University Hospitals of Leicester NHS
NHS Trust

Cover report to the Trust Board meeting to be held on 1 November 2018

	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:	Helen Stokes – Corporate and Committee Services Manager

Reporting Committee:	**People, Process and Performance Committee**
Chaired by:	Andrew Johnson, Non-Executive Director
Lead Executive Director(s):	Rebecca Brown – Chief Operating Officer Hazel Wyton – Director of People and Organisational Development
Date of last meeting:	25 October 2018
Summary of key public matters considered by the Committee and any related decisions made:	

This report provides a summary of the following key issues considered at the People, Process and Performance Committee on 25 October 2018:-

(1) <u>Performance</u>

- **Urgent and Emergency Care Performance Report**
  Updating PPPC on the current position within emergency and urgent care, the report from the Deputy Chief Operating Officer highlighted improved performance of 79.5% in September 2018 (compared to August 2018) despite higher than predicted attendances. Overnight performance had also improved. However, the impact of the CRO outbreak continued to be felt in terms of flow and clinical staffing demands. Further work was needed re: patients breaching the target while awaiting transport to other sites, and the availability of medical beds continued to be an issue – plans were in hand on both of these elements. PPPC agreed that the key focus issue remained non-admitted breaches, and requested an update in the next monthly report on why the rate of improvement was not as fast as had been hoped and what actions were being put in place as a consequence. That update should also cover any barriers to improving primary care 4-hour performance (ED front door), noting a range of discussions planned on that issue. PPPC noted the GIRFT Report attached and requested an update on the actions identified, particularly concerning incorporating a prescribing Pharmacist within ED, amongst others in future reports. PPPC welcomed a Getting It Right First Time (GIRFT) visit planned for December 2018, and suggested that it would be helpful at that time for the GIRFT team to look at how clinicians were addressing issues of qualitative variation (update to be provided accordingly to PPPC). In response to a Non-Executive Director query, the Deputy Chief Operating Officer considered that the rise in eye casualty breaches was linked largely to demand, although further work was needed to understand all of the factors involved.

  PPPC agreed with the Chief Operating Officer's view that the correct actions were currently being pursued to improve urgent and emergency care performance. It was noted that future updates would also include performance against the internal ED trajectory.

- **Cancer Performance (covered in the joint session with members of the Quality and Outcomes Committee – see below)**

- **UHL Winter Plan 2018/19**
  An update on the UHL winter plan for 2018-19 would be presented to each PPPC meeting – the Trust's plan was felt to be robust, and had been widely shared with LLR partners. The PPPC Non-Executive Director Chair noted the assurance provided to him by the level of detail in the report and the relevance of the actions identified. Although UHL had invested significantly in winter capacity, there was still a recognised residual gap, The Medical Director outlined the other mitigation plans in place for this, including the whole hospital response and escalation plans. Although based on the national steer of 85% occupancy, this was recognised as challenging due to the resulting bed gap, and UHL had also done some internal modelling on a 90% occupancy level. The Chief Operating Officer hoped that an appropriately-robust LLR-wide winter plan would be available for review at the A&E Delivery Board – that plan would then subsequently be discussed at PPPC. Given the need for appropriate assurance on partner plans (and to understand any residual system-wide risks and related actions needed), the Trust Chairman suggested that the December 2018 Trust Board also discuss the 2018-19 LLR winter plan.

(2) Process

- **Performance Management and Accountability Framework**
  PPPC reviewed the updated draft 'UHL Performance Management and Accountability Framework', now reflecting further work on the 4 areas highlighted at the September 2018 PPPC. The Chief Operating Officer proposed that any further comments on the framework (eg, the suggested inclusion of more detail on what was required of Clinical Management Groups) would be incorporated into the next annual iteration for 2019-20, and it was agreed that the Chief Operating Officer would advise the PPPC Non-Executive Director Chair outside the meeting of the intended frequency of updating PPPC on this framework. Notwithstanding this the Non-Executive Chair felt that in order to ensure the driving of accountability into CMGs there would be a need for an operational CMG performance management and accountability framework to be drawn up and agreed with CMGs – he would discuss this separately with the Chief Operating Officer. In further discussion, PPPC noted the close links between the performance management and accountability framework and UHL's culture and leadership programme.

  The performance management and accountability framework is appended to this summary, and recommended for Trust Board approval

- **Staff Flu Vaccination Campaign 2018-19**
  Dr C Goss, Occupational Health Physician attended to brief PPPC on the 2018-19 staff flu vaccination campaign, aiming to both protect staff from contracting flu and prevent them from spreading flu to patients or colleagues/family. The uptake of flu vaccine in frontline healthcare staff was subject to a CQUIN target, which in 2018-19 was for at least 75% of workers to be vaccinated. Approximately 43% of UHL frontline staff had been vaccinated in 2018-19 to date. PPPC was advised that the late publication (in September 2018) of the annual 'flu letter' for healthcare workers contained a new ambition for 100% of healthcare workers with direct patient contact to be vaccinated – this would be very challenging, and the report set out the Trust's updated plans in response to that flu letter. PPPC emphasised the need for the data collected by UHL also to include staff who had been vaccinated elsewhere, and received assurance that this was being actioned. PPPC also noted that a 'declination form' was proposed to be circulated with November 2018 payslips, allowing staff anonymously to indicate any reasons for not having the flu vaccine - those forms would then be returned to Occupational Health. In response to further queries, PPPC received assurance that UHL had sufficient stocks of vaccine.

(3) People

- **Development of the People Strategy**
  The Director of People and OD confirmed that following further work to align UHL's People, Workforce, and Leadership and Culture Strategies, the People Strategy (incorporating the medical workforce strategy and the nursing and midwifery strategy) would be presented to the November 2018 PPPC.

- **Culture and Leadership Programme**
  The report set out UHL's involvement in the NHS Improvement evidence-based Culture and Leadership Programme, which had been adopted nationally by 40 Trusts. Delivered in conjunction with the national leadership academy, the programme comprised 3 stages (discover, design, and deliver) – UHL was currently in the 'discover' phase, covering 6 diagnostics (culture and outcomes dashboard; Board interviews; leadership behaviour surveys; culture focus groups; leadership workforce analysis, and patient experience). In response to a query, the Deputy Director of Learning and OD confirmed that the Board elements diagnostic would be progressed through (rather than duplicating) the current Board review exercise. Updates on the culture and leadership programme were scheduled for the November and December 2018 Trust Board thinking days, which would inform the date of the next required update to PPPC.

- **Reports for Information**
  PPPC received and noted the following reports, as also considered at the 16 November 2018 Executive Workforce Board:-
    - Workforce and OD Plan update
    - New Starter Support at UHL – Non-Executive Directors welcomed this report, and also commented on the importance of retention of staff
    - Recruitment Update (time to hire, equality and diversity)
    - Agenda for Change update – band 1 closure/transition

- Clinical Excellence Awards 2018
- HR Employee Relations Team update
- Nursing and Midwifery Education and Practice Development update
- Apprenticeships – Public Duty of Care Target

- **Minutes received for information**
  - Executive Performance Board minutes 25.9.18
  - Executive Workforce Board actions 16.10.18

<u>Joint PPPC and QOC session:</u> due to pressure of time, discussion focused on cancer performance for August 2018; members were encouraged by improved performance compared to July 2018 despite an increasing referral rate. The 62-day cancer standard remained challenging however.

- ***Quality and Performance Report – Month 6***

  Joint paper 1 detailed performance against quality and performance indicators as at September 2018, noting encouraging progress on standard elective access targets including RTT performance, zero 52-week breaches, and achievement of both the diagnostics and cancelled operations targets in September 2018. In response to a query, the Director of Performance and Information advised that the primary risks to elective performance would be the impact of winter (and related bed availability) and related emergency activity levels. UHL's modelling suggested that – given the planning actions taken – elective activity might largely be able to be delivered despite winter pressures, but that patient waits were likely to vary between specialties. Members also discussed whether elective activity could be increased if winter was milder, or less busy, than expected.

  The QOC Non-Executive Director Chair queried the dip in Stroke TIA clinic performance – in response, the Medical Director advised that this was being explored further, with a detailed report to come to the Executive Quality Board and QOC in November 2018.

- ***CMG Performance Review Slides*** *– received and noted due to pressure of time*

Matters requiring Trust Board consideration and/or approval:

Recommendations for approval:-

1. Performance Management and Accountability Framework *(appended to this summary)*

Items highlighted to the Trust Board for information:

1. Flu vaccination plans

Matters referred to other Committees:

None.

Date of Next Meeting:	29 November 2018

UHL PERFORMANCE MANAGEMENT AND ACCOUNTABILITY FRAMEWORK

Authors: Rebecca Brown, Chief Operating Office and Stephen Ward, Director of Corporate and Legal Affairs
Sponsor: Rebecca Brown

Executive Summary Paper F

Context

Attached to this Executive summary is a draft UHL performance management and accountability framework.

The need to formalise such a framework has previously been the subject of discussion at both the Executive Performance Board and People, Process and Performance Committee.

The attached framework seeks to codify the Trust's approach to performance management, and document the Trust's accountability arrangements. It will both complement, and form an important component of, the Trust's overall Governance Framework.

The attached framework incorporates the financial management accountability framework adopted in 2017/18 via the Finance and Investment Committee.

Input Sought

Both the Executive Performance Board and People, Process and Performance Committee are invited to comment on the draft framework attached.

Subject to comments, both the Executive Performance Board and People, Process and Performance Committee are invited to endorse the framework and recommend it to the Trust Board for adoption.

For Reference

Edit as appropriate:

1. The following objectives were considered when preparing this report:

Safe, high quality, patient centred healthcare	[Yes /No /Not applicable]
Effective, integrated emergency care	[Yes /No /Not applicable]
Consistently meeting national access standards	[Yes /No /Not applicable]
Integrated care in partnership with others	[Yes /No /Not applicable]
Enhanced delivery in research, innovation & ed'	[Yes /No /Not applicable]
A caring, professional, engaged workforce	[Yes /No /Not applicable]
Clinically sustainable services with excellent facilities	[Yes /No /Not applicable]
Financially sustainable NHS organisation	[Yes /No /Not applicable]
Enabled by excellent IM&T	[Yes /No /Not applicable]

2. This matter relates to the following governance initiatives:

Organisational Risk Register	[Yes /No /Not applicable]
Board Assurance Framework	[Yes /No /Not applicable]

3. Related Patient and Public Involvement actions taken, or to be taken: [Insert here]

4. Results of any Equality Impact Assessment, relating to this matter: [Insert here]

5. Scheduled date for the next paper on this topic: [XX/XX/XX] or [TBC]

6. Executive Summaries should not exceed 1 page. [My paper does / does not comply]

7. Papers should not exceed 7 pages. [My paper does / does not comply]

DRAFT

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST

PERFORMANCE MANAGEMENT AND ACCOUNTABILITY FRAMEWORK 2018/19

Version:	1
This version issued:	September 2018
Review date:	September 2019
Number of pages:	
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 by 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.

University Hospitals of Leicester NHS
NHS Trust

Caring at its best

Our Values

We treat people how we would like to be treated

- We listen to our patients and to our colleagues, we always treat them with dignity and we respect their views and opinions
- We are always polite, honest and friendly
- We are here to help and we make sure that our patients and colleagues feel valued

We do what we say we are going to do

- When we talk to patients and their relatives we are clear about what is happening
- When we talk to colleagues we are clear about what is expected.
- We make the time to care
- If we cannot do something, we will explain why

We focus on what matters most

- We talk to patients, the public and colleagues about what matters most to them and we do not assume that we know best.
- We do not put off making difficult decisions if they are the right decisions
- We use money and resources responsibly

We are passionate and creative in our work

- We encourage and value other people's ideas
- We seek inventive solutions to problems
- We recognise people's achievements and celebrate success

We are one team and we are best when we work together

- We are professional at all times
- We set common goals and we take responsibility for our part in achieving them
- We give clear feedback and make sure that we communicate with one another effectively

One team shared values

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. NHS Improvement – the Single Oversight Framework

2.1 NHS Improvement is responsible for overseeing NHS Foundation Trusts, NHS Trusts, NHS Controlled Providers and independent healthcare Providers.

2.2 NHS Improvement has documented its approach to overseeing and supporting NHS Trusts and Foundation trusts under the Single Oversight Framework.

2.3 The purpose of the Single Oversight Framework is to:

- help NHS Improvement identify where Providers may benefit from, or require, improvement support if they are to meet the standards required of them in a safe and sustainable way, and the overall objectives for the sector are to be met,
- determines the way NHS Improvement works with each Provider to ensure appropriate support is made available.

2.4 The Single Oversight Framework sets out an oversight process which follows an ongoing cycle of:

- monitoring Providers' performance and capability under five themes,
- identifying the scale and nature of Providers' support needs,
- co-ordinating support activity so that it is targeted where it is not needed.

2.5 The full list of metrics NHS Improvement uses for monitoring Providers is set out in appendices 1 to 4.

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 will be 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.

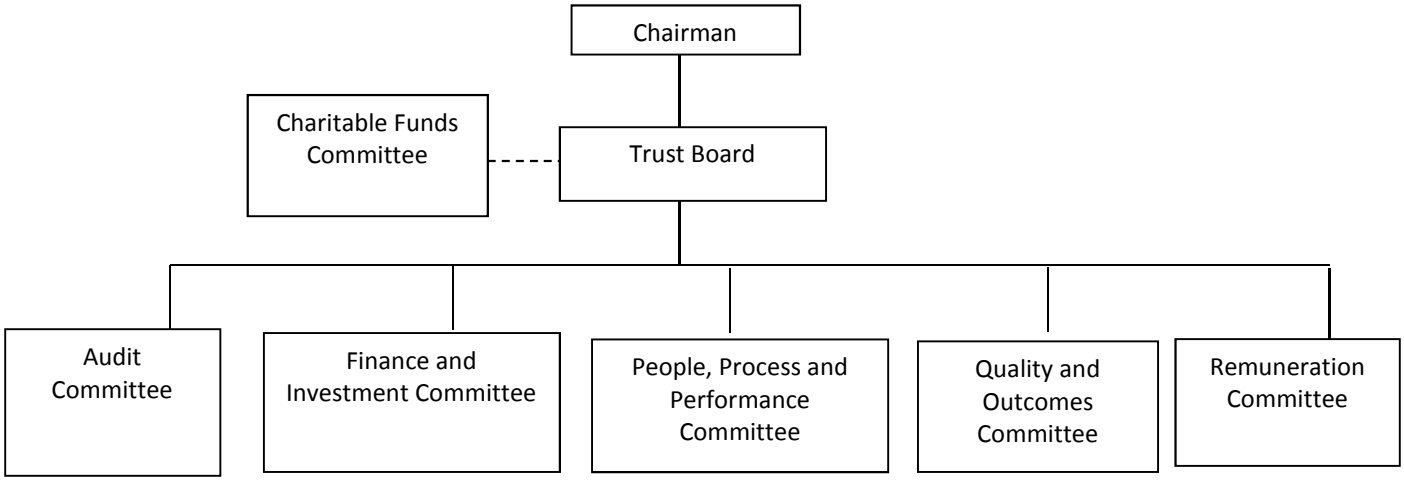
Corporate Trustees

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 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 has appointed Patient Partners as participating, non-voting members to the Finance and Investment Committee, People, Process and Performance Committee and Quality and Outcomes Committee (and Charitable Funds Committee) to contribute a different perspective to the deliberations of each group.

5. The Executive, Associate and Clinical Directors

Executive and Associate Directors

5.1 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 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 Finance 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 Workforce 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

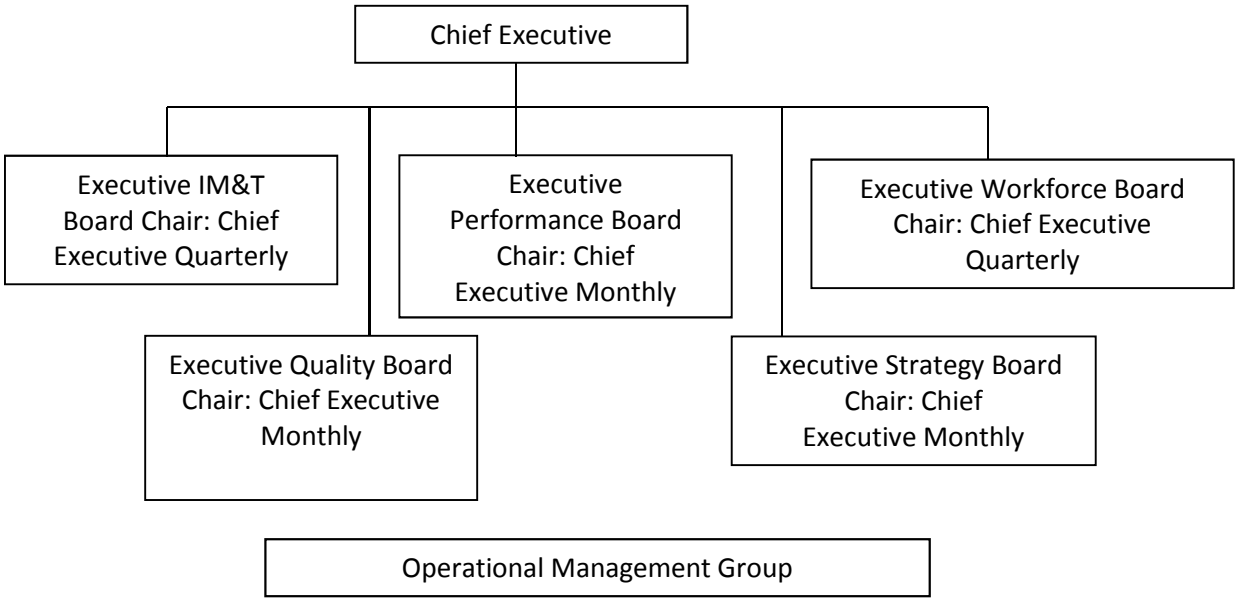
5.11 The Executive Team, with the Clinical Directors, form part of the Executive Board which meets weekly.

5.12 In order to ensure appropriate focus on key strategic issues, each weekly meeting of the Executive Board has a different focus – on strategy; quality, and performance. In addition, on a quarterly basis the Executive Board focuses specifically on workforce and organisational development issues and on information management and technology issues, respectively.

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 annual 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 5.

6. Clinical Management Groups

6.1 The Trust subdivides the operational and accountability of its clinical services into 7 Clinical Management Group (CMG):

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

b. CSI (Clinical Supporting & Imaging)

c. Acute Medicine / ED Specialist Medicine

d. ITAPS (Critical Care, Theatres, Anaesthesia, Pain and Sleep)

e. Musculoskeletal and Specialist Surgery

f. Renal, Respiratory and Cardiovascular

g. Women's and Children's

6.2 A diagram illustrating the arrangements is attached at appendix 6.

6.3 The CMG structure provides the following benefits:

a. support an improved working scheme for Executive Team and service provision, with an improvement in management visibility and increased clinical engagement and quicker, and more effective, decision-making;

b. smaller management units to support improved operational grip and clearer management accountability; and

c. improved parity between the size of the units.

6.4 There is a set structure within each of the CMGs which consists of a Clinical Director, Head of Operations and Head of Nursing, along with deputies, as well as leads from Human Resources, Finance, Quality and Safety, Education and Research. Each of the CMGs is accountable to the Chief Operating Officer.

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, with its use of performance assessment colours and symbols which draw attention to areas of potential risk. A Data Quality Forum aims to ensure the validity and robustness of data.

7.5 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.

7.6 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 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 more systematic process of escalation. This assists with bringing the necessary focus to resolving operational and financial challenges and provides and emphasises objective performance measurement.

7.9 Consequently, the Trust has in place a series of trigger points or thresholds, linked to the quality, finance, service and contractual performance measures which are used as the principal means against which the Trust's Clinical Management Groups are held to account by the Trust's Executive Directors. This use of a 'balanced scorecard' allows performance to be measured with regard to key performance indicators for quality, workforce, operational performance and financial delivery.

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 7 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 targets 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 key 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 moving forward and delivering 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 The ratings are summarised and presented to the People, Process and Performance Committee monthly as part of the Quality and Performance Report, an example of which can be seen in appendix 8 attached.

8.11 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 Table 2 below.

RAG	Assurance Rating	Actions / Interventions
O	OUTSTANDING	Monthly 121 with COO/MD/DON/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 measureable objectives and milestones to delivery
I	INADEQUATE	Recovery Plan with measureable 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 measureable improvement within 2 months

8.12 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.

8.13 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.

8.14 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, Workforce, Activity, Finance and Risk;
- escalation triggers are expected to be as robust as those applicable to CMGs.

9. Corporate functions - performance management

9.1 The Corporate Directors are held to account for their individual portfolios and objectives by the Chief Executive.

9.2 As requested from time to time, Corporate Directorates present their performance and achievements directly to the Committees of the Board.

10. Annual Priorities and Quality Commitment

10.1 Each year, the Trust Board undertakes a review of its strategic objectives and determines its priorities for the forthcoming financial year, set within the context of the Trust's annual operational plan.

10.2 As part of this process, the Trust Board also agrees annually a Quality Commitment, setting out the key clinical quality priorities for the forthcoming year, expressed under the headings of clinical effectiveness, patient safety and patient experience.

10.3 Details of the Trust's annual priorities 2018/19, and Quality Commitment for 2018/19, can be found at appendix 9.

Stephen Ward, Director of Corporate and Legal Affairs

Rebecca Brown, Chief Operating Officer

24th September 2018

Appendix 1: Quality of care metrics

NHS Improvement will use the indicators below to supplement Care Quality Commission (CQC) information to identify where providers may need support under the quality of care theme.

Measure	Type	Description/Calculation	Data frequency	Source
All providers				
Written complaints – rate	Caring	Count of written complaints/count of whole time equivalent staff	Quarterly	https://digital.nhs.uk/data-and-information/publications/statistical/data-on-written-complaints-in-the-nhs
Staff Friends and Family Test % recommended – care	Caring	Count of those categorised as extremely likely or likely to recommend/count of all responders	Quarterly	https://www.england.nhs.uk/fft/staff-fft/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	https://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	https://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	https://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	Safe	Count of trust apportioned *C. difficile* infections in patients aged two years and over compared to the number of	Monthly	Public Health England – data available here C. difficile infection objectives by trust available here:

plan (actual number v plan number)[2]		planned *C. difficile* cases		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 hospital onset 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	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 that appears in the SOF 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.

		provider to a modelled expectation of 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/

Appendix 2: Finance score

The overall finance score is a mean average of the scores on five individual metrics, which are defined and calculated as set out in Figure 3, except that:

- if a provider scores 4 on any individual finance metric, their overall finance 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 finance score will be at least 3 (ie it will be 3 or 4)
  - where they are planning a surplus their finance 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). This follows Monitor's method in assessing best performance where financial scores were rounded positively, ie towards the 'best' score for trusts.

Figure 3: Finance 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	<2.5x - ≥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 and 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 margin (surplus/deficit) in comparison to Year-to-date plan I&E margin (surplus/ deficit) on a control total basis	≥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

Appendix 3: Operational performance metrics

Measure	Description/Calculation	Data frequency	Data source	Standard[7]
Acute and specialist providers[8]				
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	https://www.england.nhs.uk/statistics/statistical-work-areas/ae-waiting-times-and-activity/ae-attendances-and-emergency-admissions-2017-18/	95%
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	Monthly	https://www.england.nhs.uk/statistics/statistical-work-areas/rtt-waiting-times/rtt-data-2017-18/	92%

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

[4] NHS Improvement is 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.

	patients whose clock has not stopped during the calendar months of the return			
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 b. the NHS screening service who have currently been waiting for less than 62 days for treatment to start	Monthly	Provider-level cancer waiting time data available here: https://www.england.nhs.uk/statistics/statistical-work-areas/cancer-waiting-times/monthly-prov-cwt/201718-monthly-provider- cancer-waiting-times- statistics/	a. 85% b. 90%
Maximum 6-week wait for diagnostic procedures	Proportion of patients referred for diagnostic tests who have been waiting for less than six weeks	Monthly	Data available here: https://www.england.nhs.uk/statistics/statistical-work-areas/diagnostics-waiting-times-and-activity/monthly-diagnostics-waiting-times-and-activity/monthly-diagnostics-data-2017-18/	99%

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 c. where the outcome was positive or inconclusive, are referred on to specialist services	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, c. where the outcome was positive or inconclusive, are referred on to specialist services.	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%

Appendix 4: Organisational health indicators

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/data-and-information/publications/statistical/nhs-sickness-absence-rates
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	Monthly provider return

NHS Staff Survey	Organisational health	Staff recommendation of the organisation as a place to work or receive treatment	Annual	Data available here: http://www.nhsstaffsurveys.com/Page/1056/Home/NHS-Staff-Survey-2017/
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

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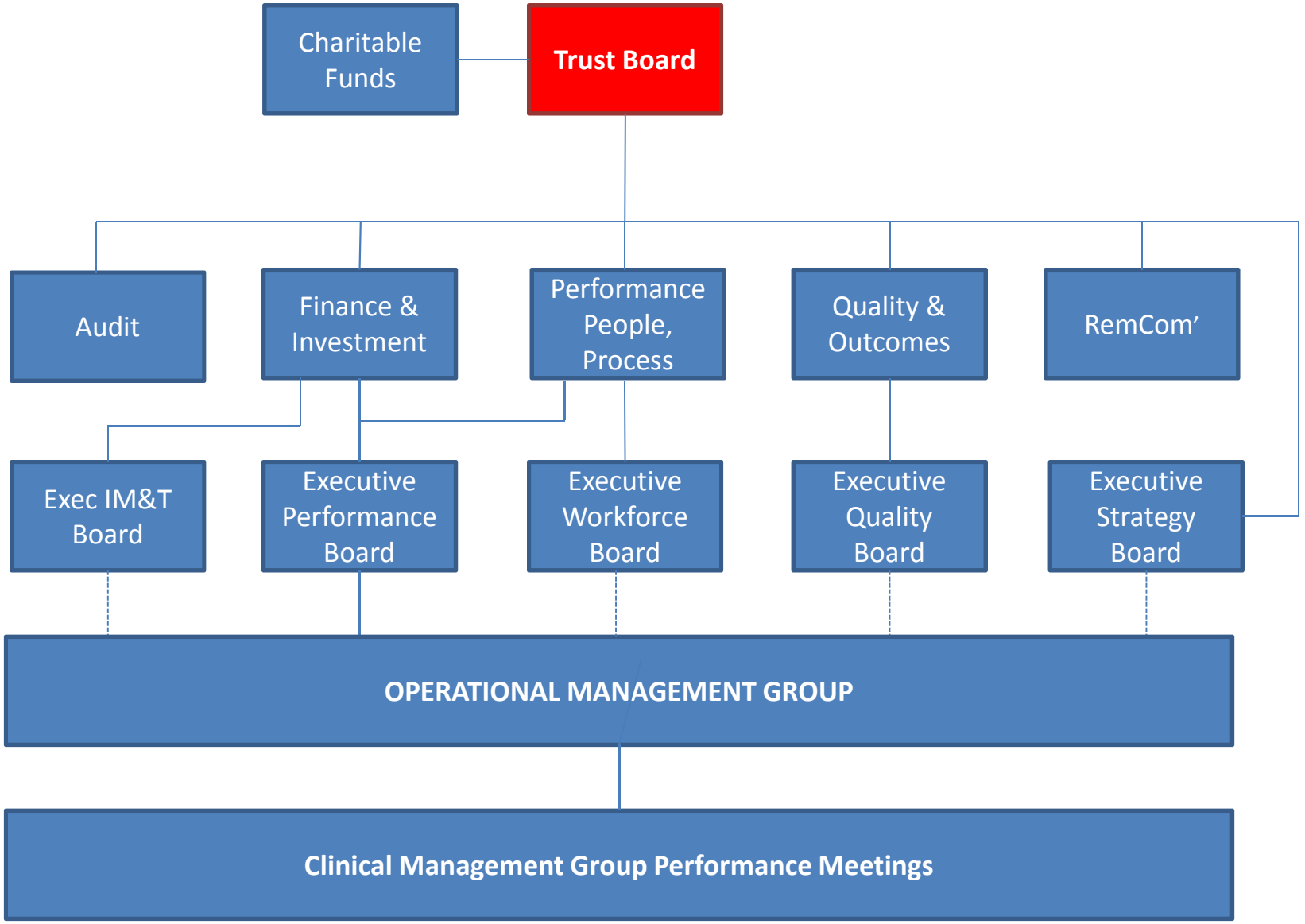
Governance Structure – assurance and escalation arrangements Appendix 5



1 August 2018

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
Charlotte Landford

Head of Nursing
Georgina Kenney

Deputy Head of Nursing
Jenny Carlin

Human Resources Lead
Debra Davies

Finance Lead
Sab Esat

Patient Safety Lead
Caroline Aplin

Medical Education Leads
Vacant (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
Andy Rickett

Deputy Clinical Director
Prashanth Patel

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)
Nelun Perera (Pathology)

Research Lead
Bruno Morgan

Administration Lead
Donna Haig

Transformation Manager
Debbie McLean

Business Information Specialist
Vacant

Acute Medicine / ED Specialist Medicine

Clinical Director of Emergency Care and ESM
Rachel Marsh

Clinical Director EM
Lee Walker

Deputy Clinical Director Specialist Medicine
Vacancy

Head of Operations (ED)
Mike Nattrass

Dep Head of Operations ED
Beth Hughes

Head of Operations (SM)
Raman Chhokar

Dep Head of Operations (SM)
Elaine Graves

Head of Nursing
Kerry Johnston (ED) Gill Staton (SM) Sue Burton (SM) (acting)

Deputy Heads of Nursing
Lisa Lane/Kerry Morgan/Judith Spiers

Human Resources Lead
Kalwant Khaira

Finance Lead
Ryggs Gill

Patient Safety Lead
Sue Jenkinson

Medical Education Lead
Biju Simon
Ruth Denton-Beaumont

PPI Lead - Gill Staton

Research Lead - Tim Coats

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

Clinical Director
Chris Allsager

Deputy Clinical Directors
Helen Brooks
David Kirkbride

Head of Operations
Gaby Harris

Deputy Head of Operations
Linda Fletcher

Head of Nursing
Jo Hollidge

Deputy Head of Nursing
Jason Loughran

Human Resources Lead
Kalwant Khaira

Finance Lead
Sapna Patel

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
Catherine Chadwick

Deputy Head of Operations
Lisa Cowen

Head of Nursing
Nicola Grant

Deputy Head of Nursing
Michelle Atterbury

Human Resources Lead
Michelle Robinson

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
Judy Gilmore

Head of Nursing
Sue Mason

Deputy Head of Nursing
Julie Lankester

Human Resources Lead
Gurprit Bahia Supra

Finance Lead
Jitan Modhwadia

Patient Safety Lead
Caroline Aplin

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
David Yeomanson

Deputy Head of Operations
Lesley Shepherd

Head of Nursing
Anna Duke (Childrens)

Deputy Head of Nursing
Elizabeth Aryeetey

Head of Midwifery
Elaine Broughton

Human Resources Lead
Tina Larder

Finance Lead
Dan Barley

Patient Safety Lead
Jenny Russell

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

PPI Lead
Carol Stevenson

Research Lead
Elaine Boyle/Doug Tincello

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
Anne Hunter (Haematology)
Kirsten Boyle (Acting) (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

UROLOGY
Head of Service
Roger Kockelbergh
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)
Jane Spiers (Gastro)

GENERAL SURGERY
Head of Service
Christopher Sutton (LRI)
Sanjay Chaudhri(LGH)
General Manager
Danisha Champaneri
Matrons
Clair Riddell (Theatre Arrivals Surgery/Urology)
Louise Carpenter (General Surgery)
Jane Baker (Day Case)
Ellen Slattery(General Surgery)

CSI (Clinical Support & Imaging)

PHARMACY & THERAPIES
Chief Pharmacist
Claire Ellwood
General Managers
Paul Couchman /Claire Meakin

THERAPIES
Head of Service
Lynn Cooke

DIETETICS
Cathy Steele

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

IMAGING
Medical Lead
Will Adair
Lead General Manager
Cathy Lea
Heads of Service
Aparna Deshpande
Guy Fishwick
Rajesh Arumugam

BREAST IMAGING
Programme/General Manager
Amanda Gibby

MEDICAL PHYSICS
Head of Service
Debbie Peet
General Managers
Mark Norton

LEICESTER PATHOLOGY SERVICES
Clinical Lead
Linda Barton

Lead General Manager
Anne Freestone

Heads of Service
Linda Barton
Prashanth Patel
Debbie Modha
Rebecca Harrison
Hafiz Qureshi
Mike Browning
Lara Cresswell

Acute Medicine / ED Specialist Medicine

EMERGENCY MEDICINE/ED
General Manager
Chris Barbrook
Rhiannon Pepper
Service Managers
Vicki Enright & Catherine Briers
Head of Service
Sam Jones (Paeds ED)
Vivek Pillai (Majors/Resus)
Lee Walker (Acute)
Matrons
Billi Hamnett (Short Stay)
Julie Burdett (Assessment)
Angela Collins (ED)
Margaret Platts (ED)
Andrew Coser (ED)

GERIATRIC MEDICINE AND NEUROSCIENCES
Head of Service
Richard Wong (Geriatrics)
David Eveson (Stroke)
Subha Vandabona (Neuro)
Jithin George (Neuro)
Matrons
Sue Eversfield (Stroke/Neurology Rehab)
Caroline Rogers (Care of the Elderly)
Evelyn Gyesi-Appiah (Stroke)
Katrina Tolond (Care of the Elderly Unit/Assessment)
Julia Preston (Care of the Elderly)

SPECIALIST MEDICINE
General Manager
Danielle Webster (Geriatrics & Rheumatology))
Jodie Bale (Dermatology, Neurology & Chem Path)
Kerris Morrell (Diabetology, Endocrinology, Infectious Diseases, Stroke Medicine)
Holly Bertalan (Operations)
Service Managers
Samantha Moore (Diabetology, Endocrinology, Infectious Diseases, Stroke Medicine)
Sandie Martin (Dermatology, Neurology and Chem Path)
Helen Rutland (Geriatrics & Rheumatology)
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/Jude Dent (Diabetology)
Sue Eversfield (Infectious Diseases)

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

ITAPS
Heads of Service
Rakesh Vaja (ITU)
Farah Ahmed (LRI)
Vipul Kaushik (LGH)
Nick Harvey (GGH)

INTENSIVE CARE
Lead Clinician
Gareth Williams, Andrew Fox and Justin Williams
General Manager
Simon Walter
Service Manager
Julie Clerc
Matrons
Jackie Redfern (GGH)
Sharon Williams (LRI & LGH)
Emma McDonald (Outreach)

THEATRES & ANAESTHETICS
General Manager
Rachel Patel
Service Managers
Leah Farquharson
Tayo Adeniji

Matrons
Karen Dixon (Theatre Arrivals)
Katie Mitchell (LGH)
Yvonne Francis-Burnett (GGH)
Cherry Lee (LRI)

PAIN
Lead Clinician
Thanthullu Vasu

SLEEP
Lead Clinician
Andrew Hall
General Manager
Simon Walter
Service Manager
Linda Chesterton

HOSPITAL 24/7
Matron
Tara Marshall

Musculoskeletal and Specialist Surgery

MUSCULOSKELETAL
Heads of Service
Radhakant Pandey Elective)
Kevin Boyd (Sports & Exercise)
Aamar Ullah (Trauma)

General Manager
Sally Le-Good(Elective/Sports Exercise)
Caroline Stokes/Laura Conway (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)
Marianne Elloy (ENT)
Hazel Busby-Earl (Maxfax and Oral Surgery)
James Deane (DESP)
General Managers
Vacancy (Ophthalmology)
Gaynor Webb (ORD & Maxfac, Plastics and Breast Surgery)
Sarah Turner (ENT)
Service Managers
Kulbinder (Kelly) Nandhra (Ophthalmology)
Lisa Osborn (ORD & Maxfac)
Natalie Dalgetty (Plastics & Breast Care)
Zack Sentence (ENT)
Matrons
Mark Leyton (Specialist Surgery)
Yvonne Kenmuir-Hogg (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
Darren Turner
Service Manager
Mittannjalee Patel/Sarah Greenan
Matrons
Martin Smith (Cardiovascular)/CCU
Sarah Barrie (Cardiology)
Ben Hyde (Cardiology Day Case)
Mary Payne/Sheila Verity (Cardiology)

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

RENAL AND TRANSPLANT
Head of Service
Richard Baines
General Manager
Geraldine Ward
Service Manager
Lisa Jeffs/Lorraine Bertram-Dickens
Matrons
Alison Stapleton (Renal)

RESPIRATORY SERVICES
Head of Service, Respiratory
Caroline Baxter
Head of Service, Thoracics, Allergy and Immunology
Mr. A Nakas
General Manager
Karen Jones
Service Manager
Pauline Hawes
Lung Cancer Service Manager
Helen King
Junior Doctor/Medical Staffing Service Manager
Mandy Mugglestone
Matrons
Vicky Osborne (Respiratory)
Geoff Davison (Respiratory)
Mary Payne/Sheila Verity (short stay)
Ruth Brown (Thoracic)

VASCULAR SERVICES
Head of Service
Mark McCarthy
General Manager
Jodie Billings (Vascular and Cardiac)
Service Managers
Caroline Sissling (Vascular)
Matron
Ruth Brown (Vascular)

Women's and Children's

WOMENS
Heads of Service
Rod Teo /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
Moe Kathrada (Gynae Genetics)
Matrons
Rachelle Bowden (Gynaecology/Emergencies)
Ann Buckley (Maternity)
Joan Morrisey (Maternity)
Vacancy (Neonates)
Louise Payne (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 (Children's Assessment Unit and Acute General Paediatrics)
Aidan Bolger (EMCHC & ECMO)
General Managers
Belinda Ross (Acting) (Medical Sub Specialties)
Nick Kirk (Surgical and Acute Paediatrics)
Charlotte King (EMMO/ICU)
Gail Faulkner (ECMO Coordinator)
Service Managers
Belinda Ross
Tracey Rochester-Jones
Muhammed Kathrada
Matrons
Carmel Hunt (Paed Cardiac)
Jo Ennis (PICU, GGH/LRI)
Sarah King (Specialties, Respiratory, Oncology, Ward 12 & 27 and LRI Outpatients))
Liz James (Surgery/Day Case Ward 10,19 and Medical Day Care)
Carol Stevenson (Medicine/ Admissions, Ward 11,28 & CAU)

Appendix 7

Financial Management Accountability Framework

1 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.

2 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.

3 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.

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

5 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.

6 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.

7 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.

8 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.

August APRM Review Ratings

University Hospitals of Leicester NHS
NHS Trust

Appendix 8

CMG	Quality & Safety	Operational Performance	Finance & CIP	Workforce
CHUGGS	RI ↔	RI ↔	RI ↔	RI ↔
CSI	G ↑	RI ↔	RI ↔	RI ↔
ESM	RI ↔	RI ↔	RI ↔	RI ↔
ITAPS	G ↔	RI ↓	G ↑	RI ↔
MSS	RI ↔	RI ↔	RI ↔	RI ↔
RRCV	G ↔	RI ↓	RI ↔	G ↔
W&C	RI ↔	RI ↔	I ↓	RI ↔

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

Our priorities for 2018/19

For 2018/19 we have revised our strategic objectives and these will be our key areas of focus for the coming year along with the revised Quality Commitment overleaf which incorporates the new 'Improve Emergency Care and Cancer Performance' objective.

We have not changed our strategy, but the Trust Board wanted to focus even more on what matters most and to present this more concisely.

In the centre is our Quality Commitment, putting safe, high quality patient-centred, efficient care at the centre of everything we do. This is our primary objective. Everything else will support the delivery of that.

Surrounding our Quality Commitment are our four supporting objectives:

In 2018/19, we will:

Our Quality Commitment

Deliver safe, high quality, patient-centred, efficient care

- Embed the use of Nervecentre for all medical handover, board rounds and Escalation of Care
- Ensure senior clinician led daily board or ward rounds in clinical areas & fully implement our plans to embed a standardised Red2Green methodology
- Ensure that frail patients in our care have a Clinical Frailty Score whilst they are in hospital
- Embed systems to ensure abnormal results are recognised and acted upon in a clinically appropriate time
- Empower staff to 'Stop the Line' in all clinical areas
- Improve the management of diabetic patients who are treated with insulin in all areas of the Trust
- Improve the patient experience in our current outpatients' service and begin work to transform the outpatient model of care in ENT and cardiology
- Improve patient involvement in care and decision making, focusing on cancer and emergency medicine

Our People

Have the right people with the right skills in the right numbers to deliver the most effective care

- Develop a sustainable 5-year workforce plan by the end of Q1 2018/19, with a delivery plan to reduce our nursing and medical vacancy rates and reduce time to hire
- Launch our People Strategy in Q1 2018/19 to attract, recruit and retain a workforce that reflects our local communities across all levels of the Trust, with a specific focus on meeting the Workforce Race Equality Standards

Partnerships & Integration

Develop more integrated care in partnership with others

- Integrate the new model of care for frail people with partners in other parts of health and social care in order to deliver an end to end pathway by the end of 2018/19
- Increase the support, education and specialist advice we offer to our patients and our partners to help them receive/deliver care in the community in order to reduce demand on our hospitals
- Lead the development of a 5-year regional Specialist Services Strategy which will place us at the heart of a regional network and supporting local district general hospital services

Education & Research

Deliver high quality, relevant education and research

- Improve the experience of our medical students and address specialty-specific shortcomings in postgraduate medical education, improving our local retention rate and the UHL medical student satisfaction score
- Explore the model for an Academic Health Sciences Partnership as part of our 5 Year Research Strategy and align priorities with our local universities

Key Strategic Enablers

Progress our key strategic enablers

- Progress our hospital reconfiguration plans by developing our plans for PACH and the maternity hospital and finalising plans to relocate Level 3 ICU and dependent services at the LRI/Glenfield
- Make progress towards a paperless hospital with user-friendly systems by replacing all computers over 5-years old, computerising services to outpatient clinics, using technology to support Quality Commitment objectives and implementing an in-house digital imaging solution
- Deliver the year 3 implementation plan for the 'UHL Way' to support and develop staff, (medical and non-medical) and offer tailored education programmes focussing on key areas
- Implement Year 2 of our Commercial Strategy in order to exploit commercial opportunities available to the Trust
- Improve the efficiency and effectiveness of our key services and our operating theatres and implement our Carter-based LLR corporate consolidation programme
- Continue on our journey towards financial stability as a consequence of the priorities described here, aiming to deliver our financial target

Quality Commitment

Our Quality Commitment has proven very successful so will remain, updated for 2018/19. We continue with the three pillars, focussed on continuing to improve effectiveness, safety and patient experience. One of the particular areas that we want to do better on this year is diagnostic results management, "acting on results".

QUALITY COMMITMENT 2018/19

Improve Clinical Effectiveness	Improve Patient Safety	Improve Patient Experience

What are we trying to accomplish?

AIM			
	To improve patient outcomes by greater use of key clinical systems and care pathways	To reduce harm by embedding a 'safety culture'	To use patient feedback to drive improvements to services and care

What will we do to achieve this?

PRIORITIES			
	• We will embed the use of Nervecentre for all medical handover, board rounds and Escalation of Care • We will ensure senior clinician led daily board or ward rounds in clinical areas and fully implement our plans to embed a standardised Red2Green methodology • We will ensure that frail patients in our care have a Clinical Frailty Score whilst they are in our hospital	• We will embed systems to ensure abnormal results are recognised and acted upon in a clinically appropriate time • We will empower staff to 'Stop the Line' in all clinical areas • We will improve the management of diabetic patients who are treated with insulin in all areas of the Trust	• We will improve the patient experience in our current outpatients' service and begin work to transform the outpatient model of care in ENT and cardiology • We will improve patient involvement in care and decision making, focusing on cancer and emergency medicine

Improve Emergency Care and Cancer Performance:

- We will eliminate all but clinical 4-hour breaches for non-admitted patients in ED
- We will resolve the problem of evening and overnight deterioration in ED performance
- We will ensure timely 7 days a week availability of medical beds for emergency admissions
- We will deliver the 62-day standard for cancer during 2018/19