corporate and clinical risks.

3.9 Risk management by the Board is underpinned by four interlocking systems of control:

- **The Board Assurance Framework**: this is a document that sets out strategic objectives, identified risks in relation to each strategic objective along with controls in place and assurances available on their operation. Formats vary but the framework generally includes:

- objective
- principal risk
- key controls
- sources of assurance
- gaps in control/assurance
- action plans for addressing gaps.

- **Organisational Risk Management**: Strategic risks are reflected in the Board Assurance Framework. A more detailed operational risk register is in use within the organisation. The Board needs to be assured that an effective risk management approach is in operation within the organisation. This involves both the design of appropriate processes and ensuring that they are properly embedded into the operations and culture of the organisation.

- **Audit**: External and internal auditors play an important role in Board assurance on internal controls. There needs to be a clear line of sight from the Board Assurance Framework to the programme of internal audit.

- The **Annual Governance Statement**: This is signed by the Chief Executive as Accountable Officer and comprehensively sets out the overall organisational approach to internal control. It should be scrutinised by the Board to ensure that the assertions within it are supported by a robust body of evidence.

The approach to risk management needs to be systematic and rigorous. However, it is crucial that Boards do not allow too much effort to be expended on processes. What matters substantively is recognition of, and reaction to, real risks – not unthinking pursuance of bureaucratic processes.

Legality

3.10 The Board seeks assurance that the organisation is operating within the law and in accordance with its statutory duties.

Decision-Making

3.11 The Board seeks assurance that processes for operational decision-making are robust and are in accordance with agreed schemes of delegation.

Probity

3.12 The Board adheres to the Nolan seven principles of public life. This includes implementing a transparent and explicit approach to the declaration and handling of conflicts of interest. Good practice here includes the maintenance and publication of a register of interest for all Board members. Board meeting agendas include an opportunity to declare any conflict at the beginning.

3.13 Another key area in relation to probity relates to the effective oversight of top level remuneration. Hence, the Board has established a Remuneration Committee. Boards are expected to adhere to HM Treasury guidance and to document and explain all decision made.

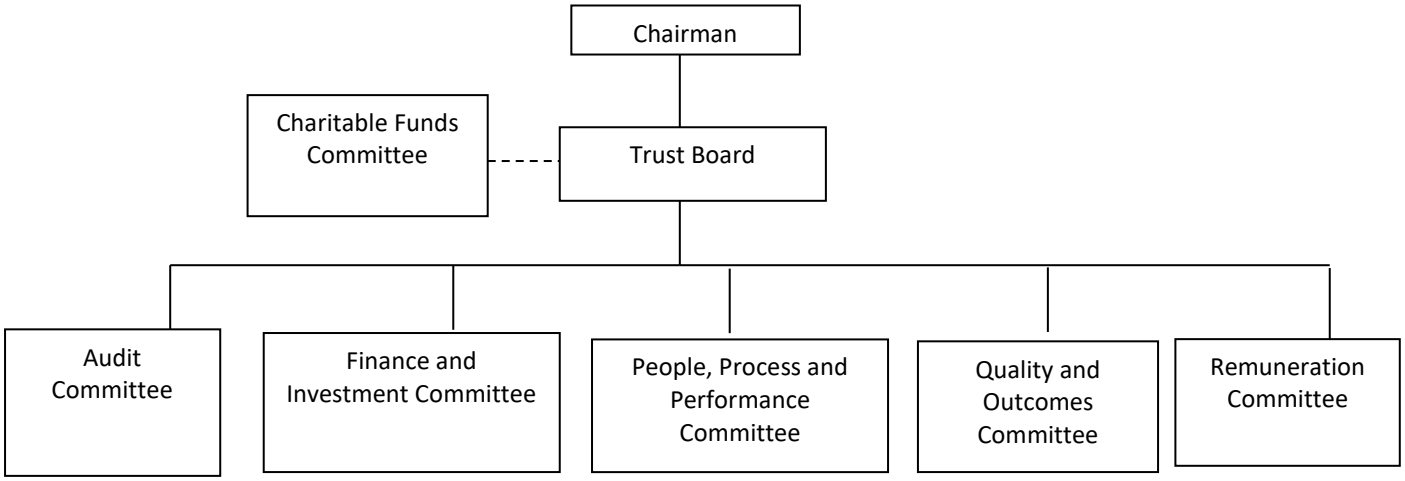
Corporate Trustees

3.14 If the organisation holds NHS charitable funds as sole corporate trustee the Board members of that body are jointly responsible for the management and control of those charitable funds, and are accountable to the Charity Commission. At UHL, the Board has established a Charitable Funds Committee.

4. Committees of the Trust Board that support accountability

4.1 In order to enable accountability, Boards are required to establish Committees responsible for audit and remuneration. Current good practice also recommends a quality-focused Committee of the Board, and also a Committee which can provide the Board with assurance on financial and operational performance matters.

4.2 The Trust operates a well-established committee structure to strengthen its focus on quality governance, finance, people, performance and process matters, and risk management. The structure has been designed to provide effective governance over, and challenge to, patient care and other business activities. The committees carry out detailed work of assurance on behalf of the Trust Board. A diagram illustrating the Board committee structure is set out below:



4.3 All of the Board committees are chaired by a Non-Executive Director and comprise a mixture of both Non-Executive and Executive Directors within their memberships). The exceptions to this are the Audit Committee and the Remuneration Committee, which (in accordance with NHS guidance) comprise Non-Executive Directors exclusively. In line with good corporate governance, the Chairman of the Trust is not a member of the Audit Committee and does not normally attend its meetings.

4.4 The Audit Committee is established under powers delegated by the Trust Board with approved terms of reference that are aligned with the NHS Audit Committee Handbook. It discharges its responsibilities for scrutinising the risks and controls which affect all aspects of our organisation's business. The Audit Committee receives reports at each of its bi-monthly meetings from the External Auditor, Internal Auditor and the Local Counter-Fraud Specialist, the latter providing the Committee with assurance on the organisation's work programme to deter fraud.

4.5 The Finance and Investment Committee meets monthly to oversee the effective management of the Trust's financial resources across a range of measures.

4.6 The Quality and Outcomes Committee also meets monthly and seeks assurances that there are effective arrangements in place for monitoring and continually improving the quality of healthcare provided to patients.

4.7 To strengthen the Board's focus on workforce issues, and on organisational systems and processes and performance management, a People, Process and

Performance Committee is in place and this also meets monthly, reporting to the Board.

4.8 The minutes of each meeting of the Board committees are submitted to the next available Trust Board meeting for consideration. Recommendations made by the committees to the Trust Board are clearly identified on a cover sheet accompanying the submission of the minutes to the Board. The Chair of each committee personally presents a summary of the Committee's deliberations and minutes at the Board meeting, highlighting material issues arising from the work of the committee to the Board.

4.9 Each Board Committee has an agreed annual work programme.

4.10 The Trust Board has agreed to appoint three Patient Partners as participating, non-voting members to the Quality and Outcomes Committee to contribute a different perspective to the deliberations of this group.

5. The Executive, Associate and Clinical Directors

Executive and Associate Directors

5.1 The Chief Executive is the Trust's 'Accountable Officer'. This is a formal role, conferred upon the organisation's Chief Officer. The role of the Accountable Officer is a key element in governance terms with a line of accountability for the proper stewardship of public money and assets and for the organisation's performance stretching up to Parliament. The Chief Executive leads the Executive Team and (as a Board Executive Director) is accountable to the Chairman and Trust Board for meeting the objectives it sets, for day to day management and for ensuring that governance arrangements are effective.

5.2 The Chief Operating Officer is accountable for performance across the Trust's seven Clinical Management Groups and reports to the Chief Executive and the Board (as a Board Executive Director).

5.3 The Chief Nurse and Medical Director are accountable for quality and safety and report to the Chief Executive and the Board (as Board Executive Directors).

5.4 The Chief Financial Officer is accountable for delivery of the financial plan and reports to the Chief Executive and the Board (as a Board Executive Director).

5.5 The Director of People and Organisational Development is accountable for the delivery of the People Strategy and reports to the Chief Executive.

5.6 The Director of Strategy and Communications is accountable for the development of the Trust's strategy and delivery of the communications function of the Trust, and reports to the Chief Executive.

5.7 The Director of Estates and Facilities is accountable for the delivery of the Trust's estate and facilities management services and reports to the Chief Executive.

5.8 The Chief Information Officer is accountable for the delivery of the Trust's IM&T strategy and reports to the Chief Executive.

5.9 The Director of Corporate and Legal Affairs monitors compliance with relevant legislation, advises the Trust Board on key governance issues; and provides support to the Trust Board and its Committees. The Director of Corporate and Legal Affairs reports to the Chief Executive.

Clinical Directors

5.10 Clinical Directors are accountable for the performance of their Clinical Management Group and report to the Chief Operating Officer. They are supported in this role by a Head of Operations and a Head of Nursing/Midwifery.

Executive Boards

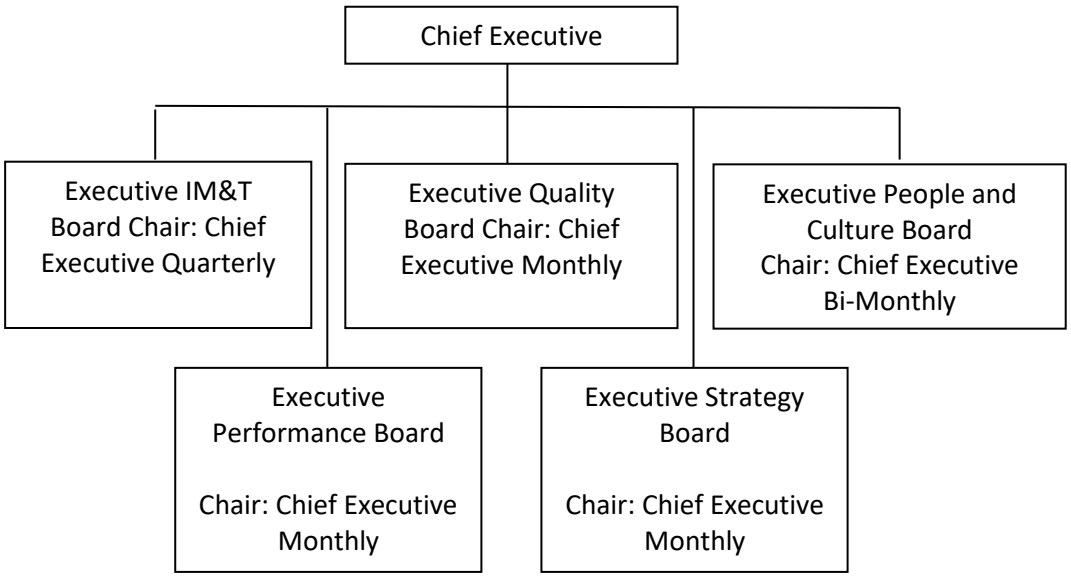
5.11 The Executive Team, with the Clinical Directors, form part of the Executive Board which meets weekly.

5.12 In order to ensure appropriate focus on key issues, each weekly meeting of the Executive Board has a different focus – on strategy; quality, and performance. In addition, on a bi-monthly basis the Executive Board focuses specifically on people and culture issues; and, on a quarterly basis, on information management and technology issues.

5.13 To support the operational delivery, the Executive Board has established an Operational Management Group (OMG). The OMG meets monthly and its focus is to bring together key postholders on a monthly basis to:

(a) review operational performance Trust-wide, focusing on exceptions in performance (both positive and negative), with a view to embedding good practice and/or discussing and agreeing corrective actions where performance needs to improve;
(b) discuss and agree any actions necessary to ensure the delivery of the Trust's Annual Operational Plan and priorities;
(c) check/confirm that the work of the Clinical Management Groups and Corporate Directorates is aligned.

5.14 The diagram below illustrates these arrangements:



5.15 A diagram illustrating the assurance and escalation arrangements in place at the Trust is attached at appendix 2.

6. Clinical Management Group performance and accountability

6.1 The Trust subdivides the operational and accountability of its clinical services into seven Clinical Management Groups (CMG):

a. CHUGGS (Cancer, Haematology, Urology, Gastroenterology and General Surgery)
b. CSI (Clinical Support & Imaging)
c. ESM (ED Specialist Medicine/Acute Medicine)
d. ITAPS (Critical Care, Theatres, Anaesthesia, Pain and Sleep)
e. MSS (Musculoskeletal and Specialist Surgery)
f. RRCV (Renal, Respiratory and Cardiovascular)
g. W&C (Women's and Children's).

6.2 Each CMG is led by a Clinical Director, Head of Operations and Head of Nursing.

6.3 Each CMG is then further divided into either Specialities or Services; a diagram illustrating the arrangements is attached at appendix 3.

6.4 This structure provides the following benefits:

- supports an improved working scheme for the speciality/service, with an improvement in management visibility, increased clinical engagement and quicker, more effective decision-making;
- smaller speciality units support improved operational grip and clearer management accountability;
- ensures speciality/service alignment.

6.5 There is a clearly defined sub-management structure within each of the CMGs, which consists of a Medical/Clinical Lead (referred to as a Head of Service), General Manager and Matron, supported by Service Managers and Ward Sisters. Each member of the team is accountable to either the CMG Clinical Director, Head of Operations or Head of Nursing. Note, however, that not all CSI CMG services have separate Head of Service/General Managers.

CMG Board Accountability

6.6 Each CMG has a Management Board which meets on a monthly basis. CMG Management Boards consider at each meeting a performance pack which covers the domains of:

- Quality
- Performance
- Finance
- Workforce
- Strategy

6.7 The purpose of this format is to ensure that there is consistency in the reporting of data at both CMG and Corporate levels and that the clinical/strategic priorities of the CMGs align to those set by the Trust. Aligning the CMG Board format in this way also ensures that issues and actions discussed within each CMG are escalated, where necessary, to the monthly Performance Review meetings with the Executive Directors.

Speciality Review Meetings

6.8 Regular Performance Review Meetings (PRM) are held at least bi-monthly by the CMG Management Team with each Speciality/Service leadership team . These are chaired by the Head of Operations, and involve the Clinical Director, Head of Finance, HR Business Partner, Head of Nursing, and CMG Business Analyst.

6.9 The CMG-level performance review data pack is used as the basis of these meetings with the Speciality/Service teams, adapting the data to ensure this represents what is happening within their areas of accountability within each domain.

6.10 The purpose of these meetings is to scrutinise speciality/service performance to ensure that any material issues are appropriately refle

6.11 cted within the CMG performance packs, thereby supporting Ward to Board escalation of critical issues and successes.

6.12 The speciality/service level performance packs are tabled at the CMG Board monthly.

7. Performance Review Meetings

7.1 Monthly performance review meetings (PRM) are held with each CMG triumvirate, chaired by the Chief Operating Officer, and involve the Chief Financial Officer, Chief Nurse, Medical Director, Director of Strategy and Communications and Director of People and Organisational Development.

7.2 The purpose of these meetings is to scrutinise CMG performance in the round. Critical issues will be escalated to the ensuing Executive Board.

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

7.4 Data presentation is designed to be fit for purpose, informative, and clear and simple to understand / interpret. Dashboards are used to indicate if a process is showing special cause or common cause variation. Icons are used to indicate whether the Trust is able to meet any stated target. The Trust's Data Quality Forum aims to ensure the validity and robustness of data.

7.5 For each PRM, a dedicated data pack is prepared, compiled centrally but completed by the individual CMG.

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

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

7.8 A standard agenda is used for each PRM (example attached as appendix 4).

7.9 After each PRM, each CMG is rated by the Executive Directors according to the level of assurance received against each of the key domains, namely:

- Quality
- Performance
- Finance
- Workforce
- Strategy

7.10 An example of the summary ratings is attached at Appendix 5. The ratings are reported monthly to the People, Process and Performance Committee, for information.

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

7.12 Details of the approach adopted are set out in the next section of this Framework.

8. Elements of the Balanced Scorecard

8.1 Each element of the balanced scorecard: Quality and Safety, Operational Performance, Finance and Cost Improvement Programme, and Workforce following the PRM will be rated by the Executive Directors according to the assurance ratings shown in the table below.

RAG	Assurance Rating	CMG Assurance to the Executive Team
O	OUTSTANDING	Sustained delivery of all KPI metrics. Robust control & proactive positive assurance processes in place.
G	GOOD	Evidence of sustained delivery of the majority of KPIs. Robust control & proactive positive assurance processes in place. Strong corrective actions in place to address areas of underperformance.
RI	REQUIRES IMPROVEMENT	Most KPIs delivered but delivery inconsistent/not sustained. Corrective actions in place to address areas of underperformance but too early to determine recovery.
I	INADEQUATE	Consistent under delivery. Weak corrective actions or assurance provided.

Quality and Safety Performance Management

8.2 Quality and safety performance is the Trust's main priority, as outlined in the Trust priorities. To ensure compliance or early detection of concerns a triangulated data set is collated into a single data pack, which is then scrutinised by both the Chief Nurse and the Medical Director. This includes a forensic review of the risk register and incident management.

Financial Performance Management

8.3 Achievement of the financial target is an important annual objective for the Trust and devolving responsibility for income and expenditure to CMGs and Corporate Directorates is an appropriate and fundamental component. The Financial Management Accountability Framework which is attached at appendix 6 supports the Trust performance management and accountability framework to formalise and more clearly define what is expected of CMGs and Directorates in terms of the sign-off of their annual budgets and their in-year management. Importantly, it also details how the performance management regime will operate, noting how adverse performance from plan will be handled.

8.4 As part of the annual planning and budget setting process each CMG and Corporate Directorate is required to sign-off their annual plan and approved budget. This sign-off process requires physical signatures of the Chief Executive, Chief Financial Officer and respective CMG board members and Corporate Director.

8.5 It should be noted that any material failure to deliver on the part of one CMG or Corporate Directorate may require other areas of the organisation to take additional action.

Operational Performance Management

8.6 Achievement of the mandated national NHS performance standards is a key priority for the Trust and includes the following standards:

- Cancer
- 4 Hour urgent care
- Diagnostics
- Referral to Treatment

8.7 Each of the CMGs must have plans in place to sustain delivery or improve performance on all of the relevant targets.

Workforce Performance Management

8.8 Oversight of the key workforce issues and metrics forms an important part of the Trust's performance management and accountability arrangements. Accordingly, a suite of key performance indicators forms part of the balanced scorecard for each CMG and scrutiny is led by the Director of People and Organisational Development.

Strategy Management

8.9 Strategy management, whilst not an assurance rated element of the PRM, is discussed each month, as delivery of the Trust's strategic objectives (particularly in response to reconfiguration) is vital to improving the long term sustainability and performance of the Trust.

8.10 Where performance is within the identified thresholds, management of any adverse performance remains within the remit of the CMG Management Team. Where performance is adverse, the CMG is expected to prepare a time-defined rectification plan to be reviewed at the CMG Performance Management meetings. In specific circumstances, the CMG can expect to receive targeted support from outside of the CMG. In the event that performance remains adverse, then the CMG may be designated as in need of 'special measures', in which case the CMG shall lose autonomy to act without Executive Director agreement. This is outlined in the diagram below. It is important to emphasise that the 'targeted support' mentioned above will be the subject of discussion between the Executive Directors and CMG Management Team : the aim is to rectify performance and put in place the necessary measures to ensure that the CMG can exit 'special measures' as soon as is practicable.

RAG	Assurance Rating	Actions / Interventions
O	OUTSTANDING	Monthly 1-2-1 with COO/MD/CN/CFO as required
G	GOOD	Monthly Performance Review meeting Progress only
RI	REQUIRES IMPROVEMENT	Monthly Performance Review meeting Progress together with corrective plans which have measurable objectives and milestones to delivery
I	INADEQUATE	Recovery Plan with measurable objectives and milestones to delivery with formal weekly meeting with the COO and appropriate Executive Director Intensive support Expected to attend escalation with CEO if no measurable improvement within 2 months

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

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

8.13 The principles within this document are equally applicable to the system of performance services review undertaken by CMGs when reviewing the performance of their portfolio of clinical services. In this respect, the CMG is acting as a 'span of control'. The system of performance management at this level includes routines and reports including, but not limited to:

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

9. Corporate functions - performance management

9.1 The Executive and Associate Directors are held to account for their individual portfolios and objectives by the Chief Executive. The Chief Executive is held to account by the Chairman, on behalf of the Board.

9.2 The Chief Executive meets (at least) monthly with each of the Executive and Associate Directors to discuss key issues. Performance against objectives (set by the Chief Executive in discussion with the individual Director) is reviewed formally by the Chief Executive mid-year, and at the end of each financial year, culminating in a report to the Remuneration Committee by the Chief Executive on each individual Director's performance.

9.3 Performance against objectives is assessed from the perspective of 'delivery' and 'approach', with the delivery score measuring the extent to which the objective was fully delivered, while the approach score is a combination of the amount the individual was involved, the effort required and the skill applied to achieving the objective.

9.4 The Chairman similarly conducts an annual appraisal of the Chief Executive's performance against objectives, and reports on the outcome to the Remuneration Committee. The Chairman leads the Committee annually in a discussion on the Chief Executive's performance which, as required, is then the subject of report to NHS Improvement annually.

9.5 In time, the Executive Team will put in place a more formal process by which the Clinical Management Groups will be able to hold the corporate services to account. It is envisaged that a formal process will be piloted and then rolled-out systematically in 2020/21.

10. Becoming the Best – Quality Strategy

10.1 Commencing Summer 2018, the Trust looked at how to make the organisation 'outstanding' or, to put it another way, how to deliver Caring at its Best to every patient, every time. Other 'outstanding' organisations were studied to learn from that experience and five key common elements were identified:

- the leadership team had an unwavering commitment to improving quality;
- a culture of improvement existed, encouraged by leaders at all levels;
- people were systematically enabled to do improvement;
- patients were put at the centre of improvement;
- working actively within the wider system.

10.2 Building on the Trust's Quality Commitment experience, and the Listening into Action approach, the Trust Board has agreed a new approach to quality improvement, set out in the Quality Strategy 2019 – 2022.

10.3 Based on learning of what has worked well elsewhere, the Board has agreed to apply the approach set out below to all of the Trust's initiatives:

- we will understand what is happening in our services, so that we know what needs to be improved;
- we will have clear priorities and plans for improvement, so that we are clear about what we are trying to do;
- we will develop our culture and leadership, so that everyone is empowered and encouraged to make improvements;
- we will adopt a single approach to improvement (our quality improvement methodology), and give people at all levels the skills to use it;
- we will always involve our patients when we are making improvements that impact on them and their care;
- we will integrate this work with the wider health and social care system, of which we are a part.

10.4 The diagram attached at appendix 7 sets out the Trust's priorities for the next 2 – 3 years.

10.5 To facilitate the achievement of these priorities, the Trust has appointed a Head of Quality Improvement, engaged a third party provider to provide support and is to recruit a central team of Quality Improvement Experts to support staff.

10.6 In parallel, the Trust is undertaking a significant amount of work to better understand its culture, and will commence training of the organisation's leaders at all levels in the right behaviours to support a positive culture.

10.7 It is possible that the new approach described above will have implications for the way in which this Framework is designed and operated and the Trust's approach will be kept under review as the implementation of the Quality Strategy is taken forward.

Stephen Ward, Director of Corporate and Legal Affairs

Rebecca Brown, Chief Operating Officer

22nd November 2019

Appendix 1

NHS Oversight Framework 2019/20 annex 2:
Provider oversight: metrics

August 2019

Introduction

This document sets out the detail of the metrics used to monitor and assess provider performance as part of our overall approach to provider oversight within the NHS Oversight Framework. It will help providers understand which metrics NHS England and NHS Improvement joint teams are using to assess their performance, how these metrics are defined and calculated, and the frequency of data publication. We provide a link to the data source where this is publicly available.

We will try to keep the data source links up to date but if you come across any outdated links, please get in touch with us at nhs.oversightandassessment@nhs.net.

New service models

Measure	Description/Calculation	Data frequency	Data source	Standard[1]
Acute and specialist providers				
A&E maximum waiting time of four hours from arrival to admission/transfer/ discharge	The percentage of attendances at an A&E department that were discharged, admitted or transferred within four hours of arrival.	Monthly	www.england.nhs.uk/statistics/statistical-work-areas/ae-waiting-times-and-activity/statistical-work-areasae-waiting-times-and-activityae-attendances-and-emergency-admissions-2016-17/	95%

[1] Minimum % of patients for whom standard must be met.

Quality of care and outcomes

In addition to the CQC inspection ratings of hospitals, we will also use the metrics below as quality 'proxies' at providers to identify any trends or other issues representing a potential concern.

Measure	Type	Description/Calculation	Data frequency	Source
General				
CQC rating	n/a	Most recent CQC inspection rating, as published on CQC website	Ad hoc based on inspection	www.cqc.org.uk/sites/default/files/Latest_ratings.xlsx
Written complaints – rate	Caring	Count of written complaints/count of whole time equivalent staff	Quarterly	http://content.digital.nhs.uk/catalogue/PUB21536
Staff Friends and Family Test % recommended – care	Caring	Count of those categorised as extremely likely or likely to recommend/count of all responders	Quarterly	www.england.nhs.uk/ourwork/pe/fft/friends-and-family-test-data/
Occurrence of any Never Event	Safe	Count of Never Events in rolling six-month period	Monthly (six-month rolling)	https://improvement.nhs.uk/resources/never-events-data/
Patient Safety Alerts not completed by deadline	Safe	Number of NHS England or NHS Improvement Patient Safety Alerts outstanding in most recent monthly snapshot	Monthly	https://improvement.nhs.uk/resources/data-patient-safety-alert-compliance/

Acute providers				
Mixed-sex accommodation breaches	Caring	Count of number of occasions sexes were mixed on same-sex wards	Monthly	www.england.nhs.uk/statistics/statistical-work-areas/mixed-sex-accommodation/msa-data/
Inpatient scores from Friends and Family Test − % positive	Caring	Count of those categorised as extremely likely or likely to recommend/count of all responders	Monthly	www.england.nhs.uk/ourwork/pe/fft/friends-and-family-test-data/
A&E scores from Friends and Family Test − % positive	Caring	Count of those categorised as extremely likely or likely to recommend/count of all responders	Monthly	www.england.nhs.uk/ourwork/pe/fft/friends-and-family-test-data/
Maternity scores from Friends and Family Test − % positive	Caring	Count of those categorised as extremely likely or likely to recommend/count of all responders	Monthly	www.england.nhs.uk/ourwork/pe/fft/friends-and-family-test-data/
Emergency c-section rate	Safe	Percentage of births where the mother was admitted as an emergency and had a c-section	Monthly	Admitted patient care Hospital Episode Statistics (HES)
CQC inpatient survey	Organisation-al health	Findings from the CQC survey looking at the experiences of people receiving inpatient services at NHS hospitals	Annual	http://www.cqc.org.uk/publications/surveys/surveys
Venous thromboembolism (VTE) risk assessment	Safe	Number of patients admitted who have a VTE risk assessment/number of patients admitted in most recently published quarter	Quarterly	https://improvement.nhs.uk/resources/vte/
Clostridium difficile (C. difficile) plan: *C.difficile* actual variance from plan	Safe	Count of trust apportioned *C. difficile* infections in patients aged two years and over compared to the number of planned *C. difficile* cases	Monthly	Public Health England – data available here *C. difficile* infection objectives by trust available here:

(actual number v plan number)[2]				https://improvement.nhs.uk/resources/clostridium-difficile-infection-objectives/
Clostridium difficile – infection rate	Safe	Rolling 12-month count of trust-apportioned *C. difficile* infections in patients aged 2 years and over/rolling 12-month average occupied bed days per 100,000 beds	Monthly (12-month rolling)	Public Health England – data available here
Meticillin-resistant *Staphylococcus aureus* (MRSA) bacteraemia infection rate	Safe	Rolling 12-month count of trust assigned MRSA infections/rolling 12-month average occupied bed days multiplied by 100,000	Monthly (12-month rolling)	Public Health England – data available here
Meticillin-susceptible *Staphylococcus aureus* (MSSA) bacteraemias	Safe	Rolling 12-month count of trust-apportioned MSSA infections/rolling 12-month average occupied bed days multiplied by 100,000	Monthly (12-month rolling)	Public Health England – data available here
Escherichia coli (*E. coli)* bacteraemia bloodstream infection (BSI)	Safe	Rolling 12-month count of all *E. coli* infections/rolling 12-month average occupied bed days multiplied by 100,000	Monthly (12-month rolling)	Public Health England – data available here
Hospital Standardised Mortality Ratio	Effective	The ratio of observed deaths that occurred following admission in a provider to a modelled expectation of	Quarterly	Dr Foster Intelligence (licensed data)

[2] NHS Improvement has access to the Public Health England (PHE) Data Capture System (DCS) through which organisations report their infection data. Infection data is downloaded from the DCS by NHS Improvement before publication to allow timely internal reporting. The agreement with PHE is that NHS Improvement will not share this information outside the organisation. This unpublished data is used in the SOF. The DCS is a live system and there may be slight differences between the data used here and that which is published by PHE on www.gov.uk and https://fingertips.phe.org.uk/ due to the timing of the data extracts.

		deaths (multiplied by 100) on the basis of the average England death rates for 56 specific clinical groups given a selected set of patient characteristics for those treated there.		
Summary Hospital-level Mortality Indicator	Effective	The ratio of the actual number of patients who die following hospitalisation at the trust or within 30 days of discharge to the number that would be expected to die on the basis of the average England death rate, given a selected set of patient characteristics for those treated there.	Quarterly	www.digital.nhs.uk/SHMI
Potential under-reporting of patient safety incidents[3]	Safe	Count of reported incidents (no harm, low harm, moderate harm, severe harm, death)/estimated total person bed days for rolling six months shown as rate per 1000 bed days	Monthly (six-month rolling)	https://improvement.nhs.uk/resources/monthly-data-patient-safety-incident-reports/
Community providers				
Community scores from Friends and Family Test – % positive	Caring	Count of those categorised as extremely likely or likely to recommend/Count of all responders	Monthly	www.england.nhs.uk/ourwork/pe/fft/friends-and-family-test-data/
Mental health providers				

[3] This indicator is valid only at the level of extreme outliers for under-reporting as per CQC Intelligent Monitoring methodology and only in non-specialist acute trusts.

CQC community mental health survey	Organisation-al health	Findings from the CQC survey which gathered information from people who received community mental health services	Annual	Data available here: www.cqc.org.uk/publications/surveys/surveys
Mental health scores from Friends and Family Test – % positive	Caring	Count of those categorised as extremely likely or likely to recommend/count of all responders	Monthly	www.england.nhs.uk/ourwork/pe/fft/friends-and-family-test-data/
Admissions to adult facilities of patients under 16 years old	Safe	Number of children and young persons under 16 who are admitted to adult wards	Monthly	NHS Digital (MHSDS) Reference: MHS24a Further information: http://content.digital.nhs.uk/mhsds
Care programme approach (CPA) follow-up – proportion of discharges from hospital followed up within seven days[4] – Mental Health Services Data Set	Effective	Proportion of discharges from hospital followed up within 7 days	Monthly	NHS England Further information: www.england.nhs.uk/statistics/statistical-work-areas/mental-health-community-teams-activity/
% clients in settled accommodation	Effective	Percentage of people aged 18 to 69 in contact with mental health services in settled accommodation	Monthly	NHS Digital (MHSDS) Reference: AMH15 Further information: http://content.digital.nhs.uk/mhsds

[4] We are following the development of indicators to measure 48-hour follow-up, in line with evidence, and will consider amending this in future oversight frameworks.

% clients in employment	Effective	Percentage of people aged 18 to 69 period in contact with mental health services in employment	Monthly	NHS Digital (MHSDS) Reference: AMH18 Further information: http://content.digital.nhs.uk/mhsds
Potential under-reporting of patient safety incidents[5]	Safe	Count of reported incidents (no harm, low harm, moderate harm, severe harm, death)/estimated total person bed days for rolling six months shown as rate per 1000 bed days	Monthly (6-month rolling)	https://improvement.nhs.uk/resources/monthly-data-patient-safety-incident-reports/
Ambulance providers				
Ambulance see-and-treat from Friends and Family Test – % positive	Caring	Count of those categorised as extremely likely or likely to recommend/Count of all responders	Monthly	www.england.nhs.uk/ourwork/pe/fft/friends-and-family-test-data/
Ambulance Clinical Outcomes Return of Spontaneous Circulation (ROSC) where the arrest was bystander witnessed and the initial rhythm was ventricular fibrillation (VF) or ventricular tachycardia (VT)	Effective	Proportion of patients who had resuscitation (advanced or basic life support) begun/continued by ambulance service following out-of-hospital cardiac arrest of presumed cardiac origin, where the arrest was bystander witnessed and the initial rhythm was VF or VT, and who had return of spontaneous circulation on arrival at hospital	Monthly	www.england.nhs.uk/statistics/statistical-work-areas/ambulance-quality-indicators/

[5] This indicator is valid only at the level of extreme outliers for under-reporting as per CQC Intelligent Monitoring methodology.

Stroke 60 minutes	Effective	Proportion of FAST[6] positive patients (assessed face to face) potentially eligible for stroke thrombolysis within agreed local guidelines arriving at hospitals with a hyperacute stroke centre within 60 minutes of call connecting to the ambulance service	Monthly	www.england.nhs.uk/statistics/statistical-work-areas/ambulance-quality-indicators/
Stroke care	Effective	Proportion of suspected stroke patients assessed face to face who received an appropriate care bundle	Monthly	www.england.nhs.uk/statistics/statistical-work-areas/ambulance-quality-indicators/
ST Segment elevation myocardial infarction (STEMI) 150 minutes	Effective	Proportion of patients with initial diagnosis of 'definite myocardial infarction' for whom primary angioplasty balloon inflation occurs within 150 minutes of call connected to the ambulance service, where first diagnostic electrocardiogram (ECG) is performed by ambulance personnel and patient was directly transferred to a designated Primary Percutaneous Coronary Intervention (PPCI) centre as locally agreed	Monthly	www.england.nhs.uk/statistics/statistical-work-areas/ambulance-quality-indicators/

[6] Act FAST is a national campaign to raise aware of the signs of stroke and encourage people to dial 999 if they recognise any one of the symptoms.

- Face: has their face fallen to one side? Can they smile?
- Arms: can they raise both arms and keep them there?
- Speech: is their speech slurred?
- Time to call 999 if you see any one of these signs of a stroke.

Measure	Description/calculation	Data frequency	Data source	Standard[7]
Acute and specialist providers[8]				
Maximum time of 18 weeks from point of referral to treatment (RTT) in aggregate − patients on an incomplete pathway	Count of the number of patients whose clock period is less than 18 weeks during the calendar months of the return/count of number of patients whose clock has not stopped during the calendar months of the return	Monthly	www.england.nhs.uk/statistics/statistical-work-areas/rtt-waiting-times/rtt-data-2016-17/#Jan17	92%
All cancers – maximum 62-day wait for first treatment from: a. urgent GP referral for suspected cancer b. NHS cancer screening service referrals	Proportion of patients referred for cancer treatment by: a. their GP, who have currently been waiting for less than 62 days for treatment to start	Monthly	Provider-level cancer waiting time data available here: www.england.nhs.uk/statistics/statistical-work-areas/cancer-waiting-times/monthly-prov-	a. 85% b. 90%

[7] Minimum % of patients for whom standard must be met.

[8] We are tracking the development of metrics to measure, analyse and improve the following aspects of liaison mental health services in acute hospitals, and may incorporate these in future iterations of this framework:

- numbers of presentations at A&E of people of all ages with a mental health condition or dementia and liaison mental health service response times
- numbers of emergency admissions of people of all ages with a mental health condition or dementia
- length of stay for people of all ages admitted with a mental health condition or dementia
- delayed transfers of care for people of all ages with a mental health condition or dementia.

	b. the NHS screening service, who have currently been waiting for less than 62 days for treatment to start		cwt/201617-monthly-prov-cwt/	
Maximum 6-week wait for diagnostic procedures	Maximum 6-week wait for diagnostic procedures: proportion of patients referred for diagnostic tests who have been waiting six weeks or longer.	Monthly	Data available here: www.england.nhs.uk/statistics/statistical-work-areas/diagnostics-waiting-times-and-activity/monthly-diagnostics-waiting-times-and-activity/monthly-diagnostics-data-2016-17/	1%
Dementia assessment and referral: the number and proportion of patients aged 75 and over admitted as an emergency for more than 72 hours: a. who have a diagnosis of dementia or delirium or to whom case finding is applied b. who, if identified as potentially having dementia or delirium, are appropriately assessed and	The number and proportion of patients aged 75 and over admitted as an emergency for more than 72 hours: a. who have a diagnosis of dementia or delirium or to whom case finding is applied b. who, if identified as potentially having dementia or delirium, are appropriately assessed and	Quarterly	Data source: NHS England Further information: www.england.nhs.uk/statistics/statistical-work-areas/dementia/dementia-assessment-and-referral-2017-18/	a. 90% b. 90% c. 90%

c. where the outcome was positive or inconclusive, are referred on to specialist services.	c. where the outcome was positive or inconclusive, are referred on to specialist services.			
Ambulance providers				
Category 1 (C1) – Life-threatening calls	The mean average response time across all incidents coded as C1 that received a response on scene = the total response time aggregated across all incidents coded as C1 that received a response on scene in the period/the count of incidents coded as C1 that received a response on scene.	Monthly	www.england.nhs.uk/statistics/statistical-work-areas/ambulance-quality-indicators/	7 minutes mean response time 15 minutes 90th centile response time
Category 2 (C2) – Emergency calls	The mean average response time across all incidents coded as C2 that received a response on scene = the total response time aggregated across all incidents coded as C2 that received a response on scene in the period/the count of incidents coded	Monthly	www.england.nhs.uk/statistics/statistical-work-areas/ambulance-quality-indicators/	18 minutes mean response time 40 minutes 90th centile response time

	as C2 that received a response on scene			
Category 3 (C3) – Urgent calls	The mean average response time across all incidents coded as C3 that received a response on scene = the total response time aggregated across all incidents coded as C3 that received a response on scene in the period/the count of incidents coded as C3 that received a response on scene.	Monthly	www.england.nhs.uk/statistics/statistical-work-areas/ambulance-quality-indicators/	120 minutes 90th centile response time
Category 4 (C4) – Less urgent calls	The mean average response time across all incidents coded as C4 that received a response on scene = the total response time aggregated across all incidents coded as C4 that received a response on scene in the period/the count of incidents coded as C4 that received a response on scene.	Monthly	https://www.england.nhs.uk/statistics/statistical-work-areas/ambulance-quality-indicators/	180 minutes 90th centile response time

Mental health providers[9]				
People with a first episode of psychosis begin treatment with a NICE-recommended care package within two weeks of referral (UNIFY2, moving to Mental Health Services Data Set – MHSDS)[10]	Percentage of people with a first episode of psychosis beginning treatment with a NICE-recommended care package within two weeks of referral	Quarterly (three-month rolling)	www.england.nhs.uk/statistics/statistical-work-areas/eip-waiting-times/	56%

[9] We are tracking the development of metrics to measure, analyse and improve the following areas, and may incorporate these in future iterations of this framework:

- access and waiting times for children and young people with eating disorders to begin NICE-recommended treatment, in line with the Five Year Forward View (5YFV) mental health commitment that by 2021, 95% of children and young people in need receive treatment within one week for urgent cases, and four weeks for routine cases.
- providers' collection of data on waiting times for: acute mental healthcare (decision to admit to time of admission, decision to home treat to time of home-treatment start) and dementia care, including memory assessment services
- the quality and responsiveness of care provided to people of all ages with urgent and emergency mental health needs, including liaison services and crisis resolution and home treatment teams
- differential rates of detention under the Mental Health Act for people from black, Asian and minority ethnic (BME) groups
- access to individual placement support.
- the implementation of the Prime Minister's Challenge on Dementia 2020
- young people's experience of transition to adult mental health services
- data quality of key data items related to 5YFV MH priorities, including data related to referral to treatment waiting times, interventions delivered, outcomes and experience.

[10] This standard applies to anyone with a suspected first episode of psychosis who is aged 14 to 65. People aged over 35 who may historically not have had access to specialist early intervention in psychosis services should not be excluded. Technical guidance is available at: www.england.nhs.uk/mentalhealth/wp-content/uploads/sites/29/2016/02/tech-cyped-eip.pdf.

Provider boards must be fully assured that RTT data submitted is complete, accurate and in line with published guidance. Both 'strands' of the standard must be delivered:

- performance against the RTT waiting-time element of the standard is being measured via MHSDS and UNIFY2 data submissions.
- performance against the National Institute for Health and Care Excellence concordance element of the standard is to be measured via:
  - a quality assessment and improvement network being hosted by the College Centre for Quality Improvement at the Royal College of Psychiatrists; all providers will be expected to take part in this network and submit self-assessment data, which will be validated and performance-scored on a four-point scale at the end of the year. This assessment will be used to track progress against the trajectory set out in *Implementing the Five Year Forward View for Mental Health*:

Data Quality Maturity Index (DQMI) – MHSDS dataset score	MHSDS quarterly score in DQMI	Quarterly	Data source: NHS Digital Further information: http://content.digital.nhs.uk/dq	95%
Improving Access to Psychological Therapies (IAPT)/talking therapies a. proportion of people completing treatment who move to recovery (from IAPT minimum dataset) b. waiting time to begin treatment (from IAPT minimum dataset): i) within 6 weeks ii) within 18 weeks	a. Percentage of people completing a course of IAPT treatment moving to recovery b. Percentage of people waiting i) six weeks or less from referral to entering a course of talking treatment under Improving Access to Psychological Therapies (IAPT) ii) 18 weeks or less from referral to entering a course of talking treatment under IAPT	a. Quarterly b i. 3-month rolling b ii. 3-month rolling	Source: NHS Digital http://content.digital.nhs.uk/iaptmonthly Further information: www.england.nhs.uk/mental-health/adults/iapt/service-standards/	a. 50% b i. 75% b ii. 95%

- submission of intervention and outcomes data using SNOMED-CT codes in line with published guidance. Provider boards must be fully assured that intervention and outcomes data submitted is complete and accurate.

Further information can be found in the implementation guidance published by NHS England:

Inappropriate out-of-area placements for adult mental health services.	Total number of bed days patients have spent out of area in last quarter	Quarterly	Source:http://content.digital.nhs.uk/oaps Further information: www.gov.uk/government/publications/oaps-in-mental-health-services-for-adults-in-acute-inpatient-care/out-of-area-placements-in-mental-health-services-for-adults-in-acute-inpatient-care	Progress in line with agreed trajectory for elimination of inappropriate adult acute out of area placements no later than 2021
Community providers				
Any relevant mental health or acute metrics above				

Leadership and workforce

Measure	Type	Description / calculation	Data frequency	Source
Staff sickness	Organisational health	Level of staff absenteeism through illness in the period Numerator = number of days sickness reporting within the month. Denominator = number of days available within the month	Monthly	NHS Digital maintains staff sickness here: https://digital.nhs.uk/article/6743/Staff-management
Staff turnover	Organisational health	Number of staff leavers reported within the period /average of number of total employees at end of the month and total employees at end of the month for previous 12-month period Numerator = number of leavers within the report period. Denominator = staff in post at the start of the reporting period	Monthly	NHS Digital maintains staff sickness here: https://digital.nhs.uk/article/4304/Workforce
NHS Staff Survey	Organisational health	Staff recommendation of the organisation as a place to work or receive treatment	Annual	Data available here: www.nhsstaffsurveys.com/Page/1006/Latest-Results/2016-Results/

Proportion of temporary staff	Organisational health	Agency staff costs (as defined in measuring performance against the provider's cap) as a proportion of total staff costs. Calculated by dividing total agency spend over total pay bill.	Monthly	Monthly provider return
Support and compassion	Organisational health	Average rating of: • % experienced harassment, bullying or abuse at work from patients/service users, their relatives or other members of the public • % experienced harassment, bullying or abuse at work from managers • % experienced harassment, bullying or abuse at work from other colleagues	Annual	www.nhsstaffsurveys.com/Page/1056/Home/NHS-Staff-Survey-2018/
Teamwork	Organisational health	Average of: • % agreeing that their team has a set of shared objectives • % agreeing that their team often meets to discuss the team's effectiveness Trusts in lowest third across the sector will represent a concern	Annual	www.nhsstaffsurveys.com/Page/1056/Home/NHS-Staff-Survey-2018/
Inclusion (1)	Organisational health	Average of • % staff believing the trust provides equal opportunities for career progression or promotion	Annual	www.nhsstaffsurveys.com/Page/1056/Home/NHS-Staff-Survey-2018/

		• % experiencing discrimination from their manager/team leader or other colleagues in the last 12 months Trusts in lowest third across the sector will represent a concern		
Inclusion (2)	Organisational health	The BME leadership ambition (WRES) re executive appointments. Trusts in lowest third across the sector will represent a concern.	Annual	www.england.nhs.uk/about/equality/equality-hub/equality-standard/

Finance and use of resources

The in-year financial performance score for providers is a mean average of the scores on five individual metrics, which are defined and calculated as set out in Figure 1, except that:

- If a provider scores 4 on any individual in year financial performance metric, their in-year financial performance score is at least a 3 – ie cannot be a 1 or 2 – triggering a potential support need.
- If a provider has not agreed a control total:
  - where they are planning a deficit their in-year financial performance score will be at least 3 (ie it will be 3 or 4)
  - where they are planning a surplus their in-year financial performance score will be at least 2 (ie it will be 2, 3 or 4).

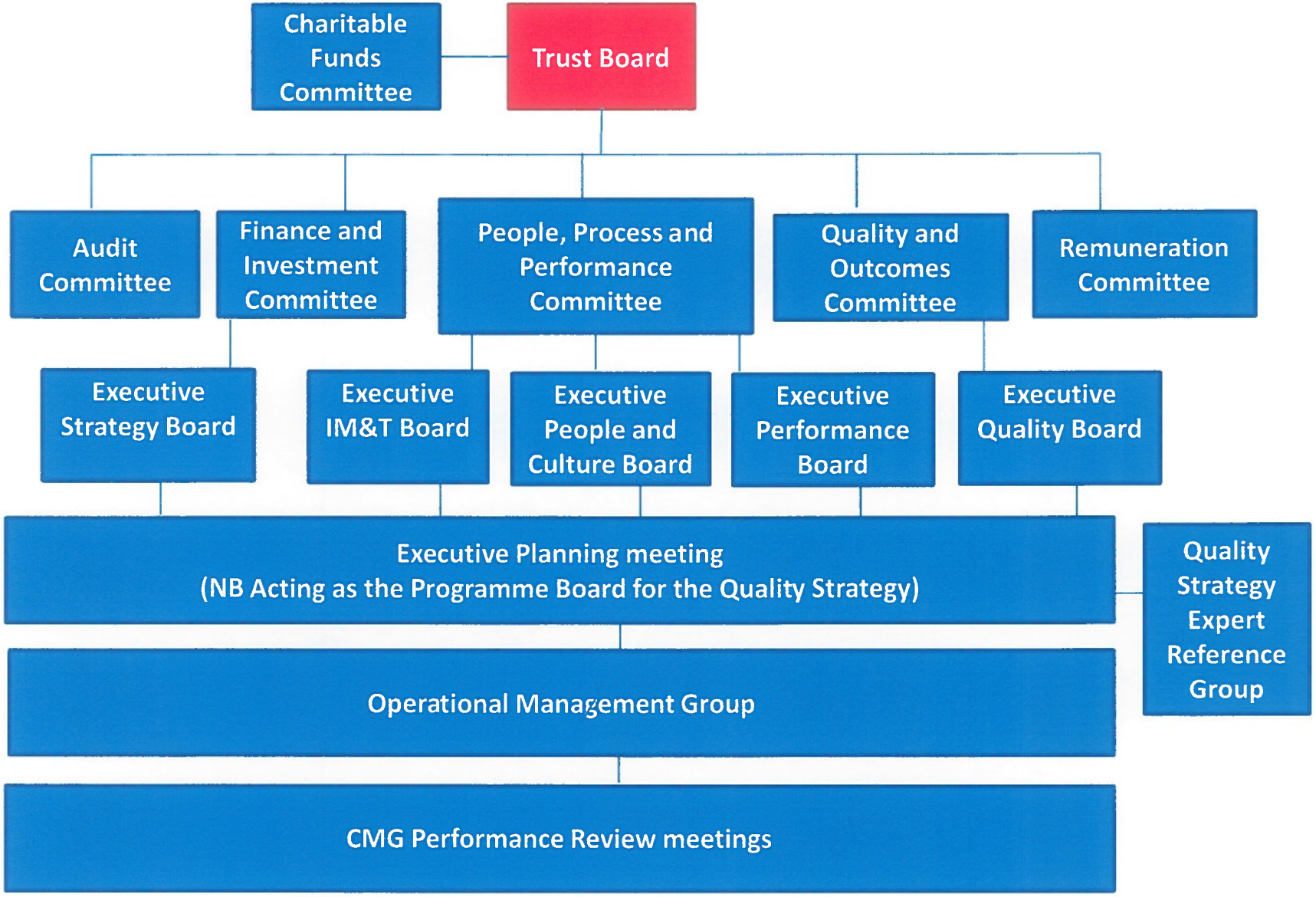
Scores are rounded to the nearest whole number. Where a trust's score is exactly between two whole numbers, it is rounded to the lower whole number (eg both 2.2 and 2.5 are rounded down to 2).

Figure 1: In-year financial performance metrics

Area	Weighting	Metric	Definition	Score			
				1	2	3	4
Financial sustainability	**0.2**	**Capital service capacity**	Degree to which the provider's generated income covers its financial obligations	≥2.5x	<2.5-≥1.75x	<1.75 -≥1.25x	< 1.25x
	0.2	**Liquidity (days)**	Days of operating costs held in cash or cash-equivalent forms, including wholly committed lines of credit available for drawdown	≥0	<0 -≥(7)	<(7)-≥(14)	<(14)
Financial efficiency	**0.2**	**Income & Expenditure (I&E) margin**	I&E surplus or deficit / total revenue	≥1%	<1-≥0%	<0-≥ (1)%	<(1)%
Financial controls	**0.2**	**Distance from financial plan**	Year-to-date actual I&E surplus/deficit in comparison to Year-to-date plan I&E surplus/ deficit	≥0%	<0 - ≥ (1)%	<(1)-≥ (2)%	<(2)%
	0.2	**Agency spend**	Distance from provider's cap	≤0%	>0-≤25%	>25-≤50%	>50%

Note: brackets indicate negative numbers

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST
GOVERNANCE STRUCTURE



November 2019

University Hospitals of Leicester NHS
NHS Trust

Caring at its best

Management Structure University Hospitals of Leicester NHS Trust

Appendix 3

Chief Executive
John Adler

Chairman
Karamjit Singh

Executive Directors

Chief Operating Officer
Rebecca Brown

Deputy Chief Operating Officer
Debra Mitchell
Deputy Chief Operating Officer
Vacancy
Head of Performance
Warren Berman
Assistant Director of Information
John Roberts
Head of Information
Shirley Priestnall
Director of Operational Improvement
Sam Leak
Head of Patient Flow
Vacancy
Cancer Centre Lead Clinician
Dan Barnes
Cancer Centre Deputy Head of Performance
Sarah Morley
Cancer Centre Lead Nurse Manager
Jane Pickard

Medical Director
Andrew Furlong

Deputy Medical Directors
John Jameson
Colette Marshall
Dan Barnes

Associate Medical Directors
Mary Mushambi
(Appraisal and Revalidation)

Chief Information Medical Officer
Tim Bourne & Steve Jackson

Director of Clinical Education
Mark McCarthy

Director of Research & Innovation
Prof Nigel Brunskill

Director of Safety and Risk
Moira Durbridge

Chief Financial Officer
Paul Traynor

Director of Operational Finance
Chris Benham
Director of Productivity
Ben Shaw
Head of Financial Planning & Analysis
Lisa Gale
Head of Financial Performance
Tarun Basra
Financial Controller
Nick Sone
Head of Procurement and Supplies
David Streets
Head of Contracts and Commissioning
Lucy Wall

Chief Nurse
Carolyn Fox

Deputy Chief Nurses
Carole Ribbins (on secondment)
Eleanor Meldrum
Natalie Green (from 01/12/19)
Assistant Chief Nurses
Julia Ball /Heather Leatham / Debbie McBride
Lead Nurse Infection Prevention
Liz Collins
Director of Clinical Quality
Becky O'Brien
Head of Safeguarding
Michael Clayton

Associate Directors

Director of People and OD
Hazel Wyton

Deputy Director of People
Joanne Tyler-Fantom
Deputy Director of Learning & OD
Bina Kotecha
Head of Equality and Diversity
Aloma Onyemah (start date tbc)
Senior Project Manager
Pete Rogers
Head of Service Occupational Health
Charles Goss
Workforce Planning Manager
Gurprit Supra (secondment)
Head of Service Amica
Gareth Price

Director of Corporate & Legal Affairs
Stephen Ward

Assistant Director (Head of Legal Services)
Steve Murray

Director of Strategy & Communications
Mark Wightman

Deputy Director of Communications & Engagement
Tiffany Jones
Wef 04/11/19 Emma Casteleijn
Head of Partnerships & Business Development
Jon Currington
Deputy Director of Strategy
Rachna Vyas
Charity Director
Lisa Davies
Membership & PPI Manager
Karl Mayes

Director of Estates and Facilities
Darryn Kerr

Deputy Director & Head of Capital Projects and Property
Nigel Bond
Head of Estates
Leigh Gates (interim)
Head of Facilities
Mike Holmes (interim)
Head of Business, Finance and Performance
Jeanette Green
Director of Reconfiguration
Nicky Topham

Acting Chief Information Officer
Andy Carruthers

Business Engagement Lead
Zoe Bliss
Head of Strategic Projects
Liz Simons
eHospital Programme Manager
Paula Dunnan
IT Service Delivery Manager
Taff Webb
Head of Privacy
Saiful Choudhury
Finance & Contracts Manager
Tammy Hind

Non Executive Directors

Philip Baker
Ian Crowe
Andrew Johnson
Kiran Jenkins
Ballu Patel
Martin Traynor
Vicky Bailey

November 2019

University Hospitals of Leicester NHS
NHS Trust

Caring at its best

Management Structure University Hospitals of Leicester NHS Trust

Chief Operating Officer
Rebecca Brown

Clinical Management Group Structure (CMGs)

CHUGGS
(Cancer, Haematology, Urology, Gastroenterology and General Surgery)

Clinical Director
Giuseppe Garcea

Deputy Clinical Director
Kirsten Boyle

Head of Operations
Suzanne Nancarrow

Deputy Head of Operations
Judy Gilmore

Head of Nursing
Georgina Kenney

Deputy Head of Nursing
Jenny Carlin

Human Resources Lead
Martha Okoye

Finance Lead
Sab Esat

Patient Safety Lead
Kathleen Mitchell

Medical Education Leads
Amy Webster (Medicine)
John Beatty/(Surgery)

PPI Leads
George Kenney
Jenny Carlin

Research Lead
Sarah Nicholson

CSI
(Clinical Support & Imaging)

Clinical Director/ Associate Director for Clinical Improvement
Prashanth Patel

Joint Deputy Clinical Directors
Bruno Morgan
Claire Ellwood

Head of Operations
Matthew Archer

Deputy Head of Operations
Chris Shatford

Head of Nursing
Jeanette Halborg

Deputy Head of Nursing
Jacqueline Elton

Human Resources Lead
Carol Yassein

Finance Lead
Tony Maton

Patient Safety Lead
Julie White

Medical Education Lead
Will Adair (Imaging)
Steve Morley(Pathology)

Research Lead
Bruno Morgan

Office Manager
Donna Haig

Transformation Lead
Debbie McLean

Business Information Specialist
Abdur Ussen

Acute Medicine / ED Specialist Medicine

Clinical Director of Emergency Care and ESM
Rachel Marsh

Deputy Clinical Directors
Lee Walker/Amit Mistry

Head of Operations (ED)
Julie Dixon

Dep Head of Operations ED
Vacant

Head of Operations (SM)
Gaby Harris

Dep Head of Operations
Richard Harding

Head of Nursing
Kerry Johnston (ED)
Sue Burton (Patient Flow & Discharge)

Deputy Heads of Nursing
Lisa Lane/Kerry Morgan

Human Resources Lead
Kalwant Khaira

Finance Lead
Ryggs Gill

Patient Safety Lead
Sue Jenkinson

Medical Education Lead
Biju Simon
Ruth Denton-Beaumont

PPI Leads – Kerry Johnson (EM)
Sue Burton (Specialty Med)

Research Lead - Tim Coats

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

Clinical Director
Chris Allsager

Deputy Clinical Directors
Janette Gross
David Kirkbride

Head of Operations
Linda Fletcher

Deputy Head of Operations
Vacant

Head of Nursing
Jo Hollidge

Deputy Head of Nursing
Jason Loughran

Human Resources Lead
Kathryn Leavesley

Finance Lead
Nicola Morton

Patient Safety Lead
Julie White

Medical Education Lead
Rajani Annamaneni

PPI Lead
Jo Hollidge

Research Lead
Jonathan Thompson

MUSCULOSKELETAL AND SPECIALIST SURGERY

Clinical Director
Andy Currie

Deputy Clinical Director
Omar Gabbar

Head of Operations
Lisa Cowan

Deputy Head of Operations
Gaynor Parker

Head of Nursing
Nicola Grant

Deputy Head of Nursing
Michelle Atterbury

Human Resources Lead
Jenna Nelson

Finance Lead
Asif Bhimani

Patient Safety Lead
Julie White

Medical Education Lead
Bhaskar Bhowal

Monica Kaushik

PPI Lead
Nicola Grant

Research Lead
Alison Armstrong

Renal, Respiratory and Cardiovascular

Clinical Director
Suzanne Khalid

Deputy Clinical Director
Vacant

Head of Operations
Sarah Taylor

Deputy Head of Operations
Karen Jones

Head of Nursing
Sue Mason

Deputy Head of Nursing
Julie Lankester
Vicky Osborne

Human Resources Lead
Roisin Ryan

Finance Lead
Jiten Modhwadia

Patient Safety Lead
Caroline Aplin (on mat leave) Kathleen Mitchell (covering)

Medical Education Lead
Rakesh Panchal (Respiratory)
Will Nicolson (Cardiology)
Atul Bagul (Transplant)

PPI Lead
Julie Lankester

Research Lead
Felix Woodhead

Women's and Children's

Clinical Director
Ian Scudamore

Head of Operations
Sue McLeod

Deputy Head of Operations
Lesley Shepherd

Head of Nursing
Anna Duke (Childrens)

Deputy Head of Nursing
Jo Wilson

Head of Midwifery
Elaine Broughton

Human Resources Lead
Tina Larder

Finance Lead
Dan Barley

Patient Safety Lead
Jenny Russell

Medical Education Lead
Nahin Hussain (Children)
Eamonn Breslin (Women)

PPI Lead
Carol Stevenson

Research Lead
Elaine Boyle

November 2019

University Hospitals of Leicester NHS
NHS Trust

Caring at its best

Management Structure University Hospitals of Leicester NHS Trust

Clinical Management Group Structure (CMGs) – Services

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

CANCER AND HAEMATOLOGY
Head of Service
Kate Hodgson(Haematology)
Thiagarajan Sridhar (Oncology)
General Manager
Clare Blakemore
Matrons
Andy Palmer (Oncology/Day Care)
Jane Lee (Haematology/Bone Marrow)

PALLIATIVE CARE
Head of Service
Rosie Bronnert
General Manager
Clare Blakemore
Lead Palliative Care Nurse
Rebecca Proctor

UROLOGY
Head of Service
Professor Killian Mellon
General Manager
Angela Barnard
Matrons
Clair Riddell (Theatres Arrivals, Surgery, Urology)
Julia Homes (Urology/Surgery Admission)

GASTROENTEROLOGY (ENDOSCOPY)
Head of Service
James Stewart (Gastro)
Clinical Lead
Peter Wurm (Endoscopy)
General Manager
Hazel Pilon
Matrons
Glynis Dublin (Endoscopy)
Evelyn Gyesi-Appiah (Gastro)
Alex Bonner (Bowel Cancer Screening)

GENERAL SURGERY
Head of Service
Christopher Sutton (LRI)
Sam Sangal (LGH)
General Manager
Nureen Butt (Interim)
Matrons
Clair Riddell (Theatre Arrivals Surgery/Urology)
Penny Franklin (General Surgery)
Jane Baker (Day Case)
Ellen Slattery (General Surgery)

CSI
(Clinical Support & Imaging)

PHARMACY
Chief Pharmacist
Claire Ellwood
General Managers
Claire Meakin
Service Managers
Paul Coachman

THERAPIES
Head of Service
Lynn Cooke

DIETETICS AND NUTRITION
Head of Service
Cathy Steele

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

IMAGING
Lead General Manager
Cathy Lea
Heads of Service
Rosemina Ahmad
Praveen Rao
David Swienton

BREAST IMAGING
Programme/General Manager
Amanda Gibby

MEDICAL PHYSICS
Head of Service
Debbie Peet
General Manager
Mark Norton

LEICESTER PATHOLOGY SERVICES
Clinical Lead
Linda Barton
General Manager
Anne Freestone
Heads of Service
Linda Barton
Pankaj Gupta
Debbie Modha
Rebecca Harrison
Hafiz Qureshi
Mike Browning
Lara Cresswell
Education Lead
Steve Morely

Acute Medicine / ED Specialist Medicine

EMERGENCY MEDICINE/ED
General Manager
Chris Barbrook (ED)
Rhiannon Pepper (Acute Med)
Service Managers
Nicky Kester (ED
Dan Neilon (Acute Med)
Head of Service
Sam Jones (Paeds ED)
Vivek Pillai (Majors/Resus)
Vittal Jadhav (Acute)
Rachel Rowlands (Paeds)
Matrons
Julie Burdett (Short Stay/GPAU/DVT clinic)
Angela Collins (Adult ED)
Margaret Platts (Adult ED)
Andrew Coser (Children's ED,CSSU)
Victoria Cartright (EDU,EFU, AFU)
Shaheen Steers (AMU)

GERIATRIC MEDICINE AND NEUROSCIENCES
Head of Service
Richard Wong (Geriatrics)
Abhishek Mathur
David Eveson (Stroke)
Subha Vandabona (Neuro)
Jithin George (Neuro)
Matrons
Sue Eversfield (Diabetes)
Caroline Rogers (Neuro)
Evelyn Gyesi-Appiah (Elderly and Neuro)
Julia Preston (Stroke, TIA and Falls)

SPECIALIST MEDICINE
General Manager
Danielle Webster (Geriatrics, Rheumatology and Chem Path)
Jodie Bale (Dermatology, Neurology & Chem Path)
Kerris Morrell (Diabetology, Endocrinology, Infectious Diseases, Stroke Medicine)
Holly Bertalan (General Medicine)
Service Managers
Samantha Moore (Diabetology, Endocrinology, Infectious Diseases, Stroke Medicine)
Sandie Martin (Dermatology & Neuro)
Helen Dew(Geriatrics & Rheumatology) and Chem Path)
Heads of Service
Alison Kinder (Rheumatology)
Robert Burd (Dermatology)
Marie-France Kong (Diabetes & Endocrinology)
Iain Stephenson (IDU)
Matrons
Melanie Hughes and Shazia Naz (Medical Day Care/DTOC Inpatients)
Sally Rollings (Hampton and Patient Exp)
Sue Eversfield (Infectious Diseases)
Judith Dent (Geriatrics)
Zaheeda Sotta (Geriatrics & Recruitment)

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

ITAPS
Heads of Service
Dorothea Morphey (LRI)
Vipul Kaushik (LGH)
Nick Harvey (GGH)

INTENSIVE CARE
Lead Clinician
Gareth Williams, James Sadler and Justin Williams
General Manager
Simon Walter
Service Manager
Vacant

Matrons
Jackie Redfern (GGH)
Sharon Williams (LRI & LGH)
Kim Key (LGH)
Kelly Noon (DART)

THEATRES & ANAESTHETICS
Theatre Transformation Lead
Cherry Lee
General Manager
Simon Martin
Linda Chesterton

Service Managers
Mohsin Contractor
Tayo Adeniji
Hyejung Garrett

Matrons
Karen Dixon (Theatre Arrivals)
Sharon Thomas LGH)
Yvonne Francis-Burnett (GGH)
Julie Clerc(LRI)

PAIN
Lead Clinician
Karim Shoukrim

SLEEP
Lead Clinician
Andrew Hall
General Manager
Simon Walter
Service Manager
Vacant

HOSPITAL 24/7
Matron
Tara Marshall

RED's Team
General Manager
Claire Jones-Manning
Service Manager
Emile Forbes

Musculoskeletal and Specialist Surgery

MUSCULOSKELETAL
Heads of Service
Maneesh Bhatia Elective)
Kevin Boyd (Sports & Exercise)
Aamar Ullah (Trauma)
General Manager
Sally Le-Good(Elective/Sports Exercise)
Caroline Stokes/Darryl Davison (Trauma)/Screening Services)
Service Manager
Estelle Percival (Elective/Sports Exercise)

SPECIALIST SURGERY
Heads of Service
Raghavan Sampath (Ophthalmology)
Ade Mosaku (ORD)
Graham Offer (Plastics)
Jarek Krupa (Breast Care)
Javed Uddin (ENT)
Hazel Busby-Earl (Maxfax and Oral Surgery & ORD)
James Deane (DESP)
General Managers
Zack Sentance (Ophthalmology)
Lisa Osborne (Plastics and Breast Surgery)
Sarah Turner (ENT, ORD & Max Fac)
Service Managers
Catherine Shepherd (ORD & Max Fac)
Tom Bocock (Ophthalmology)
Mohammed Kathrada (Ophthalmology)
Lisa Osborn (ORD & Maxfac)
Natalie Dalgetty (Plastics & Breast Care)
Nicola Galletly (ENT)
Matrons
Mark Leyton (Specialist Surgery)
Yvonne Kenmuir-Hogg (Orthopaedics)
Clair Rix (Orthopaedics)
Charlie Pawley (Specialist Surgery)
Kate Machin (Trauma)
Jo Clarson (Trauma)
Paula Eddy (Ophthalmology)

Renal, Respiratory and Cardiovascular

CARDIOLOGY
Head of Service
Elved Roberts
General Manager
Lorraine Bertram-Dickens
Service Manager
Sarah Greenan/Nishat Mohamed
Matrons
Martin Smith (Cardiovascular)/CCU
Simon Murjan (Discharge Lounge)
Ben Hyde (Cardiology Day Case)
Clair Gibson(CDU)

CARDIAC SURGERY
Head of Service
Apo Nakas
General Manager
Jodie Billings(Cardiac & Vascular)
Service Manager
Vacancy
Matrons
Sarah Barrie(Cardia c Surgery)

RENAL AND TRANSPLANT
Head of Service
Richard Baines (Renal)
Atul Bagul (Transplant)
General Manager
Geraldine Davies
Service Manager
Lisa Jeffs/Caroline Sissling
Matrons
Alison Stapleton (Renal)

RESPIRATORY SERVICES
Head of Service, Respiratory
Gerrit Woltmann
Head of Service, Thoracics, Allergy and Immunology
Mr Apo Nakas
General Manager
Darren Turner
Service Manager
Sandie Martin
Lung Cancer Service Manager
Claire Brennan
Junior Doctor/Medical Staffing Service Manager
Zaynab Khan
Matrons
Simon Murjan (Respiratory/Cardio/Discharge Lounge)
Geoff Davison (Respiratory)
Mary Payne (Cardiology)
Ruth Brown (Thoracic/Respiratory)
Clair Gibson (CDU)

VASCULAR SERVICES
Head of Service
Matt Bown
General Manager
Jodie Billings (Vascular and Cardiac)
Service Managers
Sue Holt
Matron
Sarah Barrie(Vascular)

Women's and Children's

WOMENS
Heads of Service
Olivia Barney (Gynae)
Cornelia Wiesender (Maternity)
Jonathan Cusack (Neonates)
Pradeep Vasudevan (Clinical Genetics)
General Managers
Annis Rowley (Maternity, Neonates)
Donata Marshall (Gynae, Clinical Genetics)
Service Managers
Rebecca Fry (Gynae, Clinical Genetic)
Joan Morrissey (Maternity, Neonates)
Matrons
Rachelle Bowden (Gynaecology/Emergencies)
Kerry Williams (Maternity, LGH)
Fiona Ford (Maternity)
Cara Hobby (Neonates)
Flo Cox (Community Midwifery)
Julia Austin (Public Health)
Louise Robinson (Antenatal Care and named Midwife for Safeguarding)

CHILDREN'S
Heads of Service
Simon Robinson (Paediatric Medical Sub-Specialites)
Chris Wighton (Acute and General Paediatrics)
Aidan Bolger (EMCHC & ECMO, PICU)
Anthony Owen (Paediatric Surgery)
General Managers
Agnleszka Archer (Medical Sub Specialties)
Belinda Ross (Surgical and Acute Paediatrics)
Charlotte King (EMMO/ICU)
Gail Faulkner (ECMO Coordinator)
Service Managers
Richard Lea
Tracey Rochester-Jones
Rachel Appleby
Belinda Ross
Matrons
Jo Ennis (PICU, GGH/LRI)
Sarah King (Specialties, Respiratory, Oncology, Ward 12 & 27 and LRI Outpatients))
Liz James (Medicine, War 11/14))
Carol Stevenson (Ward 30, OPD,GGH, and Paeds Cardia)
Clare Stuart (Surgery/Day Case/Ward 10/19/CDCU))

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Management Structure University Hospitals of Leicester NHS Trust

Director of Estates & Facilities
Darryn Kerr

Estates & Facilities

Estates

Head of Estates
Leigh Gates

Regional Managers
Steve Harrison, LGH
Andy Martin, LRI
Pete Pierce, GH

Senior Specialist Engineer
Martin Owen

Facilities

Head of Facilities
Mike Holmes (interim)

Facilities Manager, LRI (Patient Catering)
Marion Cockeram

Non-Acute Facilities Manager
Cheryl Shuttleworth

Facilities Manager (Domestic Services)
Bernadette Williams

Security Manager
Donna White

Travelwise Manager
Ruth Ward

CSC Manager
Mayur Kachela

Reconfiguration

Director of Reconfiguration
Nicky Topham

Head of Reconfiguration PMO
Justin Hammond

Senior Project Manager
Alex Morrall

Capital Projects, Property & Compliance

Deputy Director, Head of Capital Projects & Property
Nigel Bond

Senior Capital Projects Manager
Debra Green
Ryan Milbourne
Louise Naylor

Property Manager
Adrian Middleton

HR

Business Partner
Wayne Lloyd

HR Adviser
Pamela Peacock

Business, Finance and Performance

Head of Business, Finance & Performance
Jeanette Green

Commercial Services Manager
Karen James

Performance Manager
Melanie Moxley

Service Development Manager
Craig Waistell

Transformation Lead
Steve King

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Appendix 4

CMG Assurance Performance Review Meetings

Standing Agenda

No.	Agenda Item	Lead
1.	**Apologies**	Chair
2.	**Review of pack led by CMG:** • **Quality including Clinical Education** • **Performance** • **Finance** **(QA escalation for CIP)** • **Workforce** • **Strategy**	 Andrew Furlong / Carolyn Fox Rebecca Brown Paul Traynor Hazel Wyton Mark Wightman
3.	**Review of risks:** • **Exceptions or additions**	 CMG
4.	**Share best practice / good news**	CMG
5.	**Any concerns not addressed by the agenda**	CMG / Executive Director
6.	**Review of action notes (to check not covered by the pack)**	Chair
7.	**Confirm actions and agree ratings for submission for the month**	Chair

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Appendix 5

CMG Performance Review Meeting
Summary & Ratings

September 2019

Operational Delivery Unit

One team shared values

August APRM Review Ratings

University Hospitals of Leicester NHS
NHS Trust

CMG	Quality & Safety	Operational Performance	Finance & CIP	Workforce
CHUGGS	RI ↔	RI ↔	RI ↔	RI ↓
CSI	RI ↓	G ↔	RI ↓	G↔
ESM	G ↔	RI ↔	O ↔	RI ↓
ITAPS	G↔	G ↔	RI ↔	O ↑
MSS	RI↔	RI ↔	RI ↔	RI↔
RRCV (July Rating)	G ↔	G ↑	G ↔	G ↔
W&C	G ↔	RI ↔	RI ↔	G ↔

RAG	Assurance Rating	CMG Assurance to the Executive Team
O	OUTSTANDING	Sustained delivery of all KPI metrics. Robust control & proactive positive assurance processes in place.
G	GOOD	Evidence of sustained delivery of the majority of KPIs. Robust control & proactive positive assurance processes in place. Strong corrective actions in place to address areas of underperformance.
RI	REQUIRES IMPROVEMENT	Most KPIs delivered but delivery inconsistent/not sustained. Corrective actions in place to address areas of underperformance but too early to determine recovery.
I	INADEQUATE	Consistent under delivery. Weak corrective actions or assurance provided.

Trend	Trend Definition
↑	Improved from last review
↓	Deteriorated from last review
↔	Consistent/remains unchanged from last review

RAG ratings with asterisks * indicates improvement from previous month

Quality & Safety

University Hospitals of Leicester NHS
NHS Trust

Summary & Action Plan

CHUGGS	• Resuscitation Training – Look at improving the JDA figures for next month. Kirsten highlighted the issues they were having with consultant recruitment and retention and in particular retaining a Locum Oncologist currently working in the department. The consultant wants to stay at Leicester but requires a guarantee of 5 years work at the hospital. Hazel highlighted that a 5 year fixed term contract is not possible but agreed Kally Khaira to link with the department and draft a letter offering guaranteed work for 5 years in order to retain the consultant. • Carolyn agreed to pick up the issue of a dedicated patient partner for CHUGGS outside of the meeting. • Flu reporting to be included from next month.
CSI	• Immunology – update report to be provided for the November EQB and QOC meetings. • OP FFT coverage – agreed to include numbers as well as percentages in future packs.
ESM	• SI actions are to be closed down. • TB Drugs - Andrew Furlong is following up with Claire Ellwood. • Guidelines and Policies - Update to be provided in a revised version of the PRM pack. • MRSA Case - Follow up regarding confirmation on whether this was contamination. Summary update to be provided at next ESM PRM. This will be primarily picked up in a report to the IP Committee.
ITAPS	• SI Overdue Action – Learning Videos for Staff - ITAPS is to look at using patient partners to tell the patient's stories. ITAPS is to follow with Moira Durbridge. • Policies and Guidelines - An update on progress wording is to be added to the ITAPS PRM pack going forwards. • Maintenance – Loss of Room in Sleep Lab. Ian Scudamore is to follow up with Giuseppe Garcea re. moving cabinets, to create more clinical space. • ChloraPrep Usage - Jo Hollidge is following up. Senior support is available if required.
MSS	• Overdue SI Actions – Outstanding action to be closed. • Out of Hours Rotas - Workforce Model to be revisited. • Complaints – Plan required to address high volume of complaints for Ophthalmology. • Resuscitation Training – Further discussion to be held between Omar Gabbar and Andie Currie outwith the meeting as improvement in compliance required for medical and dental workforce. • FNOF – Improvement in performance required for September 2019 and report to be presented to Executive Quality Board and Quality & Outcomes Committee by MSS and ITAPS CMGs.
RRCV	• Meeting cancelled due to operational pressures & an unannounced CQC visit.
W&C	• Overdue SI Action – To be closed by October 2019. • Resuscitation Training – Non-compliant staff to be chased as a matter of urgency. • Policies and Guidelines – Transitional Care Policy to be reviewed/updated as a matter of urgency (CQC requirement). • Viewpoint – To be escalated to Executive Team if no further progress has been made.

Operational Performance

University Hospitals of Leicester NHS
NHS Trust

Summary & Action Plan

CHUGGS	• Some challenges in the department but Rebecca said to try to keep going with the good things and to speak to either herself or Andrew if any intervention required. • Deputy Ops Manager cover arrangements to be progressed asap. Update to next meeting. • Kirsten advised that the Head of Service for Palliative Care had stepped down from their post. Agreed to explore options at the next meeting.
CSI	• No actions.
ESM	• Ambulance Handovers - This was a key action at the last ESM PRM. Will Jones has now produced the data. A plan is to be forwarded to Rebecca Brown and Andrew Furlong within the next 2 weeks. • MADE event in October - Need to work to ensure that this event is a success. • Urgent and Emergency Care and Ambulance Performance - Rebecca Brown thanked all staff for their hard work and efforts in sustaining delivery. Thank you to everyone on behalf of all of us. • Winter Planning - Rebecca Brown is to meet with member of the ESM team to agree what is additionally required.
ITAPS	• #NOF - An update on #NOF was provided by the CMG; a dedicated surgeon is still required for 2 sessions, or a Registrar to fill staffing gaps. Andrew Furlong is to follow up on progress with the Surgeons. The CMG are to set up a weekly forum with MSS. If there are 3 months of consecutive poor #NOF performance a report will be required for Executive Board and QOC. • Cancelled Theatre sessions - ITAPS is to look at what theatre activity was not possible. This is to be discussed at Surgical Care Board. • Clinical Correspondence Turnaround - A new dashboard to come to next month's PRM. • HDU Capacity at LGH - ITAPS is looking at this currently with the aim of this coming into place in November. An update is to be provided at next the PRM.
MSS	• Theatre Staffing – Issues to be discussed further with Linda Fletcher (Head of Operations – ITAPS CMG) and Orthopaedics activity needs to continue. • Stranded Patients – To be discussed at Operational Management Group meeting.
RRCV	• Meeting cancelled due to operational pressures & an unannounced CQC visit.
W&C	• Review of Single Front Door – Paper to be presented to Executive Strategy Board. • Winter – Robust plan required.

Finance & CIP

University Hospitals of Leicester NHS
NHS Trust

Summary & Action Plan

CHUGGS	• Deep dive sessions have been useful and green shoots were beginning to appear. The Team requested continued support from Finance to keep them on track. Agreed CMG would register Requires Improvement rather than Special Measures at the next Finance and Investment meeting.
CSI	• No actions.
ESM	• No actions.
ITAPS	• No actions.
MSS	• Further support to be provided by Finance Team to resolve issues raised during Deep Dive Session.
RRCV	• Meeting cancelled due to operational pressures & an unannounced CQC visit.
W&C	• Recommendation to be made at next Financial Recovery Board meeting for W&C CMG to put into Special Measures. • Actions arising from Deep Dive Session to be followed-up.

Workforce

University Hospitals of Leicester NHS
NHS Trust

Summary & Action Plan

CHUGGS	• Hazel requested the team to meet with their Improvement Agents asap. • Team had requested additional places on the mid leadership development programme which was currently oversubscribed. Martha was asked to speak to Bina Kotecha to see if additional places could be made available.
CSI	• Nursing vacancies – data to be reviewed to try to identify why an increase has been seen.
ESM	• Dermatology Admin Staff - There was a discussion re. the sudden rapid turnover of admin staff within Dermatology. Update to be provided at next PRM. • Working on a Rotation with Cardiology - Discussions with Cardiology have been productive, and starting in 2 weeks, a pool of staff will be working on a rotational basis. The CMG are to advise Andrew Furlong if they require his assistance. • Healthcare Assistants - Retention levels for Healthcare Assistants were discussed. The CMG is to focus efforts on retention.
ITAPS	• Workforce – Time to Hire - Kathryn Leavesley is to follow up with Conor Ward regarding Band 5 nurse exemptions. • Mid Leadership Training places for ITAPS Staff - Hazel Wyton is to follow up with her team as discussed. • Re-grading of Sleep Technicians - If this matter is not resolved within the next week the CMG are to follow up with Hazel Wyton.
MSS	• Time to Hire – Improvement in performance required and Recruitment Team to meet with CMG more frequently. • Culture Engagement – CMG to meet their Improvement Agents more frequently. • Culture Engagement - Mid Leadership Development Programme – Further delegates required for next cohort and CMG to consider registration as Team.
RRCV	• Meeting cancelled due to operational pressures & an unannounced CQC visit.
W&C	• No actions.

Strategy

University Hospitals of Leicester NHS
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Summary & Action Plan

CHUGGS	• No actions.
CSI	• No actions.
ESM	• No actions.
ITAPS	• The Vital Few - Chris Benham is to follow up with Rachna Vyas as discussed.
MSS	• No actions.
RRCV	• Meeting cancelled due to operational pressures & an unannounced CQC visit.
W&C	• No actions.

Appendix 6

Financial Management Accountability Framework

0 Achievement of the financial target is an important annual objective for the Trust and devolving responsibility for our income and expenditure to CMGs and Corporate Directorates is an appropriate and fundamental component. The Financial Management Accountability Framework seeks to formalise and more clearly define what is expected of CMGs and Directorates in terms of the sign off of their annual budgets and their in-year management. Importantly, it also details how the performance management regime will operate, noting how adverse performance from plan will be handled.

1 The Financial Management Accountability Framework covers how CMGs and Directorates provide information and assurance to the Chief Financial Officer, Executive Team, Finance and Investment Committee and Trust Board on their financial performance. From the start of the year through each month and quarter, a RAG risk rating will be allocated to each CMG and Corporate Directorate determined by actual performance and level of overall risk within their plan. The risk rating stipulates the level of escalation and required actions.

2 The purpose of the Financial Management Accountability Framework is to formalise and specify some of what already exists in practice at UHL and in addition to take and implement aspects of best practice from successful NHS Foundation Trusts and Trusts in other parts of the NHS. The document sets out quite succinctly what is expected of CMG Boards and of the relevant Executive Directors.

3 The UHL financial management accountability framework was implemented from quarter 3, 2017/18.

4 The Trust is working within an annual plan for Income and Expenditure as agreed with NHS Improvement. The organisation discharges its financial commitment to CMGs and Corporate Directorates through the annual planning and budget setting processes.

5 As part of the annual planning and budget setting process each CMG and Corporate Directorate will be required to sign-off their annual plan and approved budget. This sign off process will require physical signatures of the Chief Executive, Chief Financial Officer and respective CMG board members and Corporate Director.

6 Each month, the Trust is required to report to NHS Improvement on both year-to-date financial and Cost Improvement Programme performance together with forecast outturn for the full year. The Trust remains committed to achieving the agreed Income and Expenditure position and therefore each CMG and Corporate Directorate is required to fully own and deliver its individual plan.

7 Prior to the start of each quarter, all CMGs and Corporate Directorates are required to provide an assurance statement that they will live within their budget control total for year. The assurance statement required is the standard format and will be signed off by the CMG and Corporate Directorate Board. The assurance statement will require a physical signature, be based on activity forecasts and will include:

- month by month income, pay and non-pay forecast including recurrent / non recurrent analysis,
- month by month projection of any recovery actions to mitigate cost pressures/under-performance including recurrent / non recurrent analysis,
- month by month analysis of opportunities and risks to include identification of potential investment decisions,
- any decision with the potential for increased expenditure of over £50,000 subject to a business case to be agreed at Revenue Investment Committee (RIC) prior to the expenditure being incurred (in line with the existing policy).

9. Financial Performance should align with CIP delivery with the principle that if the plan is being delivered this implies that CIP is being delivered. Whilst CIP should be predicated on recurrent savings it is recognised that this can be delivered through non-recurrent means in-year. Equally, if the financial plan is not being delivered this translates into under-delivery of CIP. In line with the existing policy, any risks surrounding delivery of the CIP target will follow the current CIP escalation route in place.

10. Following submission of the assurance statement the CMG or Corporate Directorate will be risked rated by the Chief Financial Officer.

11. This risk rating will be reviewed after the receipt of each month's financial results.

12. It should be noted that any material failure to deliver on the part of one CMG or Corporate Directorate may require other areas of the organisation to take additional action.

13. Risk rating will be defined using the following criteria:

GREEN	No risk of failure to deliver the CMG/Directorate financial plan	• YTD adverse variance of less than or equal to 2.00% of EBITDA; and • Forecast at break-even or underspend

AMBER	Risk of failure to deliver CMG/Directorate financial plan	• YTD adverse variance to plan of greater than 2.00% of EBITDA; and • Forecast to deliver break-even or underspend **OR** • YTD adverse variance of less than 2.00% of EBITDA; and • Forecast to deliver overspend
RED	Material risk of failure to deliver the CMG/Directorate financial plan	• YTD adverse variance to plan of greater than 2.00% of **EBITDA;** and • Forecast to deliver overspend

14. The escalation based on the risk rating will be set as set out in the table below:

Risk Rating	Risk rating description	Executive Monitoring	Escalation action / Incentive
Green	No risk of failure to deliver the CM/Directorate financial Plan	Quarterly	• CMGs/Directorates rated green will only be required to review financial performance quarterly. • If by the final quarter the CMG/Directorate has been on green throughout the year and is forecasting an underspend, this underspend will be: - Discounted from budget setting in the following year; and - 50% of the underspend/over performance can be invested by the CMG/Directorate on capital in the following year on the proviso that this is being delivered to assist the Trust in the delivery of its overall financial plan for the year. • If a CMG/Directorate concludes the year having been green for each quarter the Executive will consider how the Board can be rated as "Champions" with further consideration given as to how they might support other CMGs/Directorates not so graded.
Amber	Risk of failure to deliver CMG/Directorate financial plan	Monthly	• Formal letter from Chief Financial Officer requesting a formal recovery plan to be presented at the next monthly review of Performance, Finance and CIP with updates to follow at respective monthly meetings. • If graded amber for two consecutive quarters the CMG/Directorate will be graded Red
Red	Material risk of failure to deliver the CMG/Directorate financial Plan	Twice a month	• Formal letter from Chief Financial Officer requiring a formal recovery plan within two weeks of being graded Red. • The CMG/Directorate will be required to attend a meeting with the Chief Executive and to present its recovery

			plan. • If graded red for a full quarter the CMG/Directorate will go into formal escalation including: - Enhanced recruitment control which requires any new or interim posts to be taken as a business case through the Revenue Investment Committee prior to the expenditure being incurred. This is in addition to the existing recruitment process involving the Enhanced Recruitment Control Board; - Regular meetings with the Chief Executive and Executive Team with regards progression of the recovery plan. • If graded red for two consecutive quarters the executive will consider suspending the CMGs/Directorates senior management team's delegated authority and limits of approval. A competency review of the CMGs/Directorates senior management team will be conducted with regard to the failure to deliver a material part of the Trust's annual plan.

Appendix 7

Becoming the best

What are we trying to accomplish?

NHS
University Hospitals of Leicester
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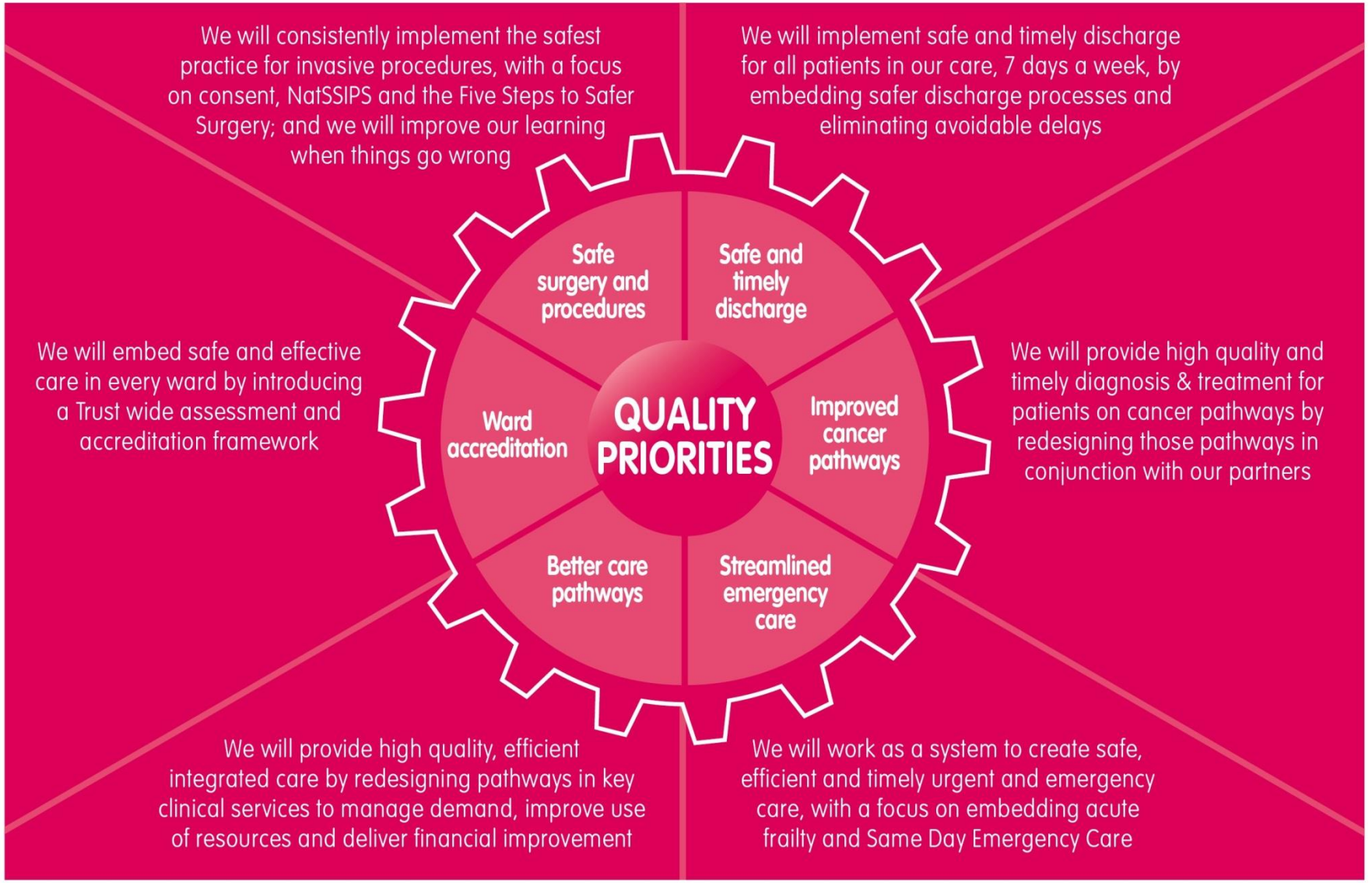

Appendix 7

What are we trying to accomplish?