Trust Board Paper S

Title:	Implementation of the Clinical Management Group Structures

Author/Responsible Directors:
Kate Bradley, Director of Human Resources /Richard Mitchell, Chief Operating Officer

Purpose of the Report:
To provide an update on the progress being made, and project arrangements in place in relation to the introduction and implementation of the new Clinical Management Group (CMG) structure across UHL.

The Report is provided to the Board for:

Decision		Discussion	
Assurance	√	Ratification	

Summary / Key Points:
The purpose of this paper is to provide an update on the work that has been completed and that continues in relation to the implementation of the new CMG structure.

The move to integrate the new structure continues to proceed well. The appointment of CMG Medical Leads, CMG Managers and CMG Lead Nurses is largely completed or recruitment to any remaining gaps is in progress. Finalisation of the structures underneath and in support of the CMG teams is on-going as part of the next phase and is being managed as part of the project arrangements.

The risk assessment continues to be monitored and assessed.

Appointments have taken place at the senior CMG levels and any remaining gaps are in active recruitment. A revised structure chart showing recent appointments is attached at **Appendix 1.**

Next steps are concerned with the new CMGs embedding their structures; ensuring that they are on track to deliver UHL objectives at CMG and Trust level, along with completing recruitment activity and confirming appointments in the remaining gaps. In addition the Medical Education and Quality & Safety Work streams to support CMGs continue to be progressed as outlined below.

Recommendations:
The Trust Board is asked to note the contents.

Strategic Risk Register A comprehensive risk assessment has been produced which includes CIP risk.	**Performance KPIs year to date** N/A

Resource Implications (eg Financial, HR)
Managerial, Human Resources, Finance, Communications.

Assurance Implications
Risk Assessment in place – monitored and assessed

Patient and Public Involvement (PPI) Implications
Patient Representatives were invited to observe the CMG LiA Event

Equality Impact - A due regard assessment has been completed.

Information exempt from Disclosure
Yes

Requirement for further review?
Updates will be provided through Executive Team.

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST

MEETING: **TRUST BOARD REPORT**

DATE: **28th November 2013**

REPORT BY: **KATE BRADLEY, DIRECTOR OF HUMAN RESOURCES/ RICHARD MITCHELL, CHIEF OPERATING OFFICER**

SUBJECT: **UPDATE - IMPLEMENTATION OF THE CLINICAL MANAGEMENT GROUP STRUCTURES (CMG's)**

1.0 INTRODUCTION

1.1 The purpose of this paper is to provide an update on the work that has been completed and that continues, in relation to implementation of the new CMG structure.

1.2 A detailed project plan covering each of the key work-streams was created and members of the Executive Team were assigned a lead role for the relevant work-stream. The Chief Operating Officer and CMG Managers now meet fortnightly as a group with CMG HR Leads to progress the embedding of the new structure, ensure work is completed and that any subsequent decisions and actions are agreed and taken forward appropriately.

2.0 BACKGROUND

2.1.1 Following agreement at the August Trust Board seven CMGs have now been established as follows:

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

3.0 CURRENT POSITION

3.1 Attached at **Appendix 1** is the current structure including new appointments.

3.2 Next steps are concerned with the new CMGs embedding their structures; ensuring that they are on track to deliver UHL objectives at CMG and Trust level, along with completing recruitment activity and confirming appointments in the remaining gaps. In addition the Medical Education and Quality & Safety Work streams to support CMGs continue to be progressed as outlined below.

4. EDUCATION STRUCTURE SUPPORT

4.1 The review of the Nurse Education and Practice Development posts has been completed. There were no changes to roles or responsibilities as all CBU posts could be aligned to CMGs. All Nurse Education posts are now professionally accountable to the Assistant Director of Nursing Services.

4.2 Each CMG will have a Medical Education Lead and work is progressing to appoint these individuals. A job role has been prepared by Rob Powell, Assistant Director of Medical Education and we will be inviting colleagues to express an interest in these opportunities in the near future. The successful candidates will have dedicated time in their job plans to fulfil this important role which will include close working with the Director of Medical Education ensuring there is a systematic approach to maintaining and improving the quality and delivery of undergraduate and postgraduate medical education within the CMG. They will work closely with the CMG management team to ensure education and training issues are regularly represented and addressed by the CMG Board and that there is transparency and accountability for CMG education resources (SIFT and MADEL). The Medical Education Lead will ensure collection of data regarding education and training key performance indicators and ensure timely and thorough response to key surveys e.g. GMC trainee survey, or GMC patient safety concerns in liaison with the UHL Department of Clinical Education

5 QUALITY AND SAFETY STRUCTURE SUPPORT

5.1 The 8a Quality and Safety Managers now report to the Senior Patient Safety Manager. Over the last month, further meetings have been held with newly appointed senior CMG staff and the Director of Safety and Risk has attended the CMG Managers' meeting to discuss some concerns and update them of progress. The Management of Change paper has been drafted subject to a final decision in relation to the Women's and Children's CMG.

5.2 Reviewed and revised job descriptions have been drafted for the new structure.

5.3 A new job description for a Business Analyst post has also been written with the banding to be determined but expected to be a Band 6. This post will provide data and information support to the CMGs, pull and provide analysis on Datix reports, and support with data reviews, safety metrics and collation of data for commissioners.

5.4 A meeting has been requested with colleagues from finance to confirm final quality and safety budgets. At present there is some concern from the Divisional post-holders regarding capacity in terms of activity that is being discussed.

5.5 Meetings with the HR lead continue and very good HR advice and support has been provided.

6 SETTING THE DIRECTION

6.1 CMG Directors met on the 1 November for a Direction Setting day facilitated by Nick Dingley. The conversation focussed on the role and expectations of CMG Directors and their teams. We discussed the framework of meetings that will be in place and importantly the ways in which the CMG Directors will work together across a range of areas. We also began the conversations about what support each CMG would need to create a high performing management team.

6.2 The first round of monthly performance management meetings commenced on 19 November 2013 and these have focussed on the financial position and forecasts for year end 2013/14.

6.3 A programme of monthly performance management and development meetings is in place through 2014.

7 KEY TIMESCALES

7.1 The key dates and considerations between are:-

- CMGs officially came in to existence on **Monday 7 October 2013**.
- As described above work is well underway on the supporting structures for Education and Quality and Safety and how they are represented / work with the new CMGs and this is looking to complete by **early December**.
- CMG Managers are working through any gaps in their management structures and recruitment plans are in place with limited change and disruption having taken place to these leadership positions below the Deputy Managers at Service and Operational Manager levels.

8 CONCLUSION

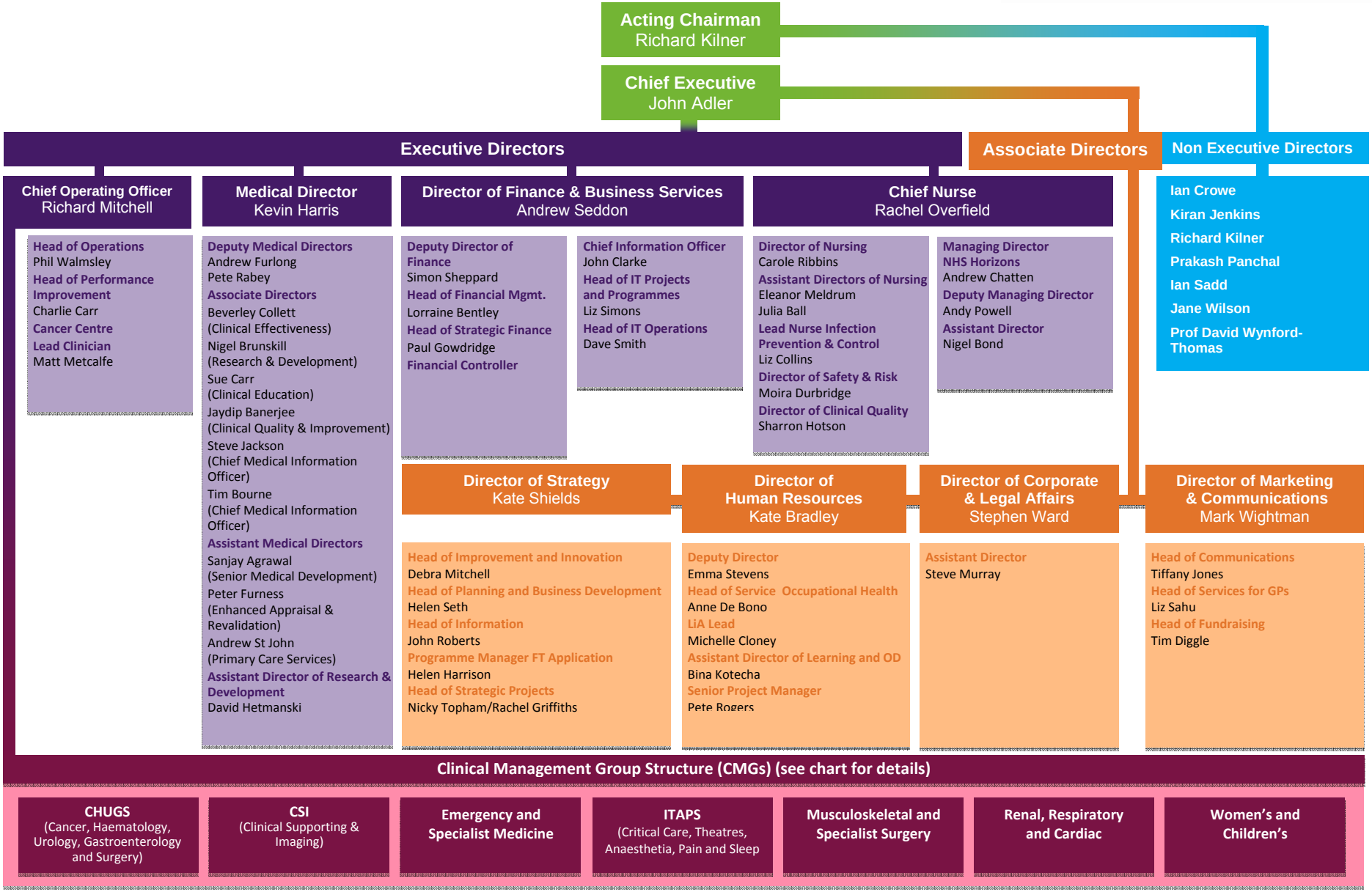
8.1 The new structure is now in place. The appointment of CMG Medical Leads, CMG Managers and CMG Lead Nurses is complete and the remaining vacant posts are being recruited to.

APPENDICES

Appendix 1 - New Structure Chart

University Hospitals of Leicester NHS
NHS Trust
Caring at its best

Management Structure University Hospitals of Leicester NHS Trust



University Hospitals of Leicester NHS
NHS Trust
Caring at its best

Management Structure University Hospitals of Leicester NHS Trust

Chief Operating Officer
Richard Mitchell

Clinical Management Group Structure (CMGs)

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

Clinical Director
John Jameson

Deputy Clinical Director
Nicky Rudd

General Manager
Jo Fawcus

Deputy General Manager
Michael Nattrass

Head of Nursing
Georgina Kenney

Deputy Head of Nursing
Kerry Johnston

Human Resources Lead
Clare Blakemore

Finance Lead
Sab Esat

Quality & Safety Lead
Helen Jones (TBC)

Education Leads
TBC

CSI
(Clinical Supporting & Imaging)

Clinical Director/Associate Director for Clinical Improvement
Suzanne Khalid

Deputy Clinical Director
Andy Rickett

General Manager
Nigel Kee

Deputy General Manager
Chris Shatford

Head of Nursing
Jeanette Halborg

Human Resources Lead
Joanne Tyler Fantom

Finance Lead
Tony Maton

Quality & Safety Lead
Sue Adams (TBC)

Education Leads
TBC

Emergency and Specialist Medicine

Clinical Director
Catherine Free

Deputy Clinical Director
Mark Ardron

General Manager
Jane Edyvean

Deputy General Manager
TBC

Head of Nursing
Gill Staton

Deputy Heads of Nursing
Lisa Lane/Kerry Morgan (Emergency)
Sue Burton (Specialist Medicine)

Human Resources Lead
Kalwant Khaira

Finance Lead
Raj Rughani

Quality & Safety Lead
Sue Adams (TBC)

Education Leads
Rose Webster

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

Clinical Director
Paul Spiers

Deputy Clinical Director
Helen Brooks

General Manager
Monica Harris

Deputy General Manager
Dale Travis

Head of Nursing
Jo Hollidge

Human Resources Lead
Kalwant Khaira

Finance Lead
Paul Gowdridge

Quality & Safety Lead
Helen Jones (TBC)

Education Leads
Justine Cadwallader

Musculoskeletal and Specialist Surgery

Clinical Director
Richard Power

Deputy Clinical Director
Kevin Boyd

General Manager
Sarah Taylor

Deputy General Manager
Chris Lyon

Head of Nursing
Nicola Grant

Deputy Head of Nursing
Kerry Pape

Human Resources Lead
Joanne Tyler Fantom

Finance Lead
Ryggs Gill

Quality & Safety Lead
Helen Jones (TBC)

Education Leads
Diane Champion

Renal, Respiratory and Cardiac

Clinical Director
Nick Moore

Deputy Clinical Director
Leon Hadjinkolaou

General Manager
Luci Blackwell
(Sam Leak Nov 13)

Deputy General Manager
Faye Gordon

Head of Nursing
Sue Mason

Deputy Head of Nursing
Jo Bayes

Human Resources Lead
Clare Blakemore

Finance Lead
Lorraine Bentley

Quality & Safety Lead
Sue Adams (TBC)

Education Leads
TBC

Women's and Children's

Clinical Director
Ian Scudamore

Deputy Clinical Director
Andy Currie

General Manager
David Yeomanson

Deputy General Manager
TBC

Head of Nursing
Kate Wilkins
Hiliary Killer

Deputy Head of Nursing
Elizabeth Aryeetey

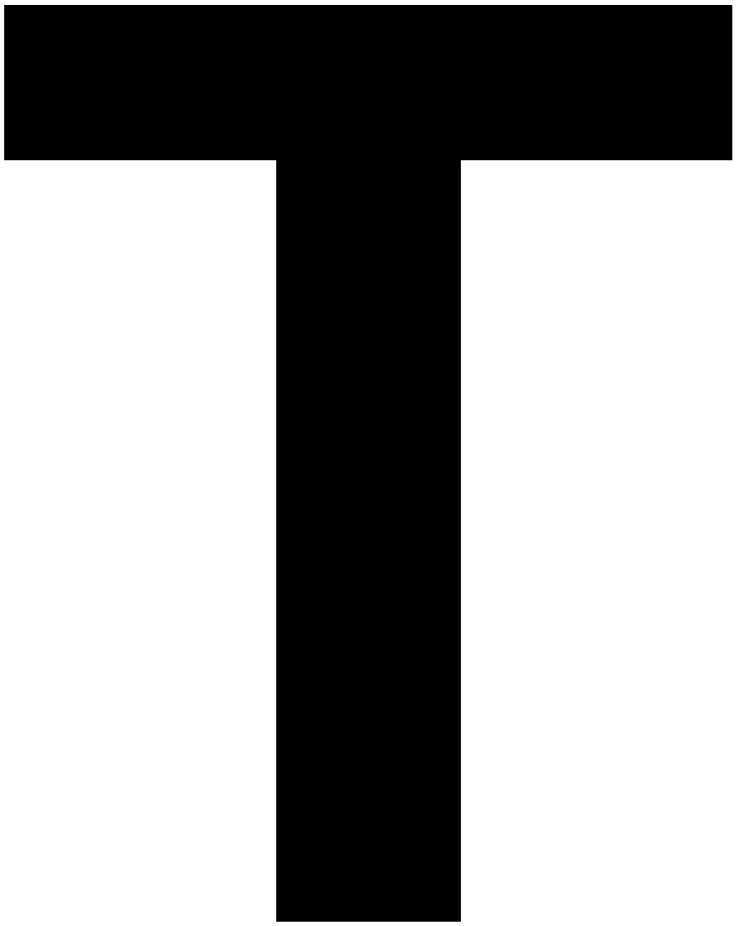
Head of Midwifery
Jane Porter

Human Resources Lead
Tina Larder

Finance Lead
Stuart Shearing

Quality & Safety Lead
Nicky Savage (TBC)

Education Leads
Lynn Stokoe



Trust Board Paper T

	TRUST BOARD
From:	Rachel Overfield, Kevin Harris, Richard Mitchell Kate Bradley Andrew Seddon
Date:	**28th November 2013**
CQC regulation	All

Title:	**Quality & Performance Report**

Author/Responsible Director: R Overfield, Chief Nurse
K. Harris, Medical Director
R, Mitchell, Chief Operating Officer
K. Bradley, Director of Human Resources
A. Seddon, Director of Finance

Purpose of the Report:
To provide members with an overview of UHL quality, operational performance against national and local indicators and Finance for the month of October.

The Report is provided to the Board for:

Decision		Discussion	√
Assurance	√	Endorsement	

Summary / Key Points:

Successes

- Theatres – 100% WHO compliant
- 62 day cancer – confirmed performance in September was 87.4%, against a national target of 85%. October is on track to deliver above trajectory.
- VTE - The 95% threshold for VTE risk assessment within 24 hours of admission has been achieved for the last 4 months
- The percentage of stoke patients spending 90% of their stay on a stroke ward has been exceeded for the last 3 months and the contract query will be formally closed by the commissioners.

Areas to watch:-

- Friends and Family Test - Performance on the FFT for October is 66.2
- C Difficile – ahead of trajectory to date with 41 reported against cumulative target of 42. Monthly target for the rest of the year is 5 a month with a full year trajectory of 67.
- Imaging – the 1% threshold was delivered for October. Action plan is being monitored to ensure sustainable delivery.
- C&B – performance similar to this time last year and target is still not delivered.

Exceptions/Contractual Queries:-

- Pressure Ulcers - progress has been made against all actions.
- ED 4hr target - Performance for emergency care 4hr wait in October was 91.8%. Actions relating to the emergency care performance are included in the ED exception report.
- Cancelled Operations – contract query has been raised by the commissioners due to consistent failure of the threshold. Remedial action plan has been requested for the November Contract Performance Meeting.
- RTT admitted and non-admitted -. The Intensive Support Team have worked with the UHL to model core capacity requirements and backlog numbers to sustainably deliver both targets at specialty level. This has been triggered by an ongoing failure to agree a remedial action plan with commissioners.
- Ambulance Handovers - Remedial Action Plan and recovery trajectory have been formally accepted by the commissioners.

Finance:-

- The Trust is reporting a deficit at the end of October of £17.3m, which is £19.5m adverse to the planned surplus of £2.2m.
- Patient care income £4.3m (1.1%) favourable against Plan.
- Pay costs are £11.0m over budget, £14.3m more than the same period in 2012/13 (5.5%). When viewed by staff group, the most significant increases year on year are seen across agency and medical locums, nursing spend and consultants' costs.
- CIP - £0.8m adverse to Plan

Recommendations: Members to note and receive the report	
Strategic Risk Register	**Performance KPIs year to date** CQC/NTDA
Resource Implications (eg Financial, HR) N/A	
Assurance Implications Underachieved targets will impact on the NTDA escalation level, CQC Intelligent Monitoring and the FT application	
Patient and Public Involvement (PPI) Implications Underachievement of targets potentially has a negative impact on patient experience and Trust reputation	
Equality Impact N/A	
Information exempt from Disclosure N/A	
Requirement for further review? Monthly review	

University Hospitals of Leicester NHS
NHS Trust

Caring at its best

Quality and Performance – October 2013

Trust Board

Thursday 28th November 2013

One team shared values

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST

REPORT TO: **TRUST BOARD**

DATE: **28th NOVEMBER 2013**

REPORT BY: **KEVIN HARRIS, MEDICAL DIRECTOR**
RACHEL OVERFIELD, CHIEF NURSE
RICHARD MITCHELL, CHIEF OPERATING OFFICER
KATE BRADLEY, DIRECTOR OF HUMAN RESOURCES
ANDREW SEDDON, DIRECTOR OF FINANCE

SUBJECT: **OCTOBER 2013 QUALITY & PERFORMANCE SUMMARY REPORT**

1.0 INTRODUCTION

The following paper provides an overview of the October 2013 Quality & Performance report highlighting key metrics and areas of escalation or further development where required.

2.0 2013/14 NTDA Oversight and Escalation Level

2.1 NTDA 2013/14 Indicators

Performance for the 2013/14 indicators in Delivering *High Quality Care for Patients: The Accountability Framework for NHS Trust Boards* was published by the NTDA early April.

The indicators to be reported on a monthly basis are grouped under the following headings:-

- Outcome Measures
- Quality Governance Measures
- Access Measures – see Section 5

Outcome Measures	Target	2012/13	Apr-13	May-13	Jun-13	Qtr1	Jul-13	Aug-13	Sep-13	Qtr2	Oct-13	YTD
30 day emergency readmissions	7.0%	7.8%	7.5%	7.8%	7.7%	7.7%	7.5%	7.6%	7.8%	7.6%		7.7%
Avoidable Incidence of MRSA	0	2	0	0	0	0	0	0	1	1	0	1
Incidence of C. Difficile	67	94	6	7	2	15	6	5	9	20	6	41
Incidence of MSSA		46	5	2	5	12	1	4	3	8	1	21
Safety Thermometer Harm free care		94.1%*	92.1%	93.7%	93.6%		93.8%	93.5%	93.1%		94.7%	
Never events	0	6	1	0	0	1	0	0	1	1	0	2
C-sections rates*	25%	23.9%	23.8%	26.1%	26.1%	25.3%	25.0%	25.2%	24.6%	24.6%	25.6%	25.1%
Maternal deaths	0	0	0	0	0	0	0	0	0	0	0	0
Avoidable Pressure Ulcers (Grade 3 and 4)	0	98	11	4	8	23	8	8	5	21	4	48
VTE risk assessment	95%	94.5%	94.1%	94.5%	93.1%	93.9%	95.9%	95.2%	95.4%	95.3%	95.5%	94.8%
Open Central Alert System (CAS) Alerts		13	14	9	15		36	10	10		14	
WHO surgical checklist compliance	100%	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes

* target revised to 25% from Qtr 3

Quality Governance Indicators	Target	2012/13	Apr-13	May-13	Jun-13	Qtr1	Jul-13	Aug-13	Sep-13	Qtr2	Oct-13	YTD
Patient satisfaction (friends and family)		64.5	66.4	73.9	64.9		66.0	69.6	67.6		66.2	67.7
Sickness/absence rate	3.0%	3.4%	3.3%	3.1%	3.0%	3.2%	3.2%	3.1%	3.3%	3.2%	3.8%	3.3%
Proportion temporary staff – clinical and non-clinical (WTE for Bank, Overtime and Agency			5.6%	5.9%	5.6%	5.7%	5.6%	5.5%	5.3%	5.5%	6.0%	5.7%
Staff turnover (excluding Junior Doctors and Facilities)	10.0%	9.0%	8.8%	8.9%	9.2%	9.2%	9.5%	9.3%	9.7%	9.7%	9.6%	9.6%
Mixed sex accommodation breaches	0	7	0	0	0	0	0	0	0	0	0	0
% staff appraised	95%	90.1%	90.9%	90.2%	90.7%	90.7%	92.4%	92.7%	91.9%	91.9%	91.0%	91.0%
Statutory and Mandatory Training	75%		45%	46%	46%	46%	48%	49%	55%	55%	58%	58%
% Corporate Induction attendance rate	95%		87%	82%	95%	95%	90%	94%	94%	94%	91%	91%

2.2 UHL NTDA Escalation Level

The Accountability Framework sets out five different categories by which Trust's are defined, depending on key quality, delivery and finance standards.

The five categories are (figures in brackets are number of non FT Trusts in each category as at July 2013):

1) No identified concerns (18 Trusts)
2) Emerging concerns (27 Trusts)
3) Concerns requiring investigation (21 Trusts)
4) Material issue (29 Trusts)
5) Formal action required (5 Trusts)

Confirmation was received from the NTDA during October that the University Hospitals of Leicester NHS Trust was escalated to Category 4 – Material issue. This decision was reached on the basis of the significant variance to financial plan for quarter one and continued failure to achieve the A&E 4hr operational standard.

3.0 QUALITY AND PATIENT SAFETY – KEVIN HARRIS/RACHEL OVERFIELD

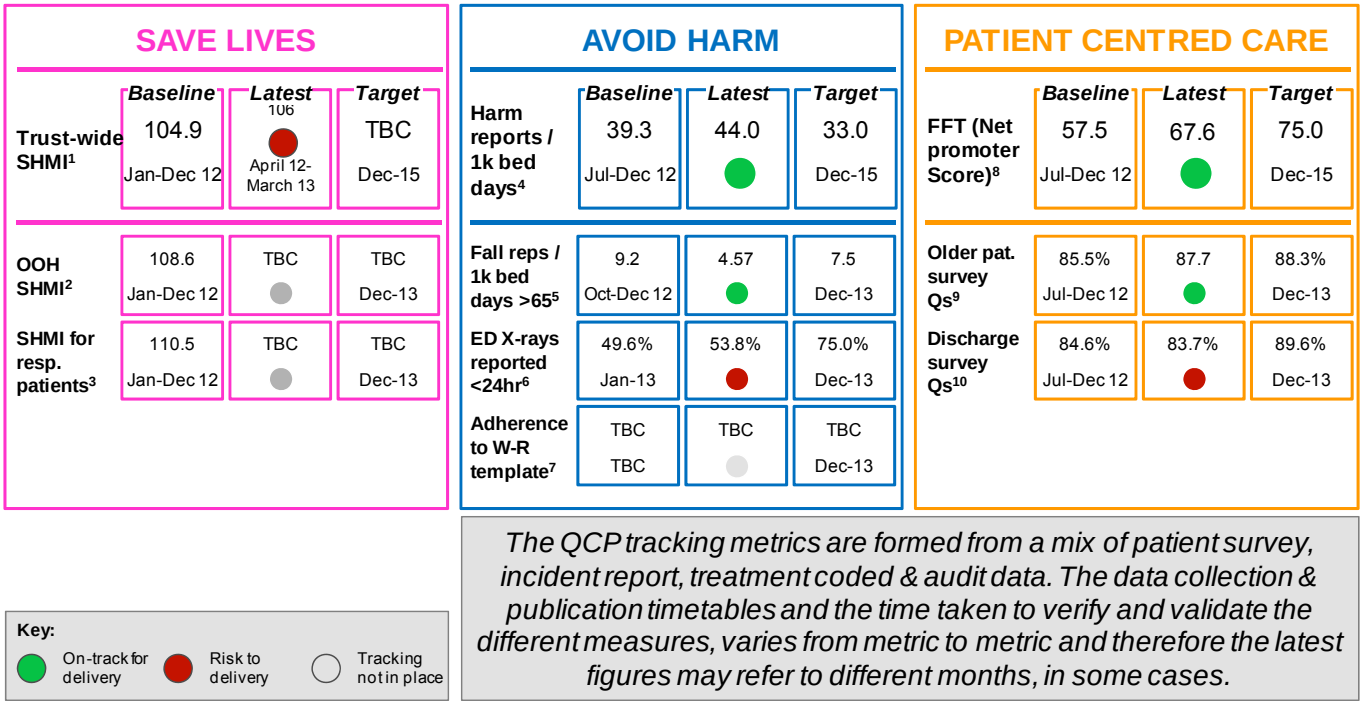
3.1 Quality Commitment

To deliver our vision of 'Caring at its best' we have developed and launched an ambitious Quality Commitment for the trust. Are priorities are being led through three over-arching strategic goals, each with a target to be delivered over the next 3 years. By 2016 we will aim to deliver a programme of quality improvements which will:

- Save 1000 extra lives
- Avoid 5000 harm events
- Provide patient centred care so that we consistently achieve a 75 point patient recommendation rate

A Quality Commitment dashboard has been developed to present updates on the 3 core metrics for tracking performance against our 3 goals (save lives, avoid harm and patient centred care). These 3 metrics will be tracked throughout the programme up to 2015. The dashboard also includes 7 sub-metrics, one to track delivery in each of the 7 work streams. These metrics are selected from a broader group of tracking metrics and were chosen to be representative of the individual workstream targets. These sub-metrics will

change during the programme as we achieve are targets and set new focus areas in 2014 and 2015.



1. 30-day relative mortality rate, excluding stillbirths, day cases & regular day/night attendees; 2. After 8pm & before 6am, excluding elective admissions & Well-Baby admissions; 3. Patients with an primary respiratory diagnosis; 4. All harms reported per 1k bed stays (excl maternity); 5. All falls reported per 1k bed stays for patients >65 years old; 6. % of ED X-rays reported by a radiologist <24hrs; 7. Ward round audit yet to be launched; 8. Net promoters on the Friends & Family survey; 9. Average score for the 3 older patient survey questions; 10. Average score for the 3 discharge experience survey questions;

Save 1000 Lives

Hospital 24/7 - successfully launched at GGH, LGH and LRI. Early response time metrics have been very promising and a handover process from has been successfully carried out. Further opportunities have been identified in medical handover processes, phlebotomy cover & culture around calling consultants. A work plan for calling culture is being developed.

Respiratory pathway - successfully launched with exclusion criteria agreed by GGH and LRI. Two dedicated pneumonia nurses have been appointed and successfully manage the pneumonia care pathway across LRI and GH sites. There has been an increase in the proportion of admissions < 86 years of age with community acquired pneumonia (CAP) to GH, 65% in Q1 to 70% Q2. A CAP care bundle database and management tool has been implemented and an audit of all aspects of pneumonia management is in place. More than 80% of CAP admissions are tracked electronically by the pneumonia nurses.

Avoid 5000 harms

Falls - Well-focussed ward engagement on falls-reduction (in the form of confirm and challenge sessions) is continuing to produce excellent results. Initiatives being trialled include cohorting into dedicated fall-risk bays, risk assessment & identification systems & staff training. Corporate over view and raising the profile of this patient safety issue, with the support of expertise from the education and practice development nurse has enabled success that has previously not been seen in this area.
Senior Medical Review and Ward Round Notation - Wide-spread support from the heads of service has been seen, with few minor changes suggested. A training plan and presentation for nursing and medical staff has been developed as a key feature of implementation and an e-learning package currently in development. The ward roll-out and the development of teaching materials is likely to require long-term engagement to drive uptake and therefore we expect it to continue to be part of our 2014 priorities.

Acting on results - Work looking at radiology turnaround times is currently being combined with a similar project investigating capacity in Radiology. Work is being carried out to decide a process for communicating significant high risk reports, this is to be discussed at a speciality leads steering group and recommendations to be made. This involves; developing a manageable list of "always diagnoses" to communicate, auditing CRIS to monitor performance and to continue the well established MDT codes for malignant disease.

Provide Patient Centred Care

Older patients & dementia - Significant ward-level engagement is taking-place in the form of the dementia champions' network, meaningful activity coordinators, memory lane events, older patient training and use of the patient profile. A moderate improvement in the older people survey questions scores has been recorded.

Discharge experience - A new discharge lounge opened at the LRI in October and re-launch of discharge lounge at the Glenfield. Other UHL wide initiatives (Right Place work & EC Rapid Access plan) have impacted on the work and progress of this work stream. Work is planned to look at improving quality around ward process which includes discharge planning, work around re launching the focus on discharge planning is planned.

3.2 Mortality Rates

Mth	Qtr 1	Qtr2	YTD

UHL's HSMR for 13/14 (Apr to Aug) is 93 (using the Dr Foster Intelligence clinical benchmarking tool). The HSMR of 93 is compared with the England average of 100 for 2012/13 and so is likely to higher following Dr Foster's annual rebasing at the end of this financial year. For 2012/13 UHL's HSMR was 101 and the SHMI covering the same time period is 106. Both of these are within expected but are above 100.

Whilst the trust's overall mortality is 'within expected', it is not where we want it to be and this is one of the key drivers behind the 'Saving Lives' work-stream of the Quality Commitment with good progress being made with the implementation of the Respiratory Pathway. Very early findings suggest that this is already having a positive impact on our mortality rates for pneumonia patients.

The LLR Patient Care Review findings are due to be presented to the LLR Mortality Summit on 26th November.

The Dr Foster Hospital Guide for 2013 will publish both Trust and Site specific mortality rates for 2012/13 and this will show the LRI site as having a 'higher than expected HSMR' at 114. The Hospital Guide will also name UHL has having a 'higher than expected' mortality rate in 12/13 for patients who died with 'low risk diagnosis groups'. (such as, chest pain, abdominal pain, abdominal hernia, speech disorder). Preliminary review of the data has found that some patients who were recorded as having a 'low risk diagnosis' on admission were subsequently confirmed as having a more significant problem (obstructed hernia, stroke, heart failure) but this subsequent diagnosis would not have been used for the Dr Foster risk adjustment. It was also identified that there were discrepancies in the number of patients Dr Foster have included in their report and further work is being undertaken to clarify this. In the meantime a full review is being undertaken of the patients' care in UHL.

In the recently published CQC Intelligent Monitoring Report, UHL has two areas of risk relating to mortality. These were identified by the CQC using coded data and the Dr

Fosters methodology. One of these is “deaths in low risk diagnosis groups”. This is being reviewed as outlined above. The other ‘risk’ identified by the CQC was for “Paediatric and Congenital Disorders”. Review of the data has identified that this ‘higher mortality’ is related to the number of babies admitted with these conditions to Glenfield for ECMO (Glenfield is one of the few centres within the UK providing this service). UHL is part of the Paediatric Intensive Care Audit Network (PICANET) and the International Extracorporeal Life Support Organisation (ELSO), and reports its outcomes for such patients to both organisations. The PICANET and ELSO risk adjusted benchmarked data demonstrate that UHL’s outcomes are in line with other organisations providing similar services.

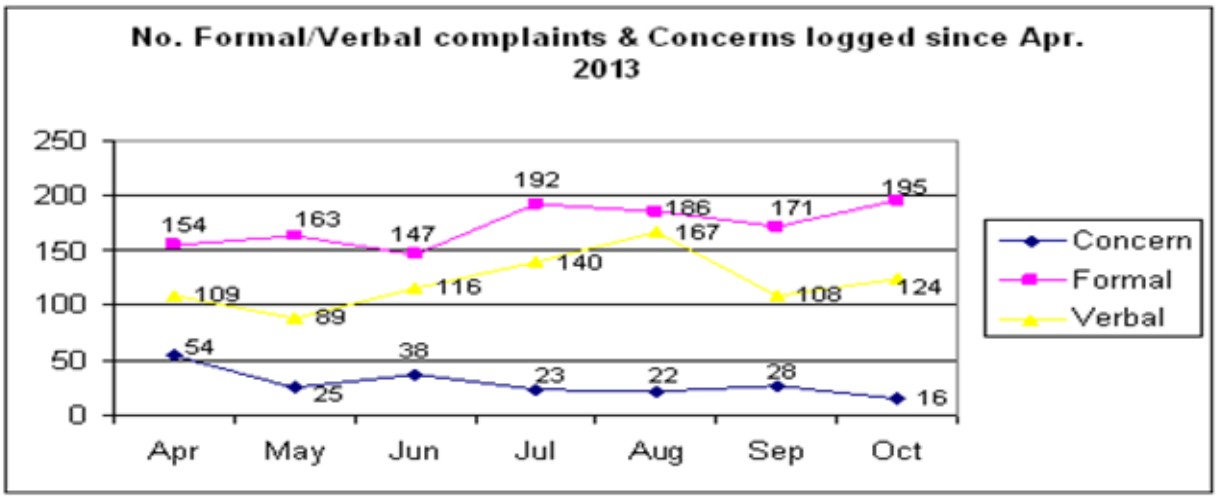
3.3 Patient Safety

Mth | Qtr 1 | Qtr2 | YTD

In October, 15 new Serious Untoward Incidents (SUIs) were opened within the Trust, 5 of which were patient safety incidents, 9 were Hospital Acquired Pressure Ulcers and 1 was a Healthcare Acquired Infection. Four patient safety root causes analysis (RCA) investigation reports were completed and signed off last month, the actions and learning of which have been shared internally.

Over the last quarter, there has been an 8.3% increase in the overall number of patient safety incidents reported with a small (0.5%) reduction of incidents where harm has occurred. This continues to demonstrate a positive reporting culture throughout the Trust. Pressure ulcers, falls and medication errors remain the highest reported incidents and these three clusters of incidents are subject to scrutiny and monitoring via the Safety Thermometer, the Safety Commitment and the Medicines Management Board. Although the numbers remain high, for each the trend shows a reduction in incidents.

High volumes of complaints, concerns and GP / CCG issues continue to be received but with reductions in re-opened complaints and exceptionally low levels of complaints upheld by the Ombudsman. The overall complaints performance has failed to reach the trust standard of 95% and this is being actively pursued with the new CMGs and also with corporate directorates and Interserve. The trend of complaints is detailed below:-



3.4 5 Critical Safety Actions

Mth | Qtr 1 | Qtr2 | YTD

The aim of the ‘Critical safety actions' (CSA’s) programme is to see a reduction in avoidable mortality and morbidity. The key indicator being focused upon by commissioners is a reduction in Serious Untoward Incidents related to the CSA's.

For Quarter 2 the Trust received the commissioner visit to assess compliance for the CSA CQUIN on 31st October. Informal feedback from this visit was positive, formal feedback will be received at CQRG meeting on 21st November 2013.

1. **Improving Clinical Handover**.

Aim - To provide a systematic, safe and effective handover of care and to provide timely and collaborative handover for out of hours shifts

Actions:-

- The Trust received the final version of the ACCA report for the pilot work with alternative Nerve Centre handover system in surgery at LRI.
- Business plan to procure and purchase system submitted to Chief Information Officer (CIO) for approval. CIO to meet with company to further negotiate costs before sign off.
- A template was sent out to all CBU leads to complete to identify and re-scope current handover practice for doctors in each speciality. There has been poor feedback from many specialities despite several chase emails. This evidence is required for CQUIN compliance. A further email has now been sent to those speciality leads who have not yet responded to this request.
- Commissioner visit was to ward 21 LRI to see a morning nurse handover and ED to see a morning medical handover.

2. Relentless attention to Early Warning Score triggers and actions

Aim - To improve care delivery and management of the deteriorating patient

Actions:-

- EWS non escalation incidents still being monitored this year. Currently on trajectory for 25% reduction in year with the exception of Womens and Childrens where the reduction will be less.
- September report from Nerve Centre with response time data for red calls including EWS>4 shows that at out of hours at the GH and LGH sites 100% of escalation calls have been responded to within 30 minutes as per pathway. LRI data will be available when 24/7 fully implemented into site.
- Commissioner visit was to Childrens ward 28 to view EWS in practice. Childrens at LRI implemented new PEWS scoring system on 14th October.

3. Acting upon Results

Aim - No avoidable death or harm as a failure to act upon results and all results to be reviewed and acted upon in a timely manner.

Actions:-

- Have now received signed off processes for managing diagnostic tests for 50% of CBUs. Plan to work closely with CMG deputy directors to ensure that those specialities without agreed processes are supported to undertake these in adherence with the CSA plan.
- Commissioner visit was to ward 32 LRI and OAU LRI to discuss with staff how they manage their diagnostic tests in line with their agreed process.

4. Senior Clinical Review, Ward Rounds and Notation

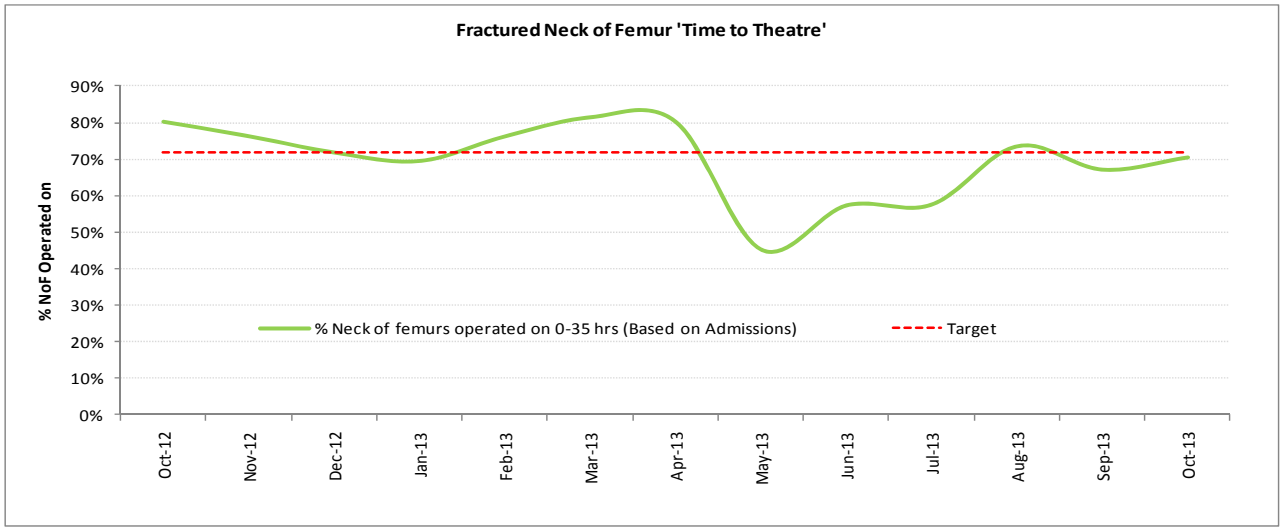
Aim -To meet national standards for clinical documentation. To provide strong medical leadership and safe and timely senior clinical reviews and ensure strong clinical governance.

Actions:-

- ❖ Ward round standards and documentation audit took place across the acute division throughout the month of October.
- ❖ Meetings have taken place to discuss and agree the costings and changeover process for the implementation of the UHL ward round safety checklist and change to continuation paper.
- ❖ Work has commenced to plan implementation of these to include education sessions and attendance at consultant and nurse meetings.
- ❖ Commissioner visit was to ward 37 LRI to see a ward round in practice.

3.5 Fractured Neck of Femur 'Time to Theatre'

Mth | Qtr 1 | Qtr2 | YTD

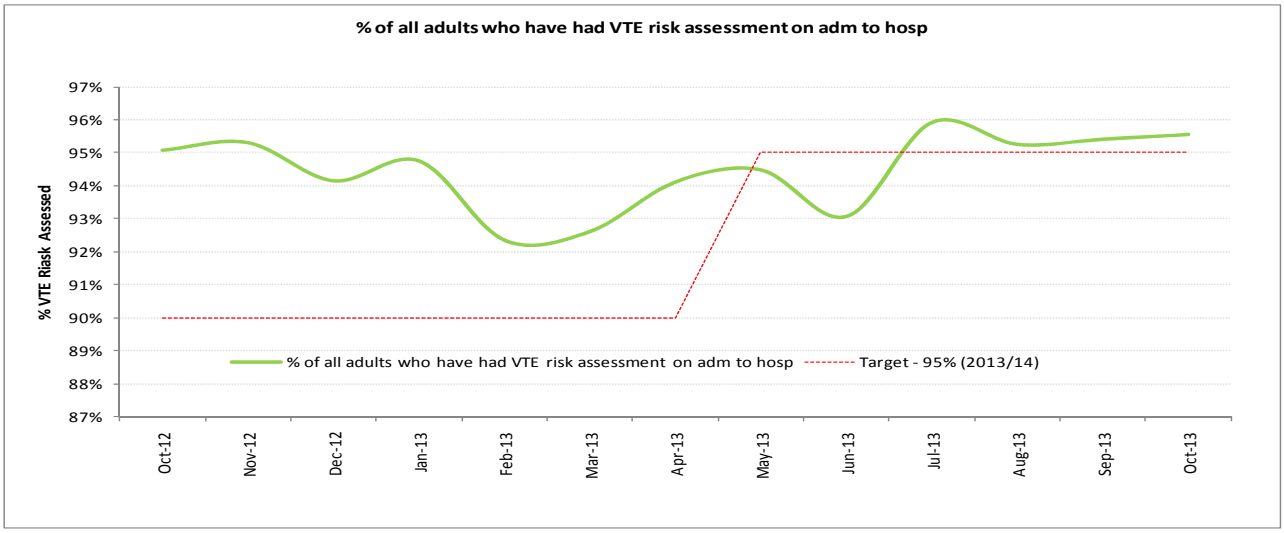


The percentage of patients admitted with fractured neck of femur during October who were operated on within 36hrs was 70.5% (43 out of 61 #NOF patients admitted during October).

As per the #NOF action plan regular weekly meetings have been instigated with musculo – skeletal management team and Ward 32 relating specifically to the Best Practice Tariff (BPT) indicators which are based on discharge. At the meetings specific issues around time to theatre are discussed. Performance has shown an improvement in October to 82% compared to Qtr 1. This is now believed to be a sustainable improvement which has been maintained in the first two weeks in October.

3.6 Venous Thrombo-embolism (VTE) Risk Assessment

Mth | Qtr 1 | Qtr2 | YTD



The 95% threshold for VTE risk assessment within 24 hours of admission has been achieved for October at 95.5%. The year to date performance is 94.8%.

3.7 CQUIN Schemes – Quarter 3

All CQUIN schemes are currently on track for meeting Q3's requirements.

Schedule	Ref	Indicator Title and Detail	Q3 Predicted RAG	Q3 Performance Comments
Nat CQUIN	Nat 1	Implementation of Friends and Family Test: 1.1 Phased Expansion 1.2 Increased Response Rate 1.3 Improved Performance on Staff Test	G	Maternity FFT commenced October with 27.7% coverage. Inpatient FFT coverage is 21.7% and ED FFT coverage is 16.3%.
Nat CQUIN	Nat 2	2.1. To collect data on the following three elements of the NHS Safety Thermometer: pressure ulcers, falls UTI in patients with a catheter 2.2a Reduction in CAUTIs 2.2b Reduction in Falls	G	UHL's Safety Thermometer data will be presented in the national tool on 10th December. Work continues to reduce both CAUTIs and Falls. Increase in Falls prevalence for October but still on track to achieve end of year threshold
Nat CQUIN	Nat 3	3.1 .Patients aged 75 and over admitted as an emergency are screened for dementia, where screening is positive they are appropriately assessed and where appropriate referred on to specialist services/GP. 3.2. Ensuring sufficient clinical leadership of dementia within providers and appropriate training of staff. 3.3. Ensuring carers of people with dementia feel adequately supported	G	90% achieved for 3 consecutive months (Aug to Oct) in all 3 parameters Training numbers continue to increase. Carers Survey undertaken and actions being taken to increase support.

Schedule	Ref	Indicator Title and Detail	Q3 Predicted RAG	Q3 Performance Comments
Nat CQUIN	Nat 4	Reduce avoidable death, disability and chronic ill health from Venous thromboembolism (VTE) 1. VTE risk assessment 2. VTE RCAs	G	95% achieved for Risk Assessment for all 3 months of Q2 and October. RCAs continue to be undertaken of all Hospital Acquired Thrombosis.
LLR CQUIN	Loc 1	Making Every Contact Count Increased advice and referral in respect to 'smoking cessation', alcohol reduction and healthy eating	G	Health Eating MECC pilot due to commence within MSK Pre-Op Assessment end of Nov
LLR CQUIN	Loc 2	Implementation of the AMBER care bundle to ensure patients and carers will receive the highest possible standards of end of life care	G	Good progress made with Phase 2 Wards implementation and slightly ahead of plan.
LLR CQUIN	Loc 3	Improve care pathway and discharge for patients with Pneumonia a) Admission directly to respiratory ward (Glenfield site) and piloting of 'pneumonia virtual clinic for patients admitted to LRI') b) Improving care pathway and discharge for patients with Pneumonia - Implementation of Pneumonia Care Bundle	G	Pneumonia nurses in post from beginning of Sept and daily visits to LRI medical wards being undertaken to support implementation of care bundle and 'Virtual Respiratory Clinic'
LLR CQUIN	Loc 4	Improving care pathway and discharge for patients with Heart Failure - Implementation of Care Bundle and discharge Check List and piloting of 'virtual ward'	G	Good progress being made and on track to achieve thresholds. Increasing number of patients receiving the Heart Failure Care Bundle.
LLR CQUIN	Loc 5	Critical Safety Actions – Clinical Handover Acting on Results Senior Review/Ward Round Standards Early Warning Score	G	For Quarter 2 the Trust received the commissioner visit to assess compliance for the CSA CQUIN on 31st October. Informal feedback from this visit was positive.
LLR CQUIN	Loc 7	Implementation of DoH Quality Mark with specific focus on Dignity Aspects	G	Co-ordinator in post and working closely with the Ward Sisters.
EMSCG CQUIN	SS1	Implementation of Specialised Service Quality Dashboards	G	Data submitted and UHL has received draft copies of Dashboards for comment.
EMSCG CQUIN	SS2	Bone Marrow Transplant (BMT) – Donor acquisition measures	G	Indicator threshold is to submit data and although data was not routinely collected previously, changes have been made to do so since Q1.
EMSCG CQUIN	SS3	Fetal Medicine – Rapidity of obtaining a tertiary level fetal medicine opinion	G	Actions on track to achieve the end of year 90% threshold.
EMSCG CQUIN	SS4	Increase use of Haemtrack for monitoring clotting factor requirements	G	CQUIN scope changed during Q2 following discussion between UHL and Specialised Services. On track to achieve end of year threshold of 50%.

Schedule	Ref	Indicator Title and Detail	Q3 Predicted RAG	Q3 Performance Comments
EMSCG CQUIN	SS5	Discharge planning is important in improving the efficiency of units and engaging parents in the care of their infants thereby improving carer satisfaction of NICU services.	G	Threshold increased following receipt of Q1 data and discussion with the Network. UHL already above the 70% threshold.
EMSCG CQUIN	SS6	Radiotherapy – Improving the proportion of radical Intensity modulated radiotherapy (excluding breast and brain) with level 2 imaging – image guided radiotherapy (IGRT)	G	Actions being taken and on track to achieve end of year threshold (30%)
EMSCG CQUIN	SS7	Acute Kidney Injury	G	Due to commence Alerting process end of November
EMSCG CQUIN	SS8	PICU - . To prevent and reduce unplanned readmissions to PICU within 48 hours	G	Performance is on track to achieve quarterly threshold.

3.8 Theatres – 100% WHO compliance

Mth | Qtr 1 | Qtr2 | YTD

The National Patient Safety Agency endorsed WHO checklist consists of four stages and is monitored and reported every month to commissioners. For October the checklist compliance stands at 100% and has been fully compliant since January 2013.

3.9 C-sections rate

Mth | Qtr 1 | Qtr2 | YTD

The C-section rate during October was 25.6% against a revised target of 25.0%.

Discussion has been held with the commissioners and given the national variation in the C/S rates, ranging from 36% in some London Hospitals to 22% in the Northumbria region, with an average of 24.8% it was agreed to alter the threshold from the start of Quarter 3 to rag rate <25% as green, 25-26% amber and > 26% as red. In the region Chesterfield had a 21% rate with other larger units having 23-25%. The action plan will continue and promoting normal birth being a priority.

The caesarean Section Toolkit (2005) from the Department of Innovation and Improvement was revisited at the Normality meeting, there is a small working party looking at this.

There is a C/S audit registered with the CASE team on 28th October 2013, to include reasons for C/S, decision making, grade of staff, consultant presence, VBAC (vaginal birth after C/S) offered or not.

3.10 Safety Thermometer

The percentage of Harm Free Care for October was 94.74% reflecting a reduction in the number of patients with newly acquired harms.

The October Safety Thermometer data includes backdated Venous Thromboembolism (VTE) prevalence rates for the months of April through to October 2013. The prevalence of newly acquired VTEs has fluctuated only slightly over the year but the data is similar to that of the last two quarters of 2012/13.

The number of patients who fell and suffered a harm as a consequence in October was two. Both of these falls occurred prior to admission to UHL. Both patients were admitted to the emergency decisions unit from their residential homes following a fall and were discharged the following day. The CCG Lead for Nursing Homes has been contacted regarding falls that occur prior to admission to ensure that this information is reviewed and acted upon where required.

There are no areas of concern noted with the prevalence data for the remaining harms.

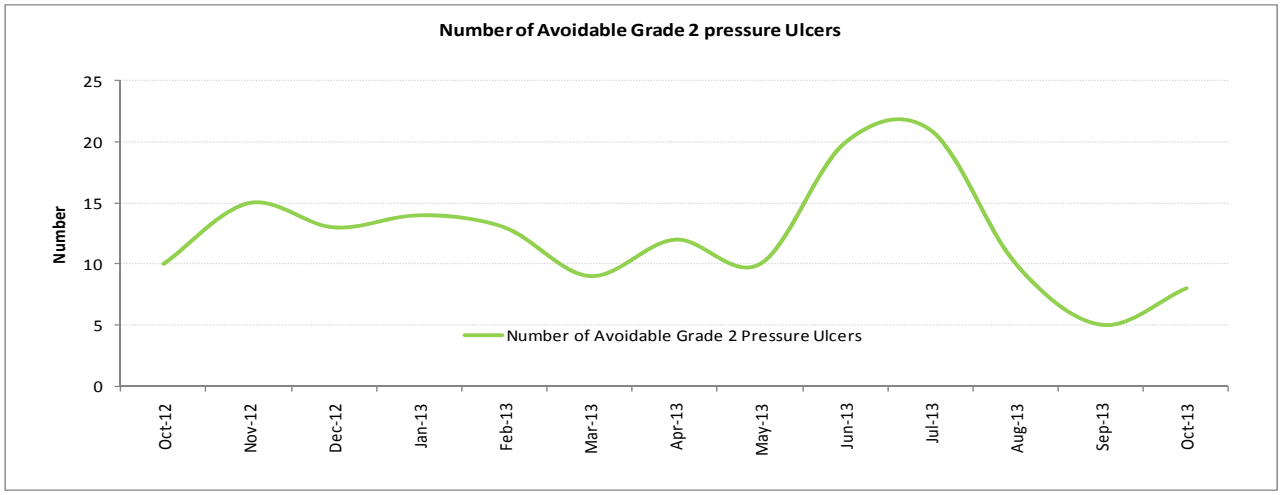
		Apr-13	May-13	Jun-13	Jul-13	Aug-13	Sep-13	Oct-13
	Number of patients on ward	1672	1686	1650	1514	1496	1579	1596
All Harms	Total No of Harms - Old (Community) and Newly Acquired (UHL)	150	117	113	100	108	121	85
	No of patients with no Harms	1531	1577	1540	1417	1392	1466	1512
	% Harm Free	91.57%	93.53%	93.33%	93.59%	93.05%	92.84%	94.74%
Newly Acquired Harms	Total No of Newly Acquired (UHL) Harms	73	58	56	49	59	46	42
	No of Patients with no Newly Acquired Harms	1600	1631	1596	1466	1438	1535	1555
	% of UHL Patients with No Newly Acquired Harms	95.69%	96.74%	96.73%	96.83%	96.12%	97.21%	97.43%
Harm One	No of Patients with either an OLD or NEWLY Acquired Grade 2, 3 or 4 Pressure Ulcers (PUs)	92	75	73	66	67	87	54
	No of Newly Acquired Grade 2, 3 or 4 PUs	26	27	26	19	25	16	19
Harm Two	No of Patients having fallen in hospital in previous 72 hrs	14	8	8	5	3	3	2
Harm Three	No of Patients with Urinary Catheter and Urine Infection (prior to or post admission)	36	27	27	25	31	25	22
	Newly Acquired UTIs with Catheter	25	16	17	21	24	21	14
Harm Four	Newly Acquired VTE (DVT, PE or Other)	8	7	5	4	7	6	7

Pressure Ulcer Incidence

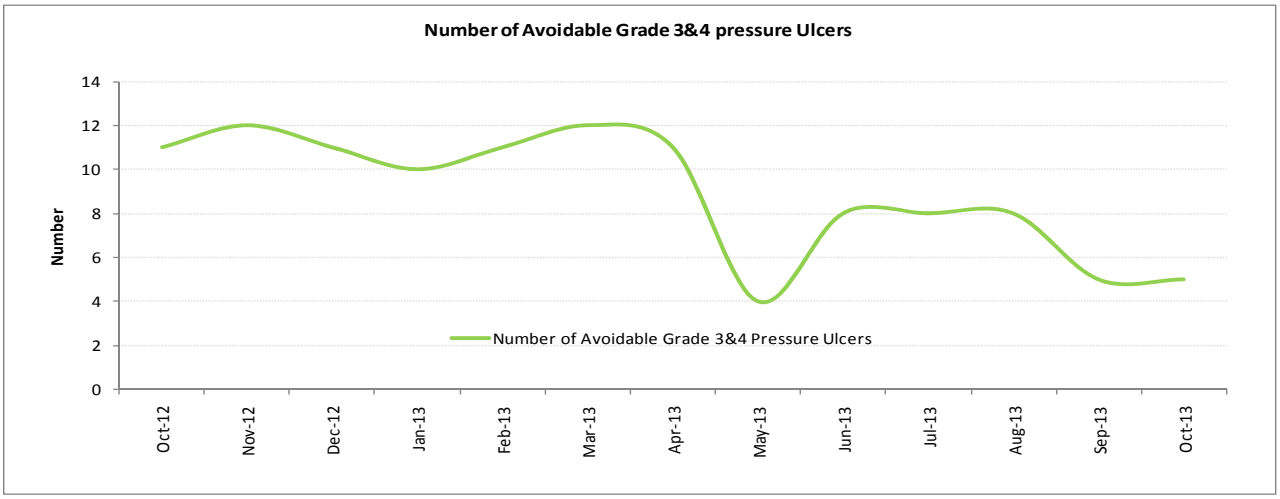
Mth | Qtr 1 | Qtr2 | YTD

Pressure ulcer incidence for October has seen a small increase in avoidable grade 2 ulcers, and a reduction of two grade 3 ulcer. One grade four avoidable pressure ulcer was reported by Ward 19 LRI, which was a deterioration in a grade 3 community acquired pressure ulcer.

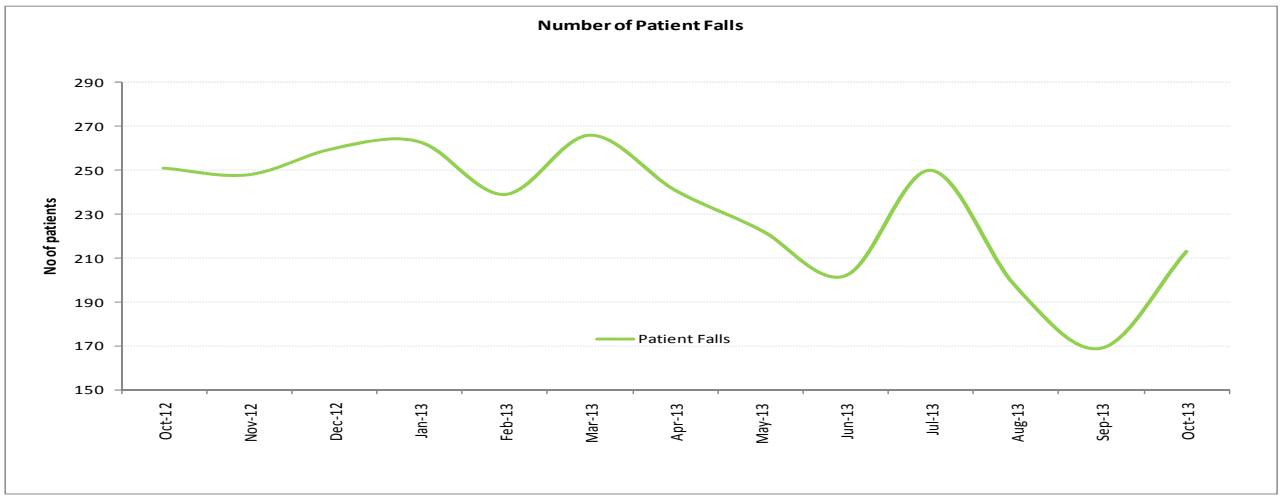
Trajectory for Grade 2 Avoidable Pressure Ulcers 2013/14													
Month	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Total YTD
Trajectory	0	0	0	11	8	4	0	0	0	0	0	0	23
G2 Incidence	12	10	20	21	10	5	8						86
+ / -	-12	-10	-20	-10	-2	-1	-8						-63



Trajectory for Grade 3 & 4 Avoidable Pressure Ulcers 2013/14													
Month	**Apr**	**May**	**Jun**	**Jul**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**	**Total YTD**
Trajectory	0	0	0	**5**	**4**	**3**	**0**	**0**	**0**	**0**	**0**	**0**	**12**
G3 Incidence	11	4	8	8	8	5	3						**47**
G4 Incidence	0	0	0	0	0	0	1						**1**
+ / -	-11	-4	-8	-3	-4	-2	-5						**-36**



Patient Falls



Although there was an increase in the number of falls during October, progress continues to be seen in the falls reduction programme with good results reported in the reduced number of falls incidents and patient safety thermometer audit.

In order to standardise the governance and accountability arrangements for all harms, the ownership of 'falls' has been transferred to the Corporate Nursing Directorate. Heads of

Nursing will now be supported to develop their own monthly, confirm and challenge processes to ascertain the main causative factors of individual patient falls and ensure that appropriate actions are in place to reduce the risk of future incidences.

The actions taken to prevent and reduce falls include:

a) Falls Validation Process

Monthly confirm and challenge meetings to review the main causative factor for individual patient falls for CBUs were initiated in March 2013 by the Head of Nursing for the Acute Division supported by the Education and Practice Development (EPD) Sister for falls. It has been acknowledged that this process has been the main driver for the focused work around falls reduction. The process includes those wards with the highest levels of falls in UHL and consists of 26 clinical areas. The majority of wards are from the previous Acute Care Division with some from Planned Care. There is now a requirement for these meetings to be held within each CMG with the recommendation that the process is managed by the CMG Head of Nursing. The ADNS has organised a briefing session for Heads of Nursing in November to support this change.

b) Key Themes and Actions for Falls Prevention

Falls have been themed around location, times of day, levels of supervision and inappropriate footwear. Common interventions have included falls prevention advice to patients and relatives in verbal and written format, ensuring patients had appropriate footwear and providing clinical staff with information about appropriate patient armchair height. Environmental audits have also been completed to identify improvements to promote patient safety and independence when using the toilets bathrooms and shower rooms.

c) NICE Falls Prevention Guidance (June 2013)

NICE Guidance states that a Stage Two Falls Prevention Risk Assessment should be completed for all patients aged 65 and over. In addition, all patients aged 50 to 64 must be judged to be at higher risk of falling because of an underlying condition regardless of the predicated risk given by the part one falls risk assessment. These requirements have been incorporated into all UHL Falls education and training programmes for nurses and HCAs

4.0 PATIENT EXPERIENCE – RACHEL OVERFIELD

4.1 Infection Prevention

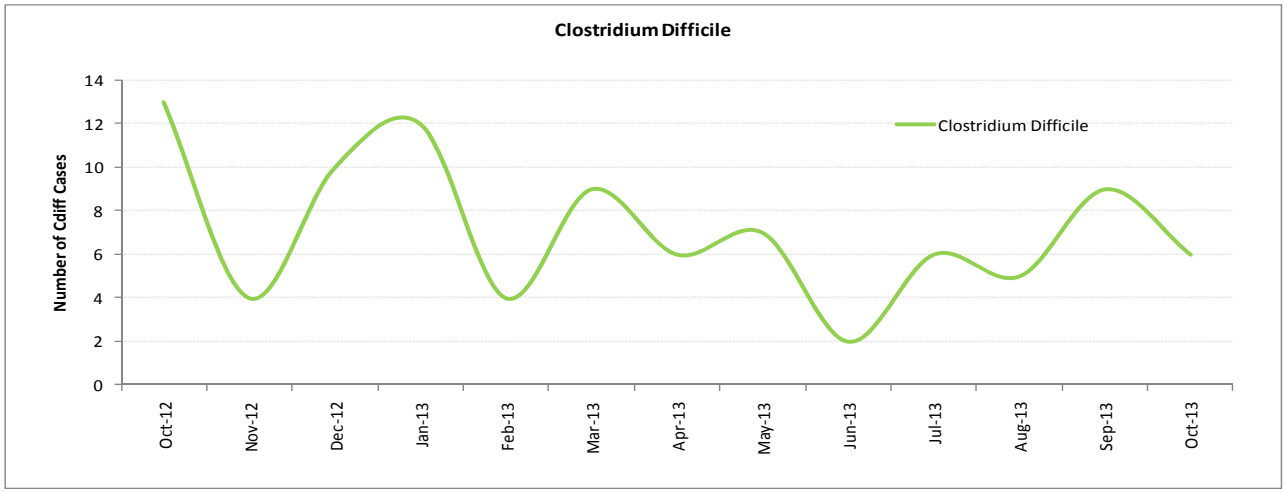
a) MRSA

There were no avoidable MRSA cases reported in October.

There was one avoidable bacteraemia in Acute Medicine reported for September. This case has been fully investigated which identified gaps in the documentation.

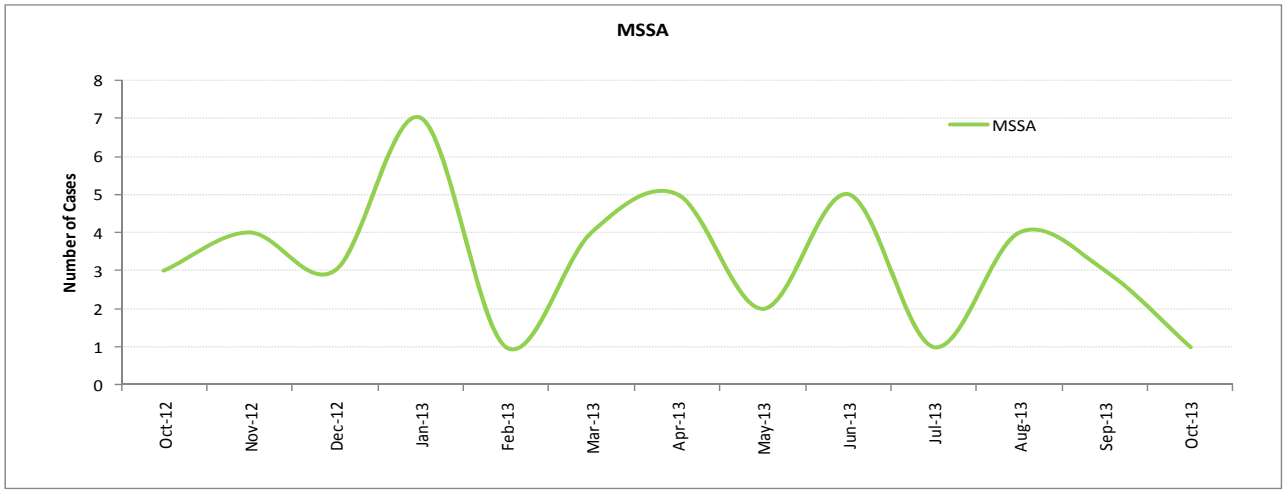
b) CDT

Ahead of trajectory to date with 41 reported against cumulative target of 42. All 6 cases of CDT reported in October have been fully investigated and there are no links between any of the cases.



c) MRSA elective and non-elective screening has continued to be achieved at 100% respectively.

d) The number of MSSA cases reported in October was 1, with a year to date figure of 21.



4.2 Patient Experience

Patient Experience Surveys continue across 94 clinical areas and have four paper surveys for adult inpatient, children's inpatient, adult day case and intensive care settings and eleven electronic surveys identified in the table below.

In October 2013, 4,120 Patient Experience Surveys were returned this is broken down to:

- 2,088 paper inpatient/day case surveys
- 1,060 electronic surveys
- 764 ED paper surveys
- 208 maternity paper surveys

Share Your Experience – Electronic Feedback Platform

In October 2013, a total of 1,060 electronic surveys were completed via email, touch screen, our Leicester's Hospitals web site or handheld devices.

A total of 278 emails were sent to patients inviting them to complete a survey. The table below shows how this breaks down across the trust:

Share Your Experience Survey	Email	Touch Screen	Hand held	Web		Total Surveys		Emails sent
Carers Survey	0	0	0	0		0		0
Children's Urgent & ED Care		47				47		
A&E Department		73	14	12		99		0
Eye Casualty		233	0	1		234		0
Glenfield CDU		48	3	0		51		0
Glenfield Radiology	2					2		21
IP and Childrens IP				17		17		
Maternity Survey			428	5		433		1
Neonatal Unit				13		13		
Outpatient Survey	45	6	77	6		134		256
Windsor Eye Clinic		30				30		
Total	**47**	**437**	**522**	**54**		**1060**		**278**

Treated with Respect and Dignity

Mth | Qtr 1 | Qtr2 | YTD

The Trust has maintained a GREEN rating for the question 'Overall do you think you were you treated with dignity and respect while in hospital' based on the scoring methodology used in the national survey.

Friends and Family Test

Inpatient

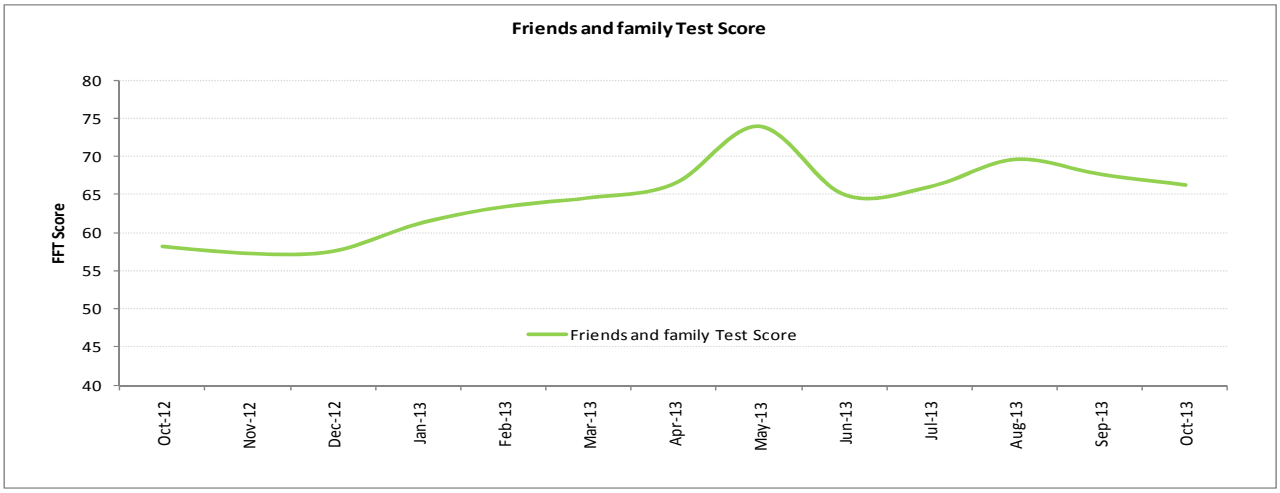
The inpatient surveys include the Friends and Family Test question; **How likely are you to recommend this ward to friends and family if they needed similar care or treatment?'** Of all the surveys received in October, 1,531 surveys included a response to this question and were considered inpatient activity (excluding day case / outpatients) and therefore were included in the Friends and Family Test score for NHS England.

Overall there were 7,042 patients in the relevant areas within the month of October 2013. The Trust easily met the 15% target achieving coverage of **21.7%.**

The Friends & Family Test responses broken down to:

Extremely likely:	1,070
Likely:	371
Neither likely nor unlikely:	40
Unlikely	18
Extremely unlikely	12
Don't know:	20

Overall Friends & Family Test Score **66.2**



September 2013 Data Published Nationally

NHS England has begun publishing all trust's Friends and Family Test scores. September data was published at the end of October and the average Friend and Family Test score for England (excluding independent sector providers) was **71**.

With private, single speciality and Trusts that achieved less than a 20% footfall excluded, the UHL Friends and Family Test score of 68 for September ranks the Trust 74th out of the remaining 118 Trusts.

Friends and family Test Scores by CMG

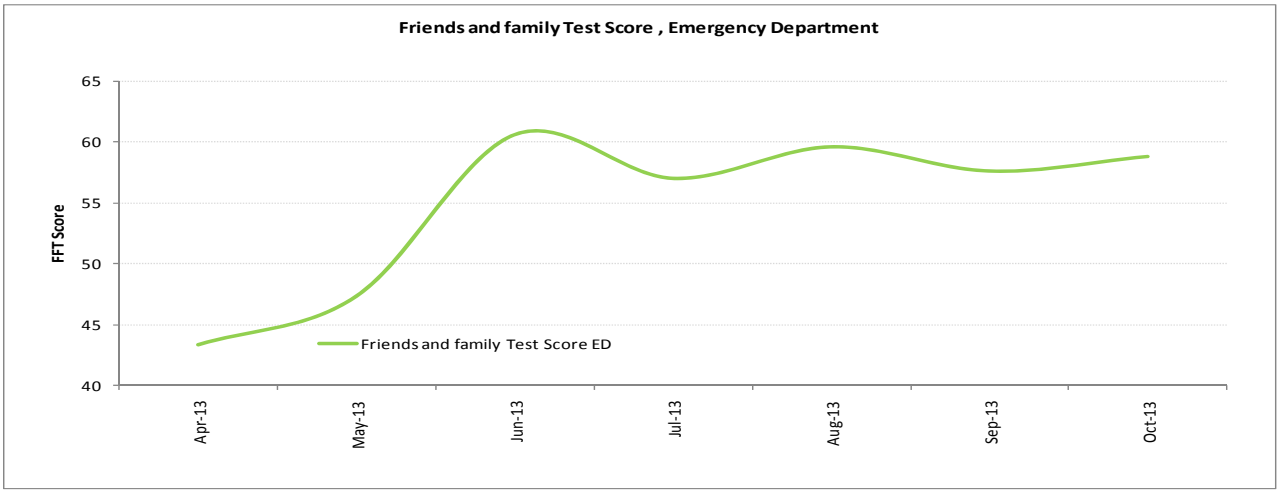
	Apr-13	May-13	Jun-13	Jul-13	Aug-13	Sep-13	Oct-13	Point Change in FFT Score (Sep -Oct 13)
UHL Trust Level Totals	**66.4**	**73.9**	**64.9**	**66.0**	**69.6**	**67.6**	**66.2**	**-1.4**
Renal, Respiratory and Cardiac	70	76	73	80	80	79	70	**-8.6**
Emergency and Specialist Medicine	64	72	57	62	63	68	63	**-4.6**
CHUGS	59	70	57	53	61	53	58	**+4.8**
Musculoskeletal and Specialist Surgery	72	75	73	66	68	69	69	**+0.0**
Women's and Children's	78	80	74	68	76	77	70	**-6.5**

Emergency Department & Eye Casualty

Electronic and paper surveys are used to offer the Friends and Family Test question; **How likely are you to recommend this A&E department to friends and family if they needed similar care or treatment?'** in A&E Minors, Majors and Eye Casualty.

Overall there were 6,141 patients who were seen in A&E and then discharged home within the month of October 2013. The Trust surveyed 1,004 eligible patients meeting **16.3%** of the footfall. The Friends & Family test responses break down to:

Extremely likely:	640
Likely:	300
Neither likely nor unlikely:	28
Unlikely	15
Extremely unlikely	12
Don't know:	9
Overall Friends & Family Test Score	**58.8**



Breakdown by department	No. of responses	FFT Score	Total no. of patients eligible to respond
Emergency Dept Majors	192	47.9	1,526
Emergency Dept Minors	461	66.3	2,414
Emergency Dept – not stated	64	68.8	
Emergency Decisions Unit	77	56.6	889
Eye Casualty	210	50.0	1,312

September 2013 Data Published Nationally

NHS England also published all trust's A&E Friends & Family Test scores. September data was published at the end of October and the average Friends and Family Test score for A&E in England was **52** including data from 144 Trusts.

If we filter out the Trusts that achieved less than 15% footfall, then we are left with 52 Trusts. However our UHL score of **60** does not feature among these as the 15% footfall was not achieved.

Maternity Services

October was the first month that Maternity Services have reported the Friends and Family Test scores externally. Electronic and paper surveys are used to offer the Friends and Family Test question to ladies at different stages of their Maternity journey. A slight variation on the standard question: **How likely are you to recommend our <service> to friends and family if they needed similar care or treatment?** is posed to patients in antenatal clinics following 36 week appointments, labour wards or birthing centres at discharge, postnatal wards at discharge and postnatal community follow-up at 10 days after birth.

Overall there were 3,581 patients in total who were eligible within the month of October 2013. The Trust surveyed 992 eligible patients meeting **27.7%** of the footfall. The Friends & Family test responses break down to:

Extremely likely:	683
Likely:	262
Neither likely nor unlikely:	26
Unlikely	12
Extremely unlikely	5
Don't know:	4

Overall Maternity Friends & Family Test Score 64.8

Breakdown by maternity journey stage	No. of responses	FFT Score	Total no. of patients eligible to respond
Antenatal following 36 week appointment	170	60.9	951
Labour Ward/Birthing centre following delivery	393	66.2	902
Postnatal Ward at discharge	357	62.5	721
Postnatal community – 10 days after birth	72	77.5	1,007

Details at hospital and ward level for those wards included in the Friends and Family Test Score are included in Appendix 1.

4.3 Nurse to Bed Ratios

Nurse to Bed Ratio by ward for September are reported in Appendix 2. This is based on a 60% qualified and 40% unqualified skill mix split, with 1 x Band 7 and 2 x Band 6s in the funded establishment:

- General base ward range = 1.1-1.3 WTE
- Specialist ward range = 1.4-1.6 WTE
- HDU area range = 3.0-4.0 WTE
- ITU areas = 5.5-6.0 WTE

When reviewing the staffing levels for wards during October they are all above the agreed minimum ratio and therefore no action plans are required.

4.4 Same Sex Accommodation

Mth | Qtr 1 | Qtr2 | YTD

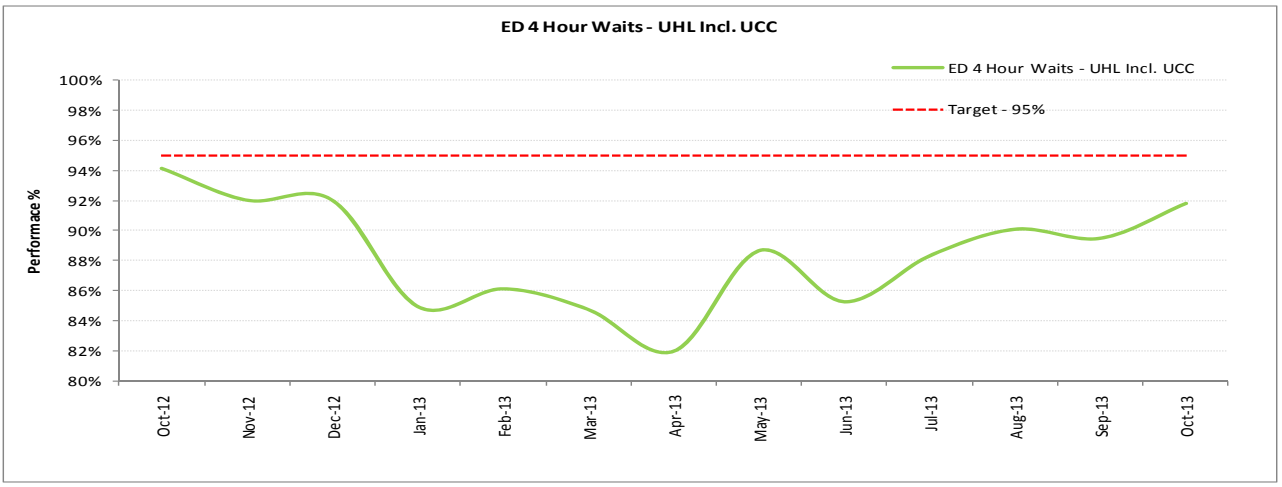
All UHL wards and intensivist areas continue to offer Same Sex Accommodation (SSA) in line with the UHL SSA Matrix guidance and delivered 100%.

5.0 OPERATIONAL PERFORMANCE – RICHARD MITCHELL

Performance Indicator	Target	2012/13	Sep-12	Q2	Oct-12	Nov-12	Dec-12	Q3	Jan-13	Feb-13	Mar-13	Q4	Apr-13	May-13	Jun-13	Q1 2013	Jul-13	Aug-13	Sep-13	Q2 2013	Oct-13	YTD
A&E - Total Time in A&E (UHL+UCC)	95%	91.9%	96.8%	97.0%	94.2%	92.0%	92.0%	92.7%	84.9%	86.1%	84.7%	85.2%	82.0%	88.7%	85.3%	85.3%	88.3%	90.1%	89.5%	89.3%	91.8%	87.9%
RTT waiting times – admitted	90%	91.3%	91.2%		91.2%	91.7%	91.9%		92.2%	91.9%	91.3%		88.2%	91.3%	85.6%	88.4%	89.1%	85.7%	81.8%	85.6%	83.5%	
RTT waiting times – non-admitted	95%	97.0%	97.7%		97.1%	96.7%	97.3%		97.3%	97.0%	97.0%		97.0%	95.9%	96.0%	96.3%	96.4%	95.5%	92.0%	94.6%	92.8%	
RTT - incomplete 92% in 18 weeks	92%	92.6%	94.0%		94.6%	93.9%	93.3%		93.4%	93.5%	92.6%		92.9%	93.4%	93.8%	93.8%	93.1%	92.9%	93.8%	93.8%	92.8%	
RTT - 52+ week waits	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Diagnostic Test Waiting Times	<1%	0.5%	0.5%		0.4%	0.6%	1.1%		0.7%	1.0%	0.5%		1.6%	0.6%	0.6%		0.6%	0.8%	0.7%		1.0%	
Cancelled operations re-booked within 28 days	100%	92.9%	100.0%	92.6%	91.0%	97.3%	89.0%	93.1%	97.1%	92.3%	94.2%	94.6%	90.3%	91.1%	86.9%	89.8%	99.1%	96.0%	98.6%	98.0%	93.8%	94.4%
Cancelled operations on the day (%)	0.8%	1.2%	0.9%	0.8%	1.1%	1.6%	1.2%	1.3%	1.6%	1.6%	1.6%	1.6%	1.5%	1.5%	1.0%	1.3%	1.2%	1.4%	2.3%	1.6%	1.7%	1.5%
Cancelled operations on the day (vol)		1247	74	202	100	149	91	340	137	130	137	404	124	135	84	343	116	124	212	452	162	957
Urgent operation being cancelled for the second time	0	1	0	0	0	0	1	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0
2 week wait - all cancers	93%	93.4%	93.9%	94.1%	93.0%	90.6%	95.1%	92.8%	89.8%	95.9%	95.2%	93.7%	93.0%	95.2%	94.8%	94.4%	94.2%	94.6%	93.0%	94.0%		94.2%
2 week wait - for symptomatic breast patients	93%	94.5%	96.3%	95.3%	93.4%	93.9%	94.6%	93.9%	93.6%	93.1%	95.4%	94.0%	94.0%	94.8%	93.2%	94.1%	93.6%	92.0%	95.2%	93.8%		93.9%
31-day for first treatment	96%	97.4%	96.9%	98.3%	98.3%	97.5%	97.4%	97.8%	96.6%	97.6%	98.8%	97.6%	97.5%	97.0%	99.0%	97.8%	98.3%	99.7%	99.1%	99.0%		98.4%
31-day for subsequent treatment - drugs	98%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%		100.0%
31-day wait for subsequent treatment - surgery	94%	95.8%	100.0%	96.6%	98.1%	97.4%	94.6%	97.1%	94.6%	94.1%	92.7%	94.0%	97.2%	94.4%	97.5%	96.4%	100.0%	98.4%	88.6%	95.9%		96.2%
31-day wait subsequent treatment - radiotherapy	94%	98.5%	100.0%	98.8%	99.3%	98.9%	100.0%	99.4%	99.1%	98.9%	99.1%	99.0%	100.0%	97.8%	99.1%	98.8%	100.0%	100.0%	97.7%	99.4%		99.1%
62-day wait for treatment	85%	83.5%	86.5%	86.5%	85.6%	85.8%	84.6%	85.3%	79.5%	75.4%	81.5%	78.8%	80.9%	80.3%	85.9%	82.3%	85.8%	88.2%	87.4%	87.1%		84.7%
62-day wait for screening	90%	94.5%	92.2%	94.6%	96.8%	98.7%	92.3%	96.3%	91.7%	95.7%	95.8%	94.4%	98.6%	94.3%	95.0%	95.9%	90.6%	97.2%	96.2%	94.1%		95.1%
Stroke - 90% of Stay on a Stroke Unit	80%	79.8%	86.3%	82.2%	83.7%	79.5%	71.3%	77.9%	77.8%	81.4%	82.3%	80.6%	77.4%	80.0%	78.0%	78.5%	86.0%	88.6%	89.1%	87.9%		82.7%
Stroke - TIA Clinic within 24 Hours (Suspected TIA)	60%	68.4%	73.4%	63.9%	68.7%	72.5%	68.7%	70.0%	60.8%	85.1%	77.0%	73.1%	51.1%	69.2%	72.0%	63.9%	60.5%	73.6%	64.6%	66.0%	62.4%	64.5%
Choose and Book Slot Unavailability	4%		11%		10%	13%	8%		5%	10%	9%		7%	9%	13%		15%	14%	11%		16%	
Delayed transfers of care	3.5%	3.1%	3.2%	3.4%	3.4%	3.6%	2.7%	3.3%	2.8%	2.7%	3.7%	3.0%	3.7%	3.9%	3.1%	3.6%	3.6%	3.1%	3.9%	3.5%	3.1%	3.5%

5.1 Emergency Care 4hr Wait Performance

Mth | Qtr 1 | Qtr2 | YTD



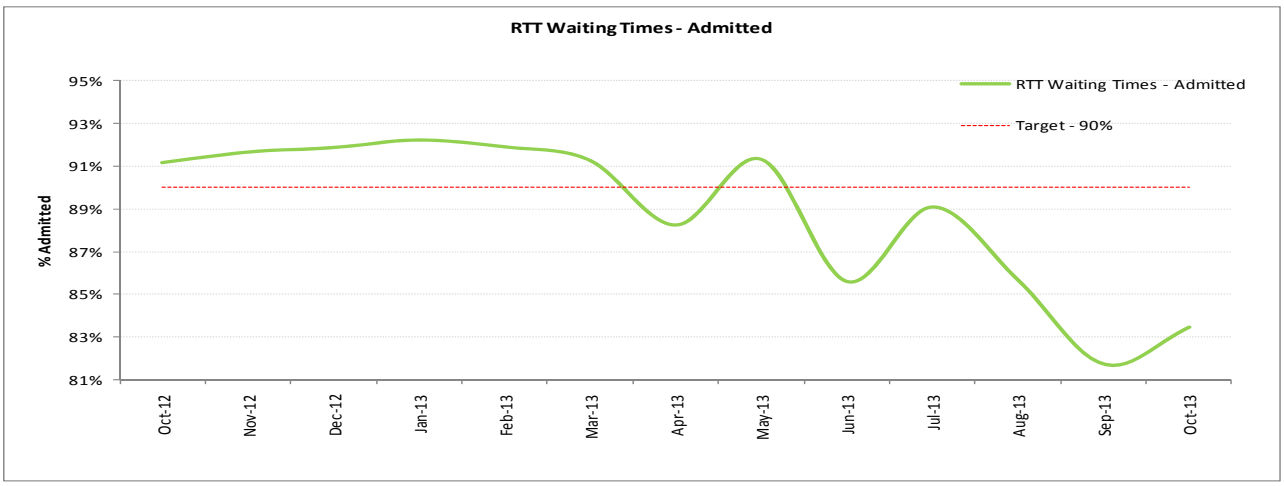
Performance for emergency care 4hr wait in October was 91.8%. Actions relating to the emergency care performance are included in the ED exception report.

UHL was ranked 137 out of 144 Trusts with Type 1 Emergency Departments in England for the four weeks up to 10th November 2013. Over the same period 93 out of 145 Acute Trusts delivered the 95% target.

5.2 RTT – 18 week performance

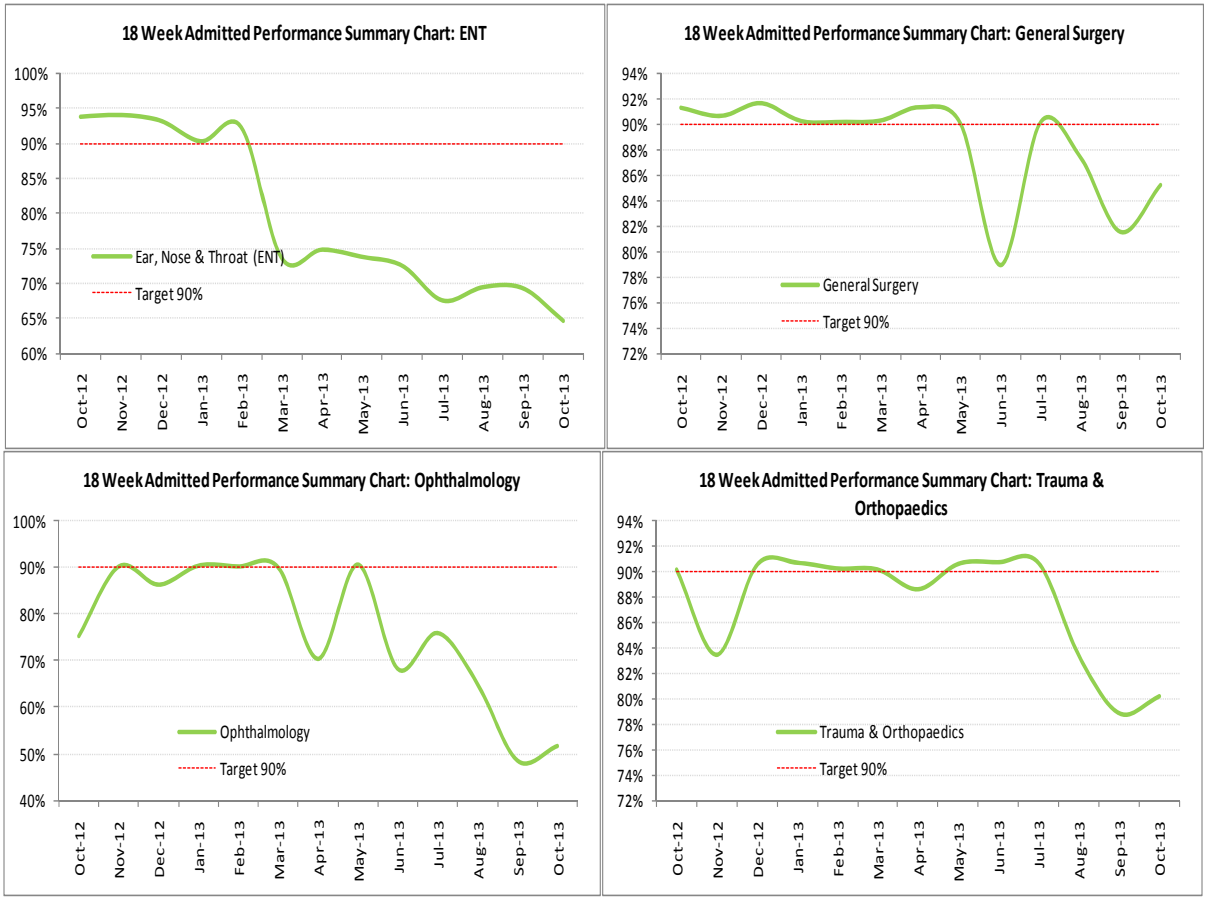
a) RTT Admitted performance

Mth | Qtr 1 | Qtr2 | YTD



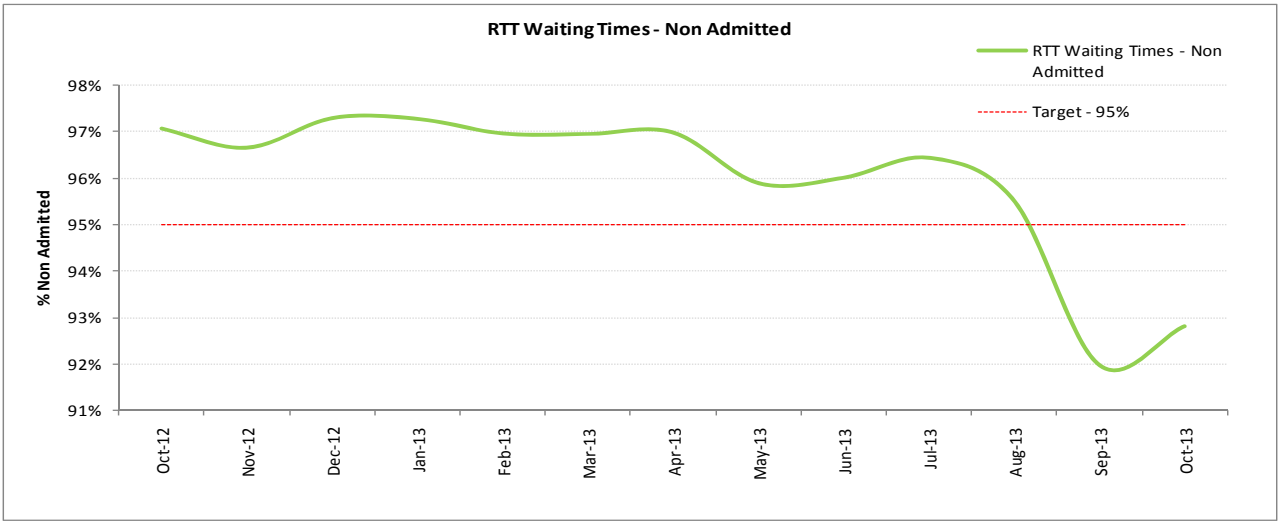
RTT admitted performance for October was 83.5% with significant speciality level failures in General Surgery, Orthopaedics, Ophthalmology and ENT. Further information is included in Appendix 3 - 18 week referral to treatment delivery report.

The national admitted performance in September (latest published figures) was 91.5%. 116 out of the 178 Trusts missed the target at specialty level and 81 Trusts had between 2 and 10 specialty failures.



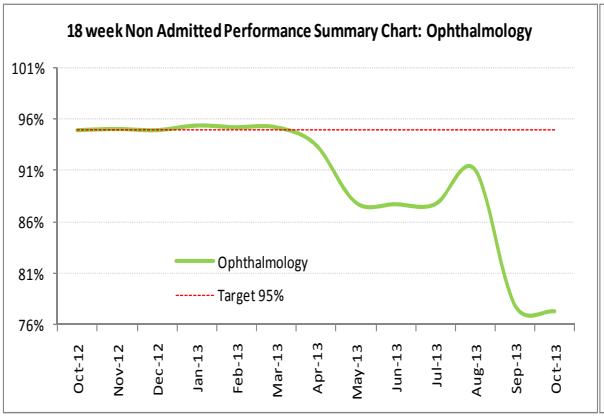
b) RTT Non Admitted performance

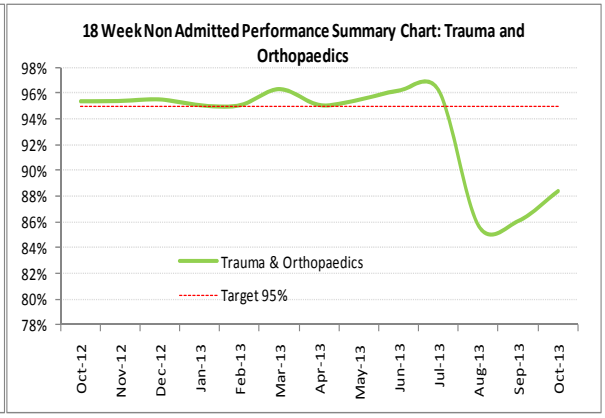
Mth | Qtr 1 | Qtr2 | YTD



Non-admitted performance during October was 92.8%, with the significant specialty level failures in Orthopaedics and Ophthalmology. The deterioration in performance during October was as a result of the continuation of the plan to reduce the number of non-admitted patients waiting 18+ weeks.

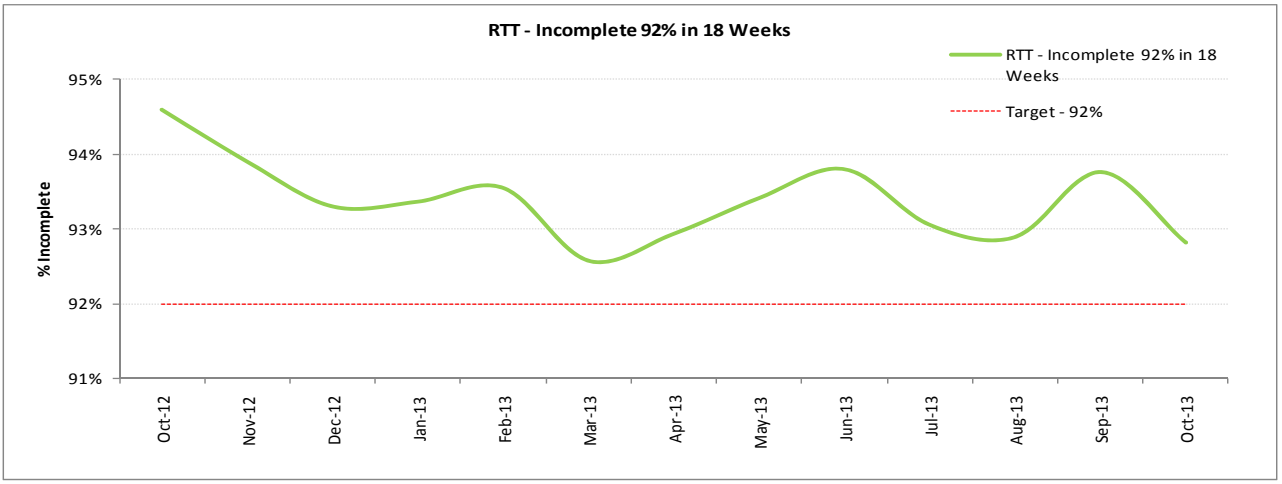
The national non-admitted performance in September (latest published figures) was 96.8%. 101 out of the 203 Trusts missed the target at specialty level and 77 Trusts had between 2 and 10 specialty failures. Further information is included in Appendix 3 - 18 week referral to treatment delivery report.





c) RTT Incomplete Pathways

Mth | Qtr 1 | Qtr2 | YTD

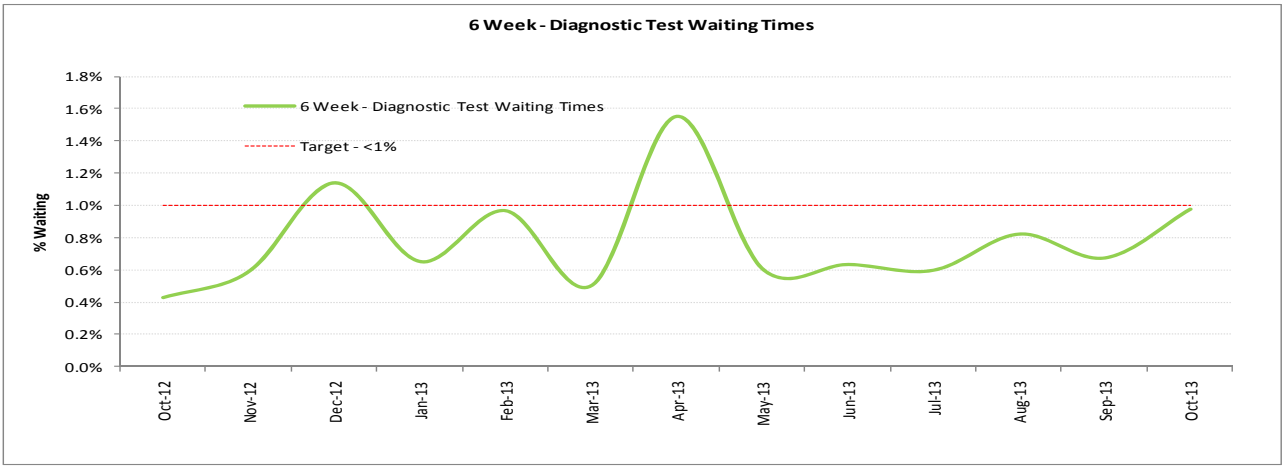


RTT incomplete (i.e. 18+ week backlog) performance was 92.8%.In numerical terms the total number of patients waiting 18+ weeks for treatment (admitted and non-admitted) at the end of October was 3,048.

The national incomplete pathways performance in September (latest published figures) was 94.2%. 104 out of the 203 Trusts missed the target at specialty level and 71 Trusts had between 2 and 10 specialty failures.

5.3 Diagnostic Waiting Times

Mth | Qtr 1 | Qtr2 | YTD



At the end of October 1.0% of patients were waiting for diagnostic tests longer than 6 weeks. National performance for September shows that 0.9% of patients were waiting for diagnostic tests longer than 6 weeks.

5.4 Cancer Targets

a) Two Week Wait

Mth	Qtr 1	Qtr2	YTD

September performance for the 2 week to be seen for an urgent GP referral for suspected cancer was achieved at 93.0% (national performance 95.1%). Performance for the 2 week symptomatic breast patients (cancer not initially suspected) was also achieved at 95.2% (national performance 94.8%).

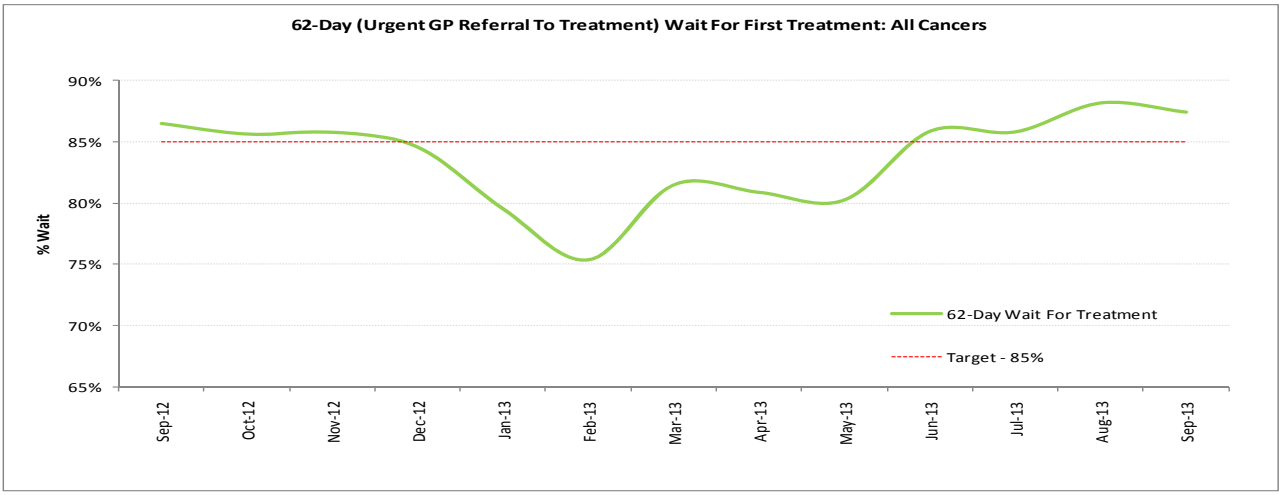
b) 31 Day Target

Mth	Qtr 1	Qtr2	YTD

Three out of four of the 31 day cancer targets have been achieved in September (latest reported month). The 31day wait for second or subsequent treatment surgery was missed in September due to capacity and patient's choice but the performance for the overall Quarter was delivered. All four targets are expected to be achieved in October.

c) 62 Day Target

Mth	Qtr 1	Qtr2	YTD



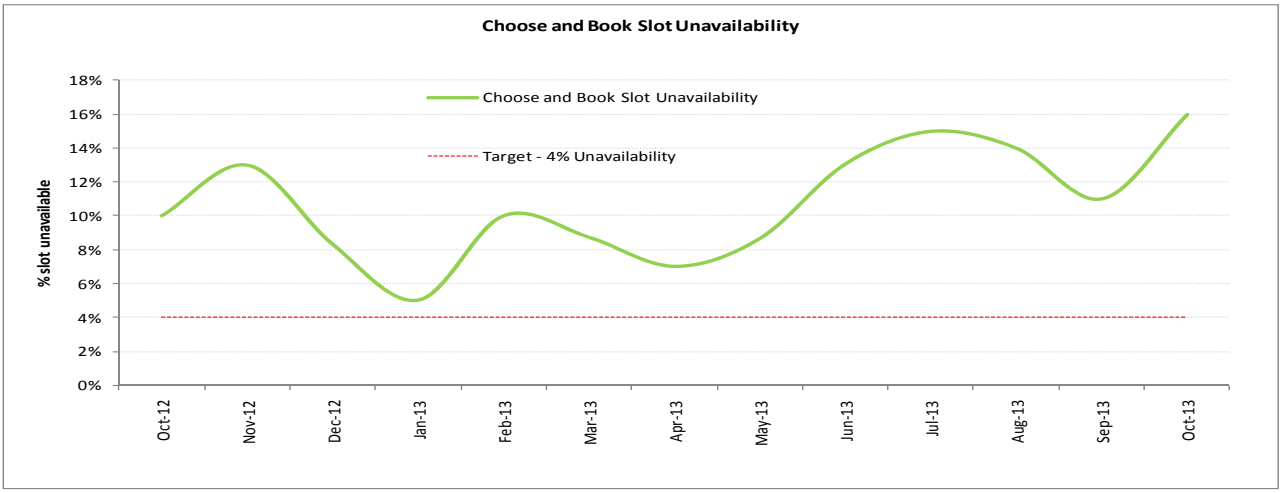
The 62 day urgent referral to treatment cancer performance in September was 87.4%, against a national target of 85%. National performance for the 62 day target was 85.6% in September. The year to date position at 84.7% is ahead of the revised trajectory of 84.1%, which was submitted as part of the recovery plan.

The Cancer Action Board continues to meet weekly, it is responsible for monitoring the Trusts Cancer Action Plan to ensure that actions are being delivered and there is representation from all the key tumour sites including Radiology and theatres. This meeting is chaired by the Cancer Centre Clinical Lead.

The key points to note this month are:-

- Performance for October is on track to deliver trajectory
- 62 day backlog is 18 as at the 15th November (threshold is 30)
- There are 2 patients waiting 100+ days both in Urology – one patient was a late referral from Derby and the other complex patient is unable to decide which treatment option to go for.

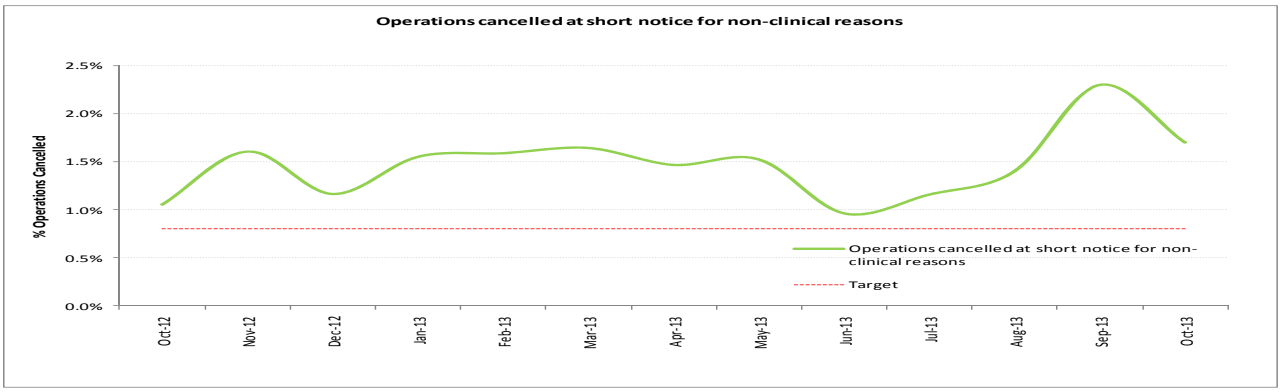
5.5 Choose and Book slot availability



Choose and book slot availability performance for October is 16% with the national average at 9%. Resolution of slot unavailability requires a reduction in waiting times for 1st outpatient appointments in key specialties and prospectively, ensuring that there is sufficient capacity available at all times. This will form part of the 18 week remedial action plan.

5.6 Short Notice Cancelled Operations

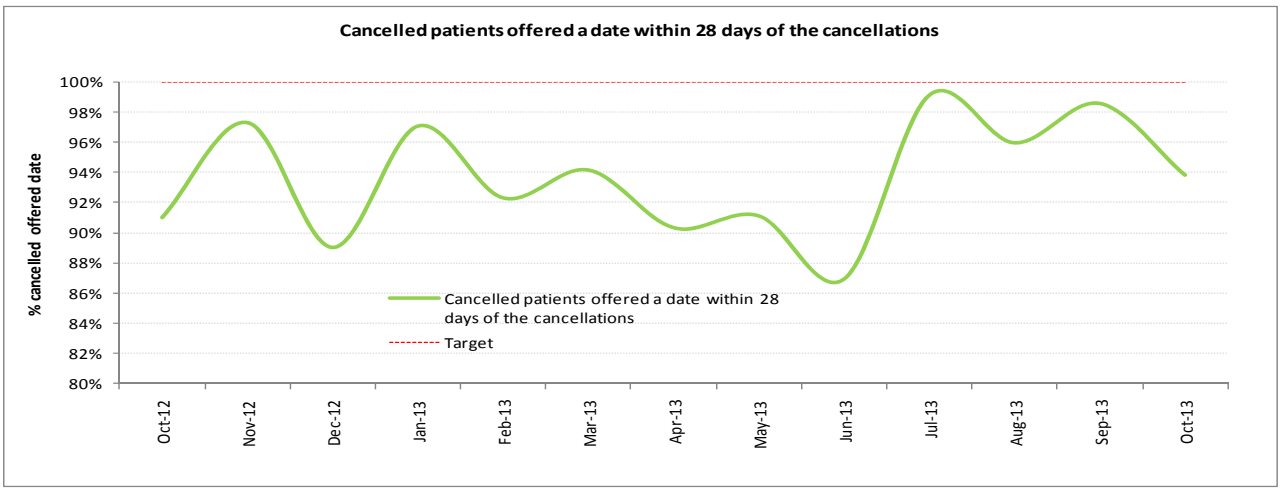
Mth | Qtr 1 | Qtr2 | YTD



October performance shows that the percentage of operations cancelled on/after the day of admissions of all elective activity for non-clinical reasons was 1.7% against a target of 0.8%. The year to date performance is 1.5%. Further details are included in the Cancelled Operation exception report, see Appendix 4.

Cancelled patients offered a date within 28 days

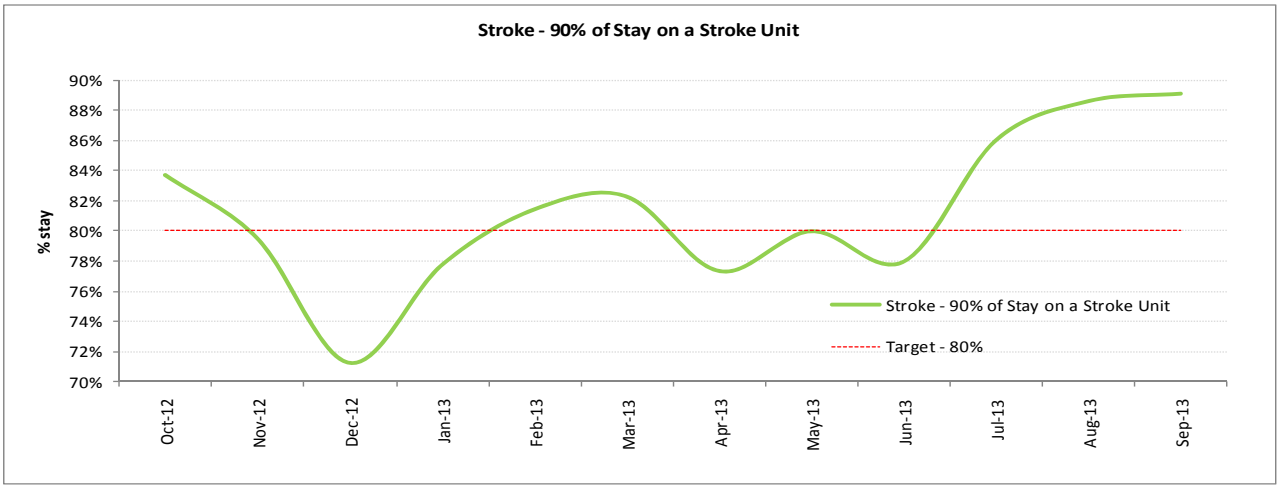
Mth | Qtr 1 | Qtr2 | YTD



The threshold has been amended from 95% to 100% to reflect that every breach of this standard is subject to a financial penalty. The number of patients breaching this standard in October was 10 with a 93.8% offered a date within 28 days of the cancellation. The reason for a reduction in performance is linked to the high number of cancellations in September which would need to be treated in October.

5.7 Stroke % stay on stroke ward

Mth | Qtr 1 | Qtr2 | YTD

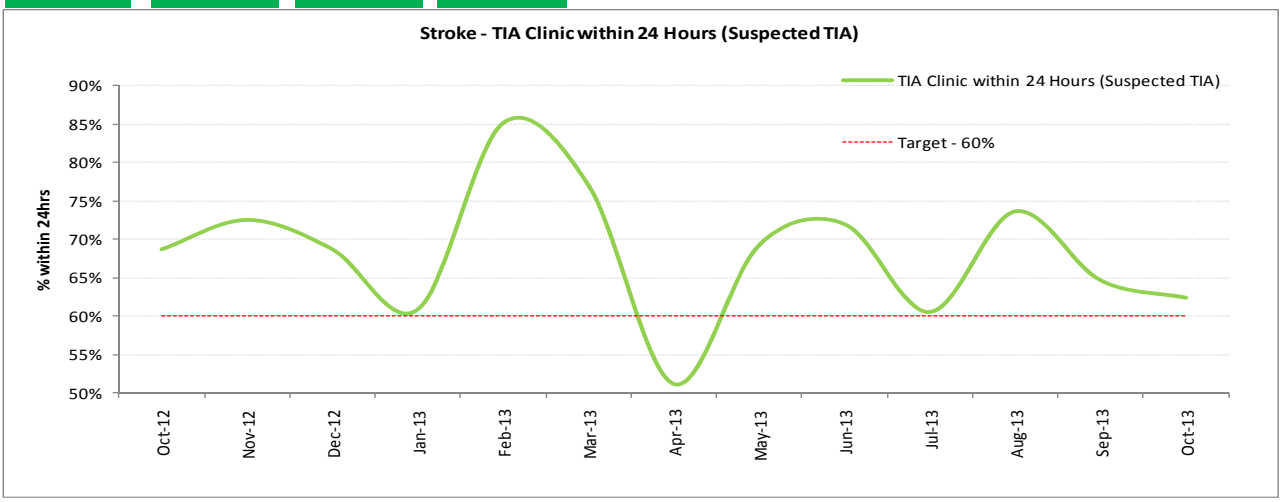


The percentage of stoke patients spending 90% of their stay on a stroke ward in September (reported one month in arrears) is 89.1% against a target of 80%.

Commissioners have confirmed verbally that due to the improved performance for stroke patients, the Contract Query will be closed. Formal confirmation is awaited.

5.8 Stroke TIA

Mth | Qtr 1 | Qtr2 | YTD



The percentage of high risk suspected TIAs receiving relevant investigations and treatment within 24 hours of referral receipt is 62.4% against a national target of 60.0%. The year to date performance is 64.5%. The contractual target for this indicator remains under review.

5.9 Delayed Transfers of Care

Mth | Qtr 1 | Qtr2 | YTD

During October 2013, UHL has seen a deterioration in the performance for both city and county patients. There were 342 episodes recorded as a 'Delayed Transfer of Care' on the weekly sitreps recorded at midnight each Thursday during October 2013, making the combined average of 7.4 delays per 100,000 population.

Numbers of delays by reason for April to October are shown below:-

Reason	Assessment		Awaiting Public funding		Availability of non acute NHS Care		Awaiting care home placement		Awaiting domiciliary package of care		Awaiting community equipment		Patient /Family choice		TOTAL	
	Cit City	Co	City	Co	City	Co	City	Co	City	Co	City	Co	City	Co	City	Co
April	7	5	10	5	70	61	10	27	9	17	12	5	1	3	119	123
May*	8	13	7	10	98	124	12	20	3	7	5	5	1	12	134	191
June	19	7	10	5	53	62	10	22	2	2	1	1	7	10	102	109
July	8	8	7	4	57	48	19	37	2	1	4	1	13	8	110	107
Aug*	12	21	7	5	56	66	11	30	0	11	4	2	23	16	113	151
Sept	15	24	6	17	26	50	25	37	6	18	2	4	19	13	99	163
Oct*	18	41	10	16	32	61	28	58	11	29	4	7	5	22	108	234

Actions taken to reduce the number of delays, include

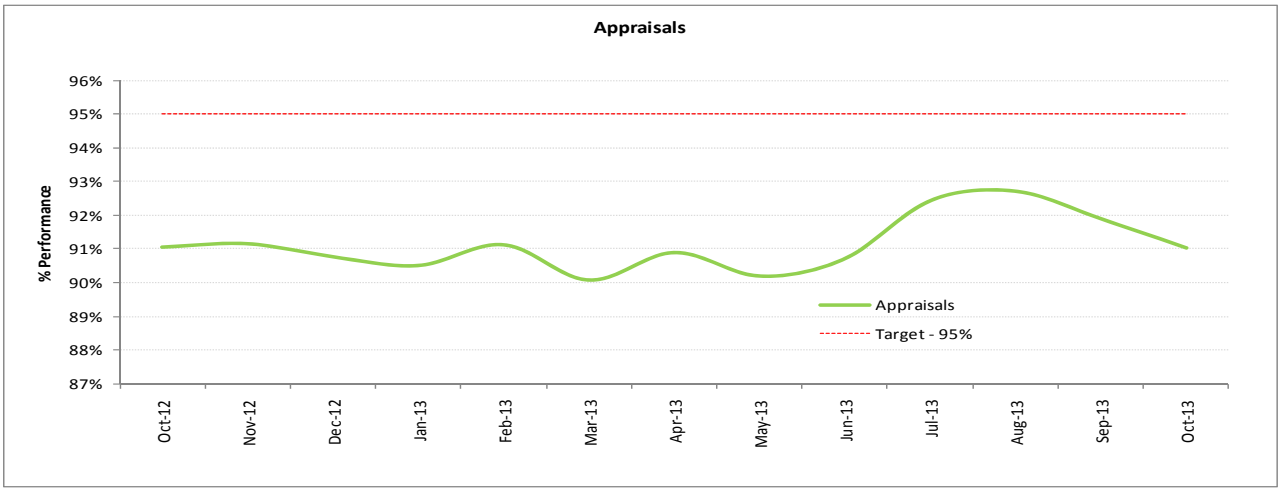
a) Review daily conference calls to ensure participants are fully aware of their responsibilities, to ensure actions to reduce delays are dealt with urgently
b) CCG to Review Discharge to assess pathway to consider other options to place patients and staffing requirements due to increased uptake of this pathway in the last 8 months.
c) CHC team to provide support with assessments on Discharge to assess pathway to reduce backlog of patients on pathway.
d) CHC team to provide member of staff to work with integrated discharge team, to reduce delays for funding decisions.
e) Care home brokerage service finished beginning of November. Temporary bank staff to be appointed to determine whether less expensive in-house alternative to care home brokerage service

f) Continue with spot purchase beds in residential placements for NWB pathway- transformation funding to continue for another year. Transformation funding for 2 band 6 posts has been agreed for the non weight bearing pathway, both in post.
g) There has been a further increase in Choice delays.- Bed bureau to ensure issues related to patient choice is escalated to matrons for further action. Revised choice policy to be agreed by key stakeholders.
h) Specialist Nurse for discharge to attend EMCARE care forum to improve partnership working with care homes. Further Care home forum to be arranged by CCG
i) 6 months Pilot for dementia care coordinator to support UHL & care providers with dementia patients on discharge to assess pathway- interviews complete mid-September, await HR recruitment process, escalated to Lead HR for urgent action; due to start in post end of November.
j) Ward 2 at Leicester General Hospital to remain open.
k) Current review of UHL discharge teams to develop single integrated discharge team with single point of access for UHL staff. Service expected to improve handover and avoid duplication between areas.
l) Development of minimum data set to provide tool for safe, efficient and timely discharge.
m) Extra capacity in city rehab and ICS schemes for East and City CCG's open.

6.0 HUMAN RESOURCES – KATE BRADLEY

6.1 Appraisal

Mth | Qtr 1 | Qtr2 | YTD



CMG / Corporate Area	Appraisal rate	% from target
CHUGS	92.4%	2.6%
Clinical Supporting & Imaging	92.5%	2.5%
Divisional Management *	96.1%	0.0%
Emergency & Specialist Medicine	88.6%	6.4%
ITAPS	90.1%	4.9%
MSK & Specialist Surgery	93.9%	1.1%
Renal, Respiratory & Cardiac	89.5%	5.5%
Women's & Children's	90.3%	4.7%
Corporate Directorates Total	91.7%	3.3%

* Divisional Management includes staff not yet incorporated into the new structure

There continues to be considerable appraisal activity over the last month, we recognise that there has been a slight reduction in overall appraisal performance at the end of October. The Clinical Management Group (CMG) restructure at an accelerated pace and the re-alignment of the responsibilities in the new CMG continues to impact on the reporting of appraisal completions.

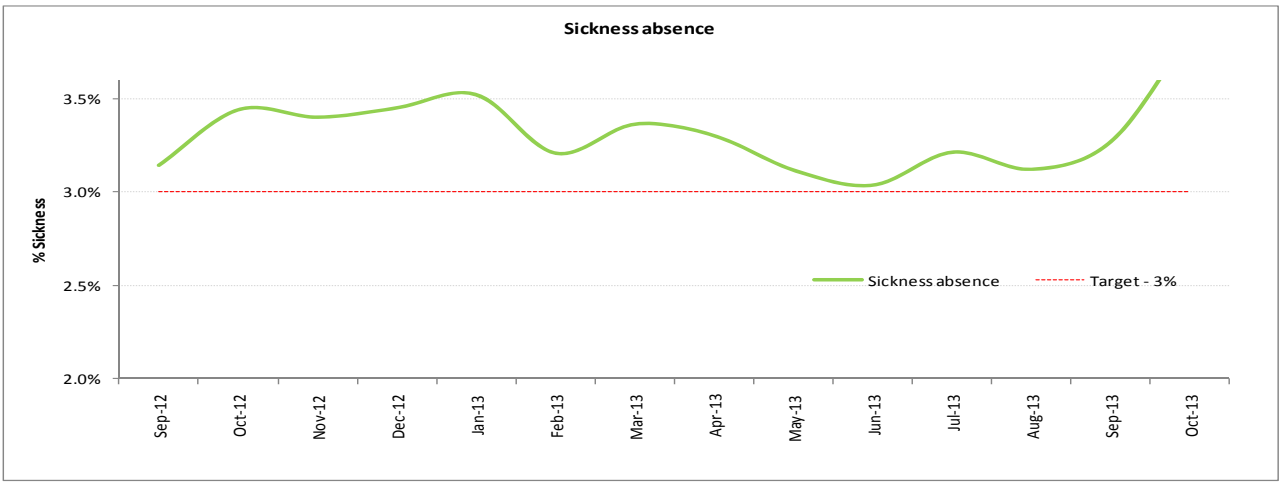
Appraisal performance continues to feature on CMG Board Meetings in monitoring the implementation of agreed actions. HR CMG Leads continue to work closely with CMGs to implement targeted 'recovery plans' and trajectory for each cost centre which will be submitted to the CMG Manager and HR by the end of November 2013.

Appraisal data leads for all service areas and CMGs will be identified in the new structure to ensure accuracy of reporting and robust monitoring.

Making it Happen reviews are arranged to pick up sickness absence, appraisals, local induction and statutory and mandatory training with CMG managers

6.2 Sickness

Mth | Qtr 1 | Qtr2 | YTD



The sickness rate for October is 3.85% and the September figure has now adjusted to 3.27% to reflect closure of absences. The overall cumulative sickness figure is now 3.32%. This is below the previous SHA's target of 3.4% but slightly above the Trust stretch target of 3%.

In order to provide a safe and healthy work environment for both staff and patients and as part of our key priority for preparations for winter 2013/14, we actively encourage our staff to have the flu vaccination. The Department of Health target is to vaccinate 75% of front line staff i.e. those delivering direct patient care. For UHL this equates to 7583 staff and to 18 November 2013 we have vaccinated 4359 i.e. (57.5%). This has exceeded last year's rate of 52%. In total UHL have vaccinated 5152 of all staff groups which is a total of 44.4% and there is sufficient supply to vaccinate all staff. In addition to our own staff we have vaccinated 319 Interserve staff who provide services to vulnerable patients.

6.3 Statutory and Mandatory Training

As a Trust we currently report against nine core subjects in relation to Statutory and Mandatory Training. These are Fire Safety Training, Moving & Handling, Hand Hygiene, Equality & Diversity, Information Governance, Safeguarding Children, Personal Safety Awareness, Bullying & Harassment and Resuscitation (BLS Equivalent).

Area	Fire Training %age	Moving & Handling %age	Hand Hygiene %age	Equality & Diversity %age	Info. Gover'ce %age	Safeguard Children ONLY %age	Personal Safety Aware'ss %age	Bullying & Harassm't %age	Resus - BLS Equivalent %age	Average %age Compliance
Refresher period in Months	12	24	12	36	12	36	36	n/a	12	
Acute Care Total	69%	72%	67%	57%	53%	76%	38%	67%	53%	61%
Planned Care Total	68%	73%	62%	47%	54%	75%	29%	66%	67%	60%
UHL Corporate Directorates Total	53%	57%	49%	45%	46%	59%	20%	50%	32%	46%
Women's & Children's Total	69%	76%	64%	43%	45%	89%	23%	65%	71%	61%
Trust wide Compliance	66%	70%	62%	50%	51%	75%	30%	64%	56%	
UHL staff are this compliant with their mandatory & statutory training from the key 9 subjects										58%

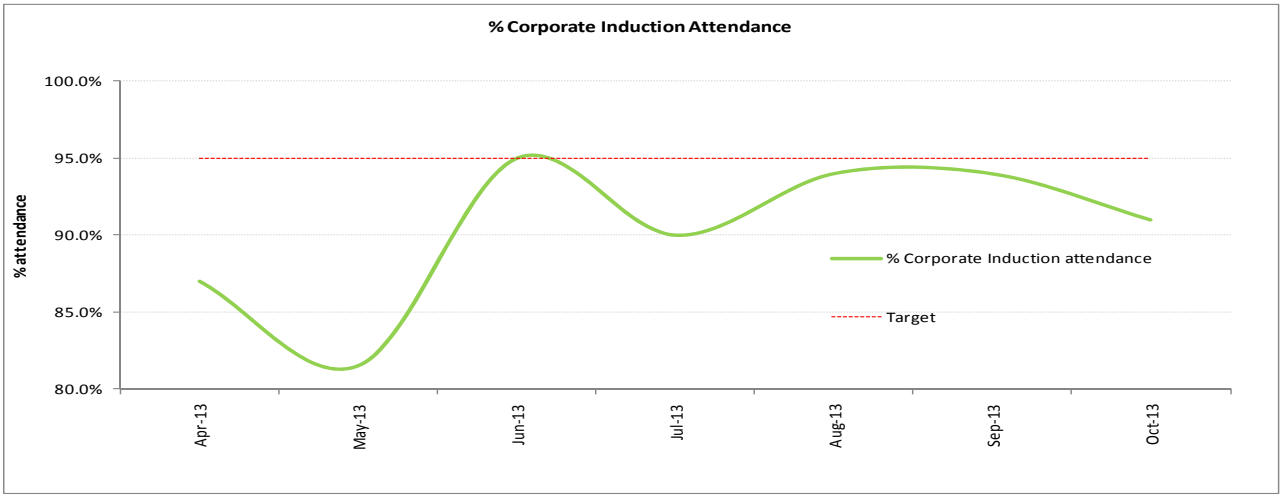
Over the last month UHL staff compliance against Statutory and Mandatory Training has increased from 55% to 58% across the nine core areas. Reporting will be updated to capture performance by Clinical Management Group and Corporate Directorates by the end of November 2013. In addition from December 2013 we will report against Health and Safety Training compliance to reflect the national Core Skills Training Framework.

This month we released the first three new e-learning modules including Equality & Diversity, Information Governance and Manual Handling (non-patient handlers) impacting positively on performance. The feedback received on new packages during the testing phase has been very positive. The next three packages will be live and launched early in December 2013.

We continue to communicate progress, essential training requirements and follow up on non-compliance at an individual level.

Work is underway in developing the new Learning Management System to improve reporting functionality and programme access.

6.4 Corporate Induction



There has been a reduction to 91% of staff attending corporate induction within the first 8 weeks. This continues to be primarily due to large numbers of new employees and limitation on venue capacity within this period.

The Task and Finish Group are undertaking a review of induction requirements and progressing with increasing the number of Corporate Inductions to weekly from 31st March

2014. The revised programme will be held on Trust premises to reduce delivery costs. This will increase our capacity to ensure new starters have the opportunity to attend Corporate Induction, wherever possible on day of commencement.

We are currently exploring the introduction of a more stringent approach to ensure 95% attendance at Corporate Induction within the first 8 weeks of employment.

7.0 2013/14 CONTRACTUAL QUERY STATUS

Commissioner Notices	Subject	Action/Update	Associated Penalty	Status
Contract Query	Cancer 62 Day	Remedial Action Plan (RAP) has been signed off Monthly progress reports against the agreed RAP	£50,000 Qtr1 fine has been repaid.	Monthly Progress Report. On/above trajectory.
Contract Query/First Exception Report sent on 19th November 2013.	ED Performance	Remedial Action Plan & Trajectory Agreed Performance against trajectory is failing.	2% Overall Contract penalty from August to October Automatic Contract Penalty (non refundable)	Failing to meet RAP.
Contract Query	18 Wk RTT	Revised Remedial Action Plan rejected September 2013. Intensive Support Team commenced work with Trust in October. Revised trajectory being worked up alongside the RAP	2% overall contract value commencing August. Automatic Individual specialty penalties	RAP Rejected. Refreshed RAP deadline is 28th November.
Contract Query	Ambulance Turnaround	Remedial Action Plan has been signed off. Agreement to re-invest incurred penalties upon trajectory achievement for the requested £90-£100k	Automatic Contract Penalty	On-going
Contract Query	Pressure Ulcers	Remedial Action Plan (RAP) has been signed off The action plan is reported as RED against the trajectory. CCG's to work with UHL to see a significant sustained improvement	Three month review of performance before 2% overall contract penalty levied (Sept 13). Automatic penalties applied.	On-going
Contract Query	Stroke	Remedial Action Plan (RAP) has been signed off Monthly progress reports against the agreed RAP	-	Contract query to be closed.
Contract Query	Short notice cancelled operations and rebooking in 28 days	Remedial Action Plan has been requested, to be submitted in time for November CPM	Automatic Contract Penalty	On-going. Action plan to be submitted in time for November CPM
Activity Query Notice	Emergency over performance	Emergency analysis provide by commissioners and initial meeting held. UHL response has been provided. Clinical meeting to be arranged.	Withholding of financial over performance	On-going
Activity Query Notice	Outpatients over performance	Analysis provided by commissioners. Next steps agreed at joint meeting.	Withholding of financial over performance	On-going

8.0 UHL - FACILITIES MANAGEMENT– RACHEL OVERFIELD

8.1 Introduction

This report provides a summary of the performance of Facilities Management (FM) services as provided through the contract with Interserve for October.

8.2 Key Performance Indicators

The contract is underpinned by detailed specifications for all 14 services and is reinforced by 83 Key Performance Indicators (KPI's) monitoring all aspects of the service. Table 1 below represents the status and trends of these 83 KPI's as recorded and reported by Interserve and comparison is made to the previous month.

Table 1 - UHL KPI Status Summary - October 2013

KPI Status (Change since last month)	Number of KPIs August - September	Number of KPIs September - October
Green	**48**	**53**
Deteriorated	2	3
Improved	10	9
No change	36	41
Amber	**5**	**5**
Deteriorated	3	3
Improved	2	2
Red	**28**	**23**
Deteriorated	15	10
Improved	13	13
Not Measured/In abeyance	**2**	**2**
	83	83
Net number improved minus number deteriorated	+5	+8

The above table shows improved performance across the UHL with regard the reporting of KPI's by Interserve for the months of September and October.

Table 2 on page 33 includes 10 KPI's covering key services which are currently being closely monitored by the Trust to identify indicative service delivery across the 3 acute hospital sites. A similar picture is demonstrated from this information in respect of the improved performance by the service provider. The analysis below shows an overall improvement in performance scores for October for several services though the RAG rated KPI's indicator in some cases remains unchanged.

Table 2 - KEY PERFORMACE INDICATORS FOR OCTOBER

Ref	Service	KPI	Red	Green	Oct	Change
2	Contract Management	Average score (%) of Customer Surveys returned in the Contract Month	≤ 80%	≥ 90%	100.00%	←→
7	Estates	Percentage of statutory inspection and testing completed in the Contract Month measured against the PPM schedule	≤ 98%	100.0%	91.69%	↑
12	Estates	Percentage of Urgent requests achieving response time	≤ 96%	≥ 98%	50.00%	↑
13	Estates	Percentage of Urgent requests achieving rectification time	≤ 96%	≥ 98%	83.33%	↓
26	Portering	Percentage of scheduled Portering tasks completed in the Contract Month	≤ 98%	99%	100.00%	←→
27	Portering	Percentage of Emergency Portering requests achieving response time	≤ 98%	100.0%	57.14%	↓
45	Cleaning	Monthly percentage of Joint Audits undertaken against agreed schedules	≤ 98%	100.0%	92.79%	↑
46	Cleaning	Percentage of audits in clinical areas achieving NCS audit scores for cleaning above 90%	≤ 98%	100.0%	93.06%	↑
57	Patient Catering	Percentage of meals delivered to wards in time for the designated meal service as per agreed schedule.	≤ 95%	97.0%	97.30%	↑
81	Helpdesk	Percentage of telephone calls to the helpdesk answered within 5 rings using a non-automated solution.	≤ 95%	≥ 97%	96.04%	←→

Encouragingly there has been a recorded improvement in overall service delivery over the past two months and Interserve continues to implement and demonstrate their FM action plans with support from NHS Horizons to ensure the continued progress is both reinforced and maintained.

9.0 October IM&T Service Delivery Review

9.1 Highlights

Upgrade of the Dictate IT system.
Upgrade to the Cris Imaging system.
Transition of Desktop Support, Network Support and Telephony support to the Managed Business Partner.

9.2 IT Service Review

There were 7686 (7296 previous month) incidents were logged during October, out of which 5220 (4666 previous month) were resolved. 1781 (1990 previous month) incidents were closed on first contact

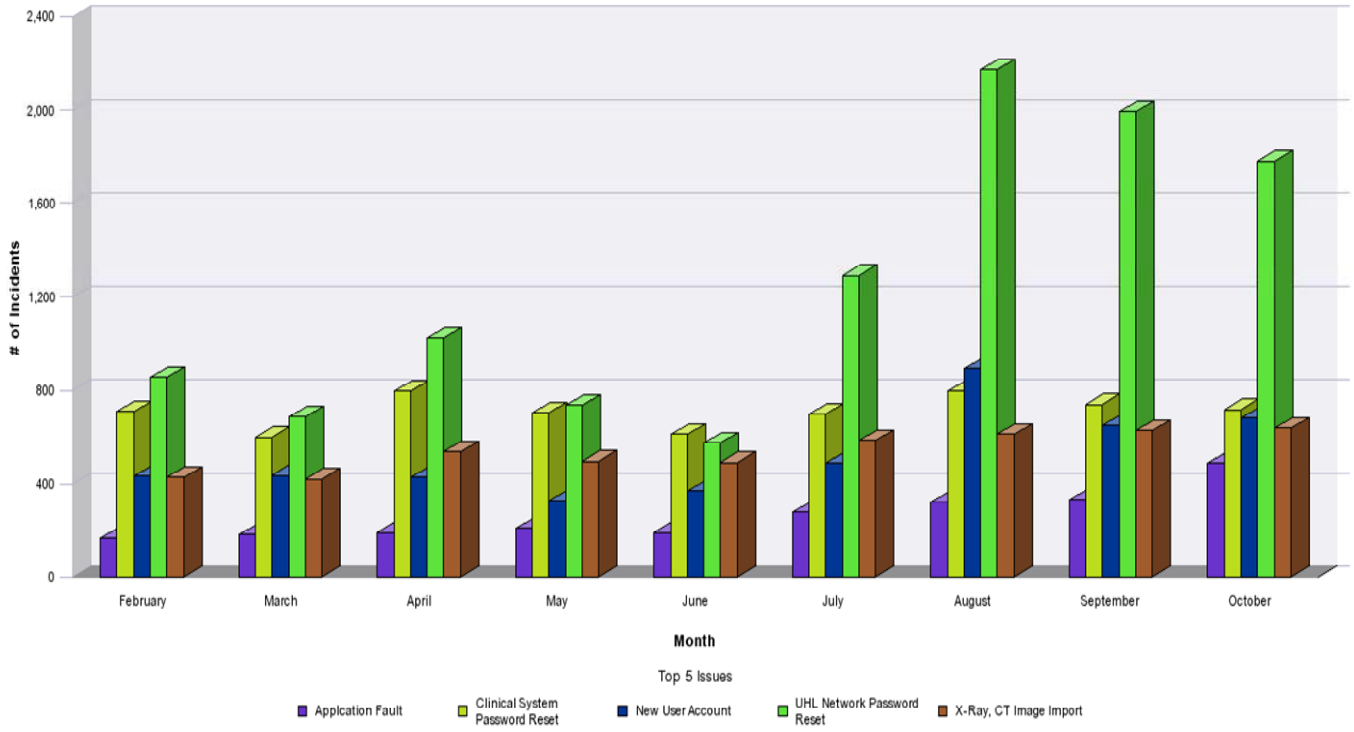
Performance against service level agreements is as expected and follows the flight path for service level agreements improvements following the transfer of staff to the Managed Business Partner.

There were 837 (1,005 previous month) incidents logged out of hours via the 24/7 service desk function

9.3 Future Action

Applications Management Wave 2 and Projects & Programmes transfer to the Managed Business Partner on 1st December 2013.

9.4 IM&T Service Desk top 5 issues



9.5 IM&T September Heatmap

				Priority 1		Priority 2		Priority 3		Priority 4		Priority 5		Totals for This Month		Totals for Last Month	
Incidents Outstanding at end of August*		221															
New Incidents Logged in September		7286															
Incidents Closed in October		7138															
Incidents Resolved awaiting Closure		8															
Outstanding Incidents**		967		*4hrs 45mins*		*1 working day*		*2 working days*		*4 working days*		*10 working days*		*(September)*		*(August)*	
Application Management	Calls resolved in SLA (%)			N/A		100%		97.14%		99.61%		100%		99.54%		99.58%	
	Resolved in SLA/Total Resolved			0	0	1	1	34	35	1033	1037	12	12	1080	1085	1197	1202
Business Intelligence	Calls resolved in SLA (%)			N/A		N/A		50%		100%		N/A		80%		100%	
	Resolved in SLA/Total Resolved			0	0	0	0	1	2	3	3	0	0	4	5	5	5
Data Centre Service Management	Calls resolved in SLA (%)			N/A		100%		95.83%		94.53%		89.74%		94.21%		98.92%	
	Resolved in SLA/Total Resolved			0	0	2	2	46	48	259	274	35	39	342	363	274	277
Desktop & AMC	Calls resolved in SLA (%)			N/A		N/A		88.31%		94.47%		95.19%		93.68%		95.46%	
	Resolved in SLA/Total Resolved			0	0	0	0	136	154	649	687	178	187	963	1028	884	926
I&D Team	Calls resolved in SLA (%)			100%		N/A		50%		79.31%		100%		80%		96.55%	
	Resolved in SLA/Total Resolved			3	3	0	0	1	2	23	29	1	1	28	35	56	58
Imaging	Calls resolved in SLA (%)			100%		100%		94.58%		86.86%		96.23%		90.28%		86.79%	
	Resolved in SLA/Total Resolved			1	1	1	1	384	406	529	609	51	53	966	1070	1183	1363
Network Services	Calls resolved in SLA (%)			100%		100%		86.11%		95.74%		99.31%		96.42%		89.91%	
	Resolved in SLA/Total Resolved			2	2	2	2	31	36	90	94	144	145	269	279	98	109
Pathology	Calls resolved in SLA (%)			N/A		N/A		0%		33.33%		N/A		25%		35%	
	Resolved in SLA/Total Resolved			0	0	0	0	0	1	1	3	0	0	1	4	7	20
Pharmacy	Calls resolved in SLA (%)			N/A		N/A		N/A		100%		N/A		100%		85.71%	
	Resolved in SLA/Total Resolved			0	0	0	0	0	0	3	3	0	0	3	3	6	7
Service Desk	Calls resolved in SLA (%)			N/A		N/A		97.06%		98.19%		99.37%		98.27%		98.81%	
	Resolved in SLA/Total Resolved			0	0	0	0	33	34	379	386	157	158	569	578	579	586
Telecoms	Calls resolved in SLA (%)			N/A		N/A		92.31%		93.75%		100%		94.83%		100%	
	Resolved in SLA/Total Resolved			0	0	0	0	12	13	75	80	23	23	110	116	135	135
Theatre Support	Calls resolved in SLA (%)			N/A		N/A		66.67%		87.14%		0%		85.14%		79%	
	Resolved in SLA/Total Resolved			0	0	0	0	2	3	61	70	0	1	63	74	79	100
Undefined Teams	Calls resolved in SLA (%)			N/A		100%		96.58%		95.69%		99.95%		99.2%		99.06%	
	Resolved in SLA/Total Resolved			0	0	1	1	141	146	311	325	2023	2024	2476	2496	2540	2564

Incidents Closed on first contact	1990	
Incidents Closed in month logged	5986	
Incidents Resolved on Day Logged	2541	
Incidents Escalated / Total Escalations	279	393
Incidents Unresolved / Total Unresolved	76	77

Service Level Agreements

Red : <90% of calls resolved within SLA

Amber : 90-94.99% of calls resolved within SLA

Green : >95% of calls resolved within SLA

Affected System	Incidents Logged	Incidents Closed
CRIS	258	248
EDIS	62	49
Euroking/E3	4	9
HISS/Clinicom	194	217
iLab/Apex	607	605
JAC	4	3
ORMIS	83	83
PACS/IMPAX	205	213
Sunquest ICE	210	212
Total:	**1627**	**1639**

10.0 FINANCE – ANDREW SEDDON

10.1.1 This paper summarises the Month 7 financial position. As well as the following commentary, this report contains a number of key financial statements included at the end of this finance section.

- Income and Expenditure
- Balance Sheet
- Cash Flow
- Capital Programme
- CIP Performance by CMG
- Financial Performance by CMG

10.2 FINANCIAL POSITION AS AT END OF OCTOBER 2013

10.2.1 The Trust is reporting a deficit at the end of October 2013 of £17.3m, which is £19.5m adverse to the planned surplus of £2.2m. The in month position is a £0.7m deficit, £3.5m adverse to the Plan. The October Plan surplus of £2.8m reflects a higher than trend expected patient care income level.

10.2.2 Table 1 outlines the current position and Table 2 outlines the Financial Risk Rating (FRR). The consequence of the current financial performance, predominately the £17.3m actual deficit, is that the FRR is 2.2. In addition, the Trust is risk rated at Level 4 by the NHS Trust Development Authority (NTDA), a rating reserved for Trusts either planning or at high risk of delivering a deficit for the year.

Table 1: Income & Expenditure Position

	October 2013			April -October 2013		
	Plan £m	Actual £m	Var £m	Plan £m	Actual £m	Var £m
Income						
Patient income	53.0	55.5	2.5	371.7	376.0	4.3
Contigency Release	0.0	0.0	0.0	5.0	5.0	0.0
Teaching, R&D	6.9	7.0	0.0	45.4	44.9	(0.5)
Other operating Income	4.3	5.0	0.6	24.1	24.1	0.0
Total Income	**64.3**	**67.4**	**3.1**	**446.3**	**450.0**	**3.8**
Operating expenditure						
Pay	38.3	39.5	(1.2)	261.6	272.6	(11.0)
Non-pay	23.0	24.8	(1.9)	160.2	169.5	(9.3)
Reserves	(3.5)	-	(3.5)	(3.5)	-	(3.5)
Total Operating Expenditure	**57.8**	**64.4**	**(6.6)**	**418.4**	**442.1**	**(23.7)**
EBITDA	**6.5**	**3.0**	**(3.5)**	**27.9**	**7.9**	**(20.0)**
Net interest	0.0	-	0.0	0.0	(0.0)	(0.0)
Depreciation	(2.7)	(2.7)	(0.0)	(18.9)	(18.8)	0.2
PDC dividend payable	(1.0)	(1.0)	0.0	(6.7)	(6.4)	0.3
Net deficit	**2.8**	**(0.7)**	**(3.5)**	**2.2**	**(17.3)**	**(19.5)**
EBITDA %		**4.5%**			**1.8%**	

Table 2: Financial Risk Rating

Criteria	Indicator	Weight	Risk Ratings 5	4	3	2	1	Reported Position: Year to Date	Forecast Outturn
Underlying performance	EBITDA margin %	25%	11	9	5	1	<1	2	3
Achievement of plan	EBITDA achieved %	10%	100	85	70	50	<50	1	4
Financial efficiency	Net return after financing %	20%	>3	2	-0.5	-5	<-5	3	5
	I&E surplus margin %	20%	3	2	1	-2	<-2	1	2
Liquidity	Liquid ratio days	25%	60	25	15	10	<10	3	3
Weighted Average		100%						2.2	3.3

10.2.3 The **key points** to highlight in the YTD position are:

- **Patient care income £4.3m (1.1%)** favourable against Plan
- **Pay costs, £11.0m (4.2%) adverse to Plan**
- **Non pay costs, £9.3m (5.8%)** adverse to Plan
- **CIP performance** of £0.8m adverse to Plan
- **Adverse variances to Plan in all CMGs**

The **Month 7 YTD position** may be analysed as follows.

10.3 INCOME

10.3.1 Within patient income, NHS income is £5.5m (1.5%) above Plan year to date. The key areas are shown in the following table:

- Elective IP activity is 3.8% down on Plan
- Emergency IP activity 3.4% up on Plan, but income is £82k (0.1%) adverse
- Over-performance in outpatients, £2.2m (4.4%) and ED, £0.1m (0.9%)
- Other income:
  - Critical care, £1.6m, 6% over performing
  - Direct access – Imaging and Pathology, £0.6m, 6%
  - End Stage Renal Failure, £0.7m, 4%
  - Excluded drugs and devices, £2.1m, 6%
  - Contractual penalties offsetting the above favourable variances

Table 3: Patient Care Activity

Case mix	Plan to Date (Activity)	Total YTD (Activity)	Variance YTD (Activity)	Variance YTD (Activity %)	Plan to Date (£000)	Total YTD (£000)	Variance YTD (£000)	Variance YTD (Activity %)
Day Case	47,725	49,490	1,765	3.70	29,174	29,823	649	2.23
Elective Inpatient	13,427	12,918	(509)	(3.79)	41,444	41,323	(121)	(0.29)
Emergency / Non-elective Inpatient	54,919	56,757	1,838	3.35	102,957	102,874	(82)	(0.08)
Marginal Rate Emergency Threshold (MRET)	0	0	0	0.00	(1,995)	(2,444)	(449)	0.00
Outpatient	433,274	445,633	12,359	2.85	48,968	51,127	2,159	4.41
Emergency Department	92,506	91,623	(883)	(0.95)	9,930	10,011	82	0.82
Other	4,512,473	4,645,419	132,946	2.95	137,024	140,311	3,286	2.40
Grand Total	**5,154,325**	**5,301,841**	**147,515**	**2.86**	**367,502**	**373,026**	**5,524**	**1.50**

10.3.2 Table 4 below highlights the impact of price and volume changes in activity across the major "points of delivery". Overall, this shows that the £5.5m Trust level over-performance

is as a consequence of a volume (activity) related £7.5m favourable impact, lessened slightly by a £2.0m adverse shift in average tariff prices.

Table 4: Price and Volume Impact on Patient Care Activity

Average tariff	Price Variance YTD %	Volume Variance YTD %	Price / Mix Variance (£000)	Volume Variance (£000)	Variance YTD (£000)
Day Case	(1.4)	3.7	(430)	1,079	649
Elective Inpatient	3.6	(3.8)	1,451	(1,572)	(121)
Emergency / Non-elective Inpatient	(3.3)	3.3	(3,528)	3,446	(82)
Marginal Rate Emergency Threshold (MRET)			(449)	0	(449)
Outpatient	1.5	2.9	762	1,397	2,159
Emergency Department	1.8	(1.0)	177	(95)	82
Other			0	3,286	3,286
Grand Total	**(1.3)**	**2.9**	**(2,017)**	**7,541**	**5,524**

The above table highlights major shifts in case mix across day case and inpatients in the year to date. The favourable price variance in elective IP arose across a number of specialties including Cardiology (complex ablation and TAVI), General Surgery and Orthopaedic Surgery. Volume has fallen below Plan largely due to capacity constraints (especially beds).

Whilst the volume increase in emergency activity reflects the patient activity, the price variance of £3.5m (3.3%) needs greater analysis. The CMGs are investigating the reasons at a specialty and sub-specialty level and we will orally update the Finance & Performance Committee. At this time, we will also have the finally coded patient care activity (in Month 6, we saw a £1m improvement from early cut to finally coded).

10.3.3 Within the year to date income position, we have made provision for the following **penalties**. Year to date, this amounts to just over £4.1m, £1.4m if we exclude re-admissions.

Table 5: Penalties & Fines

	Reported in M7 Position £'000s
EM Readmissions	2,700
RTT	635
Diagnostic Imaging	17
Never Events	6
Pressure Ulcers	42
Cancelled Ops	50
ED Wait Times (automatic)	193
ED 12 Hour Trolley Breaches	4
Cancer 62 Day Target (Automatic)	50
Contract Penalties Provision	80
CQUIN Provision	350
Total	**4,127**

The key RTT penalties relate to General

Surgery, ENT, Ophthalmology and Orthopaedics. Other includes pressure ulcers, cancelled operations and ED 12 hour trolley breaches.

As can be seen from the table, at the moment, we are not assuming any penalties around Ambulance Turnaround times, and the ED and RTT rapid action plans.

10.4 EXPENDITURE

10.4.1 Operating expenditure is £23.7m above Plan as at the end of October (5.7%).

10.4.2 The CMGs and Corporate Directorates have identified that a total of £18.5m CIP savings have been delivered year to date, representing a £0.8m adverse variance to the £19.3m CIP Plan. The 2013/14 CIP paper provides further details on the CIP performance to date, year end forecasts, remedial action plans and RAG ratings for the remaining schemes.

10.4.3 **PAY –** as at Month 7, pay costs are £11.0m over budget, £14.3m more than the same period in 2012/13 (5.5%). When viewed by staff group, the most significant increases year on year are seen across agency and medical locums, nursing spend and consultants' costs (see below).

Table 6

Staff Type	2013/14 £'000s	2012/13 £'000s	Change £'000s	Change %
A&C / Managers	34,107	35,202	1,095	3.1
Agency / Medical Locums	13,156	9,589	(3,566)	(37.2)
Allied Health Prof's	10,923	10,954	31	0.3
Medical - Non Consultant	36,397	35,381	(1,016)	(2.9)
Consultant	51,862	46,979	(4,883)	(10.4)
Nursing & Midwifery	101,220	95,881	(5,340)	(5.6)
Other	24,943	24,342	(601)	(2.5)
TOTAL	**272,609**	**258,328**	**(14,281)**	**(5.5)**

10.4.4 Analysis of the year to date £11.0m variance to Plan highlights the following key factors, and split by CMG:

	Pay - 2013/14					
CMG's	YTD Budget £000s	YTD Actual £000s	'Variance £000s	M1-7 1213 £000s	Year on Year Change £000s	Year on Year Change %
C.H.U.G.S	26,790	27,137	(347)	25,924	(1,213)	(4.7)
Clinical Support & Imagi	39,340	40,352	(1,012)	39,044	(1,307)	(3.3)
Divisional Management	2,305	2,211	94	2,201	(10)	(0.5)
Emergency & Specialist M	36,957	42,702	(5,745)	35,828	(6,875)	(19.2)
I.T.A.P.S	29,301	31,806	(2,505)	29,726	(2,080)	(7.0)
Musculo & Specialist Sur	25,418	26,101	(683)	25,866	(235)	(0.9)
Renal, Respiratory & Car	32,741	33,876	(1,135)	32,944	(932)	(2.8)
Womens & Childrens	43,351	43,232	119	41,109	(2,123)	(5.2)
	236,202	**247,416**	**(11,215)**	**232,642**	**(14,775)**	**(6.4)**

- Estimated pay over-spend due to patient care activity over-performance **- £3.7m,** assuming that pay stepped/marginal cost is c50% of patient care income volume variance and staffed at non-premium rates

- Declared under-delivery on pay CIP schemes **£1.9m**

- Continued use of extra capacity wards (Fielding Johnson, Ward 1 LRI, Ward 2 LGH, Ward 19 LRI and Odames LRI) to meet the emergency activity levels. Premium spend has covered a significant amount of the staff costs in these areas. Nursing incentives are also being paid to bank and agency to increase the "fill rates", although these are now restricted to the Emergency Care CMG
- Increased doctors and nurses in Medicine and ED to ensure the flow of patients from ED to support the 4 hour target. The CMG is now £5.7m adverse to the pay plan and spending almost £7m (20%) above the same level in 2012/13
- A continued reliance on premium payments as per Chart 1 below. Increases have continued into this financial year, climbing to almost £4m in May and June, falling to £3.5m in July, and remaining around this level for the last two months. Table 7 illustrates the relative percentages of total pay spend of each type. It can be seen that there has been a significant rise in the total percentage to almost 10% in Quarter 1 of this financial year (falling to 9% in Month 6, but increasing to almost 10% again in October)

Chart 1: Non-Contracted/Premium Pay Spend

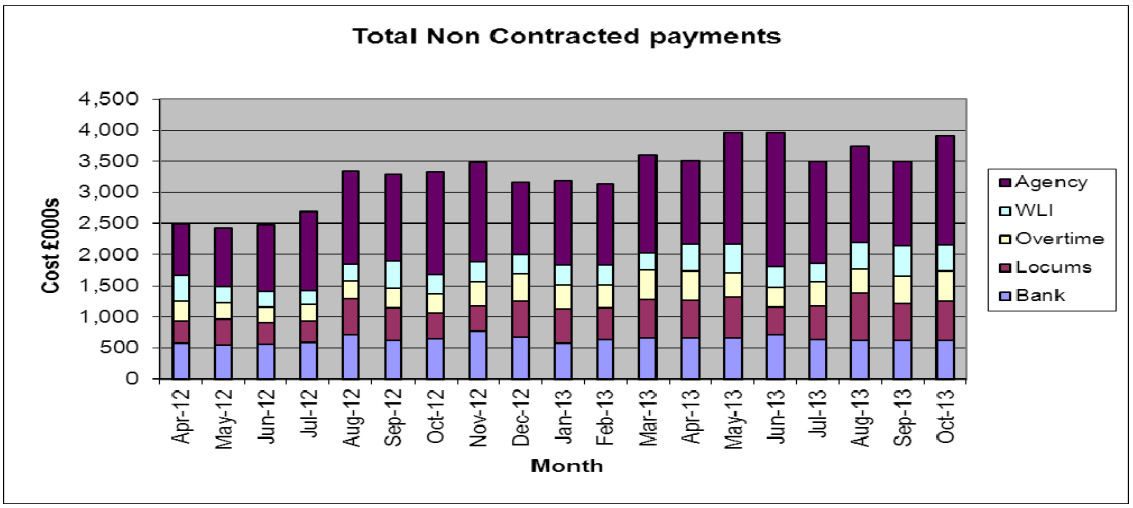


Table 7: Non-Contracted Pay Costs as %age of Total Pay Bill

Type	12/13 Q1	12/13 Q2	12/13 Q3	12/13 Q4	13/14 Q1	13/14 M6	13/14 M7
Bank	1.50%	1.70%	1.80%	1.60%	1.70%	1.60%	1.60%
Locums	1.00%	1.30%	1.20%	1.50%	1.50%	1.60%	1.60%
Overtime	0.80%	0.80%	1.00%	1.10%	1.00%	1.10%	1.20%
WLI	0.80%	0.80%	0.80%	0.80%	1.00%	1.20%	1.10%
Agency	2.50%	3.70%	3.80%	3.60%	4.50%	3.50%	4.40%
Total	**6.60%**	**8.20%**	**8.70%**	**8.50%**	**9.80%**	**9.00%**	**9.90%**

Pay costs rose steadily from April 2012 to June 2013, hitting a peak of £39.4m in June; July saw a reduction to £39.0m with August (£38.8m) and September continuing this trend down at £38.6m. The October position, however, is disappointing (£39.5m). Whilst some of the increase from September can be attributed to the payment of the August bank holiday enhancement and the additional patient care activity in October, there has been a marked increase in premium pay.

Nursing and related agency costs make up the largest part of the adverse pay variance. Some of the overspend, as described above, is volume related (extra capacity opened) and the impact of agency rates is clear. Increase in nurse:bed ratios have also pushed up costs.

Chart 2: Monthly Pay Costs

10.4.6 The continued reliance on premium staff comes at the same time as our contracted staff numbers in medical and nursing professions have increased by 4.0%, equivalent to an increase of 252 WTE since March 2012 (Table 8). Further investigation is also required as to the increase in Consultant numbers by 41wte, or 7.7%.

Table 8: Contracted WTE

Staff Type	Movement Oct 13 - March 12		Contracted Staff	
	WTE	(%)	Oct 13 WTE	March 12 WTE
ADMIN & CLERICAL	(24)	(1.4)	1,762	1,787
ALLIED HEALTH PROFESSIONALS	(7)	(1.5)	451	458
CAREER GRADES	11	15.3	81	70
CONSULTANT	41	7.7	574	533
HEALTHCARE ASSISTANTS	25	11.5	242	217
HEALTHCARE SCIENTISTS	(19)	(2.5)	722	741
MAINTENANCE & WORKS	1	10.6	7	6
NURSING QUALIFIED	15	0.4	3,363	3,348
NURSING UNQUALIFIED	124	10.4	1,319	1,195
OTHER MEDICAL & DENTAL STAFF	36	4.0	934	899
OTHER SCIEN, THERAP & TECH	54	19.6	328	274
SENIOR MANAGERS	(34)	(19.7)	137	171
TOTAL	**223**	**2.3**	**9,921**	**9,699**
MEDICAL & NURSING	252	4.0	6,513	6,262
OTHER STAFF GROUPS	(29)	(0.9)	3,408	3,437
TOTAL	**223**	**2.3**	**9,921**	**9,699**

10.4.7 **NON PAY** – operating non pay spend, excluding reserves, is now showing a YTD adverse position to Plan of £9.3m (6%) which is spread across all the CMGs with the exception of Women's & Children's.

10.4.8 This is as a result of three main factors:

- Activity related marginal costs e.g. keeping Ward 19 open - **£1.9m** (assuming that non pay marginal cost is c25% of patient care income variance)
- Patient care income backed costs such as NICE/HCT costs - **£2.2m** e.g. haemophilia patients, high cost devices in Acute and Women's & Children's
- Other cost pressures/over-stated non-pay CIP delivery - **£5.2m.** This includes:

  - £0.8m Imaging consumables
  - £1.2m Use of independent sector and contracted clinical services
  - £0.4m Blood products
  - £0.5m Printing, stationery and postage
  - £0.3m Security
  - £0.5m Maintenance and MES costs
  - £0.7m Consultancy
  - £0.4m Furniture, office equipment and IT

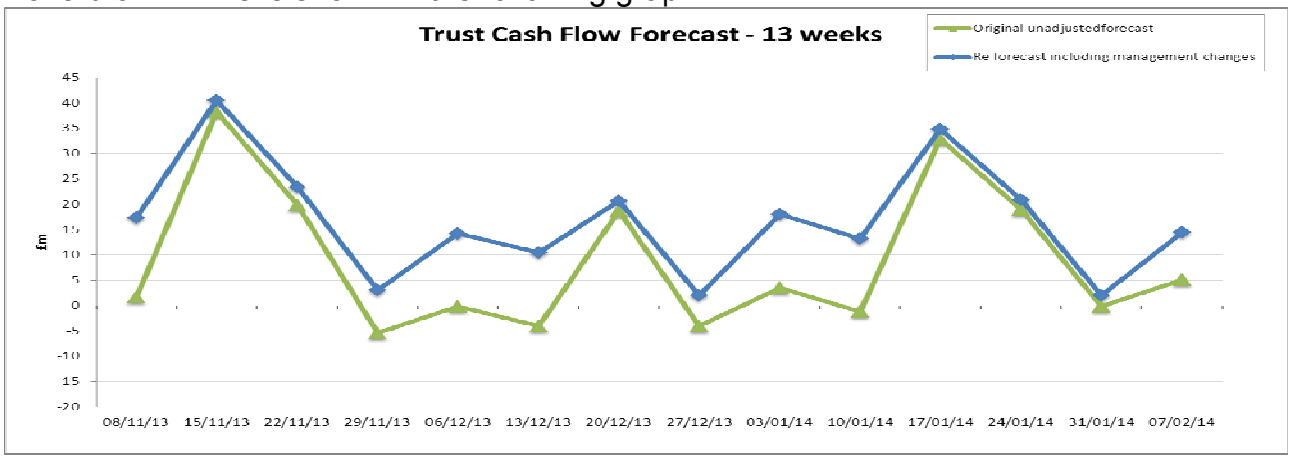
10.4.9 As well as the operating non pay deficit of £9.3m, there is an in month adverse variance of £3.5m against reserves. This is as a consequence of the contingency created through the annual planning cycle being over committed due to in year pressures and agreed changes. These include the investment in the nursing budgets, the re-basing of the initial £40.4m CIP target for "over heating" issues, and additional cost pressures supported post AOP submission e.g. CQUIN posts.

In order to provide greater transparency to the CMGs, Executive Team and the Finance & Performance Committee, the Finance Team will be providing a monthly schedule of all budgetary changes (pay, non-pay and income) and the impact in year and recurrently. This is predicated on the annual planning process for 2014/15 being based on recurrent budgets.

10.5 CASH

10.5.1 The Trust's cash balance was £5.3m at the end of October 2013.

10.5.2 In mid December and January, the unadjusted cash balance is forecast to fall below the £2m minimum allowable level that has been set by the Trust and would be significantly overdrawn. This is shown in the following graph:



10.5.3 We have agreed with local CCGs to bring forward £21m of the monthly SLA payments to the start of each month instead of the 15th and this covers the in-month shortfalls. We are still continuing to manage our creditor payment runs in order to maintain sufficient operating cash.

10.5.4 We will also continue to manage our creditor payment runs to ensure that we pay essential suppliers whilst deferring non-essential payments. We prioritise the payment of:

- Payroll, tax and national insurance
- Large business critical suppliers
- Small local suppliers who are dependent on income from the Trust

10.6 CAPITAL

10.6.1 The Trust has spent £13.4m of capital at the end of October 2013, which is approximately 75% of the YTD Plan. The year-end forecast, as shown with the appendices, has now reduced to £34.1m, £5.7m below the planned level.

10.6.2 A detailed paper highlighting the risks and opportunities around the year end capital programme is being presented to the Executive Performance Board on 26 November 2013 – the key actions will be updated to the Finance & Performance Committee.

10.7 CONCLUSION

10.7.1 The Trust has reported to the NTDA that we are £19.5m adverse to our planned £2.2m surplus. Urgent discussions continue with Commissioners and the NTDA regarding the year end forecast implications of the current financial position.

Income and Expenditure Account for the Period Ended 31 October 2013

	October 2013			April 2013 - October 2013		
	Plan	Actual	Variance (Adv) / Fav	Plan	Actual	Variance (Adv) / Fav
	£ 000	£ 000	£ 000	£ 000	£ 000	£ 000
Elective	6,171	**5,967**	(204)	41,444	**41,323**	(121)
Day Case	4,521	**4,650**	129	29,174	**29,823**	649
Emergency	14,249	**13,950**	(299)	100,962	**100,431**	(532)
Outpatient	7,374	**7,891**	517	48,968	**51,127**	2,159
Contingency Release	0	**0**	0	5,000	**5,000**	0
Non NHS Patient Care	615	**240**	(375)	4,238	**2,977**	(1,261)
Other	20,076	**22,763**	2,687	146,954	**150,322**	3,368
Patient Care Income	**53,006**	**55,461**	**2,455**	**376,740**	**381,003**	**4,263**
Teaching, R&D income	6,922	**6,971**	49	45,433	**44,921**	(512)
Other operating Income	4,331	**4,959**	628	24,089	**24,102**	13
Total Income	**64,259**	**67,391**	**3,132**	**446,262**	**450,026**	**3,764**
Pay Expenditure	**38,302**	**39,533**	**(1,231)**	**261,624**	**272,609**	**(10,985)**
Non Pay Expenditure	**22,955**	**24,832**	**(1,877)**	**160,225**	**169,483**	**(9,258)**
Central Reserves	**(3,492)**	**0**	**(3,492)**	**(3,492)**	**0**	**(3,492)**
Total Operating Expenditure	**57,765**	**64,365**	**(6,600)**	**418,357**	**442,092**	**(23,735)**
EBITDA	**6,494**	**3,026**	**(3,468)**	**27,905**	**7,934**	**(19,971)**
Interest Receivable	7	**5**	(2)	48	**124**	76
Interest Payable	(5)	**(5)**	0	(35)	**(133)**	(98)
Depreciation & Amortisation	(2,706)	**(2,743)**	(37)	(18,947)	**(18,768)**	179
Surplus / (Deficit) Before Dividend and Disposal of Fixed Assets	**3,790**	**283**	**(3,507)**	**8,971**	**(10,843)**	**(19,814)**
Dividend Payable on PDC	(964)	**(964)**	0	**(6,748)**	**(6,418)**	330
Net Surplus / (Deficit)	**2,826**	**(681)**	**(3,507)**	**2,223**	**(17,261)**	**(19,484)**
EBITDA MARGIN		**4.49%**			**1.76%**	

Balance Sheet

BALANCE SHEET	Mar-13 £000's Actual	Apr-13 £000's Actual	May-13 £000's Actual	Jun-13 £000's Actual	Jul-13 £000's Actual	Aug-13 £000's Actual	Sep-13 £000's Actual	Oct-13 £000's Actual
Non Current Assets								
Intangible assets	5,318	5,160	5,012	4,940	4,795	4,650	4,627	4,419
Property, plant and equipment	354,680	353,855	353,723	352,327	352,803	353,255	352,521	352,993
Trade and other receivables	3,125	3,183	3,181	3,252	3,302	3,291	3,331	3,268
TOTAL NON CURRENT ASSETS	**363,123**	**362,198**	**361,916**	**360,519**	**360,900**	**361,196**	**360,479**	**360,680**
Current Assets								
Inventories	13,064	13,869	13,257	13,778	13,861	13,776	14,499	14,176
Trade and other receivables	44,616	42,408	42,628	35,756	40,713	44,182	46,674	42,210
Other Assets	40	40	40	40	40	40	40	40
Cash and cash equivalents	19,986	19,957	14,257	19,129	15,343	7,203	4,484	5,335
TOTAL CURRENT ASSETS	**77,706**	**76,274**	**70,182**	**68,703**	**69,957**	**65,201**	**65,697**	**61,761**
Current Liabilities								
Trade and other payables	(75,559)	(73,056)	(67,971)	(68,079)	(71,026)	(69,123)	(77,327)	(81,916)
Dividend payable	0	(964)	(1,928)	(2,892)	(3,856)	(4,820)	0	(964)
Borrowings	(2,726)	(2,800)	(2,800)	(2,800)	(2,800)	(2,800)	(2,800)	(2,800)
Provisions for liabilities and charges	(1,906)	(1,906)	(1,906)	(1,906)	(1,906)	(1,906)	(1,342)	(1,342)
TOTAL CURRENT LIABILITIES	**(80,191)**	**(78,726)**	**(74,605)**	**(75,677)**	**(79,588)**	**(78,649)**	**(81,469)**	**(87,022)**
NET CURRENT ASSETS (LIABILITIES)	**(2,485)**	**(2,452)**	**(4,423)**	**(6,974)**	**(9,631)**	**(13,448)**	**(15,772)**	**(25,261)**
TOTAL ASSETS LESS CURRENT LIABILITIES	**360,638**	**359,746**	**357,493**	**353,545**	**351,269**	**347,748**	**344,707**	**335,419**
Non Current Liabilities								
Borrowings	(10,906)	(10,958)	(11,190)	(10,809)	(11,522)	(11,484)	(11,159)	(10,797)
Other Liabilities	0	0	0	0	0	0	0	0
Provisions for liabilities and charges	(2,407)	(2,454)	(2,488)	(2,404)	(2,315)	(2,312)	(2,986)	(2,910)
TOTAL NON CURRENT LIABILITIES	**(13,313)**	**(13,412)**	**(13,678)**	**(13,213)**	**(13,837)**	**(13,796)**	**(14,145)**	**(13,707)**
TOTAL ASSETS EMPLOYED	**347,325**	**346,334**	**343,815**	**340,332**	**337,432**	**333,952**	**330,562**	**321,712**
Public dividend capital	277,733	277,733	277,733	277,733	277,733	277,733	277,733	277,733
Revaluation reserve	64,628	64,626	64,628	64,632	64,632	64,628	64,628	64,628
Retained earnings	4,960	3,975	1,454	(2,033)	(4,933)	(8,409)	(11,799)	(20,649)
TOTAL TAXPAYERS EQUITY	**347,325**	**346,334**	**343,815**	**340,332**	**337,432**	**333,952**	**330,562**	**321,712**

Cash Flow Forecast

Cash Flow for the period ended 31st October 2013				Rolling 12 month cashflow forecast - November 2013 to October 2014											
	2013/14 Apr - Oct Plan £ 000	2013/14 Apr - Oct Actual £ 000	2013/14 Apr - Oct Variance £ 000	2013/14 November Forecast £ 000	2013/14 December Forecast £ 000	2013/14 January Forecast £ 000	2013/14 February Forecast £ 000	2013/14 March Forecast £ 000	2014-15 April Forecast £ 000	2014-15 May Forecast £ 000	2014-15 June Forecast £ 000	2014-15 July Forecast £ 000	2014/15 August Forecast £ 000	2014/15 September Forecast £ 000	2014/15 October Forecast £ 000
CASH FLOWS FROM OPERATING ACTIVITIES															
Operating surplus before Depreciation and Amortisation	27,971	7,934	(20,037)	4,566	3,658	5,321	1,279	3,366	2,098	5,468	2,098	5,468	5,468	2,971	6,341
Donated assets received credited to revenue and non cash	(1,550)	(151)	1,399	(25)	(25)	(25)	(25)	(26)	(26)	(26)	(26)	(26)	(26)	(26)	(26)
Interest paid	(490)	(494)	(4)	(77)	(77)	(77)	(79)	(78)	(82)	(82)	(81)	(81)	(80)	(80)	(79)
Movements in Working Capital:			-												
- Inventories (Inc)/Dec	(241)	(1,112)	(871)												
- Trade and Other Receivables (Inc)/Dec	2,506	2,263	(243)	50	65	20	74	2,937	(2,869)	(10)	41	9	8	41	(11)
- Trade and Other Payables Inc/(Dec)	1,268	1,933	665	(5,065)	(1,065)	(2,564)	6,500	4,431	(83)	(83)	(83)	(83)	(83)	(83)	(83)
- Provisions Inc/(Dec)		(61)	(61)	(8)	(8)	(8)	(8)	(8)	(8)	(8)	(8)	(8)	(8)	(8)	(8)
PDC Dividends paid	(5,568)	(5,454)	114					(5,619)						(5,615)	
Other non-cash movements			-									(21)			
Net Cash Inflow / (Outflow) from Operating Activities	**23,896**	**4,858**	**(19,038)**	**(560)**	**2,547**	**2,667**	**7,741**	**5,003**	**(970)**	**5,259**	**1,941**	**5,258**	**5,279**	**(2,800)**	**6,134**
CASH FLOWS FROM INVESTING ACTIVITIES															
Interest Received	37	39	2	7	8	8	8	8	6	6	6	6	7	7	7
Payments for Property, Plant and Equipment	(18,375)	(16,692)	1,683	(2,251)	(2,251)	(2,252)	(2,251)	(2,262)	(2,294)	(2,295)	(2,294)	(2,295)	(2,294)	(2,295)	(2,294)
Capital element of finance leases	(2,701)	(2,856)	(155)	(382)	(382)	(382)	(382)	(384)	(391)	(391)	(391)	(391)	(391)	(391)	(391)
Net Cash Inflow / (Outflow) from Investing Activities	**(21,039)**	**(19,509)**	**1,530**	**(2,626)**	**(2,625)**	**(2,626)**	**(2,625)**	**(2,638)**	**(2,679)**	**(2,680)**	**(2,679)**	**(2,680)**	**(2,678)**	**(2,679)**	**(2,678)**
CASH FLOWS FROM FINANCING ACTIVITIES															
New PDC															
Other Capital Receipts															
Net Cash Inflow / (Outflow) from Financing															
Opening cash	18,200	19,986	1,786	**5,335**	**2,149**	**2,071**	**2,112**	**7,228**	**9,593**	**5,944**	**8,523**	**7,785**	**10,363**	**12,964**	**7,485**
Increase / (Decrease) in Cash	2,857	(14,651)	**(17,508)**	(3,186)	(78)	41	5,116	2,365	(3,649)	2,579	(738)	2,578	2,601	(5,479)	3,456
Closing cash	**21,057**	**5,335**	**(15,722)**	**2,149**	**2,071**	**2,112**	**7,228**	**9,593**	**5,944**	**8,523**	**7,785**	**10,363**	**12,964**	**7,485**	**10,941**

Capital Programme

	Capital Plan 2013/14	YTD Spend 13/14	Expenditure Profile												Forecast Out Turn	Variance
			Actual							Forecast						
			Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar		
	£000's	£000's	£000's	£000's	£000's	£000's	£000's	£000's	£000's	£000's	£000's	£000's	£000's	£000's	£000's	£'000's
Recurrent Budgets																
IM&T	3,375	2,817	69	226	290	203	688	311	1,031	110	122	196	114	16	3,375	0
Medical Equipment	4,187	2,236	264	7	209	119	386	347	904	577	180	280	506	408	4,187	0
Facilities Sub Group	6,000	1,554	286	204	193	388	261	143	78	500	946	1,000	1,000	1,000	6,000	0
Divisional Discretionary Capital	406	318	150	65	9	10	16	12	56	40	48	0	0	0	406	0
MES Installation Costs	1,750	1,490	38	178	343	455	40	403	32	250	250	250	250	260	2,750	(1,000)
Total Recurrent Budgets	**15,718**	**8,415**	**807**	**680**	**1,045**	**1,174**	**1,392**	**1,215**	**2,102**	**1,477**	**1,546**	**1,726**	**1,870**	**1,683**	**16,718**	**(1,000)**
Reconfiguration Schemes																
Emergency Flow	4,000	622	2	7	14	79	79	130	312	100	100	1,070	1,070	180	3,142	858
Theatres Assessment Area (TAA)	1,549	810	4	10	27	30	491	172	75	180	200	191	199	0	1,580	(31)
Advanced Recovery LRI & LGH	625	141	63	(7)	55	11	7	(6)	18	12	15	15	100	231	514	111
GGH Vascular Surgery	1,156	24	0	0	0	0	0	0	24	0	0	0	0	602	626	530
Hybrid Theatre (Vascular)	500	0	0	0	0	0	0	0	0	0	0	0	0	0	0	500
Daycase / OPD Hub	350	0	0	0	0	0	0	0	0	0	0	0	0	0	0	350
GH Imaging	500	0	0	0	0	0	0	0	0	0	0	0	0	0	0	500
Ward 4 LGH / H Block Isolation	283	1	0	0	0	0	0	0	1	32	0	50	100	100	283	0
GH Modular Wards * 2	4,050	0	0	0	0	0	0	0	0	43	0	0	0	0	43	4,007
Brandon Unit Refurb: OPD 1-4	2,000	10	0	0	0	0	5	4	1	95	0	0	0	(0)	105	1,895
ITU Consolidation	140	0	0	0	0	0	0	0	0	0	0	0	0	0	0	140
Poppies Conversion	250	0	0	0	0	0	0	0	0	0	0	100	100	100	300	(50)
Feasibility Studies	100	35	0	0	0	0	0	0	35	5	5	5	5	5	60	40
Total Reconfiguration	**15,503**	**1,643**	**70**	**10**	**96**	**121**	**582**	**300**	**465**	**467**	**320**	**1,431**	**1,574**	**1,218**	**6,653**	**8,850**
Corporate / Other Schemes																
Osborne Ventilation	566	31	0	0	0	0	13	(1)	18	120	120	120	120	139	650	(84)
Endoscopy Redesign	250	150	0	80	(1)	24	5	28	16	14	0	0	0	1	165	85
Maternity Interim Development	2,800	1,213	3	18	9	273	388	332	190	350	330	362	354	391	3,000	(200)
Aseptic Suite	650	15	7	0	1	0	0	2	5	125	125	125	125	135	650	0
Diabetes BRU	600	598	0	62	125	128	141	37	105	117	0	0	0	0	715	(115)
Respiratory BRU	500	730	3	809	(245)	190	9	(46)	10	0	0	0	0	(0)	730	(230)
Stock Management System	3,000	3	0	0	0	0	0	0	3	20	20	957	1,000	1,000	3,000	0
LIA Schemes		0	0	0	0	0	0	0	0	100	100	100	100	100	500	(500)
CMG Contingency	194	0	0	0	0	0	0	0	0	19	40	45	45	45	194	0
Other Developments	0	578	163	123	91	36	69	(9)	104	100	100	100	100	107	1,085	(1,085)
	8,560	**3,318**	**177**	**1,093**	**(20)**	**650**	**625**	**343**	**450**	**965**	**835**	**1,809**	**1,844**	**1,917**	**10,689**	**(2,129)**
Total Capital Programme	**39,781**	**13,376**	**1,054**	**1,783**	**1,121**	**1,945**	**2,598**	**1,858**	**3,017**	**2,910**	**2,701**	**4,966**	**5,288**	**4,818**	**34,060**	**5,721**

COST IMPROVEMENT PROGRAMME – October, Year to Date and Year end Forecast

	October			Year to date			Projected Year End Out-turn			Financial Risk			
	Plan £000	Actual £000	Surplus / (Deficit) £000	Plan £000	Actual £000	Surplus / (Deficit) £000	Plan £000	Actual £000	Surplus / (Deficit) £000	Red - forecast under-delivery	Red £'000	Amber £'000	Green £'000
Cancer, Haematology, GI Medicine and Surgery	361	277	**-84**	1,525	1,603	**78**	3,380	3,754	**374**	-374	-0	683	3,071
		76.8%			*105.1%*			*111.1%*		*-11.1%*	*0.0%*	*20.2%*	*90.9%*
Emergency and Specialist Medicine	318	370	**51**	1,953	1,638	**-315**	3,623	4,070	**447**	-447	0	514	3,556
		116.2%			*83.9%*			*112.3%*		*-12.3%*	*0.0%*	*14.2%*	*98.2%*
Professional Services, Imaging, Medical Physics and Empath	412	308	**-105**	2,262	1,909	**-353**	4,448	3,517	**-931**	931	0	100	3,417
		74.6%			*84.4%*			*79.1%*		*20.9%*	*0.0%*	*2.2%*	*76.8%*
Cardiac, Renal and Respiratory	386	438	**52**	2,158	2,002	**-156**	4,150	4,051	**-99**	99	-	602	3,449
		113.4%			*92.8%*			*97.6%*		*2.4%*	*0.0%*	*14.5%*	*83.1%*
Musculoskeletal and Specialist Surgery	379	735	**357**	1,700	1,943	**243**	3,604	3,607	**4**	-4	(0)	90	3,517
		194.3%			*114.3%*			*100.1%*		*-0.1%*	*0.0%*	*2.5%*	*97.6%*
Theatres, Anaesthesia, Pain and Sleep, (ITAPS)	432	541	**109**	2,246	2,323	**77**	4,405	4,533	**129**	-129	-	-	4,533
		125.2%			*103.4%*			*102.9%*		*-2.9%*	*0.0%*	*0.0%*	*102.9%*
Women's and Children's	477	434	**-43**	2,794	2,636	**-158**	5,258	5,274	**16**	-16	-	48	5,225
		90.9%			*94.3%*			*100.3%*		*-0.3%*	*0.0%*	*0.9%*	*99.4%*
Corporate													
Communications & Ext Relations	15	2	**-13**	71	13	**-58**	148	44	**-105**	105	-	-	44
Corporate & Legal	26	26	**0**	184	185	**1**	315	317	**2**	-2	-	-	317
Corporate Medical	82	40	**-42**	146	189	**42**	558	449	**-108**	108	-	261	189
Facilities	236	264	**28**	1,321	1,576	**255**	2,500	2,504	**4**	-4	-	-	2,504
Finance & Procurement	52	75	**22**	493	591	**99**	754	841	**87**	-87	-	-	841
Human Resources	42	35	**-8**	294	332	**38**	505	527	**22**	-22	-	-	527
IMT	233	40	**-193**	1,300	225	**-1,075**	2,500	462	**-2,038**	2,038	-	100	361
Corporate Nursing	52	41	**-10**	371	326	**-45**	628	556	**-72**	72	-	-	556
Operations	61	53	**-7**	311	317	**6**	614	574	**-40**	40	-	-	574
Strategic Devt	21	21	**0**	144	145	**1**	247	249	**2**	-2	-	-	249
Former Divisional Management	4	1	**-3**	28	27	**-1**	48	32	**-16**	16	-	-	32
Central	0	152	**152**	0	570	**570**	0	1,922	**1,922**	-1,922	-	875	1,047
Sub-total - Corporate	**824**	**750**	**-74**	**4,663**	**4,496**	**-167**	**8,818**	**8,478**	**-340**	**340**	**-**	**1,236**	**7,242**
		91.0%			***96.4%***			***96.1%***		***3.9%***	***0.0%***	***14.0%***	***82.1%***
TRUST TOTAL	**3,589**	**3,852**	**263**	**19,301**	**18,549**	**-751**	**37,684**	**37,284**	**-400**	**400**	**-0**	**3,274**	**34,010**
		107.3%			***96.1%***			***98.9%***		***1.1%***	***0.0%***	***8.7%***	***90.2%***

YTD Position as at 31st October 2013 - Month 7

		Patient Care Income adj for penalties held centrally			Other Income			Pay			Non Pay			TOTAL		
Division	CMG's	YTD Budget £000s	YTD Actual £000s	'Variance £000s	YTD Budget £000s	YTD Actual £000s	'Variance £000s	YTD Budget £000s	YTD Actual £000s	'Variance £000s	YTD Budget £000s	YTD Actual £000s	'Variance £000s	YTD Budget £000s	YTD Actual £000s	'Variance £000s
Clinical Cmg'S	C.H.U.G.S	68,951	69,862	911	1,732	1,682	(51)	26,790	27,137	(347)	20,819	23,211	(2,392)	23,074	21,195	(1,879)
	Clinical Support & Imaging	14,013	14,653	639	4,231	4,031	(200)	39,340	40,352	(1,012)	1,084	3,066	(1,982)	(22,179)	(24,734)	(2,555)
	Divisional Management Codes	0	0	0	365	3	(362)	2,305	2,211	94	483	109	374	(2,423)	(2,317)	106
	Emergency & Specialist Med	58,609	62,814	4,205	2,885	4,266	1,381	36,957	42,702	(5,745)	17,701	18,500	(798)	6,836	5,878	(958)
	I.T.A.P.S	16,019	16,068	48	428	406	(22)	29,301	31,806	(2,505)	11,424	12,246	(823)	(24,277)	(27,579)	(3,302)
	Musculo & Specialist Surgery	55,273	55,455	182	1,133	815	(317)	25,418	26,101	(683)	10,812	11,033	(221)	20,176	19,137	(1,039)
	Renal, Respiratory & Cardiac	73,723	74,142	419	1,907	1,481	(426)	32,741	33,876	(1,135)	24,648	26,381	(1,733)	18,241	15,366	(2,875)
	Womens & Childrens	79,749	80,425	676	2,372	2,095	(277)	43,351	43,232	119	17,212	17,776	(564)	21,559	21,512	(46)
Clinical Cmg'S Total		**366,338**	**373,418**	**7,080**	**15,054**	**14,779**	**(275)**	**236,202**	**247,416**	**(11,215)**	**104,183**	**112,322**	**(8,139)**	**41,007**	**28,459**	**(12,548)**
Corporate	Communications & Ext Relations	0	0	0	19	15	(5)	458	507	(49)	71	70	1	(510)	(562)	(52)
	Corporate & Legal	0	0	0	0	72	72	566	565	1	681	795	(113)	(1,248)	(1,288)	(40)
	Corporate Medical	0	0	0	849	879	29	2,215	2,211	4	481	430	51	(1,846)	(1,762)	84
	Facilities	216	216	0	6,690	6,738	48	743	703	40	31,620	30,535	1,085	(25,457)	(24,284)	1,173
	Finance & Procurement	0	0	0	29	66	37	2,474	2,425	49	1,572	1,500	72	(4,017)	(3,859)	157
	Human Resources	0	0	0	1,667	1,870	202	3,178	3,135	43	1,058	1,208	(150)	(2,569)	(2,473)	96
	Im&T	0	0	0	122	113	(9)	1,994	1,863	131	2,324	2,478	(154)	(4,196)	(4,228)	(32)
	Nursing	0	0	0	160	193	33	3,309	2,975	334	7,736	7,805	(69)	(10,885)	(10,587)	297
	Operations	276	276	0	0	131	131	2,367	2,397	(31)	173	329	(157)	(2,263)	(2,319)	(56)
	Strategic Devt	0	0	0	0	58	58	746	875	(128)	21	233	(212)	(767)	(1,050)	(283)
Corporate Total		**492**	**492**	**0**	**9,537**	**10,133**	**596**	**18,051**	**17,657**	**394**	**45,735**	**45,381**	**354**	**(53,757)**	**(52,413)**	**1,344**
Research & Development Total		**0**	**0**	**0**	**18,835**	**18,838**	**3**	**7,373**	**7,371**	**2**	**9,887**	**9,886**	**1**	**1,575**	**1,581**	**6**
Central Division Total		**5,672**	**4,116**	**(1,556)**	**30,334**	**28,250**	**(2,084)**	**0**	**164**	**(164)**	**22,608**	**27,089**	**(4,481)**	**13,398**	**5,112**	**(8,286)**
Grand Total		**372,502**	**378,026**	**5,524**	**73,760**	**72,000**	**(1,760)**	**261,626**	**272,609**	**(10,983)**	**182,413**	**194,678**	**(12,265)**	**2,223**	**(17,261)**	**(19,484)**

APPENDIX 1

University Hospitals of Leicester NHS
NHS Trust
Caring at its best

Friends & Families Test

What is the Friends & Family test?

The Friends & Family score is obtained by asking patients a single question, *"How likely are you to recommend our <ward/A&E department> to friends and family if they needed similar care or treatment"*

Patients can choose from one of the following answers:

Answer	Group
Extemely	Promoter
Likely	Passive
Neither likely or	Detractor
Unlikely	Detractor
Extremel	Detractor
Don't	Excluded

Friends & Family score is calculated as : % promoters minus % detractors.
*((promoters-detractors)/(total responses-'don't know' responses))*100*

Patients to be surveyed:
- Adult Acute Inpatients (who have stayed at least one night in hospital)
- Adult patients who have attended A&E and left without being admitted to hospital or were transferred to a Medical Assesment Unit and then discharged

Exceptions:
- Daycases
- Maternity Service Users
- Outpatients
- Patients under 16 yrs old

NB. Wards with fewer than 5 survey responses per month are excluded from this information to maintain patient confidentiality

Response Rate:
It is expected that responses will be received from at least 15% of the Trusts survey group - this will increase to 20% by the end of the financial year

Current methods of collection:
- Paper survey
- Online : either via web-link or email
- Kiosks
- Hand held devices

University Hospitals of Leicester NHS
NHS Trust

Caring at its best

FRIENDS AND FAMILY TEST - April - October '13

										OCTOBER SCORE BREAKDOWN				
			Apr-13	May-13	Jun-13	Jul-13	Aug-13	Sep-13	Oct-13	Total Responses	Promoters	Passives	Detractors	Score
GLENFIELD HOSPITAL	GH WD 15	F15	55	0	100	91	100	82	91	21	19	2	0	91
	GH WD 16 Respiratory Unit	F16	88	69	74	80	68	80	80	30	24	6	0	80
	GH WD 20	F20	0	73	61	77	79	-	59	31	19	8	2	59
	GH WD 23A	F23A	65	80	100	83	-	80	55	11	6	5	0	55
	GH WD 24	F24	75	87	94	100	-	95	96	22	21	1	0	96
	GH WD 24	F24	75	87	94	100	-	95	96	22	21	1	0	96
	GH WD 26	F26	92	87	-	0	94	93	87	38	33	5	0	87
	GH WD 27	F27	0	0	66	45	90	67	54	26	15	10	1	54
	GH WD 28	F28	79	85	88	90	96	76	89	26	23	3	0	89
	GH WD 29	F29	-10	42	21	96	75	68	74	23	17	6	0	74
	GH WD 31	F31	0	79	79	87	94	88	90	20	18	2	0	90
	GH WD 32	F32	74	85	83	81	87	81	74	31	23	8	0	74
	GH WD 33	F33	85	84	79	81	73	76	77	64	50	10	2	77
	GH WD 33A	F33A	68	94	86	80	84	67	80	25	20	5	0	80
	GH WD Clinical Decisions Unit	FCDU	48	72	46	49	58	50	44	114	67	27	18	44
	GH WD Coronary Care Unit	FCCU	84	86	90	98	90	91	100	3	2	0	0	100

University Hospitals of Leicester NHS
NHS Trust

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FRIENDS AND FAMILY TEST - April - October '13

										OCTOBER SCORE BREAKDOWN				
			Apr-13	May-13	Jun-13	Jul-13	Aug-13	Sep-13	Oct-13	Total Responses	Promoters	Passives	Detractors	Score
LEICESTER GENERAL HOSPITAL	LGH WD 10	G10	100	48	60	80	70	50	56	9	5	4	0	56
	LGH WD 14	G14	77	71	83	70	85	61	78	40	32	7	1	78
	LGH WD 15N Nephrology	G15N	0	0	75	-	-	38	60	10	7	2	1	60
	LGH WD 16	G16	67	88	95	75	71	50	94	16	15	1	0	94
	LGH WD 17 Transplant	G17	75	92	84	81	84	88	86	29	25	4	0	86
	LGH WD 18	G18	88	100	91	75	93	71	81	44	34	8	0	81
	LGH WD 18	G18	88	100	91	75	93	71	81	44	34	8	0	81
	LGH WD 2	G2	0	0	-	25	-	87	57	7	4	3	0	57
	LGH WD 22	G22	42	95	45	42	50	79	46	26	14	7	3	46
	LGH WD 26 SAU	G26	0	46	52	65	48	46	52	22	12	8	1	52
	LGH WD 27	G27	83	89	57	0	64	55	58	19	13	4	2	58
	LGH WD 28 Urology	G28	45	24	55	31	100	24	51	36	22	9	4	51
	LGH WD 3	G3	0	0	33	67	70	43	100	3	3	0	0	100
	LGH WD 31	G31	-	90	79	84	73	83	89	28	25	3	0	89
	LGH WD Brain Injury Unit	GBIU	0	0	-	100	-	100	100	3	3	0	0	100
	LGH WD Young Disabled	GYDU	100	0	100	-	100	100	50	2	1	1	0	50

University Hospitals of Leicester NHS
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FRIENDS AND FAMILY TEST - April - October '13

										OCTOBER SCORE BREAKDOWN				
			Apr-13	May-13	Jun-13	Jul-13	Aug-13	Sep-13	Oct-13	Total Responses	Promoters	Passives	Detractors	Score
LEICESTER ROYAL INFIRMARY	LRI WD 15 AMU Bal L5	R15	40	33	31	43	65	56	53	41	23	15	2	53
	LRI WD 16 AMU Bal L5	R16	52	88	58	42	11	93	63	38	26	10	2	63
	LRI WD 17 Bal L5	R17	0	57	-9	0	48	74	44	46	26	14	6	44
	LRI WD 18 Bal L5	R18	64	65	-	47	-100	57	48	32	20	6	5	48
	LRI WD 19 Bal L6	R19	44	-	5	43	35	59	44	25	11	14	0	44
	LRI WD 21 Bal L6	R21	88	90	91	-	89	100	91	23	21	2	0	91
	LRI WD 22 Bal 6	R22	38	55	48	64	44	38	63	24	15	9	0	63
	LRI WD 24 Win L3	R24	58	67	47	29	52	38	25	20	7	11	2	25
	LRI WD 25 Win L3	R25	95	100	60	75	69	88	73	22	16	6	0	73
	LRI WD 26 Win L3	R26	92	80	58	80	65	0	69	36	25	11	0	69
	LRI WD 27 Win L4	R27	60	100	33	75	100	75	100	5	5	0	0	100
	LRI WD 29 Win L4	R29	61	100	65	55	70	65	75	20	15	5	0	75
	LRI WD 31 Win L5	R31	0	73	48	64	48	23	72	25	19	5	1	72
	LRI WD 32 Win L5	R32	86	80	43	23	48	58	54	14	9	2	2	54
	LRI WD 33 Win L5	R33	71	67	58	77	75	58	81	23	17	4	0	81
	LRI WD 34 Windsor Level 5	R34	80	70	-	80	58	55	55	20	11	9	0	55
	LRI WD 36 Win L6	R36	20	61	0	50	50	60	57	21	14	5	2	57
	LRI WD 37 Win L6	R37	68	86	91	86	71	81	52	21	12	8	1	52
	LRI WD 38 Win L6	R38	94	100	100	87	85	100	82	22	19	2	1	82
	LRI WD 39 Osb L1	R39	70	89	89	87	72	88	81	26	21	5	0	81
	LRI WD 40 Osb L1	R40	88	89	82	77	-	71	56	33	21	8	3	56
	LRI WD 41 Osb L2	R41	42	50	47	55	73	50	75	20	15	5	0	75
	LRI WD 7 Bal L3	R07	65	76	70	71	64	61	75	33	24	8	0	75
	LRI WD 8 SAU Bal L3	RSAU	35	52	70	49	52	56	14	21	8	8	5	14
	LRI WD Bone Marrow	RBMT	100	88	0	100	67	33	25	4	2	1	1	25
	LRI WD Fielding John Vic L1	RFJW	-	-	60	71	67	86	81	36	29	7	0	81
	LRI WD GAU Ken L1	RGAU	-	65	70	46	82	65	53	38	22	14	2	53
	LRI WD IDU Infectious Diseases	RIDU	65	67	69	80	68	48	67	18	12	6	0	67
	LRI WD Kinmonth Unit Bal L3	RKIN	65	68	80	70	57	89	74	23	17	6	0	74
	LRI WD Osborne Assess Unit	ROND	68	88	88	68	84	88	73	22	16	6	0	73

University Hospitals of Leicester NHS
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FRIENDS AND FAMILY TEST - April - October '13

									OCTOBER SCORE BREAKDOWN				
		Apr-13	May-13	Jun-13	Jul-13	Aug-13	Sep-13	Oct-13	Total Responses	Promoters	Passives	Detractors	Score
EMERGENCY DEPARTMENT	ED - Majors	35	45	42	50	47	23	48	192	110	61	19	48
	ED - Minors	38	37	64	60	65	31	66	461	324	112	21	66
	ED - (not stated)	64	60	60	63	72	65	69	64	48	12	4	69
	Eye Casualty	65	75	70	55	54	44	50	210	111	90	7	50
	Emergency Decisions Unit	-	-	-	-	69	81	57	77	47	25	4	57

Appendix 2 Nurse to Bed Ratio October 2013

Oct-13	Appendix 2		Per finance ledger									
Cost centre	Cost centre description	No. of beds	Actual worked WTEs(per finance ledger)	Including bank wtes	Including agency wtes	Budgeted Nurse to bed ratio	Actual Nurse to bed ratio	Accuity Ward Type	Oct RAG Rating	Sept RAG Rating	Budgeted Qualified %age	Budgeted Unqualified %age
C20	Ward 15	30	37.71	2.86	0.00	1.31	1.26	Base			60.4%	39.6%
C21	Ward 16	30	35.08	4.45	0.26	1.21	1.17	Base			63.4%	36.6%
C23	Ward 17 - Respiratory	30	38.20	6.88	0.07	1.35	1.27	Base			75.0%	25.0%
C24	Ward 27	27	33.23	2.56	0.07	1.16	1.23	Base			61.9%	38.1%
C27	Coronary Care Unit - Ggh	19	51.22	0.28	0.07	2.77	2.70	Specialist			75.6%	24.4%
C29	Clin Dec. Unit - Ward 19 Ggh	25	85.50	2.32	0.12	3.84	3.42	Specialist			62.9%	37.1%
C30	Ward 28 - Cardio	31	39.41	9.40	0.00	1.11	1.27	Base			60.0%	40.0%
C31	Ward 33	29	31.74	1.50	0.09	1.17	1.10	Base			70.2%	29.8%
C32	Ward 32	17	21.94	6.14	0.07	1.19	1.29	Base			74.7%	25.3%
C33	Ward 33a	20	26.45	4.10	-0.09	1.32	1.32	Base			64.2%	35.8%
C35	Ward 31	34	44.82	2.70	0.00	1.29	1.32	Base			76.9%	23.1%
C38	Ward 26	15	27.92	2.50	0.13	2.05	1.86	Specialist			76.5%	23.5%
C48	Ward 23a	17	21.17	1.18	0.00	0.89	1.25	Specialist			45.2%	54.8%
C99	Ward 29 - Resp	25	35.87	7.63	0.15	1.22	1.43	Base			61.3%	38.7%
S04	Ward 15 High Dependency	9	25.43	1.86	0.00	3.07	2.83	Specialist			85.9%	14.1%
S05	Ward 15 Nephrology	18	27.90	1.30	0.00	1.78	1.55	Specialist			63.1%	36.9%
S21	Ward 10 Capd	18	34.83	0.06	0.00	2.15	1.94	Specialist			60.9%	39.1%
S64	Ward 17 - Capd	14	21.27	0.33	0.00	1.43	1.52	Specialist			70.3%	29.7%
N15	Admissions Unit (15/16) Lri	52	111.68	10.74	5.60	2.23	2.15	Specialist			60.0%	40.0%
N44	Emergency Decisions Unit Lri	16	20.40	0.00	6.00	1.76	1.28	Specialist			66.8%	33.2%
N24	Ward 24 Lri	27	35.43	0.92	2.40	1.43	1.31	Base			60.0%	40.0%
N26	Ward 36 Lri	28	31.15	2.84	5.97	1.41	1.11	Base			60.0%	40.0%
N31	Ward 31 Lri - Med	30	36.14	1.36	0.00	1.41	1.20	Base			60.0%	40.0%
N33	Ward 37 Lri	24	37.34	3.51	3.15	1.42	1.56	Base			60.0%	40.0%
N36	Ward 23 Lri	28	33.61	3.50	1.78	1.41	1.20	Base			60.0%	40.0%
N38	Ward 38 Lri	28	32.54	2.23	2.64	1.30	1.16	Base			60.0%	40.0%
N39	Infectious Diseases Unit	18	23.81	2.15	0.99	1.31	1.32	Specialist			60.0%	40.0%
N51	Ward 19 Lri	30	33.52	1.50	5.58	1.41	1.12	Specialist			60.0%	40.0%
N52	Ward 2 Lgh	21	24.12	9.37	10.23	1.32	1.15	Specialist			60.0%	40.0%
N56	Ward 8 Lgh	15	28.40	3.55	0.11	1.84	1.89	Specialist			60.0%	40.0%
N57	Stroke Unit - Ward 25 & 26 Lri	36	58.66	1.79	8.89	1.61	1.63	Specialist			70.0%	30.0%
N60	Ydu Wakerley Lodge Lgh	8	17.81	0.35	0.18	2.40	2.23	Specialist			60.0%	40.0%
N61	Brain Injury Unit Lgh	7	18.40	1.63	0.00	3.06	2.63	Specialist			70.0%	30.0%
N84	Fielding Johnson - Medicine	20	27.16	7.99	3.86	1.60	1.36	Base			60.0%	40.0%
N92	Ward 34 Lri	26	34.42	1.82	1.48	1.37	1.32	Base			60.0%	40.0%
B01	Onc Ward East	19	21.23	2.24	0.08	1.28	1.12	Base			65.8%	34.2%
B02	Osbourne Assessment Unit	6	10.23	1.01	0.12	2.04	1.71	Specialist			67.0%	33.0%
B06	Onc Ward West	19	23.54	0.78	0.24	1.28	1.24	Base			72.5%	27.5%
B21	Haem Ward	22	26.51	1.18	0.56	1.52	1.21	Specialist			71.5%	28.5%
B24	Bmtu	5	13.72	0.43	0.00	3.02	2.74	Specialist			96.7%	3.3%
N29	Ward 29 Lri	28	36.62	1.14	8.48	1.31	1.31	Base			60.0%	40.0%
N30	Ward 30 Lri	30	33.91	0.25	1.94	1.32	1.13	Base			60.0%	40.0%
S75	Ward 26 Lgh	25	35.78	12.16	0.31	1.12	1.43	Base			65.7%	34.3%
W63	Sau - Lri	30	39.00	0.93	1.39	1.51	1.30	Specilaist			56.3%	43.7%
W64	Ward 22 - Lri	30	35.24	3.80	0.48	1.21	1.17	Base			63.3%	36.7%
W70	Ward 29 - Lgh	27	31.75	0.15	0.00	1.42	1.18	Base			58.1%	41.9%
W71	Ward 22 - Lgh	20	26.00	0.13	0.00	1.32	1.30	Base			61.8%	38.2%
W72	Ward 28 - Lgh	25	31.69	1.33	0.88	1.41	1.27	Base			62.4%	37.6%
W73	Ward 20 - Lgh	20	34.08	15.19	0.00	1.22	1.70	Base			60.8%	39.2%
W74	Sacu - Lgh	6	15.82	0.28	0.56	2.78	2.64	Specialist			68.4%	31.6%
C60	Itu Gh	19	110.54	0.00	0.00	6.60	5.90	ITU			92.3%	7.7%
A10	Itu Lri	15	90.60	0.08	0.00	6.75	6.09	ITU			89.0%	11.0%
A11	Itu Lgh	8	54.44	0.03	0.00	7.43	6.85	ITU			95.2%	4.8%
Y13	Ward 17 Lri	30	37.43	1.51	0.17	1.43	1.25	Base			57.5%	42.5%
Y14	Ward 18 Lri	30	34.75	0.38	0.00	1.41	1.16	Base			55.2%	44.8%
Y16	Ward 32 Lri	24	39.42	1.03	1.18	1.62	1.64	Specialist			56.3%	43.7%
Y23	Ward 18 Lgh	15	24.13	0.00	0.00	0.88	1.61	Base			76.8%	23.2%
Y24	Ward 14 Lgh	20	23.36	2.63	0.00	1.19	1.17	Base			66.5%	33.5%
W13	Ward 7 - Lri	29	33.48	2.38	0.22	1.19	1.15	Base			57.6%	42.4%
W23	Kinmouth Unit	14	21.91	0.37	0.00	1.81	1.57	Specialist			65.1%	34.9%
W43	Ward 21 - Lri	28	34.60	6.80	0.00	1.20	1.24	Base			60.9%	39.1%
C61	Paediatric Itu	6	40.93	0.00	3.26	7.18	6.82	ITU			100.0%	0.0%
D11	Ward 11	12	29.56	0.00	0.25	3.10	2.46	Specialist			67.3%	32.7%
D12	Ward 12	5	19.00	0.22	0.00	5.72	3.80	Specialist			83.1%	16.9%
D13	Children'S Intensive Care Unit	6	40.82	0.00	3.60	6.70	6.80	ITU			94.7%	5.3%
D14	Children'S Admissions Unit	9	17.87	0.00	0.00	2.89	1.99	Specialist			68.6%	31.4%
D17	Ward 27 - Childrens	9	22.06	0.00	0.00	3.18	2.45	Specialist			80.0%	20.0%
D40	Ward 28 - Childrens	14	19.88	0.80	0.00	1.86	1.42	Specialist			73.6%	26.4%
D41	Ward 10	14	20.88	0.00	0.00	1.97	1.49	Specialist			69.2%	30.8%
D51	Ward 14	19	24.96	0.00	0.00	1.42	1.31	Specialist			69.7%	30.3%
X10	Neo-Natal Unit (Lri)	24	77.13	0.00	0.00	3.76	3.21	Specialist			89.8%	10.2%
X13	N.I.C.U. (Lgh)	12	24.60	0.00	0.00	2.40	2.05	HDU			65.3%	34.7%
X34	Ward 5 Obstetrics (Lri)	26	36.54	0.00	0.00	1.54	1.41	Specialist			59.9%	40.1%
X35	Ward 6 Obstetrics (Lri)	26	39.14	0.00	0.00	1.65	1.51	Specialist			63.4%	36.6%
X37	Lgh Delivery Suite & Ward 30	32	103.69	0.00	0.00	3.56	3.24	HDU			76.4%	23.6%
X51	Gau	20	22.26	0.21	0.50	1.44	1.11	Base			66.8%	33.2%
X57	Lgh Ward 31 Gynae	21	26.81	0.11	0.00	1.38	1.28	Base			61.3%	38.7%

Appendix 3 OPERATIONAL PERFORMANCE EXCEPTION REPORT

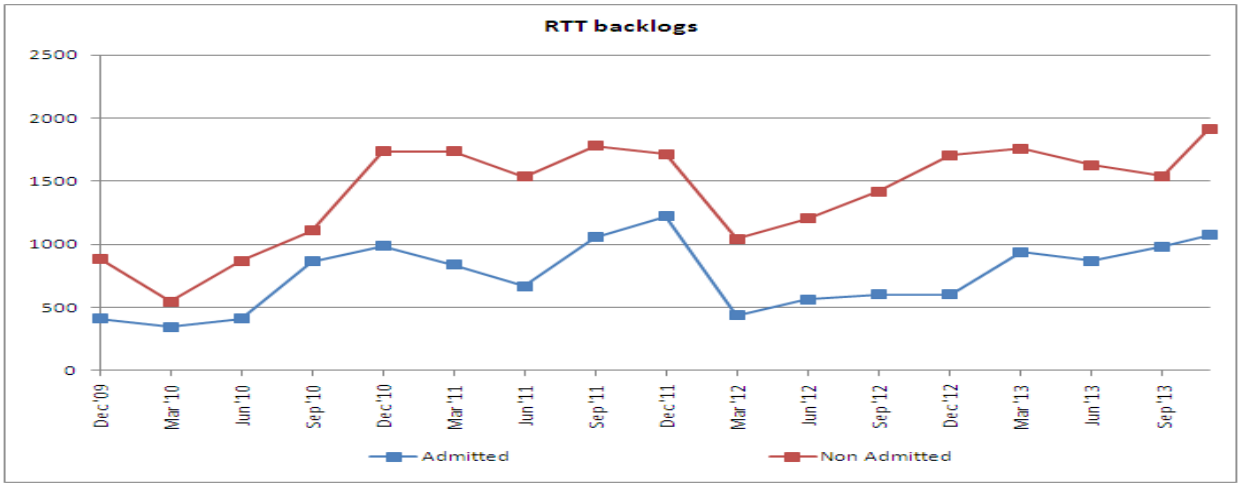
REPORT TO:	**TRUST BOARD**
DATE:	**NOVEMBER 2013**
REPORT BY:	**RICHARD MITCHELL, CHIEF OPERATING OFFICER**
SUBJECT:	**18 WEEK RTT DELIVERY**

Present state

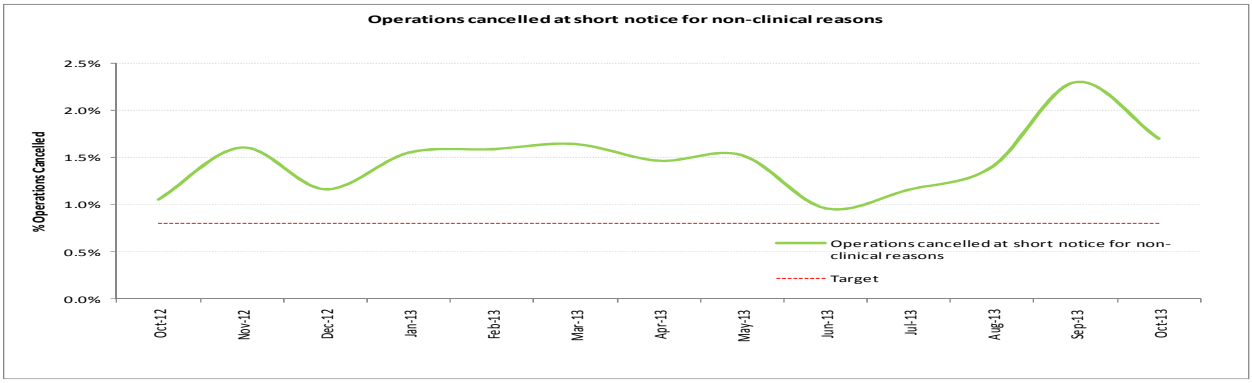
The Trust is required to ensure that at least 90% of patients on an admitted pathway and 95% on a non-admitted pathway are seen and treated within 18 weeks from time of referral. From 2013/2014, this target is measured at specialty level.

RTT admitted performance for October was 83.5% with significant speciality level failures in General Surgery, Orthopaedics, Ophthalmology and ENT.
Non-admitted performance during October was 92.8%, with the significant specialty level failures in Orthopaedics and Ophthalmology. The deterioration in performance during October was as a result of the continuation of the plan to reduce the number of non-admitted patients waiting 18+ weeks.

Commissioners issued a formal 'joint failure to agree' notice regarding RTT backlogs and the Trust recover action plan has not yet been formally agreed. During October The Trust invited the IST (Intensive support team) in to formally review capacity and demand for the challenged specialties: ENT, Orthopaedics, General Surgery and Ophthalmology. This work clearly shows a core capacity gap in both outpatients and electives.
The graph below illustrates the long standing backlogs in non admitted and admitted specialties which is symptomatic of this underlying capacity gap. In addition to this the imperative to achieve monthly performance has meant that historically not all RTT patients were treated strictly in date order. This is no longer the case. The result is that at both speciality and Trust level performance has continued to be below standard.



The ongoing cancellations of elective activity resulting from acute bed pressures is an additional cause of backlog retention.



Commissioners have requested a final recovery action plan under the contractual requirements by the 28th November. Prior to submission this will be discussed at the Executive Team Performance Board on 26th November. Key to the delivery of a sustainable plan will be, ensuring core capacity is adequate and that backlogs are significantly reduced. Sourcing additional capacity will involve additional in house activity and both local and non local independent sector capacity.

Recovery of the admitted and non admitted standards at Trust and speciality level is not anticipated until the new financial year.

Appendix 4 - OPERATIONAL PERFORMANCE EXCEPTION REPORT

REPORT TO:	**TRUST BOARD**
DATE:	**NOVEMBER 2013**
REPORT BY:	**RICHARD MITCHELL, CHIEF OPERATING OFFICER**
AUTHOR:	**MONICA HARRIS – CMG MANAGER**
CMG DIRECTOR:	**PAUL SPIERS**
SUBJECT:	**CANCELLED OPERATIONS UPDATE**

Present state

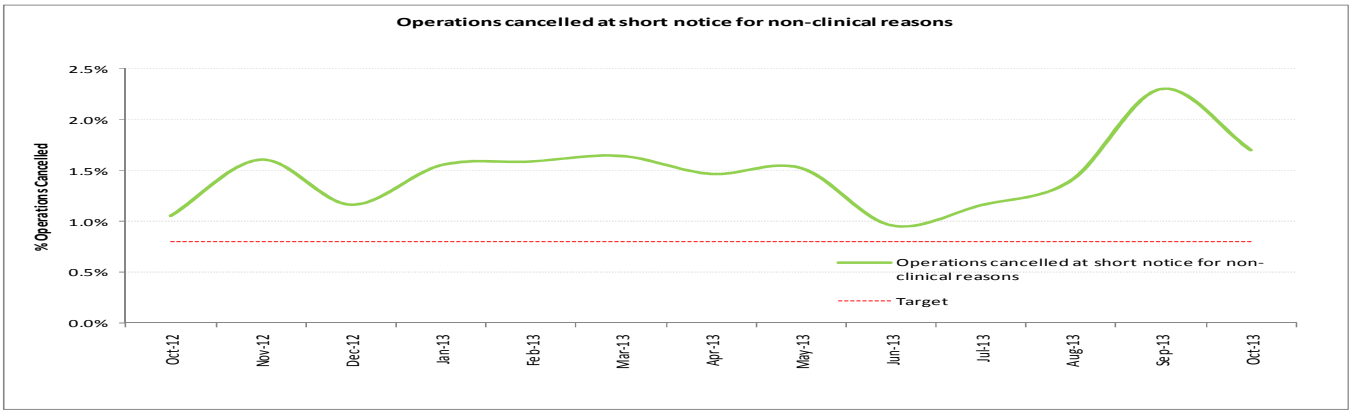
The cancelled operations target comprises of three components:

1. The % of cancelled operations for non clinical reasons on the day of admission
2. The % of patients cancelled are offered another date within 28 days of the cancellation
3. The number of urgent operations cancelled for a second time

For October we met only one of the three targets. Our performance for cancelled operations 'on the day' for non clinical reasons and our performance for offering another date within 28 days continues to fall below that of the national target but we were able to ensure that no urgent operations were cancelled for a second time.

The % of cancelled operations for non-clinical reasons on the day of admission

Performance in October shows that the percentage of operations cancelled on/after the day of admission of all elective activity for non-clinical reasons was 1.7% against a target of 0.8%. Performance in October is showing an improvement when compared to the September.



The two main reasons for cancellations were due to lack of bed capacity, 75%, and lack of theatre time /list overruns, 17.5%.

The highest number of cancellations was due the lack of bed capacity, 75%, this is mainly due to the lack of a hospital bed. Only on two occasions was it as a result of a HDU/ITU bed. The other reasons are detailed below in table one and are responsible for the remaining 25% of cancellations.

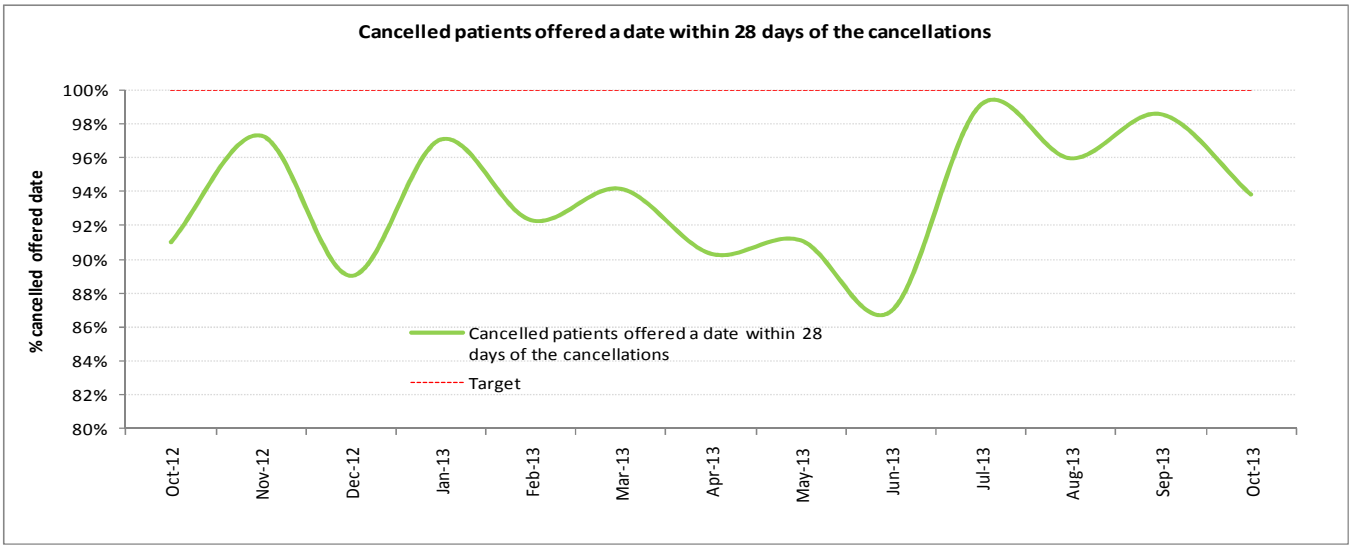
Other	HOSPITAL CANCEL - CASENOTES MISSING	5
	HOSPITAL CANCEL - LACK ANAESTHETIC STAFF	5
	HOSPITAL CANCEL - LACK SURGEON	2
	HOSPITAL CANCEL - LACK THEATRE EQUIPMENT	4
	HOSPITAL CANCEL - LACK THEATRE STAFF	1
	HOSPITAL CANCEL - LACK THEATRE TIME / LIST OVERRUN	29
	HOSPITAL CANCEL - MRSA TEST RESULTS	1
	UNREASONABLE OFFER TO PATIENT	
	TOTAL	**47**

Table 1 the reasons for 'other' cancellations.

The second highest reason for cancellation was the lack of theatre time/list overruns, which in the majority of cases appears to be due to a significant number of lists starting late resulting in patients on the lists being cancelled Further analysis is being undertaken to understand in more detail the reasons for late starts

The % of patients cancelled are offered another date within 28 days of the cancellation

The percentage offered a date within 28 days of the cancellation was 93.8% against a revised threshold of 100%. Plans are in place to monitor performance and regain our position for November.



Work is currently being undertaken to review and update the current action plan in response to the contract query that has been submitted from our CCGs. Following a formal meeting with the CCGs an agreement was reach to update the plan presented and will this be available in November 2013.

University Hospitals of Leicester NHS
NHS Trust

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST

REPORT BY TRUST BOARD COMMITTEE TO TRUST BOARD

DATE OF TRUST BOARD MEETING: 28 November 2013

COMMITTEE: Quality Assurance Committee

CHAIRMAN: Ms J Wilson, Non-Executive Director

DATE OF COMMITTEE MEETING: 29 October 2013

RECOMMENDATIONS MADE BY THE COMMITTEE FOR CONSIDERATION BY THE TRUST BOARD:

- None

OTHER KEY ISSUES IDENTIFIED BY THE COMMITTEE FOR CONSIDERATION/ RESOLUTION BY THE TRUST BOARD:

- **PLACE assessments (Minute 99/13);**
- **Nursing workforce (Minute 100/13/2), and**
- **Quality Commitment (Minute 101/13/3).**

DATE OF NEXT COMMITTEE MEETING: 27 November 2013

Ms J Wilson
22 November 2013

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST

MINUTES OF A MEETING OF THE QUALITY ASSURANCE COMMITTEE HELD ON TUESDAY 29 OCTOBER 2013 AT 9.30AM IN THE BOARD ROOM, VICTORIA BUILDING, LEICESTER ROYAL INFIRMARY

Present:
Ms J Wilson – Non-Executive Director (Chair)
Mr M Caple – Patient Adviser (non-voting member)
Dr K Harris – Medical Director
Ms S Hotson – Director of Clinical Quality
Ms C O'Brien – Chief Nurse and Quality Officer East Leicestershire and Rutland CCG (non-voting member)
Ms R Overfield – Chief Nurse
Professor D Wynford-Thomas – Non-Executive Director and Dean of the University of Leicester Medical School

In Attendance:
Miss C Hughes – Interim Trust Administrator
Ms D Mitchell – Head of Improvement and Innovation (for Minute 98/13)
Ms R Broughton – Head of Outcomes and Effectiveness (for minute 101/13/2)

RESOLVED ITEMS **ACTION**

95/13 APOLOGIES

Apologies for absence were received from Mr J Adler, Chief Executive, Dr B Collett, Associate Medical Director, Miss M Durbridge, Director of Safety and Risk, Mr P Panchal, Non-Executive Director and Ms C Ribbins, Director of Nursing.

96/13 MINUTES

Resolved – that the Minutes of the meeting held on 25 September 2013 (papers A and A1 refer) be confirmed as a correct record.

97/13 MATTERS ARISING REPORT

In respect of Minute 87/13/4, the Chief Nurse advised that numeracy checks would now be carried out on new starters and that mandatory training would commence on all nursing staff giving medications. The question was raised around numeracy checks for all staff and it was agreed that this action would be updated before Christmas.

Minute 88/13/2 – the Chief Nurse advised that the recommendations surrounding the contract with Medstorm for the provision of mattresses and equipment had been considered and agreed and this action was now complete. **TA**

Minute 88/13/4 (i) – the Trust vacancy position would be addressed under Item 4.2 of the agenda, Nursing Workforce Report, and it was therefore agreed that this item could now be removed from the log. **TA**

Minute 88/13/4 (ii) – it was noted that the Director of Nursing and the QAC Patient Adviser had met to discuss the availability of nursing workforce details into the public domain and therefore it was agreed that this action could now be removed from the log. **TA**

Minute 88/13/6 (iii) – it was noted that the Ophthalmology Recovery Plan would be presented to the Finance and Performance meeting on 30 October 2013 and that Trust Administration would circulate copies of that report to the Committee following the meeting. **TA**

Minute 66/13/6 – the Medical Director advised that the results of the LLR Mortality Review were being submitted to the Trust Board on the 30 October 2013 and would be presented to the Quality Assurance Committee (QAC) meeting in November 2013. **MD**

<u>Resolved</u> – that the matters arising report (paper B) and the actions above, be noted. **TA**

98/13 CIP IMPROVEMENT AND INNOVATION FRAMEWORK – GOVERNANCE ARRANGEMENTS

The Head of Improvement and Innovation attended the meeting to provide verbal assurance on the CIP Improvement and Innovation Framework. It was noted that all CIP Schemes would be voted on by five Executive Directors and signed off by the Chief Nurse. Once approved, quarterly formal reviews would be carried out on each scheme. It was noted that the financial status of the schemes would be reviewed at each CMG performance meeting and that three schemes would be chosen at random for a Quality and Risk Assessment.

The Medical Director stressed the importance of ensuring that the schemes chosen for Quality and Risk Assessments were appropriate schemes and asked for assurance of the cognisance of cross cutting risks. The Chief Nurse and Quality Officer East Leicestershire and Rutland CCG raised the question of what the formal quarterly reviews would look like. The Head of Improvement and Innovation responded that once per quarter the CMGs would assess the risks and would attend the IIF Board meeting for updates. The Director of Safety and Risk would bring a formal report on the Quality and Risk Assessments back to the November 2013 QAC meeting. **DSR**

<u>Resolved</u> – that (A) the verbal update be received and noted, and

(B) the Director of Safety and Risk to present a formal report on the CIP Quality and Risk Assessments to the November 2013 QAC meeting. **DSR**

99/13 PATIENT LED ASSESSMENT OF THE CARE ENVIRONMENT (PLACE) RESULTS

The Chief Nurse presented paper C advising members that work had taken place comparing UHL to the national figures and provided a brief analysis of the results. It was noted that there were some concerns around cleanliness but as a Trust UHL was not performing as badly as some other Trusts. An action plan for cleanliness would be presented to the Executive Quality Board (EQB) in November 2013 and submitted to the QAC in December 2013. Performance against the Key Performance Indicators for September 2013 was noted to be variable however some improvement had been made.

A discussion took place around the public areas within the Trust and it was noted that Interserve had experienced staff shortages resulting in the focus of cleanliness being more around clinical areas. Staff vacancies within Interserve had recently been filled and it was felt that poor cleanliness of public areas would now improve. The Chief Nurse commented that a six month review by Interserve and NHS Horizons had been requested and the report and action plans would be presented at future QAC meetings. It was agreed that a representative of Interserve would be invited to attend the December meeting to present the report. **CN**

The Director of Clinical Quality reported that whistle blowing had now been included in the CQC report and it was felt that as one incident had been reported at the Leicester Royal Infirmary and subsequently in the public domain, the CQC would now give greater focus on the subject.

An issue was raised around the timeliness of meal delivery to patients and it was noted that this was regarded as a contractual issue. The Chief Nurse suggested that a solution to the issue might be the implementation of additional microwaves and

microwavers or the combination of the role of the cleaning staff and microwavers to ensure better working to ward timescales. However, it was noted that this would be subject to contractual negotiation.

Resolved – (A) that the contents of paper C and the verbal update be received and noted, and

(B) the Chief Nurse to invite a representative of Interserve and NHS Horizons to attend the QAC meeting in December 2013 to provide an update on cleanliness and present the six monthly review and action plans. **CN**

100/13 SAFETY

100/13/1 Monthly update on the NHS Safety Thermometer (ST) and Prevalence of the Four Harms in UHL

The Chief Nurse presented paper D and provided the Committee with assurance that a steady state was being maintained and noted that there had been no change.

Resolved – that the contents of paper D be received and noted.

100/13/2 Nursing Workforce Report

The Chief Nurse presented paper E and gave a brief update on reviews undertaken in the last twelve months. It was noted that future reviews would take place on a six monthly basis and that the acuity tool would be used as part of the review.

The Chief Nurse commented that the ward performance review system would commence in November 2013 and that a real time ward dashboard would be in place in the near future. It was noted that ward staffing levels would be communicated to the public via notices put up on wards which would give information on the number of staff on duty on the ward and the reasons behind any staff shortages.

It was highlighted that Matrons had returned to the wards and would be relieving themselves of non ward activity to ensure the correct supervision of ward staff.

Resolved – that the contents of paper D be received and noted.

100/13/3 Care of the Dying Patient – Interim Guidance

Resolved – that the verbal report be deferred to the November 2013 QAC meeting. **TA**

100/13/4 Overview and Update of Safeguarding Serious Case Reviews and Incidents

Resolved – that this item be classed as confidential and taken in private accordingly.

100/13/5 UHL Action Plan in Response to LLR CCG Emergency Department Visit

The Director of Clinical Quality presented paper G, a brief on the action plan being developed in response to the unannounced quality and safety visit on 19 September 2013 by the LLR CCG Commissioners to UHL's Emergency Department. It was agreed that the action plan would be presented to the next Executive Quality Board meeting.

In discussion the Chief Nurse and Quality Officer East Leicestershire and Rutland CCG asked for assurance on the access to Resuscitation trolleys and it was noted that random checks were being carried out. It was agreed that the Chief Nurse would ensure that the Resuscitation Trolley checking procedures were being adhered to and appropriately documented.

In further discussion it was noted that the mandatory safeguarding training was not being reported as being carried out and it was agreed that the Chief Nurse would review the process of reporting.

Pressure in the Emergency Department was discussed and it was noted that additional staff were being placed on each shift to look after long wait patients, and to try to relieve the pressure on Emergency Department staff. Long wait patients would be made aware of the additional staff and it would be communicated that these staff would be the point of contact should the patients need any assistance. A verbal update on this item would be presented to the next QAC meeting.

Resolved – that (A) the contents of paper G be received and noted;

(B) the action plan in response to the outcome of the LLR CCG visit be presented to the November 2013 Executive Quality Board meeting; **DCQ**

(C) the Chief Nurse to ensure that Resuscitation Trolley checking procedures were being adhered to and correctly documented; **CN**

(D) the Chief Nurse to review the process of mandatory safeguarding training reporting, and **CN**

(E) the Chief Nurse to provide a verbal update on the additional staff placed in the Emergency Department, to the November 2013 QAC meeting. **CN**

100/13/6 Governance Arrangements for Outsourcing Elective Work

Paper H provided a report on suggestions to accelerate the backlog reduction in elective surgery and it was agreed that the preferred option would be option 1. The question of assurance of quality and safety reporting was raised and it was agreed that the Chief Nurse would contact the Chief Operating Officer to request a paper be presented to the November 2013 QAC meeting for assurance. **CN** In discussion on the governance of the outstanding arrangements for private providers, it was noted that the Chief Nurse/Medical Director would be required to sign-off these arrangements. **MD/CN**

Resolved – (A) that the contents of paper H be received and noted;

(B) the Chief Nurse to contact the Chief Operating Officer to request a paper be presented to the November 2013 QAC meeting to provide assurance on the reporting of Quality and Safety for outsourced elective surgery work, and **CN**

(**C) the Chief Nurse and Medical Director be requested to sign-off governance arrangements for private providers.** **MD/CN**

100/13/7 Patient Safety Report

The Director of Clinical Quality presented paper I, the patient safety report, on behalf of the Director of Safety and Risk. The following points were highlighted in particular:-

(i) Responding to a query from the Non Executive Director and the Dean of the University of Leicester Medical School, the Director of Clinical Quality advised that she would present an action plan and a route map for information to the November 2013 QAC on how the ePMA would be progressed following the implementation of the CMGs;

(ii) It was suggested that complaints should be triangulated with the patient experience metrics and it was agreed that the Director of Clinical Quality would contact the Patient Experience Committee for an update on what is reported and

discussed. The November 2013 report would be deferred to the December 2013 meeting and the Director of Clinical Quality would present a patient views proposal to include a more detailed report to the December 2013 QAC, and

(iii) responding to a query regarding a recent Never Event it was agreed that the Medical Director would review whether additional checks needed to be put in place to prevent any further reoccurrence. It was agreed that once the investigation report was available it would be presented to QAC. **MD**

Resolved – that (A) the contents of paper I be received and noted;

(B) the Director of Clinical Quality to present an action plan and a route map for information to the next QAC on how the ePMA would be progressed following the implementation of the CMGs; **DCQ**

(C) the Director of Clinical Quality to contact the Patient Experience Committee for an update on what is reported and discussed; **DCQ**

(D) the November report to be deferred to the December meeting and the Director of Clinical Quality to present a patient views proposal to include a more detailed report to the December QAC, and **TA/DCQ**

(E) the Never Event investigation report is presented to QAC once completed. **MD**

101/13 QUALITY

101/13/1 Month 6 – Quality and Performance Update

Paper J provided an overview of the September 2013 quality and performance report highlighting key metrics and areas of escalation or further development where required.

The following issues were highlighted in particular:-

(a) a full report on mortality would be presented to the Board on 30 October 2013, and

(b) neck of femur performance remained fragile. It was agreed that reported actual numbers would be added into the Quality and Performance report so that fluctuation in demand was clearly visible, and **MD**

(c) the Committee Chair noted the intention to meet with the Chief Nurse and Trust Administrator to agree a calendar of business for the QAC including appropriate scheduling of items. **Chair CN/TA**

Resolved – that (A) the contents of paper J be received and noted;

(B) the reported actual figures for neck of femur be added to the #NOF report, and **MD**

(C) the Committee Chair, Chief Nurse and Trust Administrator to meet to agree a calendar of business for the QAC meetings including appropriate scheduling of items for future agendas. **Chair CN/TA**

101/13/2 CQUIN – Quarter 2 Report

The Head of Outcomes and Effectiveness presented paper K which provided a summary of the LLR and Specialised Services CQUIN indicators for 2013/14 and the anticipated RAGs in respect of quarter 2 performance. It was noted that there had been no exception reports and that it was predicted that the Trust would achieve quarter 2 targets. It was agreed that the comparisons for the end of month against the year would be shown in the report.

Resolved – that (A) the contents of paper K be received and noted, and

(B) the Head of Outcomes and Effectiveness to include comparisons for the end of month against the year in future reports. **DCQ**

101/13/3 Quality Commitment 2013 - 16

The Director of Clinical Quality presented paper L, which provided a summary of the performance against Quality Commitment quarter 2 2013/14 and commented that the dashboard reported on progress and not the anticipated position. Some good progress had been made in particular within the pneumonia pathway. A discussion took place around patient centred care and it was noted that the speeding up of the process of discharge had resulted in a worsened patient experience. It was agreed that the profile of patient centred care should be raised and it was noted that this would be included in the next Chief Executive's Briefing. A report would be presented to QAC on a quarterly basis and presented to the Trust Board on or before 20 December 2013. **CN**

Resolved – that the contents of paper L be received and noted, and

(B) the Chief Nurse to present a report on patient centred care to QAC on a quarterly basis and to the Trust Board by 20 December 2013. **CN**

102/13 ITEMS FOR APPROVAL

102/13/1 QAC Meeting Dates 2014

Members agreed and noted paper M which provided a summary of proposed dates for 2014 QAC meetings. These were noted and agreed as follows:-

Wednesday 29 January 2014 – venue to be confirmed
Wednesday 26 February 2014 – venue to be confirmed
Wednesday 26 March 2014 – venue to be confirmed
Wednesday 23 April 2014 – venue to be confirmed
Wednesday 28 May 2014 – venue to be confirmed
Wednesday 25 June 2014 – venue to be confirmed
Wednesday 30July 2014 – venue to be confirmed
Wednesday 27 August 2014 – venue to be confirmed
Wednesday 24 September 2014 – venue to be confirmed
Wednesday 29 October 2014 – venue to be confirmed
Wednesday 26 November 2014 – venue to be confirmed
Thursday 18 December 2014 from 9.30am to 12.30pm – venue to be confirmed

Resolved – that the contents of paper M be received and noted.

102/13 MINUTES FOR INFORMATION

102/13/1 Finance and Performance Committee

Resolved – that the public Minutes of the Finance and Performance Committee meeting held on 25 September 2013 (paper N refers) be received and noted.

102/13/2 Executive Performance Board

Resolved – that the action notes of the Executive Performance Board meeting held on 24 September 2013 (paper O refers) be received and noted.

103/13 ANY OTHER BUSINESS

103/13/1 Patient Experience

Mr M Caple commented on a template for CMG presentations due to the F&PC which was to be presented to the Finance and Performance Committee on 30 October 2013 and raised the question as to whether it would apply to the QAC. Ms J Wilson would receive feedback from the Finance and Performance Board and report back to Mr Caple.

Resolved – that the Committee Chair undertake the above action. **DCQ**

104/13 IDENTIFICATION OF ANY KEY ISSUES FOR THE ATTENTION OF THE TRUST BOARD

Resolved – that the following items be brought to the attention of the Trust Board on 31 October 2013:-

- **PLACE assessments (Minute 99/13);**
- **Nursing workforce (Minute 100/13/2), and**
- **Quality Commitment (Minute 101/13/3).**

105/13 DATE OF NEXT MEETING

Resolved – that the next meeting be held on Wednesday 27 November 2013 at 12.00 noon in the Large Committee Room, Leicester General Hospital.

The meeting closed at 12.00 noon.

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

Name	*Possible*	*Actual*	*% attendance*	*Name*	*Possible*	*Actual*	*% attendance*
J Adler	*7*	*4*	*57*	*R Overfield*	*2*	*2*	*100*
*M Caple**	*7*	*6*	*86*	*R Palin**	*4*	*3*	*75*
S Dauncey	*1*	*1*	*100*	*P Panchal*	*7*	*4*	*57*
K Harris	*7*	*5*	*71*	*C Ribbins*	*6*	*4*	*66*
S Hinchliffe	*1*	*1*	*100*	*J Wilson (Chair)*	*7*	*7*	*100*
*C O'Brien – East Leicestershire/Rutland CCG**	*7*	*5*	*71*	*D Wynford-Thomas*	*7*	*5*	*71*

** non-voting members*

Cheryl Hughes, **Interim Trust Administrator**

University Hospitals of Leicester NHS
NHS Trust

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST

REPORT BY TRUST BOARD COMMITTEE TO TRUST BOARD

DATE OF TRUST BOARD MEETING: 28 November 2013

COMMITTEE: Finance and Performance Committee

CHAIRMAN: Mr R Kilner, Non-Executive Director

DATE OF COMMITTEE MEETING: 30 October 2013

RECOMMENDATIONS MADE BY THE COMMITTEE FOR CONSIDERATION BY THE TRUST BOARD:

None

OTHER KEY ISSUES IDENTIFIED BY THE COMMITTEE FOR CONSIDERATION/ RESOLUTION BY THE TRUST BOARD:

- **Minute 115/13/1 – including the month 6 financial performance, RTT performance and the improved position relating to performance against cancer targets.**

DATE OF NEXT COMMITTEE MEETING: 27 November 2013

Mr R Kilner
22 November 2013

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST

MINUTES OF A MEETING OF THE FINANCE AND PERFORMANCE COMMITTEE, HELD ON WEDNESDAY 30 OCTOBER 2013 AT 8.30AM IN THE C J BOND ROOM, CLINICAL EDUCATION CENTRE, LEICESTER ROYAL INFIRMARY

Present:
Mr R Kilner – Acting Chairman (Committee Chair)
Colonel (Retired) I Crowe – Non-Executive Director
Mr R Mitchell – Chief Operating Officer
Mr P Panchal – Non-Executive Director (excluding Minutes 114/13/6, 114/13/7 and part of Minute 115/13/1)
Mr A Seddon – Director of Finance and Business Services
Mr G Smith – Patient Adviser (non-voting member)
Ms J Wilson – Non-Executive Director

In Attendance:
Mr P Burns – Head of Trust Cost Improvement Programme (for Minute 116/13/1 only)
Mrs S Khalid – Head of Improvement and Innovation (for Minute 114/13/4 only)
Ms R Overfield – Chief Nurse (for Minute 114/13/1 only)
Mrs K Rayns – Trust Administrator
Mr I Sadd – Non-Executive Director (up to and including Minute 115/13/1)
Ms H Seth – Head of Planning and Business Development (for Minute 109/13/1 only)

ACTION

RECOMMENDED ITEMS

109/13 REPORT BY THE HEAD OF PLANNING AND BUSINESS DEVELOPMENT

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

110/13 REPORT BY THE DIRECTOR OF FINANCE AND BUSINESS SERVICES

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

RESOLVED ITEMS

111/13 APOLOGIES

Apologies for absence were received from Mr J Adler, Chief Executive and Mr S Sheppard, Deputy Director of Finance.

112/13 MINUTES

Resolved – that the Minutes of the 25 September 2013 Finance and Performance Committee meeting (papers A and A1) be confirmed as a correct record.

113/13 MATTERS ARISING PROGRESS REPORT

The Committee Chairman confirmed that the matters arising report provided at paper B detailed the status of all previous matters arising. Particular discussion took place in respect of the following items:-

(a) Minute 100/13(c) of 25 September 2013 – the performance management interface

between the Finance and Performance Committee and the new Clinical Management Groups (CMGs) was due to be considered by the Chief Executive and the Acting Chairman during week commencing 4 November 2013 and an update would be provided to the 27 November 2013 meeting; **CE/ Acting Chair**

(b) Minute 100/13(d) of 25 September 2013 – the Acting Chairman noted that the expected report on benchmarking of Consultant costs in the context of patient care activity and case mix had been deferred from this meeting. Noting the extensive work required to gather the data to inform this report, he requested that this work be completed as soon as possible and that the outputs be presented to the 27 November 2013 meeting; **DFBS**

(c) Minute 101/13/3 of 25 September 2013 – Mr P Panchal, Non-Executive Director noted that the outline business case (OBC) for developing UHL's residential accommodation proposals was due to be presented to the November 2013 meeting and he requested that all options be explored, including the scope for co-operation with local housing associations. In response, the Director of Finance and Business Services noted the importance of feeding in such criteria during the development work for the strategic outline case (SOC), and

(d) Minute 103/13/1.1 of 25 September 2013 – the Chief Operating Officer reported on the arrangements to identify senior strategic project management resources for both the Outpatients and Theatres improvement workstreams. In addition, he agreed to contact Mr O Sudar, Outpatient Project Manager to explore the scope to provide some more immediate (lower grade) administrative support. **COO**

<u>Resolved</u> – that the matters arising report and any associated actions above, be noted. **NAMED LEADS**

114/13 STRATEGIC MATTERS

114/13/1 <u>Nursing Workforce Report</u>

Further to Minute 101/13/2 of 25 September 2013, the Chief Nurse attended the meeting to provide a high level overview of the Trust's nursing workforce position (paper D refers). She particularly noted that the standards, ratios and skill mixes specified in the report were considered to be the minimum requirement for each area and that these levels might become mandated in future. Table 1 on page 3 of paper C set out the agreed nurse to bed ratios and skill mix for each type of ward area following the nurse staffing and acuity level review undertaken in 2013.

Between March and April 2013 ward establishment levels were revised, resulting in a significant increase in reported vacancies (from around 150 posts to almost 500 posts). The Chief Nurse provided assurance that UHL's nurse staffing turnover rate was relatively low (approximately 35 posts per month) and that under normal circumstances the Trust was able to appoint and retain sufficient numbers of trainee nurses annually to cover this. However, like many other Trusts, UHL was now progressing intensive recruitment action plans through both UK and international job fairs to address the current level of vacancies. Apprentice HCAs and Assistant Health Practitioner roles were also being actively recruited to.

Work continued to try to improve the ratio between bank and agency nursing expenditure but with approximately 750 shifts per week currently not being filled, the Chief Nurse was not optimistic that agency nursing costs would reduce in the next 18 months, unless a consolidated framework approach was implemented towards renegotiation of regional agency rates. The Chief Nurse was requested to provide a verbal update report to the November 2013 Finance and Performance Committee in respect of progress towards addressing this key issue. The Committee also requested that a copy of the nursing **CN**

budget reconciliation report be circulated to members outside of the meeting for information. **CN**

Further discussion took place regarding the following points:-

(i) the national structure for commissioning nursing trainees and the minimum entry requirements (3 A levels) which might prevent some individuals with the appropriate caring nature from entering the nursing profession;
(ii) ways in which UHL might be able to influence nurse education funding through the Local Education and Training Board (LETB);
(iii) opportunities for increasing administrative support on wards to release more time for nursing duties, and
(iv) the creation of a dedicated bed space cleaning team to undertake the 45 minute process required following all patient discharges.

Resolved – that (A) the Nursing Workforce Report (paper D) be received and noted;

(B) the Chief Nurse be requested to provide a verbal update on the framework approach to reducing agency nursing rates at the 27 November 2013 meeting, and **CN**

(C) the Chief Nurse be requested to circulate a copy of the nursing budget reconciliation report to members of the Committee for information. **CN**

114/13/2 Ophthalmology Performance Recovery Plan

The Chief Operating Officer introduced paper E, providing an update on the challenges within the Ophthalmology service and the actions underway to address them. A copy of the updated risk assessment was appended to the report and this had been shared with the CCGs as part of UHL's RTT performance recovery plans.

Finance and Performance Committee members particularly noted recent changes in personnel, the arrangements in place to recruit additional administrative and clerical resources and the progress made towards reducing the waiting time for new referrals. The backlog of clinic letters waiting to be typed had reduced from 15,000 to 12,000 over the last 4 weeks, but the 20 week timescale to reduce the backlog to one week's work (1,200 letters) was still considered too long. The Chief Operating Officer confirmed that he would be driving further actions to improve this timescale. **COO**

Discussion took place regarding the timing and quality of patient communications mid-way through their clinical pathways and the impact of short notice prior to surgery. A number of patient complaints had been received on this subject. Currently 3 weeks' notice was being provided to patients before surgery and a focus was being maintained to increase this to 6 weeks' notice.

Colonel (Retired) I Crowe, Non-Executive Director noted that a number of patient complaints had been made regarding contacting the Ophthalmology department by telephone and he queried whether the Trust had a mechanism for tracking the number of abandoned telephone calls. The Chief Operating Officer agreed to check this point, but he commented that this issue was symptomatic of the decentralised approach which currently covered approximately 50 different specialties. Longer term plans to centralise such transactional functions were under development and a proposal was being prepared by Interserve to create a Patient Care Centre under the Lot 2 contract. **COO**

The Committee requested that a further update on Ophthalmology performance be provided to the 18 December 2013 Finance and Performance Committee meeting and that an Ophthalmology clinician be invited to attend the meeting for this item. Members also requested that appropriate KPIs be developed in order to monitor improvements and they queried the scope to implement LEAN working methodologies within this service. **COO** **COO**

<u>Resolved</u> – that (A) the Ophthalmology Performance recovery report (paper E) be received and noted, and

(B) the Chief Operating Officer be requested to:-

(1) continue to drive reductions in the timescale to address the backlog of clinical letters; **COO**

(2) confirm whether data on abandoned telephone calls to the Ophthalmology service was captured and recorded; **COO**

(3) arrange for an updated position statement to be presented to the Finance and Performance Committee on 18 December 2013 by an Ophthalmology clinician; **COO**

(4) develop appropriate KPIs by which improvements could be monitored, and **COO**

(5) explore the scope to implement LEAN working methodologies. **COO**

114/13/3 <u>Update on Review of Apportionment of Medical Staffing Costs Between UNH and the University of Leicester</u>

Paper F summarised the current status of the ongoing review of medical staffing costs recharged from the University of Leicester to the Trust. The initial findings of the review were detailed in appendix 1 and it was noted that the forecast variance to current charges was £3.37m. The Director of Finance and Business Services briefed the Committee on the next steps to validate the individual job plans to ensure accurate apportionment of sessions between the 2 organisations and to discuss migration plans with the University's Director of Finance.

Discussion took place regarding the performance management arrangements being implemented by the University to help improve education standards and support the quotas for overseas students. From benchmarking work undertaken, it was confirmed that UHL was an outlier in this area and this was partly attributed to historical cross-subsidies arranged during the University's development. The Committee requested an update on progress be provided to the 18 December 2013 Finance and Performance Committee meeting. **DFBS**

<u>Resolved</u> – that an update on progress with the migration plans for appropriate apportionment of medical staffing costs be presented to the 18 December 2013 meeting. **DFBS**

114/13/4 <u>Improvement and Innovation Framework Update</u>

Paper G provided a progress report on the implementation and roll out of UHL's Improvement and Innovation Framework (IIF). Ms S Khalid, Head of Improvement and Innovation attended the meeting to present this item and members congratulated her on her recent appointment as CMG Director for the Clinical Supporting and Imaging CMG. During the discussion on this item, Finance and Performance Committee members:-

(a) considered the selection process for participation in the IBM-led Innovation Workshop, noting that approximately 20 members of UHL staff would be selected to attend this event and that an appropriate method would be developed to define nominees by the end of December 2013. Assurance was provided that the nominees were expected to come from a broad cross-section of grades, disciplines and departments and that a particular focus on "strategic thinkers" would be sought;
(b) noted the development of an e-learning package to reinforce the meaning of quality improvement and how individuals could identify target areas and support further development;
(c) supported the proposal for additional Trust Board and Executive Team development sessions to support the Framework, noting that the arrangements were being made to build this into the existing Trust Board development programme;
(d) sought further information regarding the synergies between IIF and Listening into

Action (LiA). The Head of Improvement and Innovation provided feedback from a meeting held with Ms M Cloney, LiA Lead regarding the mapping arrangements and the benefits of improving staff engagement within the Framework;

(e) queried the links with the Productive Ward and Productive Theatre workstreams and noted that the same LEAN approach would be utilised. Improvements already achieved would be recognised and built into the Framework accordingly, and

(f) queried the future arrangements for leadership of the Improvement and Innovation Framework given the forthcoming changes to the Head of Improvement and Innovation roles undertaken jointly by Ms D Mitchell and Ms S Khalid. In response, it was noted that work was taking place to identify any gaps in the programme management arrangements and that proposals would be presented to Ms K Shields, Director of Strategy once she commenced in post on 4 November 2013. **HIIF**

<u>Resolved</u> – (A) that the progress report on UHL's Improvement and Innovation Framework (paper G) be received and noted, and

(B) a further progress report be provided to the 27 November 2013 Finance and Performance Committee meeting (to include the future IIF management arrangements). **CE/HII**

114/13/5 <u>Arrangements for Mapping Divisional Financial Recovery Plans into CMG Structure</u>

The Director of Finance and Business Services and the Chief Operating Officer reported orally on the developmental process for the 7 new Clinical Management Groups (CMGs), noting that appointments had been made to 34 of the 35 key posts and that interviews had now been arranged for the final post. Each of the new CMGs had either existed as a stand alone Clinical Business Unit (CBU) previously or had been combined from 2 CBUs. Meetings had been held with each of the CMG management teams to gain assurance that they recognised and accepted accountability for their respective elements of the Divisional financial recovery plans.

The Patient Adviser drew members' attention to a question he had raised at the 29 August 2013 Trust Board meeting regarding the accountability arrangements for Patient and Public Involvement within each CMG and he expressed concern that the Trust was only now seeking the views of the new CMG management teams regarding the optimum arrangements to address this within the CMG structure.

<u>Resolved</u> – that the verbal report on mapping arrangements between the Divisional recovery plans into the new CMG structure be received and noted.

114/13/6 <u>Outputs from Confirm and Challenge of Corporate Directorate Financial Performance</u>

Paper H briefed Finance and Performance Committee members on the outcome of the Executive Team confirm and challenge process for Corporate Directorates (as undertaken during September 2013) and the ongoing financial governance process to deliver an improved year end position. Detailed commentaries on the financial performance and recovery plans for the IM&T, Pathology and Strategy Directorates were appended to paper H as these Directorates had reported the largest adverse variances to plan. Members noted that recovery plans for the Pathology service (Empath) would now be driven by the Clinical Supporting and Imaging (CSI) CMG.

During discussion on paper H, the Finance and Performance Committee:-

(a) requested that a progress report on the Corporate Directorates' financial recovery plans be presented to the 18 December 2013 meeting; **DFBS**

(b) queried the scope for benchmarking the costs of providing Corporate services with other Trusts noting in response that services were delivered in a variety of models which made it difficult to draw direct comparisons;

(c) considered presentational aspects of the outsourced models for IM&T and Facilities Management financial performance;
(d) discussed the planned 6% CIP target for 2013-14 and noted the challenges faced by some of the smaller Directorates to achieve this;
(e) requested that the scope for restructuring the Corporate Directorates be explored and an update be provided to the Committee in December 2013; **CE**
(f) challenged the value of non-ward based nursing staff who were not actively involved in delivering patient care, and
(g) noted that the CMG management teams had expressed support for centralised corporate service functions in preference to a dispersed model.

Resolved – that (A) the outputs from the Corporate Directorate confirm and challenge process (paper H) be received and noted;

(B) the Director of Finance and Business Services be requested to provide a further progress report to the 18 December 2013 meeting, and **DFBS**

(C) the Chief Executive be requested to review the scope to restructure UHL's Corporate Directorates and report back to the Committee in December 2013. **CE**

114/13/7 Payment by Results (PbR) Consultation on 2014-15 Tariff

Further to Minute 101/13/6 of 25 September 2013, paper I provided a briefing on Monitor's consultation process which allowed providers to feedback on the 2014-15 PbR tariff proposals within strict parameters. Figure 1 set out the proposed tariff adjustments (with and without CNST) with inflation being applied at between 1.6% and 1.9% and the efficiency requirement set at 4%. Whilst these adjustments did not represent any surprises for the Trust, the Director of Finance and Business Services invited members to consider whether they were financially sustainable in the longer term.

Resolved – that the briefing on the PbR Consultation for the 2014-15 Tariff (paper I) be received and noted.

115/13 PERFORMANCE

115/13/1 Month 6 Quality, Performance and Finance Report

Paper J provided an overview of UHL's quality, patient experience, operational targets, HR and financial performance against national, regional and local indicators for the month ending 31 August 2013 and a high level overview of the Divisional Heatmap report. The Chief Operating Officer reported on the following aspects of UHL's operational performance:-

(a) ED performance against the 4 hour target continued to fluctuate – a 3 week period of sustained improvement during September and October 2013 had delivered compliant performance for 1 week, but then a spike in admissions (8% increase) had adversely affected performance again and a major internal response had been declared. The Chief Operating Officer briefed the Committee on the key actions being progressed by the Collaborative Hub to recover ED performance and the following comments and queries were raised in respect of ED performance:-
    - In response to a query raised by Mr I Sadd, Non-Executive Director, it was noted that ED recovery plans were predicated on the existing levels of demand continuing but there was some reliance on there being no further significant increases in ED attendances;
    - Ms J Wilson, Non-Executive Director sought and received additional information of the level of rigour being applied to improving discharge processes and their consistent application throughout the Trust, and
    - the Committee Chair noted the impact of staff taking annual leave during the

October 2013 half term school holidays and recommended that a robust approach be taken towards annual leave planning over the Christmas period;

(b) RTT 18 week performance stood at 81.8% for admitted and 92% for non-admitted. The third iteration of UHL's RTT recovery plan had been submitted to Commissioners for sign-off and Ophthalmology specific plans were being developed with input from the Intensive Support Team. Plans to address backlogs were being developed which were likely to include the use of some CQC accredited independent sector providers;

(c) cancelled operations performance stood at 2.2% (against the threshold of 0.8%). A detailed exception report was provided at appendix 3 and the Chief Operating Officer advised that the target to offer patients a new date for surgery within 28 days of their cancellation was being raised from 95% to 100%;

(d) UHL's performance against all cancer targets (reported 1 month in arrears) continued to improve. For August 2013, the 93% target for 2 week waits for symptomatic breast patients (where cancer was not initially suspected) had been missed by just 2 cases, due to 10 patients choosing to schedule their appointments outside the 2 week period. Indications were that all cancer targets would be compliant for September 2013. Ms J Wilson, Non-Executive Director commended the Trust's progress with the Cancer Improvement Plan particularly highlighting the focus and leadership provided by Mr M Metcalfe, Cancer Centre Lead Clinician and suggesting that he might be invited to present the improvement plan to a future meeting of the Finance and Performance Committee or the Trust Board. Members supported a potential nomination from the cancer management team to attend the IBM improvement and innovation workshop and discussion took place regarding opportunities to share the learning from the Cancer Improvement Plan into the RTT workstream;

(e) choose and book slot availability continued to be affected by speciality level shortfalls in clinic capacity and actions to reduce the waiting times for first Outpatient appointments were being taken forward under the RTT remedial action plan, and

(f) delayed transfers of care continued to be escalated appropriately and actions to address these were being taken forward as a sub-section of the discharge workstream to develop a systematic and consistent standardised process to improve the position for those patients requiring non-acute NHS care.

The Director of Finance and Business Services briefed members on the key aspects relating to UHL's financial performance and the key performance indicators (KPIs) for outsourced Facilities Management (FM) and IM&T services, particularly noting:-

1) the status of contractual queries relating to ED performance, RTT performance and ambulance turnaround times (as set out in the table on page 29 of paper J). The Committee Chair queried whether penalties relating to pressure ulcer performance had been transacted in September 2013 and noted in response that these were not reflected in the month 6 Income and Expenditure position;
2) that the Chief Nurse was the designated accountable Director for FM performance and KPI trends were summarised in table 1 on page 30 of paper J. It was confirmed that the Trust was enacting financial deductions for areas of contractual non-compliance;
3) that IBM had been asked to review the selection of IM&T metrics included in the quality and performance reporting template, and
4) a reported in-month income and expenditure deficit of £3.2m (£3.4m adverse to plan) and a year to date deficit of £16.6m. Year to date pay and non-pay costs were £9.8m and £7.4m adverse to plan respectively, mainly due to overheating in the emergency care system and a lack of recognition of additional income components assumed within the Trust's recovery plans for strategic transitional support and transformation investment.

In discussion on FM performance, Mr P Panchal, Non-Executive Director queried whether Interserve had advised the Trust of any proposed strike action (as referenced in an article in that day's Leicester Mercury). The Chief Operating Officer agreed to liaise with the Chief Nurse to ascertain whether such notice had been received. **COO**

The Committee Chair noted (from table 6 on page 37 of paper J) that the month 6 Consultant pay costs had increased by 10.4% since the same period of 2012-13 and that this increase did not appear to be covered by additional patient activity. The Director of Finance and Business Services commented upon the direction of travel towards more Consultant delivered models of care and wider changes in the shape of UHL's workforce. Ms J Wilson, Non-Executive Director suggested that the same level of rigour should be applied as was currently being applied to the nursing workforce plans and the Committee Chair confirmed that he would be progressing this issue at his next 1 to 1 meeting with the Chief Executive.

<u>Resolved</u> – that (A) the month 6 Quality, Performance and Finance report (paper J) be received and noted;

(B) detailed discussion on ED performance and emergency care issues be deferred to the public Trust Board meeting on 31 October 2013; **COO**

(C) consideration be given to inviting Mr M Metcalfe, Cancer Centre Lead Clinician to present the cancer improvement plan to a future meeting of the Finance and Performance Committee or Trust Board; **COO**

(D) consideration be given to nominating a representative from the Cancer Centre to attend the IBM-led innovation workshop; **COO**

(E) the Chief Operating Officer be requested to liaise with the Chief Nurse to ascertain whether any notice of strike action had been received from Interserve, and **COO**

(F) the Committee Chair be requested to discuss the governance arrangements for wider workforce planning with the Chief Executive outside the meeting. **Chair**

116/13 FINANCE

116/13/1 <u>Cost Improvement Programme (CIP) 2013-14 Update</u>

The Head of Trust CIP introduced paper K, providing the September 2013 status report on the Cost Improvement Programme for 2013-14, consisting of 330 schemes with a total forecast delivery value of £37.7m against the revised £37.7m target. The RAG ratings for each scheme were provided in a table on page 2 of paper K – no schemes were RAG rated as red and 12.7% of schemes were RAG rated as amber. Particular discussion took place regarding the following schemes:-

(a) Pathology CIP schemes – the Head of Trust CIP briefed members on the arrangements for handing over Empath related CIP schemes to the Clinical Supporting and Imaging CMG. Discussion took place regarding variances in the number and type of pathology tests carried out by HRG and by clinician. Assurance was provided that clinical engagement was being progressed appropriately and that an analysis of repeat tests and the intervals between them was being undertaken in order to address the issue of the same tests being ordered on arrival in ED, then again on the assessment units and again on the base wards. The Committee requested that a progress report on this workstream be presented to the January 2014 meeting;

(b) procurement CIP schemes – delays were noted with the implementation of the

stock management system now that the TDA approvals mechanism had been clarified. In the meantime savings of £134k were expected to be delivered through stocktaking processes and the Accenture work plan was expected to deliver £242k;

(c) ongoing discussions with the University of Leicester regarding re-imbursement of funding for academic and clinical posts;

(d) projected changes in CMG level workforce plans (as set out in tables 3 and 4 on page 5 of paper K). Ms J Wilson, Non-Executive Director sought additional clarity regarding the impact upon UHL's headcount and changes in the future shape of the workforce. In the interests of transparency, the Head of Trust CIP agreed to compile a summary of headcount changes for the November 2013 meeting. The Committee Chair clarified that the Corporate Services WTE movements reflected the Facilities and IM&T staff who had transferred across to the outsourced providers under TUPE and he suggested that the Director of Human Resources be requested to present a report to the November 2013 Finance and Performance Committee meeting.

Resolved – that (A) the 2013-14 CIP update (paper K) be received and noted, and

(B) an update on progress towards addressing variances in the number and type of pathology tests carried out be provided to the January 2014 Finance and Performance Committee meeting; **HTCIP**

(C) the Head of Trust CIP be requested to provide a summary of CIP related headcount changes for the 27 November 2013 meeting, and **HTCIP**

(D) the Director of Human Resources be requested to report on changes in the future shape of the workforce to the 27 November 2013 meeting. **DHR**

116/13/2 Management of Cost Improvement Programme

Paper K1 outline the future arrangements for managing CIP governance once the fixed term contract for Mr P Burns, Head of Trust CIP came to a conclusion at the end of November 2013. The Director of Finance and Business Services introduced a discussion on the proposed interim solution noting that Ms D Mitchell, Head of Improvement and Innovation had been working alongside the Head of Trust CIP for some months already and recognising that additional resources might be required to act as a creative catalyst for the identification of new schemes at key points in the planning process.

Members supported the transition of this key role from an external contractor to an internal resource on an interim trial basis, recognising the positive message that this demonstrated for the Trust. Clarity was provided that Ms D Mitchell would not be a member of the Executive Team, but that the Executive Team would provide additional support in the areas of clinical engagement, Theatre improvements and Consultant job planning. The Committee requested that both Mr P Burns and Ms D Mitchell be invited to present the CIP report to the 27 November 2013 meeting.

Resolved – that (A) the proposal for future management of CIP (paper K1) be supported, and

(B) Mr P Burns and Ms D Mitchell be requested to attend the 27 November 2013 meeting to present the CIP report jointly. **HTCIP/ HIIF**

116/13/3 Cash Management Actions

Paper M briefed the Committee on the cash management arrangements in place and the corrective actions underway to mitigate significant forecast cash shortfalls at 3 strategic points over the next 13 week period. Particular discussion took place regarding the local agreement for CCGs to pay elements of their monthly SLA payments at the beginning of

the month instead of the 15th of the month. A request for further elements of the monthly SLA to be paid early had not yet been formally agreed with the CCGs and the Committee Chair confirmed that this issue had been escalated accordingly.

Resolved – that (A) the report on cash management (paper M) be received and noted.

117/13 SCRUTINY AND INFORMATION

117/13/1 Template for Clinical Management Group Presentations

The Committee supported the draft template for CMG presentations noting the scope to off-set some dimensions of robust income and expenditure performance against CIP performance and that separate discussions would be held outside the meeting to ensure that the presentations encompassed the full range of performance metrics, including quality, safety, complaints and patient and public involvement.

The Patient Adviser queried whether a similar template would be developed for CMG presentations to the Quality Assurance Committee (QAC) and Ms J Wilson, QAC Chair advised that there were no plans to introduce CMG presentations for this Committee.

Resolved – that the template for CMG presentations to the Finance and Performance Committee (paper N) be supported.

117/13/2 Divisional Confirm and Challenge

Resolved – that the notes of the 18 September 2013 Divisional Confirm and Challenge meeting (paper O) be received and noted.

117/13/3 Executive Performance Board

Resolved – that the notes of the 24 September 2013 Executive Performance Board meeting (paper P) be received and noted.

117/13/4 Improvement and Innovation Framework Board

Resolved – that the notes of the 10 October 2013 Improvement and Innovation Framework Board meeting (paper Q) be received and noted.

117/13/5 Quality Assurance Committee (QAC)

Resolved – that the Minutes of the 25 September 2013 QAC meeting (paper R) be received and noted.

117/13/6 Quality and Performance Management Group (QPMG)

Resolved – that the notes of the 4 September 2013 QPMG meeting (paper S) be received and noted.

118/13 ITEMS FOR DISCUSSION AT THE NEXT FINANCE AND PERFORMANCE COMMITTEE

Paper T provided a draft agenda for the 27 November 2013 meeting. It was agreed that the Trust Administrator would update this draft agenda to include a number of additional items arising from this meeting and recirculate the draft agenda outside the meeting. **TA**

Resolved – that (A) the items for consideration at the Finance and Performance Committee meeting on 27 November 2013 (paper T) be noted, and

(B) the Trust Administrator be requested to update the draft agenda and recirculate it outside the meeting. **TA**

119/13 FORMAL RECOMMENDATIONS FOR THE TRUST BOARD

Recommended – that the following recommendations be highlighted for Trust Board approval:- **FPC CHAIR**

- **Confidential Minute 109/13 – report by the Head of Planning and Business Development, and**
- **Confidential Minute 110/13 – report by the Director of Finance and Business Services.**

120/13 ITEMS TO BE HIGHLIGHTED TO THE TRUST BOARD

Resolved – that the following issues be highlighted verbally to the Trust Board meeting on 31 October 2013:- **FPC CHAIR**

- **Minute 115/13/1 – including the month 6 financial performance, RTT performance and the improved position relating to performance against cancer targets.**

121/13 ANY OTHER BUSINESS

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

122/13 DATE OF NEXT MEETING

Resolved – that the next Finance and Performance Committee be held on Wednesday 27 November 2013 from 8.30am – 11.30am in Seminar Rooms A & B, Clinical Education Centre, Leicester General Hospital.

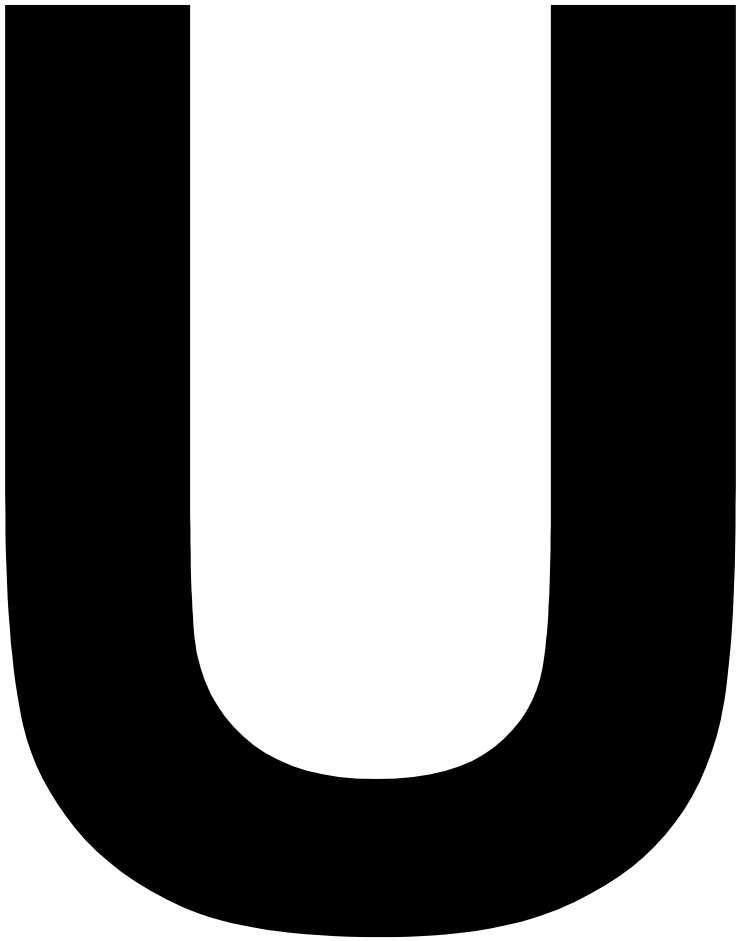
The meeting closed at 11.26am

Kate Rayns,
Trust Administrator

Attendance Record

Name	Possible	Actual	% attendance	Name	Possible	Actual	% attendance
R Kilner (Chair from 1.7.13)	7	7	100%	I Reid (Chair until 30.6.13)	3	3	100%
J Adler	7	6	86%	A Seddon	7	7	100%
I Crowe	4	4	100%	G Smith *	7	6	86%
R Mitchell	4	3	75%	J Tozer *	2	2	100%
P Panchal	4	2	50%	J Wilson	7	6	86%

* non-voting members



To:	**Trust Board**
From:	**Richard Mitchell, Chief Operating Officer**
Date:	**28 November 2013**
CQC regulation:	**As applicable**

Title:	Emergency Department Performance Report

Author: Richard Mitchell, Chief Operating Officer

Purpose of the Report:
To provide an overview on ED performance.

The Report is provided to the Board for:

Decision		Discussion	
Assurance	√	Endorsement	

Summary / Key Points:

- Performance in October was 91.80%
- Performance year to date is 87.90%
- Emergency admissions continue to increase creating significant capacity problems
- Sixteen additional admissions beds opened at the LRI on 4 November 2013
- A resilience checklist has been implemented
- The discharge rate has begun to improve
- There is an increased focus on non-admitted breaches
- Continuing the selective elective work outsourcing
- Performance continues to come under considerable external scrutiny.

Recommendations:
The Trust Board is invited to receive and note this report.

Previously considered at another UHL corporate Committee N/A

Strategic Risk Register Yes	**Performance KPIs year to date** Please see report

Resource Implications (eg Financial, HR)
Yes

Assurance Implications
The 95% (4hr) target and ED quality indicators.

Patient and Public Involvement (PPI) Implications
Impact on patient experience where long waiting times are experienced

Equality Impact
N/A

Information exempt from Disclosure
N/A

Requirement for further review
Monthly

REPORT TO:	**Trust Board**
REPORT FROM:	**Richard Mitchell, Chief Operating Officer**
REPORT SUBJECT:	**Emergency Care Performance Report**
REPORT DATE:	**28 November 2013**

Introduction

UHL's performance continues to vary against the four hour emergency care measure.Plans for performance improvementincluding the 'Hub' integrated plan have developed over the last eight weeks. This report provides an overview of performance for October and November 2013.

Performance overview

In October 2013,91.80% of patients were treated, admitted or discharged within four hours. Thiswas the strongest monthly performance since September 2012.November 2013 performance, month to date, (up to and including 21November 2013) has dropped to 87.9%.Year to date performance is 87.89%.

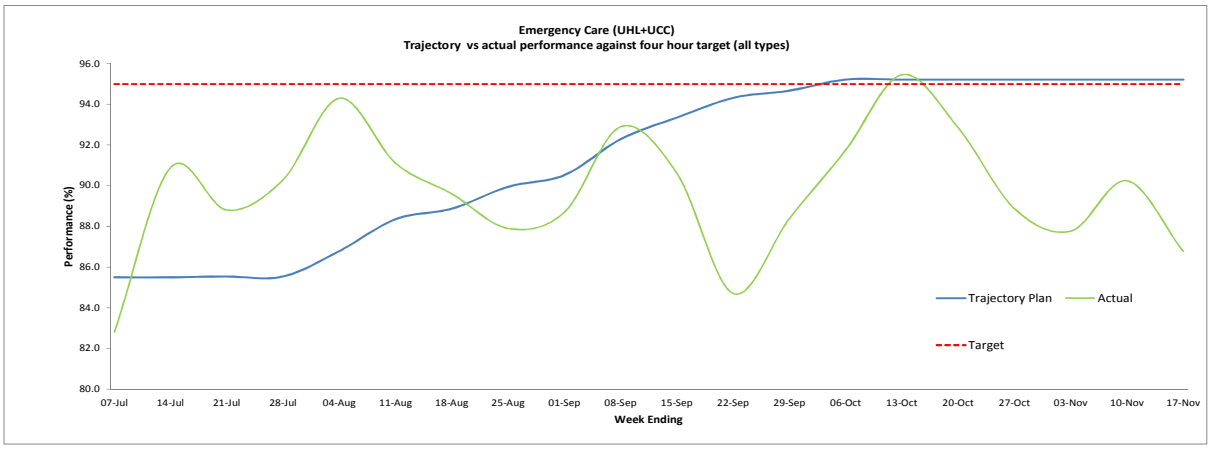


Table one

Root cause of poor performance

As detailed previously, an in-depth diagnosis of causative factors for poor performance was conducted in July and early August and actions were put in place to negate the factors. Some success occurred with the range of factors at play reducing but the primary reason for poor performance is access to beds.

The key contextual issues at UHL remain:

- UHL is the biggest single site A&E in the country. Many other single site EDs such as Heart of England NHS FT (85.0%) and Nottingham University Hospitals NHS Trust (86.6%) are experiencing problems
- UHL has the second highest number of elective and non-elective admissions in the NHS. The highest, Barts Health Trust has 300 more beds than UHL
- Admissions are increasing (table two).Two of the last five weeks have had more admissions than at any stage last winter. This is a national problem but is particularly pronounced in our health economy. Adult emergency admissions are 3.89% higher than this time last year (table three)
- This is particularly challenging in the over 65 year old patients whose admissions rate has doubled since 2012.
- Our non-elective medicine length of stay is significantly below peer average with only one Trust of our complexity with a lower length of stay
- UHL treats 160,000 in a A&E built for 100,000

The consequence is flow out of A&E is often poor which means too many patients back up in the department and breach. Unlike many peer organisations, UHL cannot open significant numbers of additional beds this winter because of staffing and estates constraints.

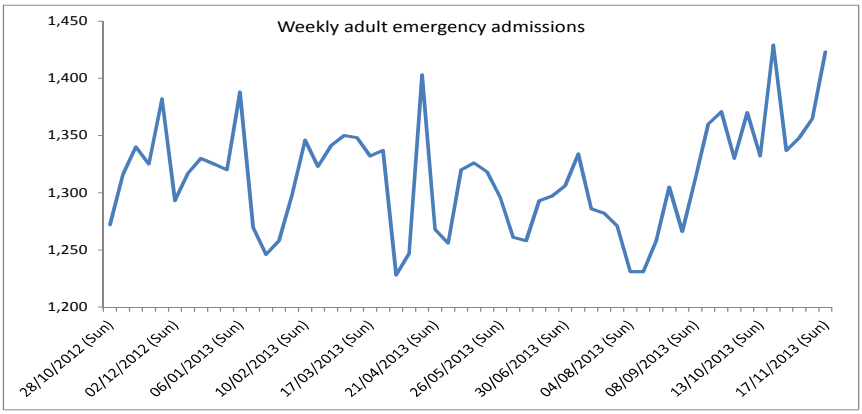


Table two

Week Ending	Emergency Admissions	Emergency Admissions (Adults)	Discharges (Emerg Adm)	Discharges (Emerg Adm) Adult
04/11/2012 (Sun)	1,426	1,316	1,394	1,279
11/11/2012 (Sun)	1,472	1,340	1,507	1,385
18/11/2012 (Sun)	1,456	1,325	1,459	1,321
Total	**4,354**	**3,981**	**4,360**	**3,985**
03/11/2013 (Sun)	1,476	1,348	1,521	1,400
10/11/2013 (Sun)	1,501	1,365	1,503	1,358
17/11/2013 (Sun)	1,598	1,423	1,547	1,393
Total	**4,575**	**4,136**	**4,571**	**4,151**

Change	**221**	**155**	**211**	**166**
% Change	**5.08%**	**3.89%**	**4.84%**	**4.17%**

Table three

Key actions since last month

- Resilience checklist implemented (attached)
- Improved discharge process (attached) and tables four and five
- Improved focus on non-admitted breaches
- Sixteen additional assessment beds opened on 4 November 2013
- Continuing the spend of winter monies
- Continuing the selective elective work outsourcing

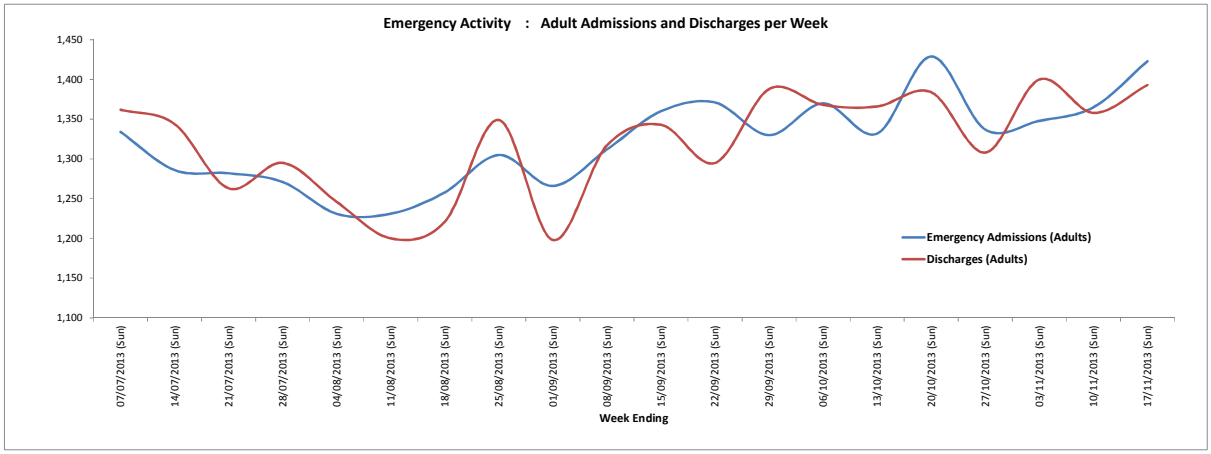


Table four

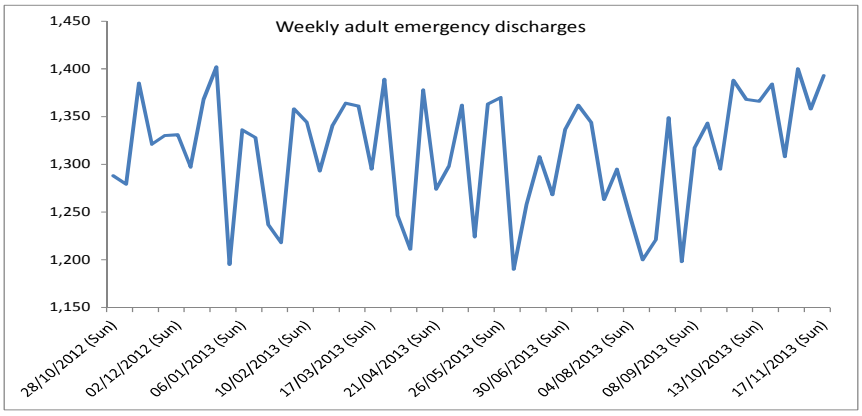


Table five

Recommendations

The board are asked to:

- Note the contents of the report
- Acknowledge the continuing focus on further and continued sustained performance improvement

Briefing Note – Urgent Care Working Group

November 2013

Rachel Overfield Chief Nurse UHL

The Patient Census – Pathway Monitoring and Escalation

1. Introduction

Part of the Emergency Care Hub action plan, the need to work to a single list of patient information that's updated at least daily was identified as a key action.

Responsibility for delivery of this action has been shared between operational and nursing leadership.

Originally described as 'developing a single discharge list' this action has been further refined to what we believe the organisation and wider system actually need – a patient census (updated at least daily) that details every patient by where they are in their individual pathway. There is no system ability to do this currently. The census will then be monitored for delays and actions escalated where necessary. This process to be done via conference calls.

2. The Problem – what are we trying to resolve?

When we first identified the need to work towards a single discharge list UHL (and others) were working from various paper lists of patients with varying degrees of information. The information was entirely focused on 'today's discharges' and was gathered by both bed management staff walking the wards and also ward staff attending 2 – 3 discharge/bed meetings daily. In other words a fairly traditional bed management model.

In addition specialist teams were working to other lists eg Delayed transfer of care. The daily discharge lists were not rolled over from one day to the next and so there was no audit trail of actions undertaken or required.

Problems with this model :

- Huge amount of nursing time reporting into meetings
- Meetings not about challenge, learning or action – just data collection
- No forward planning
- No audit trail or collection of information to learn from
- No holding anyone to account

- Entirely focused on delays in discharge today and not delays in pathway progress.

Inevitably this model leads to very limited ability to resolve pathway delays in a timely way, forces discharges in a chaotic way, wastes staff time duplicating 'counting' and does not support effective, well planned discharges.

3. The New Model

For the past 3 weeks we have been working with ward tams across the medical wards at the LRI to introduce a more proactive approach to pathway management and discharge planning.

Key features of the New Model

Before 8.30am – Ward Produces Patient Census

Before 9.30am – All wards have a MD Board Round

Between 11am – 12 noon – wards phone in to call centre to update patient census (5 – 10 min conversation maximum)

- Pathway position known for all patients including
  - Delays in pathway
  - Medically fit status
  - Discharge status
  - Discharge plan status
- Wards challenged and coached to act and learn
- Other key staff involved in call centre
  - Transport
  - Pharmacy
  - Therapies
- Actions for other staff clearly identified and assigned.

3pm - Repeat conference call to update progress and escalate actions.

Lists are rolled over to the next day and kept for audit/accountability purposes.

Conference call needs to be led by a

senior, credible operational/nursing professional (preferably both) with admin/ tracker support.

4. **Issues so Far**

- Paper system
- Ward leadership not owning the process/accountable
- Unfamiliarity conference call process – intimidating
- Some calls led by staff too junior and/or too entrenched in old bed management model
- Opportunity to support/coach ward staff not valued/done every day
- Shifting location and frequent changes (minor) to process – confusion
- Weekends and scaling up – not yet resolved.
- However every day the system is improving.

5. **Benefits New Model**

- Ability to track pathway progress of every patient
- Clear accountability for actions
- Ability to learn and therefore deliver sustainable approach
- Nurses not wasting time in meetings – remain in clinical area
- Rapidly engages/escalates to others
- Provides rolling census and rolling actions
- Provides audit trail of delays/themes/actions
- Identifies areas that need particular help/support
- Provides single list for others to work from.

6. **Further actions this week**

- Move to electronic list by next week (appendix 1)
- Re-issue clear process, timings, location and roles
- Identify wider team of credible senior staff to run call centre
- Daily involvement CN/COO
- Mandatory 'attendance' at calls from wider teams – phone in
- Concluded snap shot detailed patient census – see high level early results (appendix 2)
- Redefine 'language' eg census not discharge list

7. **Conclusion**

We believe that this change is fundamental to the effective flow of patients through the system and is innovative in its approach. However it must be recognised that this will only embed into practice if ward staff understand and relate to its value ; are supported and developed to use the system with confidence and without fear of criticism; that it recognises the need for safe and caring discharge and duplication of information collection is eradicated. In other words this is about culture and leadership development and not just

about system application and data collection. It will therefore take some time to fully introduce and embed.

We will continue to focus on medical wards at the LRI initially whilst resolving scaling up across the Trust ; involvement of other organisations and weekend processes.

Appendix 2

Initial results of patient snapshot census undertaken 18-20th November 2013 across LRI Medical Wards

Purpose

To capture current delays in actual discharge from Acute hospital care.

Auditors

Corporate Nursing Team and Senior Operational Staff

Findings/Delays (NB just LRI Medical Wards)

Fast track/CHC terminal care	**X 3**
Rapid discharge terminal care	**X 1**
CHC packages of care	**X 9**
Waiting Nursing Home Assessment	**X10**
Waiting patient choice of destination	**X 2**
Waiting mental health location	**X 6**
Waiting family choosing nursing home	**X 5**
Waiting brain injury/YDU/stroke rehab	**X 6**
Waiting social situation issue e.g. boiler repair	**X 3**

In addition, team picked up several internal delays in pathway progression

- **Therapy**
- **Medical review**
- **CNS review**
- **Outlier delays**

Team also noted ward staff reluctance to start discharge arrangements until medical fit status declared.

Action Area Number	Action Area	Lead	Action Reference	Action	Lead Organisation	Lead Individual	Project Support	Completion Date & RAG	Update	Planned Progress Next Week
1	Inflow	Sue Lock	1.1	Analysis of exclamation orders and rapid feedback to referrers + links to UCC audit of inappropriate attenders	UHL/GEH/CCGs	Kim Wilding	N/A	30.11.13	KW has shared the data from the pilot and avoidable data for September. This will be shared with practices individually and via the Nov localities for LC CCG. Oct/Nov data is now being reviewed by UCC GP on 13.11,13. and will be fed back to GPs during the December localities as opposed to November localities. Audit of GP inappropriate referrals expected on 27/11/13	
			1.2	Implementing a 15 min handover times between UCC and ED	UHL / GEH	Jane Edyvean Kim Wilding	Catherine Free Kim Wilding	30.11.13	Nursing proceses have been agreed by KW and JE. There is also now a dedicated porter in the Assessment Bay area. The new nursing process is making a big difference to handover process. As an ongoing measure, a process has been implemented whereby KW contacts JE in the event of a significant delay for handover.	
			1.3	Patients referred by GPs in to ED to be triaged through UCC	GEH	Julie Whittikar	Kim Wilding	30.11.13	Pilot went live on 28.10.13 for one week using additional resource and is now completed. A detailed review of data was undertaken on 11/11/13. The second phase pilot will be undertaken from 18.11.13 onwards to triage GP referrals through the ED Front Door without any additional resources. If successful, the process will remain in place.	
			1.4	Patients transferring from UCC following assessment late into the 4 hour pathway	GEH	Jane Edyvean Kim Wilding	N/A	18.11.13	UCC to ensure that duty manager at UHL called and informed immmediately as and when this happens - this process has been implemented. Richard Mitchell is confirming with UHL Information Team whether they have the >20minute triage to ED data. An audit tool will also be added to this process for 1 week. No information has yet been received by KW. MK to discuss with UHL the feasability of sharing with GEH (UCC) which of these patients breach. No breach information has been received from UHL.	
			1.5	Results management out of hours - pathology reporting	UHL / OOH	Angus McGregor Roy Aston	Michael Kaiser	30.11.13	Generic use of ICE would assist with this. ICE requesting rates in primary care are a little over 85% at the moment. We believe that the telephone number is a part of that requesting process; that the GPs will have more up to date records of patient information (address and phone number) than the Trust; and that increasing the usage of ICE requesting will improve the quality of the data and in particular ensure that all patients have the right telephone number linked to the pathology request. Access to the patients phone number is the key issue and creating a mandatory field in ICE will resolve this. Pathology are investigating this. A significant proportion of cases will have a phone number in iLab (the laboratory computer) already and staff who are phoning out results will provide that number with immediate effect. Pathology have investigated the above by auditing ICE requests and iLab to find that the proportion of patients for whom the telephone number is known is 99.1%, however the accuracy of these phone numbers is questionable. Pathology are also reviewing how ICE links to PAS and iLab Access to ICE for OOH would allow them to view previous results easily. A If GPs are expecting the results to be high GPs will be asked to complete a OOH will provide numbers of Pathology patients flowing through their se UHL will look at numbers of Pathology patients attending ED.	

			1.6	**Potential duplication of Clinic 1 and ED front door/UCC or not complimenting as best it could.**	CCGs	Tim Sacks	Roy Aston Kim Wilding	30.11.13	Rapid review Clinic 1 OOH and UCC functions will be organised to ensure that any duplication is removed and the two services align. An initial meeting to be set up by 18.11.13. Despite contacting CNCS several times, we are still awaiting a response from them re: arranging a meeting.	
			1.7	**Consultant triage of GP referrals for medical admission via Bed Bureau.**	UHL	Lee Walker	Sue Harris	Monthly	Lee Walker will continue to provide a monthly update of the effectiveness of this at the Inflow Group meetings. A report of October data is in progress.	
			1.8	**Streamlining of cardiology and respiratory admissions via the clinical decisions unit at GGH.**	UHL	Catherine Free Tim Sacks	N/A	01.11.13	Pathway now written and agreed with UHL. Pathway now signed off by EMAS clinical governance forum. Pathway became live on 18.11.13	
			1.9	**GP Bounce Back levels are poor from both UCCs.**	GEH	Kim Wilding Angela Bright	Kim Wilding Simon Sourt	30.11.13	A review of the '20 minute triage window' for these patients will commence at the Inflow meeting on 04.11.13. Completed. In addition, a pilot of the original Bounce Back pathway will occur. A date for this is still to be decided. A proposed pilot process will be discussed with the UCC CD on 20.11.13.	
			1.10	**There is inconsistency of criteria used WiC/MIU/UCCs to refer into ED.**	CCGs	Angela Bright Sue Lock Tim Sacks	Kim Wilding Simon Court	02.12.13	CCG COO's provided a review of ED referrals and Bounce Back levels as well as issues to understand issues. The Merlyn Vaz contract due for renewal next year and this will align with the UCC SOP.	
			1.11	**Lack of consistency in implementing EOL Pathway across CCGs.**	CCGs	Angela Bright Sue Lock Tim Sacks	N/A	18.11.13	CCGs and GEH met on 18.11.13 to compare current EoL pathways and relative levels of uptake, to test and confirm that each CCG is doing all they can to prevent EOL patients getting into ED. WL CCG is in the 2nd year of a QIPP programme including EoL resulting in a higher number of patients on EoL registers. WL will use winter funding to set up a GP telephone triage for those at the end of life. ELR CCG will use winter funding to increase care planning. LC CCG plan to fund a mix of both. Learning from the GP triage system will be shared with ELR CCG. The meeting will also review those EOL patients that arrive at the ED Front Door or ED itself to ensure that the patients are following the most appropriate pathways. CCGs do not have robust data on EoL patients arriving at ED. JE and GEM requested to review the number of EoL patients (last 12 months of life) and the number of dying patients attending A&E. Additionally, all inpatient EOL issues and what is being undertaken to ensure that all EOL patients already in UHL are being treated in the right place will be discussed. AB to contact TY and JT to discuss potential for in	
			1.12	**Frequent Flyers**	UHL	Jane Edyvean	TBC	31.12.13		
			1.13	**Batching of calls – EMAS.**	EMAS	TBC	TBC	TBC	This has been investigated and confirmed with EMAS that this does not occur. It is proposed that this is removed.	
			1.14	**Low % of patients seen by GP prior to presentation at hospital.**	CCGs	Angela Bright Sue Lock Tim Sacks	N/A	30.11.13	The three CCG COOs will meet on 25.11.13 to satisfy each other that each CCG is doing all it can within Primary Care to keep patients out of ED. COOs have discussed this issue. CCGs are focusing on highlighting appropriate pathways to GPs. We do not have information to support this action and require further evidence that we can take to GPs for discussion.	
			1.15	**GP – admits earlier in the day.**	CCGs	Angela Bright Sue Lock Tim Sacks	N/A	30.11.13	The three CCG COOs will meet on 25.11.13 to satisfy each other that each CCG is doing all it can to ensure that GPs admit patients earlier in the day.	
			2.1	**Streamline and speed up TTO process**	UHL	Suzanne Khalid	Claire Ellwood David Kearney Kevin Harris Nick Pulman	30.11.13	Proof of concept studies with Pharmacist on ward round coordinating discharge medication and ensuring appropriate medication and using Pharmacist to update ICE letter successfully completed. This has been very positive and pharmacist input is well received by medical staff. Two locums will start 25.11.13 to provide pharmacists on ward rounds. Roll out aligned with where other discharge improvement work to maximize impact. Advertisements for further 2 to 3 locums placed with recruitment by 2.12.13 to allow full implementation at LRI through December. Testing of IT fix is ongoing. Estimated date for this to be used in medicine is beginning of December at which time the EPMA discharge tab will be rolled out across all medical wards at LRI.	

			2.2	**Locum inductions**	UHL	Pete Rabey	Rachel Williams	15.11.13.	Handbook developed as well as the process flash cards to help them. Any new locum is left an envelope in the pocket near majors desk and a note for the doctor in charge on the daily sheet to induct them and give this envelope to the doctor. They are allocated a locum EDIS account. Also developing a folder with CV's and feedback on all locums working or worked in the department and this is then taken to the consultant meetings for feedback on competency of the doctors. A final review of this process to ensure completeness will occur by 15.11.13.	
			2.3	**Timely Specialty engagement (workshop with specialties to understand the blocks)**	UHL	Andrew Furlong	Sarah Morley	14.11.13	Successful Specialty/ED engagement workshop held on 8.11.2013 (with Hub support). Initial resulting plans for MSK, Surgey, Critical Care and ENT reveiwed on 15/11/13. COMPLETE	
			2.4	**Progress CMG/Specialty project plans - output from workshop 8/11/13 - gain agreement to progress**	UHL	Andrew Furlong	Sarah Morley	~~15.11.13~~ 29.11.13	x4 specialty plans (Gen Surgery, MSK, ITU, ENT) submitted to ECAT by Andrew Furlong/specialty representatives on 15/11/13. ECAT 15.11.13 decision that an amalgamated paper for all 4 plans to be compiled (using the Urgent Care template). ITU to return business plans by 29.11.13 to AF, remaining 3 services by 21/11/13 for presentation at ECAT.	
			2.5	**Setup Task & Finish Group to monitor, track, measure and report on agreed outputs from 2.3.1**	UHL	Andrew Furlong	Sarah Morley	~~29.11.13~~ 04.12.13	AF to communicate w/e 22/11/13 to lead clinicians with a view to the initial meeting taking place 1st week fo December.	
			2.6	**Quick wins identified from workshop 8/11/13 to be prioritised for action _ track via Task & Finish Group2.3.1.1**	UHL	Andrew Furlong	Sarah Morley	22.11.13	IBM IPWC project tool to be used for tracking/reporting subject to receiving go ahead for 2.4/2.5.	
			2.7	**EDIS to be put into place for identified areas**	UHL	Andrew Furlong	Sarah Morley	6.12.13	? Specialties to confirm requirements and specialty leads for implementation to be identified	
			2.8	**Walk through ED from ITU Consultant**	UHL	Andrew Furlong	John Parker	22.11.13	Agreed at the workshop by ITU - completed action - requires monitoring through related action. AF to check with Ben Teasdale w/e 22.11.13 that this is in practice and working as required.	
			2.9	**Reconvene daily operational meetings between ED & Specialties to enforce communication and change culture**	UHL	Andrew Furlong	Sarah Morley/Specialty Leads	29.11.13	Requires further expansion on quick wins to agree on outline for daily 5 minute meeting prior to 8am capacity planning meeting. To be revisited through task/finish group.	
			2.10	**Re-establish communication lines between ED & specialties through a month/bi-weekly meeting between ED & HOS**	UHL	Andrew Furlong	Sarah Morley/Specialty Leads	~~22.11.13~~ 29.11.13	Being arranged - delayed by 1 week.	
			2.11	**Review existing SOPs for accuracy, effectiveness and adherence.**	UHL	Andrew Furlong	Sarah Morley/Specialty Leads	06.12.13	List compiled. To be led by the individual specialties/CMGs - to implement "no-brainer" processes, eg Fractured NOF. ED/Specialty leads will review and revise where appropriate once regular meetings (2.10) are setup. Action will be monitored through the task/finish group (2.5).	
			2.12	**Radiology availability and rapid access to investigations by ED consultants (avoiding specialty sanction)(Radiologists in ED)**	UHL	Andrew Furlong	Sarah Morley	~~30.11.13~~ 16.12.13	Radiology/ED working group already exists and update 19.11.13 shows good progress is being made with many actions estimated to be complete by mid December 2013. Aim to bring Imaging into the task/finish group for engagement and to track progress against current action plan with Radiology and to pick up any identified issues as a result of other workstreams.	
2	**ED/ Specialty Working**	Kevin Harris	2.13	**Clear ED SOP's and implementation**	UHL	Catherine Free Ben Teasdale		~~15.11.13~~ 22.11.13	3 have been written but need to be amended to account for new structures. External comparisions being undertaken. To be signed off 22 11-13	
			2.14	**Ensure consistent shift by shift ED leadership**	UHL	Ben Teasdale	Jay Banerjee	~~15.11.13~~ 13.12.13	Rotas have been re-organised to reduce exposure of those less able to cope with high levels of pressure. A SOP is being written that includes a checklist of measurable actions on behalf of the doctor in charge and based on the SBAR concept to maintain safety in the department and address the escalation plan to reduce variation under these extreme conditions. This will go to ECAT for sign off by end of November. Coaching plan for specific individuals has been developed with HR and will commence in December. Although the deadline	
			~~2.15~~	~~**Review of roles and responsibilities of who can discharge (including confidence and competence)**~~	~~UHL~~	~~Pete Rabey Nursing Lead (TBC)~~	~~Julia Ball~~	~~15.11.13~~	~~All discharge work in UHL reviewed at a meeting w/c 04.11.13. Task and Finish group to meet Monday 18th Novemeber. Meetings with matrons and sisters in medical CMG to take plavce with RO & JB Thursday/Friday next week~~	This Action will be moved to Action Area 3 (Ward Practice) moving forward and is identified as Action 3.14 on this sheet.

~~2.16~~	~~**Communication to patients - setting expectations at point of admission**~~	~~UHL~~	~~Pete Rabey~~	~~Ann Hall~~	~~15.11.13~~	~~Rachel Overfield has had several meetings with nursing staff to ensure that their communication to patients is accurate.~~ ~~There is a new ward round standard being written which will be reviewed to account for this.~~ ~~There will be a need to target specific areas where messages communicated to patients are not accurate and can create more complex patients than necessary.~~	This Action will be moved to Action Area 3 (Ward Practice) moving forward and is identified as Action 3.15 on this sheet.
2.17	**Engagement with services that have wider capacity issues – Critical care, theatre capacity for emergency surgery, out of hours capacity etc. –(link to specialty discussions)**	UHL / CCGs	Andrew Furlong	Sarah Morley	15.11.13	Gen surgery have produced a short business case for SAU triage model along similar lines to LRI MAU. Now ro be linked to action following speciality workshop. T&O have also produced plan for increased senior decision maker pull through from ED to # clinic assessment area. **19.11.13 UPDATE** - Suggest that this is removed as covered by earlier action points. In addition, timeframe for rapid improvement plan suggests ability to have a reasonable impact as a separate workstream is limited. Business plans to be submitted from the specialties all aim to improve capacity issues within the specialties in order to support improved flow and process with ED.	
2.18	**Robust ED medical staffing**	UHL	Catherine Free/Ben Teasdale	Rachel Williams	~~15.11.13~~ 06.12.13	Plan revised to include fundamental demand and capacity review, re-basing of establishment and ongoing recruitment plan. New reporting template developed to highlight gaps and relationship to breached - to be reported weekly. Recruitment of international doctors is on going with inductions of the NHS and clinical skills set up . Regular junior staff adverts are placed and then interviewed into vacancies . Fixed term contracts are negogiated for Agency locum staff to ensure consistency for the deaprtment .	
2.19	**Specialty referrals being routed through ED + adherence to SOP's**	UHL	Andrew Furlong	Sarah Morley	30.11.13	KW and PW met and initiated new process. Any declines of speciality referrals will be raised with duty manager. Any referrals to ED from UCC will be marked as such on S1. In relation to the SOPs being adhered to, AF is reviewing and Inflow believe these need to be looked at from GP, UCC and other agency referrals. A.Furlong reviewed SOPs prior to the meeting on 08.11.13 Inflow group to set up monitoring process/data set to monitor. UCC have report for their referrals and KW to speak to Simon Court at Loughborugh UCC to ensure they can utilise the same report. Complete as per the above detail - outstanding SOP review/engagement now detailed elsewhere. **AF UPDATE 19.11.13** - Suggest this is now merged with similar workstream in action 2.11 above.	
3.1	**Liberating nursing time - Keeping senior nurses in clinical areas for the next month (no meetings)**	UHL	Rachel Overfield	Julia Ball	Completed	This is now operational and will be monitored for effectiveness. Complete Ward Managers/Matrons returned to wards full time from early October	
3.2	**Establish Ward round – baselines - rapid improvement (using exemplar wards)**	UHL	Andrew Furlong Julia Ball	Julia Ball	~~15.11.13~~ 01/12/13	Review group to agree operational standards for surgical and medical ward rounds. Audit tool to be produced for matrons to audit week commencing 04.11.13. task and finish group planned for 21.11.13.matron audit completed and audit information from completed by medics throughout October being collated to inform on 21st November. (Purpose of task and finish is to drive forward standards with emphais on communication /responsibility /accountability) Consultant and junior medical leads identified.	
3.3	**Prevent computers hibernating – action now**	UHL	John Clarke	Jane Edyvean	Completed	Completed	

3	**Ward Practice**	Rachel Overfield	3.4	**Management plan for all patients transferring to community hospitals (and GP letters)**	LPT	Jude Smith	Julia Ball	~~15.11.13~~ 01/12/13	Meeting with Jude Smith 23/10/13 Link in with work stream led by Paul Hunt on minimum data set. Meeting this week. Meeting with Paul on 11.11.13. paul taking forward discussions with leicestershire HISS team . JB to discuss with John Clarke re tool required /nterface etc this week. Work will continue through task and finish group which PH will attend. JB to contact Paula Dunnan to link in with work on patient discharge tracker tool currently under development. Discussed at task and finish group 18.11.13 and work ing to look for interim solution to take place next week (JB/PH)	
			3.5	**Minimum data set for transfer information / avoidance of re-clerking**	LPT	Jude Smith	Julia Ball	~~15.11.13~~ 01/12/13	As above	
			3.6	**Expedited recruitment – increase of HR expertise to increase pace (recent significant increase in nursing establishment following workforce and skill mix review)**	UHL	Kate Bradley	Elenour Meldrum (Nurse) TBC (HR)	31.12.13	Recruitment action plan in place and progressing as expected. 100 overseas nurses offered posts to start in January, more overseas recruitment planned. Over recruiting to HCA posts. week commencing 11 November 538 nursing posts vacant.	
			3.7	**Discharge / transfer checklist**	UHL	Rachel Overfield	Julia Ball	17.10.13	Transfer checklist reviwed. Meeting with Mandy Gillespie for final sign off. Roll out via matrons next week (11.11.13) District nurse /practice nuse referral letters /drug authorisation letter now all available on ICE and this will replace where possible all paper versions by end of November. Ann Hall supporting access to ICE /ICM and training for all medical ward sisters and matrons . Will be completed by 28.11.13	
			3.8	**Access to equipment**	UHL	Rachel Overfield	Releasing Time To Care Team	~~15.11.13~~ 01/12/13	Equipment list now available, pending funding approval. £50K funding agreed. Details of equipment to be agreed this week. Equipment purchase agreed and being purchased.	
			3.9	**Ward clerk resources**	UHL	Rachel Overfield	Rachel Overfield	~~15.11.13~~ 01/12/13	Induction/training programme being finalised Funding agreed. Detail to be confirmed re posts later this week. Aim to have in post end of November.	
			3.10	**Facilities engagement in roles and responsibilities over meal times**	UHL	Rachel Overfield	Releasing Time To Care Team	~~15.11.13~~ 31/12/13	LiA events planned from 6 November 2013 onwards. KPIs improving. Issue with meal time deliveries. May need contractual changes. 1st LiA meeting has taken place at LRI and had excellent engagement from both UHL nursing and interserve teams. Further meetings booked for LGH and GGH sites.	
			3.11	**Environment for Medical teams to work at ward level (including IT)**	UHL	Rachel Overfield	Releasing Time To Care Team	~~15.11.13~~ 01/12/13	Information from matrons to be collated next week Funding agreed. RT2C team to give detailed plan by 18.11.13. majority of areas have space designated and signage will be put up to clearly identify areas. Where minor works needed to provide space costings being requested this week.	
			3.12	**Consistency of practice and protocols across wards**	UHL	Rachel Overfield Andrew Furlong	Julia Ball	15.11.13	Audit current practice against internal professional standards. Complete audit along side 1.2 This workstream to be combined with 3.2 going foward.	
			3.13	**Recruit discharge cleaning team - releasing 40 minutes of nusing time for every discharge bed space cleaned.**	UHL	Rachel Overfield	Julia Ball	01.12.13	Interserve asked to provide source. Weekly to take too long to get therough contract variation process therefore Bank HCAs to be used for first two months. 8:00 am - 8:00 pm cover at LRI/LGH - in place 1 December 2013.	
			3.14	**Review of roles and responsibilities of who can discharge (including confidence and competence)**	UHL	Pete Rabey Nursing Lead (TBC)	Julia Ball	15.11.13	All discharge work in UHL reviewed at a meeting w/c 04.11.13. Task and Finish group to meet Monday 18th Novemeber. Meetings with matrons and sisters in medical CMG to take plavce with RO & JB Thursday/Friday next week	This Action has been moved from Action Area 2 (ED/Specialty Working) moving forward and was previously identified as Action 2.15 on this sheet.
			3.15	**Communication to patients - setting expectations at point of admission**	UHL	Pete Rabey	Ann Hall	15.11.13	Rachel Overfield has had several meetings with nursing staff to ensure that their communication to patients is accurate. There is a new ward round standard being written which will be reviewed to account for this. There will be a need to target specific areas where messages communicated to patients are not accurate and can create more complex patients than necessary.	This Action has been moved from Action Area 2 (ED/Specialty Working) moving forward and was previously identified as Action 2.16 on this sheet.
			3.16	**Implementation of a functional patient census used consistently, twice every day**	UHL	Rachel Overfield	Julia Ball	30.11.13	Rachel Overfield has had several meetings with nursing staff to ensure that their communication to patients is accurate. There is a new ward round standard being written which will be reviewed to account for this. There will be a need to target specific areas where messages communicated to patients are not accurate and can create more complex patients than necessary.	This Action has been moved from Action Area 4 (Operational) moving forward and was previously identified as Action 4.1 on this sheet.
			3.17	**External agencies to feed into the patient census and use the information to pull any patients out of UHL on a daily basis.**	UHL	Rachel Overfield	Julia Ball	30.11.13		
			3.18	**Protocols and procedures for the patient census to be written.**	UHL	Julia Ball	N/A	30.11.13		

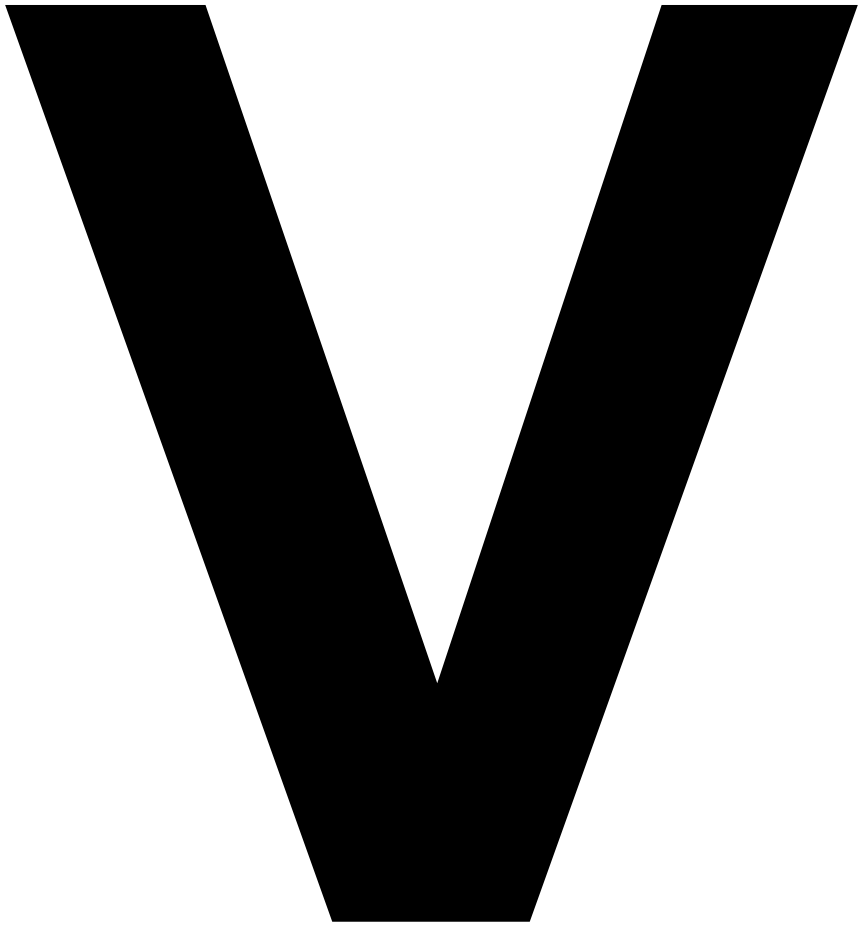
				~~4.1~~	~~**Implementation of a functional single discharge list used consistently every day**~~	~~UHL~~	~~Richard Mitchell~~	~~Phil Walmsley~~	~~30.11.13~~	~~List in place since 29/10/13. Ongoing work to fine tune the effectiveness. UHL execs now dial into the meeting and further change to the process will be implemented on Thursday.~~	This Action will be moved to Action Area 3 (Ward Practice) moving forward and is identified as Action 3.16 on this sheet.
				4.2	**Review and improvement to bed bureau process Ensure one process is in place for allocating beds at UHL**	UHL	Phil Walmsley	Helen Mather	~~15.11.13~~ 12.12.13	Some changes implemented but date extended to incorporate more extensive process improvements	
				4.3	**ED process - lots of just do it issues : telecoms, IT (including IT passwords), equipment**	UHL	Jane Edyvean	Ann Hall	Complete	Complete.	
				4.4	**Fully staffed site management team and bed coordinators team**	UHL	Phil Walmsley	Helen Mather	~~30.11.13~~ 02.01.14	Date changed to note staff in post/ change of detail in action. Assessment centre next week. We are confident some staff can start immediately. **Nb- this is not a significant delay but is a mission critical action**	
				4.5	**Non clinical vacancies recruited to with staff in post**	UHL	Jane Edyvean	Rachel Williams	~~30.11.13~~ 02.01.14	Date changed to note staff in post/ change of detail in action. Advert for vacancies has been placed. Currently covered through bank and agency.	
				4.6	**Review protocols for discharge lounge - re – trollies**	UHL	Richard Mitchell	Phil Walmsley	Complete	Protocal written. Appropriate patients transferred to the discharge lounge.	
				4.7	**Minor estates work discharge lounge**	UHL	Richard Mitchell	Phil Walmsley	13.12.13	Minor estates work required to increase scope of patient mix in discharge lounge	
				4.8	**Investigate the feasibility for UHL to open an additional 24 beds at LGH.**	UHL	Richard Mitchell	Phil Walmsley	Complete	Completed. Not Feastble.	
				4.9	**Meeting to review impact of FOPAL changes on admission rates**	UHL / CCGs	Simon Conroy Spencer Gay	Catherine Free	30.11.13	Meeting held. More up to date information circulated. Discussion at ECAT last week and CMG are exploring ways to increase EFU/ EDU function	
				4.10	**Meeting to agree the subcontracting of elective activity**	UHL	Richard Mitchell	Sarah Taylor	Complete	Agreement made to outsource work whilst plan to increase core capacity and reduce backlog agreed.	
4	**Operational**	Richard Mitchell		4.11	**Opening of additional assessment unit capacity and benefits fully realised**	UHL	Catherine Free	Jane Edyvean	30.11.13	Beds opened. Date change to note change of detail in action	
				4.12	**Additional Decanting space via Vanguard converting daycase unit into an inpatient unit.**	UHL	Richard Mitchell	Sarah Taylor	30.11.13	Estates work begun- will be complete by 30.11.13.	
				4.13	**Completion of capacity modelling**	UHL	Richard Mitchell	John Roberts	Complete	Complete and shared with Emergency Care Hub, UCWG. Response paper received and meeting being organised to discuss modelling assumptions with Dave Briggs	
				4.14	**Ensure consistent use of the outlier list**	UHL	Richard Mitchell	Helen Mather	Monthly	Outlier list is shared at 1400 and reviewed at 1700 each day	
				4.15	**Increased use of discharge lounge for patients who do not need to be on a ward- learning from LTH**	UHL	Richard Mitchell	Jane Edyvean	Monthly	Patient suitable for the discharge list are discussed at each site meeting	
				4.16	**Improve patient signage in ED- learning from LTH**	UHL	Jane Edyvean	Gill Staton	02.01.14	Estates and ED team are now working on plans. Agreed at ECAT	
				4.17	**Review of internal escalation process**	UHL	Richard Mitchell	Phil Walmsley	30.11.13	Meeting with HM 7/11/13. Escalation plan being reviewed	
				4.18	**Appoint to senior site manager post**	UHL	Richard Mitchell	Richard Mitchell	31.01.14	JD writtten, candidates contacted. Interviews planned for end of wc 2/12/12 **Nb- this is not a significant delay but is a mission critical action**	
				4.19	**Appoint to substantive SMOC posts**	UHL	Richard Mitchell	Richard Mitchell	31.01.14	JD written. Now advertising. **Nb- this is not a significant delay but is a mission critical action**	
				4.20	**Review best clinical and physical location for patients awaiting beds**	UHL	John Adler	Richard Mitchell/ Rachel Overfield	30.11.13	Discussed at ECAT 15-11-13. Further discussions to be held and decision paper to ECAT on 29-11-13	
				4.21	**Explore ways for greater exec leadership in site meetings and out of hours**	UHL	Richard Mitchell	Richard Mitchell	Monthly	COO or CN attend, when possible, every site meeting.	
				4.22	**Refocus on zero minors breaches**	UHL	Richard Mitchell	Jane Edyvean	Monthly	This is checked at every site meeting and disciplinary warning has been shared	
				4.23	**Refocus on minimal non-admitted breaches**	UHL	Richard Mitchell	Jane Edyvean	Monthly	This is checked at every site meeting and disciplinary warning has been shared. New escalation process is in place	
				4.24	**Ensure set agenda in site meetings is adhered to and new resileince checklist being implemented.**	UHL	Richard Mitchell	Helen Mather	Monthly	COO or CN attend, when possible, every site meeting.	

			Mental Health	5.1	**Mental health assessment and crisis response - matching of capacity and demand – immediate actions**	LPT	Jim Bosworth Debi O'Donovan	N/A	30.11.13	Funding has been approved. This has also been reviewed for accuracy given the progress now made in relation to recruitment processes and required agency staff. Staffing structure has been reviewed with LPT and is now complete. Of 10 vacancies identified across the SPA and CRT teams, 10 have now been recruited to. KPIs have been written as well as a formal delivery plan for this sub-section. Intention is to Go Live with a pilot on 02.12.13 until the end of March. All parties agreed to a structured <2 hour assessment time across UCC and ED. 2 additional staff are required to support the CDR through the night. The banding is now confirmed but appointments are expected to have older people background. EMAS are sharing data on the number MH patients that are medically stable that are taken to ED that this service would redirect. GEH sharing peak time data for MH patients arriving at the UCC. Recruitment will immediatley followin gthe meeting on 14.11.13.	
				5.2	**Community hospital and Mental Health inflow (talk to consultant in ED first)**	LPT	Jim Bosworth Debi O'Donovan	N/A	30.11.13	As 5.1	
			Use of Community Hospital Capacity	5.3	**Set number of CH transfers at 9am daily – pre book Arriva for immediate transfer ***	UHL / LPT	Phil Walmsley Rachel Bilsborough	Rachel Bilsborough Nikki Beacher Hospital Matron tbc	17.10.13	The process was set up by the initial date, the ability to identify 4 patients every day and then have them transfer before 9 has been a challenge. Data collection process refined to capture activity on an on going basis. The corrolation between patients identified and those been transferred before 9 is being sought to ensure bed use is maximised. 4 patients are not being tansfered before 9 every day but the process to maximise bed use through the day is being driven.	
5	**Multi-agency Integration**	Jane Taylor		5.4	**24 additional rehab / step down beds at LPT 12 at Loughborough and 12 at LGH.**	LPT	Rachel Bilsborough	Rachel Bilsborough	15.11.13	No further progress on previous weeks update: - All City beds are planned to be open by the 1st December - The additional 24 Loughborough beds are opening on a phased basis as staff are recruited - 12 open currently - In addition the ICS service will be at full capacity prior to Christmas at present activiity is being phased in. - City are working towards 24 beds, EAst have 12 open and are working towards 48 and West have 48 already open.	
			Integrated Discharge	5.5	**Single integrated discharge team ***	CCGs	Jane Taylor	Tracy Yole	30.11.13	CHC team member comenced this week. Additional admin support to support care home placement / D2A due to start within the next 2 weeks Office accomodationis due to be available next week and will further support integration.	
				5.6	**Directory of Services – knowing what's available**	CCGs	Jane Taylor	Tracy Yole	31.12.13	Further work is being undertaken to ensure appropriate referral for EOL care which is provided by LPT and palliative care which is provided thorugh CHC fast track. At the moment the role of these services are being confused.	
			CHC and Care Homes	5.7	**Expediting CHC decisions***	LA	Jackie Wright Helen Manning	Alison Cain	30.11.13	CHC - 1 WTE has been allocated to the integrated discharge team and started this week. The remit is expidite health funding desisions, review and agree fast track referrals, provide quality checks on DST sumissions to avoid bounce back. Support for D2A DST assessments has now been schedulled and the first 10 assessments agreed and further 10 is being reviewed with a view to completing by the end of next week. No pannel delays as of 19th Nov.	
				5.8	**Expediting discharge whilst waiting dispute resolution and facilitation of discharge to assess continuing health needs**	LA / CCGs / GEM	Jackie Wright Helen Manning	Alison Cain	~~30.11.13~~ 31.03.14	Following meeting with Clarendon Mews and partner organisations - the option of pursing a block booking with the home for the purpose of D2A is not an apppropriate option. The facilities for dementia patients are well worth persuing and this will be picked up by the discharge team at UHL. There is not quick solution to cohort D2A in the right environment / model of care. This needs taking forward with strategy leads to commission approprite environments for what will be an increasing need.	

	5.9	**Care homes and protocol for falls management**	LA / CCGs / GEM	Jackie Wright Helen Manning Caroline Trevethick	Jane Taylor	30.11.13	An initial meeting has been set up with care homes and wider partners for the 3rd December.	
EOL	5.10	**Expansion of capacity of existing EOL service to result in 3 EOL patients per day to be discharged.**	CCGs	Tracey Yole	N/A	15.12.13	Meeting set up for 21st November. Links with 5.6	
Choice	5.11	**Withdrawn choice for Rehab location – agree protocol to avoid expectation of choice for next step care. UCWG to sign off next week**	UCB / UHL	Kevin Harris Richard Mitchell Azhar Farooqi Nick Pulman Hamant Mistry	Julia Ball	30.11.13	Awaiting information from UHL on proposed patient information.	

RAG Status Key:	
5	Complete.
4	On Track / Delivered with continuing monitoring.
3	Slight delay to delivery but within a reasonable tolerance level and a risk of not being completed as planned. Any action with a delayed delivery date will be marked Amber if on track for the revised delivery date.
2	Significant Risk or Issue or Deadline already missed – unlikely to be completed as planned.
1	Not yet commenced.

		Monday				Tuesday				Wednesday				Thursday				Friday				Saturday				Sunday			
Activity checklist	Lead	830	1100	1400	1700	830	1100	1400	1700	830	1100	1400	1700	830	1100	1400	1700	830	1100	1400	1700	830	1100	1400	1700	830	1100	1400	1700
Site meeting started on time and all bed numbers inputted before the start of the meeting	DM																												
Representation from all specialities at site meeting	DM																												
Confirm current performance (%)	DM																												
Note any IPC issues and key actions	IPC																												
Review of actions from previous meeting	DM	X				X				X				X				X				X				X			
All preventable non-admitted breaches escalated since the previous meeting	ED rep	X				X				X				X				X				X				X			
Confirm patient level plans for all patients in dept over 180 minutes	ED rep																												
ED staffing numbers checked- plans in place to resolve any problems	ED rep																												
Confirm capacity and staffing at the Glenfield	DM																												
Confirm capacity and staffing at the General	DM																												
Confirm next two patients to move out of AMU and AFU	AMU rep																												
Confirm priority discharges for the day	Med rep		X	X	X		X	X	X		X	X	X		X	X	X		X	X	X		X	X	X		X	X	X
Confirm how many patients are in the discharge lounge	Med rep	X				X				X				X				X				X				X			
Confirm number of empty beds on ward two	DM																												
Confirm there are no patients suitable for the discharge lounge not already in the discharge lounge	Med rep																												
Discharge list completed by all wards- clear single discharge plan in place	Med rep	X				X				X				X				X				X				X			
Confirm how many discharges will take place before the next site meeting- medicine	Med rep				X				X				X				X				X				X				X
Confirm how many discharges will take place before the next site meeting- surgery	Surg rep				X				X				X				X				X				X				X
Confirm how many, if any surgical patients will be cancelled today and tomorrow	Surg rep	X	X		X	X	X		X	X	X		X	X	X		X	X	X		X	X	X		X	X	X		X
Confirm how many discharges will take place before the next site meeting- orthopaedics	Ortho rep				X				X				X				X				X				X				X
Confirm how many, if any ortho patients will be cancelled today and tomorrow	Ortho rep	X	X		X	X	X		X	X	X		X	X	X		X	X	X		X	X	X		X	X	X		X
Confirm how many discharges will take place before the next site meeting- cancer	Ca rep				X				X				X				X				X				X				X
Confirm how many discharges will take place before the next site meeting- gynaecology	Gynae rep				X				X				X				X				X				X				X
Confirm how many discharges will take place before the next site meeting- paediatrics	Paeds rep				X				X				X				X				X				X				X
Confirm how many discharges will take place before the next site meeting- ITU	ITU rep				X				X				X				X				X				X				X
Confirm outcome from 1pm single discharge meeting	Med rep	X	X		X	X	X		X	X	X		X	X	X		X	X	X		X	X	X		X	X	X		X
Afternoon outliers identified and list shared	DM	X	X			X	X			X	X			X	X			X	X			X	X			X	X		
Plan to move outliers before 8pm shared	Med rep	X	X	X		X	X	X		X	X	X		X	X	X		X	X	X		X	X	X		X	X	X	
Confirm Acute Medical Clinic will stay open	Med rep																												
AMU staffing numbers checked-plans in place to resolve any problems	Med rep																												
Any other staffing shortages confirmed with bank team	DM																												
Confirm of DTOC state- all problems escalated	PW TBC																												
Confirm community bed state- all problems escalated	DM																												
Confirm portering situation - all problems escalated	Speci-alities																												
Confirm TTO situation- all problems escalated	Speci-alities																												
Two duty managers on duty, with one in ED	DM																												
Two bed coordinators on	DM																												
Confirm site state (RAG) for all sites	DM																												
Confirm any other issues for escalation	DM	X	X	X		X	X	X		X	X	X		X	X	X		X	X	X		X	X	X		X	X	X	
Confirm plan for the evening for all sites, signed off by SMOC and exec oncall informed	SMOC	X	X	X		X	X	X		X	X	X		X	X	X		X	X	X		X	X	X		X	X	X	
Site meeting actions for all sites confirmed and circulated immediately	DM																												



Trust Board Paper V

To:	Trust Board
From:	Stephen Ward, Director of Corporate & Legal Affairs
Date:	28th November 2013
CQC regulation:	N/A

Title:	NHS trust oversight self certification

Author/Responsible Director: Helen Harrison, FT Programme Manager / Stephen Ward, Director of Corporate & Legal Affairs

Purpose of the Report:

At the beginning of April 2013, the NHS Trust Development Authority (NTDA) published a single set of systems, policies and processes governing all aspects of its interactions with NHS trusts in the form of **'***Delivering High Quality Care for Patients: The Accountability Framework for NHS Trust Boards'.*

In accordance with the Accountability Framework, the Trust is required to complete two self certifications in relation to the Foundation Trust application process. Draft copies of these are attached as Appendix A and B.

The Report is provided to the Board for:

Decision	X	Discussion	
Assurance		Endorsement	

Summary / Key Points:

- As agreed at the October 2013 Trust Board meeting, the Trust will be carrying out a re-forecast of its financial position for 2013/14 during November 2013 and will review its position at the Trust Board meeting to be held on the 28th November 2013

- The Trust is working towards sustainable compliance with the ED target. An Emergency Care Improvement Hub has been established, which brings together partners from across health and social care. Whilst the Hub is focussing on delivering the short-term actions longer-term and more strategic actions are being taken forward by the Urgent Care Board

- An initial RTT action plan was submitted to commissioners on 14th August 2013 and a revised plan was subsequently submitted on 11th September 2013. Formal agreement of a plan by commissioners remains outstanding

Recommendations:

The Trust Board is asked to **approve** the Monitor Licensing Requirements and Trust Board Statements self certifications for October (attached as Appendix A and Appendix B)

Previously considered at another corporate UHL Committee? No

Strategic Risk Register: No	**Performance KPIs year to date:** N/A

Resource Implications (eg Financial, HR): No

Assurance Implications: Yes

Patient and Public Involvement (PPI) Implications: No

Stakeholder Engagement Implications: No

Equality Impact: None
Information exempt from Disclosure: None
Requirement for further review? All future trust oversight self certifications will be presented to the Trust Board for approval

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST

REPORT TO: Trust Board

DATE: 28th November 2013

REPORT FROM: Stephen Ward, Director of Corporate & Legal Affairs

SUBJECT: NHS trust oversight self certification

---

1) Introduction

At the beginning of April 2013, the NHS Trust Development Authority (NTDA) published a single set of systems, policies and processes governing all aspects of its interactions with NHS trusts in the form of **'***Delivering High Quality Care for Patients: The Accountability Framework for NHS Trust Boards'.*

In accordance with the Accountability Framework, the Trust is required to complete two self certifications in relation to the Foundation Trust application process. Draft copies of these are attached as Appendix A and B.

2) Key points to note

Appendix B:-

- As agreed at the October 2013 Trust Board meeting, the Trust will be carrying out a re-forecast of its financial position for 2013/14 during November 2013 and will review its position at the Trust Board meeting to be held on the 28th November 2013

- The Trust is working towards sustainable compliance with the ED target. An Emergency Care Improvement Hub has been established, which brings together partners from across health and social care. Whilst the Hub is focussing on delivering the short-term actions longer-term and more strategic actions are being taken forward by the Urgent Care Board

- An initial RTT action plan was submitted to commissioners on 14th August 2013 and a revised plan was subsequently submitted on 11th September 2013. Formal agreement of a plan by commissioners remains outstanding

3) Recommendations

The Trust Board is asked to **approve** the Monitor Licensing Requirements and Trust Board Statements self certifications for November 2013 (attached as Appendix A and Appendix B)

NHS TRUST DEVELOPMENT AUTHORITY

OVERSIGHT: Monthly self-certification requirements - Compliance Monitor

Monthly Data.

CONTACT INFORMATION:

Enter Your Name: John Adler

Enter Your Email Address john.adler@uhl-tr.nhs.uk

Full Telephone Number: 01162588940 Tel Extension: 8940

SELF-CERTIFICATION DETAILS:

Select Your Trust: University Hospitals Of Leicester NHS Trust

Submission Date: 29/11/2013 Reporting Year: 2013/14

Select the Month

○ April	○ May	○ June
○ July	○ August	○ September
◉ October	○ November	○ December
○ January	○ February	○ March

COMPLIANCE WITH MONITOR LICENCE REQUIREMENTS FOR NHS TRUSTS:

1. **Condition G4** – Fit and proper persons as Governors and Directors (also applicable to those performing equivalent or similar functions).
2. **Condition G5** – Having regard to monitor Guidance.
3. **Condition G7** – Registration with the Care Quality Commission.
4. **Condition G8** – Patient eligibility and selection criteria.

5. **Condition P1** – Recording of information.
6. **Condition P2** – Provision of information.
7. **Condition P3** – Assurance report on submissions to Monitor.
8. **Condition P4** – Compliance with the National Tariff.
9. **Condition P5** – Constructive engagement concerning local tariff modifications.

10. **Condition C1** – The right of patients to make choices.
11. **Condition C2** – Competition oversight.

12. **Condition IC1** – Provision of integrated care.

Further guidance can be found in Monitor's response to the statutory consultation on the new NHS provider licence: The new NHS Provider Licence

COMPLIANCE WITH MONITOR LICENCE REQUIREMENTS FOR NHS TRUSTS:

		Comment where non-compliant or at risk of non-compliance
1. Condition G4 Fit and proper persons as Governors and Directors.	Yes	
		Timescale for compliance:
2. Condition G5 Having regard to monitor Guidance.	Yes	
		Timescale for compliance:
3. Condition G7 Registration with the Care Quality Commission.	Yes	
		Timescale for compliance:
		Comment where non-compliant or at risk of non-compliance
4. Condition G8 Patient eligibility and selection criteria.	Yes	
		Timescale for compliance:

		Comment where non-compliant or at risk of non-compliance
5. Condition P1 Recording of information.	Yes	
		Timescale for compliance:
6. Condition P2 Provision of information.	Yes	
		Timescale for compliance:
7. Condition P3 Assurance report on submissions to Monitor.	Yes	
		Timescale for compliance:
8. Condition P4 Compliance with the National Tariff.	Yes	
		Timescale for compliance:

		Comment where non-compliant or at risk of non-compliance
9. Condition P5 Constructive engagement concerning local tariff modifications.	Yes	
		Timescale for compliance:

		Comment where non-compliant or at risk of non-compliance
10. Condition C1 The right of patients to make choices.	Yes	
		Timescale for compliance:
11. Condition C2 Competition oversight.	Yes	
		Timescale for compliance:
12. Condition IC1 Provision of integrated care.	Yes	
		Timescale for compliance:

NHS TRUST DEVELOPMENT AUTHORITY

OVERSIGHT: Monthly self-certification requirements - Board Statements

Monthly Data.

CONTACT INFORMATION:

Enter Your Name: John Adler

Enter Your Email Address: john.adler@uhl-tr.nhs.uk

Full Telephone Number: 01162588940 Tel Extension: 8940

SELF-CERTIFICATION DETAILS:

Select Your Trust: University Hospitals Of Leicester NHS Trust

Submission Date: 29/11/2013 Reporting Year: 2013/14

Select the Month

○ April	○ May	○ June
○ July	○ August	○ September
◉ October	○ November	○ December
○ January	○ February	○ March

BOARD STATEMENTS:

CLINICAL QUALITY
FINANCE
GOVERNANCE

The NHS TDA's role is to ensure, on behalf of the Secretary of State, that aspirant FTs are ready to proceed for assessment by Monitor. As such, the processes outlined here replace those previously undertaken by both SHAs and the Department of Health.

In line with the recommendations of the Mid Staffordshire Public Inquiry, the achievement of FT status will only be possible for NHS Trusts that are delivering the key fundamentals of clinical quality, good patient experience, and national and local standards and targets, within the available financial envelope.

BOARD STATEMENTS:

For CLINICAL QUALITY, that

1. The Board is satisfied that, to the best of its knowledge and using its own processes and having had regard to the TDA's oversight model (supported by Care Quality Commission information, its own information on serious incidents, patterns of complaints, and including any further metrics it chooses to adopt), the trust has, and will keep in place, effective arrangements for the purpose of monitoring and continually improving the quality of healthcare provided to its patients.

1. CLINICAL QUALITY Indicate compliance.	Yes
Timescale for compliance:	
RESPONSE: Comment where non-compliant or at risk of non-compliance	

BOARD STATEMENTS:

For CLINICAL QUALITY, that

2. The board is satisfied that plans in place are sufficient to ensure ongoing compliance with the Care Quality Commission's registration requirements.

2. CLINICAL QUALITY
Indicate compliance.

Yes

Timescale for compliance:

RESPONSE:

Comment where non-compliant or at risk of non-compliance

BOARD STATEMENTS:

For CLINICAL QUALITY, that

3. The board is satisfied that processes and procedures are in place to ensure all medical practitioners providing care on behalf of the trust have met the relevant registration and revalidation requirements.

3. CLINICAL QUALITY
Indicate compliance.

Yes

Timescale for compliance:

RESPONSE:

Comment where non-compliant or at risk of non-compliance

BOARD STATEMENTS:

For FINANCE, that

4. The board is satisfied that the trust shall at all times remain a going concern, as defined by the most up to date accounting standards in force from time to time.

4. FINANCE
Indicate compliance.

Yes

Timescale for compliance:

RESPONSE:

Comment where non-compliant or at risk of non-compliance

BOARD STATEMENTS:

For GOVERNANCE, that

5. The board will ensure that the trust remains at all times compliant with the NTDA accountability framework and shows regard to the NHS Constitution at all times.

5. GOVERNANCE
Indicate compliance.

Yes

Timescale for compliance:

RESPONSE:

Comment where non-compliant or at risk of non-compliance

BOARD STATEMENTS:

For GOVERNANCE, that

6. All current key risks to compliance with the NTDA's Accountability Framework have been identified (raised either internally or by external audit and assessment bodies) and addressed – or there are appropriate action plans in place to address the issues in a timely manner.

6. GOVERNANCE
Indicate compliance.

Risk

Timescale for compliance:

28/11/2013

RESPONSE:

Comment where non-compliant or at risk of non-compliance

As agreed at the October 2013 Trust Board meeting, the Trust will be carrying out a re-forecast of its financial position for 2013/14 during November 2013 and will review its position at the Trust Board meeting to be held on the 28th November 2013.

BOARD STATEMENTS:

For GOVERNANCE, that

7. The board has considered all likely future risks to compliance with the NTDA Accountability Framework and has reviewed appropriate evidence regarding the level of severity, likelihood of a breach occurring and the plans for mitigation of these risks to ensure continued compliance.

7. GOVERNANCE
Indicate compliance.

Yes

Timescale for compliance:

RESPONSE:

Comment where non-compliant or at risk of non-compliance

BOARD STATEMENTS:

For GOVERNANCE, that

8. The necessary planning, performance management and corporate and clinical risk management processes and mitigation plans are in place to deliver the annual operating plan, including that all audit committee recommendations accepted by the board are implemented satisfactorily.

8. GOVERNANCE
Indicate compliance.

Yes

Timescale for compliance:

RESPONSE:

Comment where non-compliant or at risk of non-compliance

BOARD STATEMENTS:

For GOVERNANCE, that

9. An Annual Governance Statement is in place, and the trust is compliant with the risk management and assurance framework requirements that support the Statement pursuant to the most up to date guidance from HM Treasury (www.hm-treasury.gov.uk).

9. GOVERNANCE
Indicate compliance.

Yes

Timescale for compliance:

RESPONSE:

Comment where non-compliant or at risk of non-compliance

BOARD STATEMENTS:

For GOVERNANCE, that

10. The Board is satisfied that plans in place are sufficient to ensure ongoing compliance with all existing targets as set out in the NTDA oversight model; and a commitment to comply with all known targets going forward.

10. GOVERNANCE
Indicate compliance.

No

Timescale for compliance:

30/11/2013

RESPONSE:

Comment where non-compliant or at risk of non-compliance

UHL is currently non compliant with the ED 4 hour wait target and the Referral to Treatment (RTT) - admitted and non-admitted targets.
The Trust is working towards sustainable compliance with the ED target. An Emergency Care Improvement Hub has been established, which brings together partners from across health and social care. Whilst the Hub is focussing on delivering the short-term actions longer-term and more strategic actions are being taken forward by the Urgent Care Board. The Trust is aiming for compliance by November 2013.
An initial RTT action plan was submitted to commissioners on 14th August 2013 and a revised plan was subsequently submitted on 11th September 2013. The formal agreement of a plan by commissioners remains outstanding.

BOARD STATEMENTS:

For GOVERNANCE, that

11. The trust has achieved a minimum of Level 2 performance against the requirements of the Information Governance Toolkit.

11. GOVERNANCE
Indicate compliance.

Yes

Timescale for compliance:

RESPONSE:

Comment where non-compliant or at risk of non-compliance

BOARD STATEMENTS:

For GOVERNANCE, that

12. The board will ensure that the trust will at all times operate effectively. This includes maintaining its register of interests, ensuring that there are no material conflicts of interest in the board of directors; and that all board positions are filled, or plans are in place to fill any vacancies.

12. GOVERNANCE
Indicate compliance.

Yes

Timescale for compliance:

RESPONSE:

Comment where non-compliant or at risk of non-compliance

BOARD STATEMENTS:

For GOVERNANCE, that

13. The board is satisfied that all executive and non-executive directors have the appropriate qualifications, experience and skills to discharge their functions effectively, including setting strategy, monitoring and managing performance and risks, and ensuring management capacity and capability.

13. GOVERNANCE
Indicate compliance.

Yes

Timescale for compliance:

RESPONSE:

Comment where non-compliant or at risk of non-compliance

BOARD STATEMENTS:

For GOVERNANCE, that

14. The board is satisfied that: the management team has the capacity, capability and experience necessary to deliver the annual operating plan; and the management structure in place is adequate to deliver the annual operating plan.

14. GOVERNANCE Indicate compliance.	Yes
Timescale for compliance:	
RESPONSE:	
Comment where non-compliant or at risk of non-compliance	

W

Trust Board Paper W

To:	**Trust Board**
From:	Aaron Vogel – Emergency Planning Officer
Date:	**28 November 2013**
CQC regulation:	Regulation 9 (Regulated activities) Outcomes 4 Regulation 24 (Regulated activities) Outcome 6

Title:	**EPRR Core Standards Self-Assessment**

Author/Responsible Director: Aaron Vogel – Emergency Planning Officer, Richard Mitchell - COO

Purpose of the Report: To outline the current position of the trust against its requirements under NHS England EPRR Core Standards in support of the Trust's legal requirements under the Civil Contingencies Act 2004 and Health and Social Care Act 2012.

NHS England are currently reviewing the position of all Acute Trust's in relation to the core standard.

The Report is provided to the Board for:

Decision		Discussion	
Assurance		Endorsement	**X**

Summary / Key Points:
Of the 119 standards being assessed it has been identified that we are compliant with 63.9% of the standards, 22.7% exist in draft stage and 13.4% are noncompliant.
An action plan has been developed, and is included, to ensure that the outstanding issues are resolved.

The Trust Executive will monitor progress and review in January 2013.

Recommendations:
The Board are asked to accept this report and endorse the programme of work with support from relevant staff and service areas within the Trust.

Previously considered at another corporate UHL Committee?
Trust Executive

Board Assurance Framework: 11 – Loss of Business Continuity	**Performance KPIs year to date:** Since March 2013 43.4% increase in compliant standards and a decrease of 35.7% and 46.7% in amber and red standards

Resource Implications (eg Financial, HR):
Training and Exercising
Process, plans and policy development requiring support from all CMGs and Corporate services

Assurance Implications:
Assurance to NHS England against core standards in Emergency Planning

Patient and Public Involvement (PPI) Implications:
None

Stakeholder Engagement Implications:

Will support our requirements to engage with external partners i.e. other emergency services. It will ensure that appropriate arrangements are in place
Equality Impact: None
Information exempt from Disclosure: None
Requirement for further review? Annually – will form part of the annual plan and reporting Executive Team will review progress in January 2013

Emergency Preparedness, Resilience and Response (EPRR) Self-Assessment Assurance Report

Aaron Vogel

Emergency Planning Officer

November 2013

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1 Introduction

1.1 In April 2013, NHS England produced details of new structures, procedures and core standards for the providers of NHS funded care in relation to Emergency Preparedness, Resilience and Response (EPRR). These support and elaborate on the Trust's requirements under the Civil Contingencies Act 2004 (CCA) and the Health and Social Care Act 2012.

1.2 In October 2013, NHS England began its first annual assurance process of the new EPRR arrangements. The Trust is required to submit a self-assessment with board sign off, to be reviewed and provide assurance to NHS England of the compliance of the Trust with the core standards (119 to be reviewed in 2013). This report provides a summary of the core standards, the position of the trust, a summary of the improvements made since March 2013 based on an internal self-assessment and action plans to resolve any outstanding issues.

1.3 The Trust Board is requested to note this report, its recommendations and sign it off for further ratification by NHS England.

2 Core Standards in Summary

2.1 The EPRR core standards are the minimum standards to which the Trust must meet and be able to evidence against compliance. It is the responsibility of the Accountable Emergency Officer (Chief Operating Officer) to ensure that the core standards are being met. There are 125 core standards that apply to the Trust covering both EPRR and service resilience (Business Continuity). In general these standards require the Trust to;

a) Nominate an accountable emergency officer who will be responsible for EPRR; and

b) Contribute to area planning for EPRR through local health resilience partnerships (LHRPs) and other relevant groups[1].

[1] LHRPs provide a strategic forum for local NHS organisations to facilitate health sector preparedness and planning for emergencies at LRF level. It is co-chaired by NHS England LAT Directors responsible for EPRR and a lead Director for Public Health (DPH).

2.2 In relation to EPRR the Trust must have;

a) Suitable up to date plans which set out how they plan for, respond to and recover from major incidents and emergencies as identified in local and community risk registers;

b) Test these plans through
- A communications exercise every six months;
- A desktop exercise once a year;
- A major live or simulated exercise every three years

c) Have suitably trained, competent staff and the right facilities available 24/7 365 days a year to effectively manage a major incident or emergency

d) Share their resources as required to respond to a major incident or emergency

2.3 In relation to service resilience the Trust must have suitable plans which set out how we will;

a) Maintain continuous service when faced with disruption from identified local risks

b) Resume key services which have been disrupted by, for example severe weather, IT failure, an infectious disease, a fuel shortage or industrial action

This planning should follow the principles of ISO 22301 and PAS 2015.

3 Summary of the Current UHL Position

Table 1 Current position summary and comparison against compliance of EPRR core standards

	October 2013		March 2013		
	Total	Percentage	Total	Percentage	Percentage Difference
GREEN - arrangements in place now, compliant with core standards	76	63.9%	53	42.4%	+43.4%
AMBER - draft or scheduled on action plan for completion by Dec 2013	27	22.7%	42	33.6%	-35.7%
RED - arrangements not in place or scheduled for completion after Jan 2014	16	13.4%	30	24.0%	-46.7%
Total	119	100	125	100	

3.1 As table 1 shows the current results show that 63.9% of the standards were assessed as green; which is a 43.4% increase in compliance compared to the March 2013 self-assessment. The number of standards assessed as amber and red are 22.7% and 13.4% respectively, with a reduction of 35.7% of standards assessed as amber and 46.7% assessed as red. So an overall improving situation compared to March 2013.

3.2 The core standards assessed as amber largely relate arrangements that are currently undergoing development, are in a draft format, require updating or exist as anecdotal/adhoc arrangement that require formalising and documenting in relative plans and policies. Such examples include development of business continuity plans, pandemic flu plan, response strategies and other specific response arrangements. However there are some considerable areas such as lock down plans and site evacuation plans that are not fully developed.

3.3 The majority of the core standards that are assessed as red relate to lack of specific details listed in policy documents, arrangements for resources and services required to support a response. For example; details on supplies, incurred expenditure control and support to/from wider partners through mutual aid and predetermined planning arrangements.

4 Action Plan

4.1 Each core standard assessed as amber or red has been given an action and deadline date to resolve. The full list is included in Annex 1. It is anticipated that many of the outstanding issues will be resolved by the development of the new Trust Major Incident Plan, scheduled for completion in March 2014 and other areas of work currently being undertaken. The Emergency Planning and Business Continuity Committee will monitor the progress of the action plan through to the Executive Team. The next update to the Executive will be 21st January 2014.

5 Conclusion

5.1 There are a number of areas that still require addressing however they should not impede the ability of the Trust to respond. Plans and procedures that are in place should provide for an appropriate response. The Board are asked to accept this report and endorse the programme of work with support from relevant staff and service areas within the Trust.

Annex 1 – Overview of the amber and red assessed standards

	NHS Core Standards for Emergency Preparedness, Resilience & Response (EPRR)	Commentary/ References to Evidence Supplied	Self Assessment	Priority for resolution	Action	Deadline
2	**All NHS organisations and providers of NHS funded care must share their resources as necessary when they are required to respond to a significant incident or emergency.**	LLR Local Health Resilience Partnership - Memorandum of Understanding requires further development in IRPs	AMBER	LOW	Add reference to MOUs and process for activating into the revised major incident plan.	Mar-14
4 . 2	Organisations must maintain a risk register which links back to the National Risk Assessment (NRA) and Community Risk Register (CRR).	Nothing currently recorded but involvement developing the CRR. Many risks may be captured locally on DATIX. Discussions and process agreed with risk management team as to how to capture.	AMBER	MEDIUM	Document the top 10 risks from the CRR on to DATIX with suitable reference to CRR and NRA.	Nov-13
5 . 5	include plans to maintain the resilience of the organisation as a whole, so that the Estates Department and Facilities Department are not planning in isolation.	Interserve included in the Emergency Planning Committee, Action cards in Major Incident Plan and Draft Trust Business Continuity Action cards contain actions that Interserve require the Trust to undertake during a loss/disruption of a service	AMBER	HIGH	Interserve to complete their response plans	Dec-13
5 . 11	have been written in collaboration with all burns, trauma and critical care networks; and	Burn network draft plan developed, flu plan being developed with Trust critical care lead	AMBER	MEDIUM	Network arrangements to be included in reviewed plans	Mar-14
5 . 21	explain how predicted and unexpected spending will be covered and how a unique cost centre and budget code can be made available to track costs; and	Requirements agreed. Requires developing and implimenting. Agreed that a new cost code will be established with company credit cards linked to it.	RED	MEDIUM	Process needs to be developed with Finance and Procurement as part of the current major incident plan review.	Mar-14
5 . 22	demonstrate a systematic risk assessment process in identifying risks relating to any part of the plan or the identified emergency.		RED	MEDIUM	To address with risk manager	Dec-13

5 . 32	Set out the responsibilities of key staff and departments.	Action Cards within all plans More detailed responsibilities for each department being worked into revised plans	AMBER	MEDIUM	Being developed as part of the Major Incident Plan review. Some old plans currently contain details	Mar-14
5 . 34	Explain how mutual aid arrangements will be activated and maintained.		RED	MEDIUM	Some initial discussions with NHS England and other health partners. Details to be finalised and incorporated into the new Major Incident Plan	Mar-14
5 . 37	**Best Practice:** Use an electronic data-logging system to record the decisions made.	Options being considered. Loggist currently trained in using standard log book and best practice	RED	MEDIUM	Research options and submit proposals on an electronic logging system	Jan-14
5 . 38	**Best Practice:** Use the National Resilience Extranet.	Options being considered	RED	LOW	Dependant on how the NRE is being developed	
5 . 42	Explain how to communicate with partners, the public and internal staff based on a formal communications strategy. This must take into account the FOI Act 2000, the Data Protection Act 1998 and the CCA 2004 'duty to communicate with the public'. Social networking tools may be of use here.	Communications Lead action card, Section on Communications and Information sharing during a major incident. Will require updating and further development.	AMBER	MEDIUM	Communications plan to be updated and liaise with LRF coms leads and LRF coms plan	Apr-14
5 . 43	Have agreements in place with local 111 providers so they know how they can help with an incident		RED	LOW	Liaise with NHS England and CCGs as to what can be done and whose responsibility it would be.	Jun-14
5 . 44	Consider using helplines in an emergency. Set up procedures in advance which explain the arrangements. Make sure foreign language lines are part of these arrangements.	Hotline number and procedure available. Requires minor updating	AMBER	MEDIUM	Telecoms/NTT to confirm details with hotline provider and validate arrangements	Dec-13
5 . 45	Describe how stores and supplies will be maintained.		RED	MEDIUM	Liaise with finance and procurement to develop a process	Jun-14
5 . 46	Explain how specific casualties will be managed – for example, burns, paediatrics and those from certain faiths.	Some local SOPs not written into the Major Incident Plan	AMBER	MEDIUM	Incorporate into the revised Major Incident Plan	Mar-14
5 . 48	Explain the process of recovery and returning to normal processes.	Major Incident Plan states to implement a recovery plan no further details	RED	HIGH	Develop recovery arrangements and incorporate into the new major incident plan	Mar-14

5 . 50	Explain how to support patients, staff and relatives before, during and after an incident (including counselling and mental health services).	Currently detailed in the Relatives' Reception Centre Plan to be moved to MIP	AMBER	LOW	Incorporate into the revised Major Incident Plan	Mar-14
5 . 56	patients with burns requiring critical care; and	Burn network draft plan developed Nothing specifically available for critical care	AMBER	MEDIUM	Incorporate into the revised Major Incident Plan	Mar-14
6 . 2	There must be detailed operating procedures to help manage the ICC (for example, contact lists and reporting templates).	New SOPs to be developed with creation of new ICC	RED	HIGH	Incorporate into the revised Major Incident Plan	Dec-13
7	**All NHS organisations and providers of NHS funded care must develop, maintain and continually improve their business continuity management systems. This means having suitable plans which set out how each organisation will maintain continuity in its services during a disruption from identified local risks and how they will recover delivery of key services in line with ISO22301. Organisations must:**	Business Continuity Policy - currently based on BS25999 Draft templates of local plans - currently being redeveloped Trust Major Incident Plan includes reference to internal incidents - same structure would be applied. PwC Audit report	AMBER	MEDIUM	BCMS is due for review in January 2014. Will undertake a review and update based from the review	Jun-14
7 . 2	set out how finances and unexpected spending will be covered, and how unique cost centres and budget codes can be made available to track costs;	Requirements agreed. Requires developing and implimenting	RED	MEDIUM	Process needs to be developed with Finance and Procurement as part of the current major incident plan review.	Mar-14
7 . 3	develop business continuity strategies for continuing and recovering critical activities within agreed timescales, including the resources required such as people, premises, ICT, information, utilities, equipment, suppliers and stakeholders; and	Harder to quantify for an Acute setting, BIAs developed, IM&T plans identify priority order systems. IM&T working towards ISO 22000. Time frames and priorities would be determined by the hospital control team during an incident based on services impacted	RED	LOW	Set out principles/strategy for managing downtime of critical resources	Jun-14
7 . 4	develop, use and maintain business continuity plans to manage disruptions and significant incidents based on recovery time objectives and timescales identified in the business impact analysis	Draft templates of local plans - currently being redeveloped	AMBER	HIGH	Continue on programme of work to develop BCPs	Dec-13

7 . 13	Risk assessments must take into account community risk registers and at very least include worst-case scenarios for: • severe weather (including snow, Heatwave, prolonged periods of cold weather and flooding); • staff absence (including industrial action); • the working environment, buildings and equipment; • fuel shortages; • surges in activity; • IT and communications; • supply chain failure; and • associated risks in the surrounding area (e.g. COMAH and iconic sites).	Emergency Planning Committee review CRR and identify any issues/risks to the organisation. No current process to formalise this although work is underway to address. Loss of Business Continuity is on the Corporate Risk Register (Board Assurance Framework).	AMBER	MEDIUM	Document the top 10 risks from the CRR on to DATIX with suitable reference to CRR and NRA.	Nov-13
7 . 16	Organisations must highlight which of their critical activities have been put on the corporate risk register and how these risks are being addressed.	Loss of Business Continuity is on the Corporate Risk Register (Board Assurance Framework). Individual risks need to be included on corporate risk register	AMBER	MEDIUM	incorporated into action 7.13	Nov-13
7 . 17	Organisations must develop, use, maintain and test procedures for receiving and cascading warnings and other communications before, during and after a disruption or significant incident. If appropriate, business continuity plans must be published on external websites and through other information-sharing media.	Included in training packages, draft service area action cards with appropriate levels of escalation to notify the Trust of an incident.	AMBER	HIGH	Continue on programme of work to develop BCPs	
7 . 19	the procedures for escalating emergencies to CCGs and the NHS England area, regional and national teams;	Issues are routinely escalated to NHS England and CCGs however requires further detail in major incident plan but details of key agencies to contact are contained in the Major Incident Plan	AMBER	MEDIUM	Liaise with NHS England and CCGs to ensure process is documented	Dec-13
7 . 21	the responsibilities of key staff and departments;	Action Cards within all plans More detailed responsibilities for each department being worked into revised plans	AMBER	MEDIUM	Being developed as part of the Major Incident Plan review. Some old plans currently contain details	Mar-14

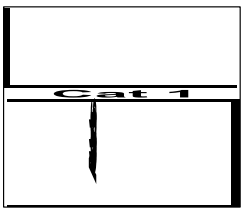
7 . 23	how mutual aid arrangements will be called into use and maintained;		RED	LOW	Liaise with NHS England to ensure the process is developed and incorporate into new Major Incident Plan	Dec-13
7 . 25	how the independent healthcare sector may help if required; and		RED	LOW	Determine which services are outsourced and what the capabilities of the private providers can assist with.	Dec-14
7 . 26	the insurance arrangement that are in place and how they may apply.	Requirements agreed. Requires developing and implimenting	RED	LOW	Liaise with finance and procurement to clarify	Dec-14
7 . 27	contact details for all key stakeholders;	Major Incident plan details key agencies to contact. Further stakeholders to be included. Local plans contain some details	AMBER	LOW	Key stakeholders to be included in local plans when developed	Dec-13
7 . 28	alternative locations for the business;	Services are limited by availability of other resources and infrastructure. Would be determined within Hospital Control Team. Some local understanding and arrangements where services can be relocated	AMBER	MEDIUM	Further developed through the development of local plans.	Apr-14
7 . 30	recovery and restoration processes and how they will be set up following an incident;	Some detail on how services will be restored and what actions to undertake during the recovery included in the service area action cards	AMBER	HIGH	Develop recovery arrangements and incorporate into the new major incident plan	
7 . 32	how the organisation will respond to the media following a significant incident, in line with the formal communications strategy;	Communications Lead action card, Section on Communications and Information sharing during a major incident. Will require updating and further development.	AMBER	MEDIUM	Communications plan to be updated and liaise with LRF coms leads and LRF coms plan	Apr-14
7 . 33	how staff will be accommodated overnight if necessary;	Draft arrangements for use of hotel (Holiday Inn) and on call rooms. On call rooms are regularly used routinely and Holiday Inn accommodation was used during the cold weather in January 2013.	AMBER	LOW	Arrangements to be developed and formalised with HR.	Nov-13
7 . 34	how stores and supplies will be managed and maintained; and		RED	MEDIUM	Liaise with finance and procurement to develop a process	Jun-14

8 . 1	detailed lockdown procedures;	Available for the LRI	AMBER	MEDIUM	Requires updating and development across all three sites by Interserve	May-14
8 . 2	detailed evacuation procedures;	Fire Plans - more development required	AMBER	HIGH	Requires updating and development across all three sites	
8 . 3	details of how they will manage relatives for any length of time, how patients and relatives will be reunited and how patients will be transported home if necessary;	Draft relatives' reception centre plan	AMBER	MEDIUM	Plan due to be finalised and agreed with division of Nursing and signed off by Emergency Planning Committee. Police documentation team exercise is being developed to test elements of this plan.	Jan-14
8 . 4	details of how they will manage fatalities and the relatives of fatalities; and	Draft relatives' reception centre plan	AMBER	MEDIUM	Plan due to be finalised and agreed with division of Nursing and signed off by Emergency Planning Committee. Police documentation team exercise is being developed to test elements of this plan.	Jan-14
8 . 5	**Best Practice:** reference to the Clinical Guidelines for Major Incidents.		RED	MEDIUM	ED plan to be updated to reflect where appropriate	Mar-14
19 . 1	outline how they can support NHS organisations affected by service disruption, especially by treating minor injuries to reduce the pressure on emergency departments. They will need to develop procedures for this in partnership with local acute trusts and ambulance and patient care transport providers.	UCC manages the front door for ambulatory adults arriving at ED. SOPs in place to support the routine admission and treatment of patients.	AMBER	MEDIUM	New front door policy and procedures to be reflected in the new major incident plan	Mar-14

Please complete Cells E1-E5 with your organisational details

Insert Organisation name
Insert Organisation type(s)
Insert name of completing officer
Insert name of authorising officer
Insert submission date

Select dropdown menu for relevant organisation type



Filters have been provided to select only those questions relevant to each organisation type.

For example, if you represent an Acute Trust, click the down arrow for Acute trusts and check the X, this will hide the questions that are not relevant to acute trusts

If your organisation provides two types of service (eg: acute and community services, or mental health and community services) then you will need to select the appropriate columns sequentially, ensuring you have deselected the intial colum first.

For example, if you represent an Acute Trust, click the down arrow for Acute trusts and check the X and complete the relevant questions. Once completed, re-click the down arrow for acute trusts, ensure all boxes are checked, select the Community Trust down arrow, and check the X box under that field and complete any unanswered fields.

Specialist Trusts should use Acute Trust dropdown, however some areas may not be applicable to them

Suggested Minimum Level of Evidence to be submitted to review group

Submit a SINGLE COPY of the Incident Response Plan (MI Plan), appendices/ annexes and the Business Continuity Plan (Business Continuity Policy or Business Continuity Management System documents), appendices/ annexes and clearly reference where information can be found within the submitted documents in the *Assurance Commentary/ References to Evidence Supplied* column (Document Name, Section Number, Page Number).

There is no need to submit multiple copies of the same document.

DO NOT INCLUDE DOCUMENTS within the Assurance Spreadsheet or create an additional Word Document or PDF document with attached files.

Evidence can be submitted in .ZIP archives – preferably compressed in clearly identified folders; however ensure that FilePaths in .ZIP files are not excessively long. Use basic WinZip or the ZIP tool built into Windows, as NHS England does not have access to other .ZIP applications. Whilst it is appreciated that your submissions are very large, there are limitations to the NHS England IT system which makes it difficult for us to access Memory Sticks or CD ROMs.

There is a file size limit for NHS.net, please break your evidence into segments not exceeding 10mb

The Panel will review the checklist and evidence supplied, and assess whether the arrangements described and documented provide assurance. Feedback will be provided to organisations in the form of specific comments relating to each area, employing a Red/Amber/Green system to clearly communicate areas where further work is considered necessary.

The reason that an Amber or Red rating is applied should be explicit from the comments of the Review panel in the NHS England assessment column. Documents which are marked as DRAFT, or need to be ratified by a committee will automatically attract an Amber rating.

When the feedback from the Review meeting is prepared (usually within a day or two of the meeting) the Chair of the review panel will send an initial response (v1) to the Emergency Planning Officer, or a nominated contact.

The Emergency Planning Officer, who will have a 24hr period to address any Red or Amber rated questions highlighted by the Review Panel Chair where the evidence may not have been clearly referenced, or evidence was omitted in error, prior to formal feedback to CEOs and Accountable Executive Officers.

In the case of any RED or Amber rated questions where it is felt that a quick amendment will address the concern of the panel, or provide the missing information, the EPLO will have one working day from receipt of the initial feedback to clarify the item highlighted by a RED rating, by email or telephone conversation to the review meeting Chair (cc england.london-assurance@nhs.net).

If the information supplied provides sufficient assurance, the Review Panel Chair will amend the response, or will request one of the other reviewers to provide their input. A formal response will then be made to the organisation via the CEO, and Executive lead, cc the EPLO, within a week of the Review meeting.

If the EPLO/ submitter is not going to be in the office in the days immediately following the scheduled review meeting, please provide details of an alternative contact person with the submission (or personal contact details for the EPLO, if this is felt appropriate). The nominated individual should be able to amend the information, provide additional details or advise on where the information is located in the submitted documents.

After receiving feedback from the review meeting, each organisation should prepare their action plan in light of the comments received to address the gaps identified (where one has not been previously constructed). This is to be agreed with your EPRR Patch Manager and submitted to NHS England (London) within 4 weeks of receiving the return.

University Hospitals of Leicester NHS Trust

Acute Trust

Aaron Vogel - Emergency Planning Officer
Richard Mitchell - Chief Operating Officer
19th November 2013

GREEN - arrangements in place now, compliant with core standards
AMBER - draft or scheduled on action plan for completion by Dec 2013
RED - arrangements not in place or scheduled for completion after Jan 2014
N/A - Not applicable to organisation
N/R - Not rated by reviewing team

GREEN - Assured
AMBER - Partially assured, seeking clarification/ draft
RED - Not assured; insufficient evidence provided
N/A - Not applicable to organisation
N/R - Not rated by reviewing team

		Cat 1								
	NHS Core Standards for Emergency Preparedness, Resilience & Response (EPRR)	**Acute trusts**	**Suggested Minimum Level of Evidence to be submitted to review group**	**Commentary/ References to Evidence Supplied**	**Self Assessment**	**Priority for resolution**	**Action**	**Deadline**	**Review Team Comment**	**Review Team Assessment**
1	**All NHS organisations and providers of NHS funded care must nominate an accountable emergency officer who will be responsible for EPRR and business continuity management.**	X	● Accountable Emergency Officer (AEO) details (name, role) ● AEO job description ●Evidence that AEO completed relevant training (SLC, witness familiarisation etc. - dates completed) ● Competency assessed against National Occupational Standards	Chief Operating Officer Richard Mitchell with duties discharged by Head of Operations Phil Walmsley	GREEN	RESOLVED				
2	**All NHS organisations and providers of NHS funded care must share their resources as necessary when they are required to respond to a significant incident or emergency.**	X	● Articulated in Incident Response Plans (IRP) ● MoU/ mutual aid arrangements, evidence of participation in multiagency planning groups/ LHRP as appropriate	LLR Local Health Resilience Partnership - Memorandum of Understanding requires further development in IRPs	AMBER	LOW	Add reference to MOUs and process for activating into the revised major incident plan.	Mar-14		
3	**All NHS organisations and providers of NHS funded care must have plans setting out how they contribute to co-ordinated planning for emergency preparedness and resilience (for example surge, winter & service continuity) across the area through LHRPs and relevant sub-groups. These plans must include details of:**	X	● Local Health Resilience Partnership (LHRP) and Local Resilience Forum (LRF) where applicable ● Borough Resilience Forum (BRF)/ subgroup participation	LLR Local Health Resilience Partnership - Memorandum of Understanding Local Resilience Forum Constitution LHRP Operational Support Group Terms of Reference	GREEN	RESOLVED				
3 . 1	director-level representation at the LHRP; and	X	● LHRP Terms of Reference (ToR), membership list ● most recent LHRP minutes	LLR Local Health Resilience Partnership - Memorandum of Understanding	GREEN	RESOLVED				
3 . 2	representation at the LRF.	-	● LHRP ToR, membership list ● most recent LHRP minutes	Practioner and Director level representation at all agreed meetings.	GREEN	RESOLVED				
4	**All NHS organisations and providers of NHS funded care must contribute to an annual NHS England report on the health sector's EPRR capability and capacity in responding to national, regional and LRF incidents. Reports must include control and assurance processes, information-sharing, training and exercise programmes and national capabilities surveys. They must be made through the organisations' formal reporting structures.**	X	● Participation in annual NHS Safe System process ● EPRR Board report/ formal reporting structure outlined ● Training and exercise programmes ● Post exercise reports, showing lessons identified, with an action plan to address gaps	This self assessment is the first requirement to participate in an annual NHS England report	GREEN	RESOLVED				
4 . 1	Organisations must have an annual work programme to reduce risks and learn the lessons identified relating to EPRR (including details of training and exercises). This work programme must link back to the National Risk Assessment (NRA) and Community Risk Register (CRR).	X	● Work plan for EPRR ● Risk Register reflects community risk register ● EPRR Board report, issues/ lessons log	EPRR work plan overseen by the Trust Emergency Planning Committee. Executive oversight from AEO and NED for EP. Including incident/issue logs	GREEN	RESOLVED				
4 . 2	Organisations must maintain a risk register which links back to the National Risk Assessment (NRA) and Community Risk Register (CRR).	X	● Risk register ● Details on the process/ schedule of review	Nothing currently recorded but involvement developing the CRR. Many risks may be captured locally on DATIX. Discussions and process agreed with risk management team as to how to capture.	AMBER	MEDIUM	Document the top 10 risks from the CRR on to DATIX with suitable reference to CRR and NRA.	Nov-13		
5	**All NHS organisations and providers of NHS funded care must have plans which set out how they plan for, respond to and recover from disruptions, significant incidents and emergencies. Incident response plans must:**	X	● PLEASE SUPPLY ONE COPY OF YOUR MAJOR INCIDENT/ INCIDENT RESPONSE PLAN AND APPENDICES	Major Incident Plan Version 3.1 October 2013, signed off by the Trust Board in April 2013. Due to restructuring plan will need further development	GREEN	RESOLVED				
5 . 1	be based on risk-assessed worst-case scenarios;	X	● Page/ section reference in arrangements demonstrating how the organisation plans for incidents ● Demonstration of risk assessments ● ToR of MI/BC Planning Groups	Terms of Reference for the Emergency Planning and Business Continuity Committee contained within the Business Continuity - Delivering Resilient Health Care Policy Supporting plans such as Operation Consort and CBRN Plans, Flu Plans, Cold Weather Plan.	GREEN	RESOLVED				
5 . 2	make sure that all arrangements are trialled and validated through testing or exercises;	X	● Testing and Exercising programme / log that complies with national exercising standards ● Post exercise/ incident reports, showing lessons identified, with an action plan to address gaps	Training Needs Analysis and Training Programme developed and incorporated into EPRR work plan. Training based on the NOS. Post incident reports available	GREEN	RESOLVED				
5 . 3	make sure that the funding and resources are available to cover the EPRR arrangements;	X	● Details of agreed budget ● EPRR business cases/ papers for funding, ● EPLO job description showing WTE	Emergency Planning Officer to ensure compliance against EPRR Core Standards. Funding managed within Corporate Operations budget.	GREEN	RESOLVED				
5 . 4	plan for the potential effects of a significant incident or emergency or for providing healthcare services to prisons, the military and iconic sites; and	X	● Demonstrate representation on relevant planning groups, ToR/ minutes (e.g.: Security Liaison Groups for COMAH sites etc.) ● Associated risk reflected on local risk register ● IRPs recognise specific local challenges	Don't provide on site medical care. We have our Major Incident Plan. Clarification required as to who will update/be responsible for the EM Mass Casualties plan. Currently the Trust only has access to	GREEN	RESOLVED				
5 . 5	include plans to maintain the resilience of the organisation as a whole, so that the Estates Department and Facilities Department are not planning in isolation.	X	● Business Continuity planning arrangements demonstrate joint working between EP and estates/ facilities staff (ToR for related meetings, task and finish groups) ● Action card for E&F in IRP/ BCP	Interserve included in the Emergency Planning Committee, Action cards in Major Incident Plan and Draft Trust Business Continuity Action cards contain actions that Interserve require the Trust to undertake during a loss/disruption of a service	AMBER	HIGH	Interserve to complete their response plans	Dec-13		
	Incident response plans must be in line with published guidance, threat-specific plans and the plans of other responding partners. They must:	X								
5 . 6	refer to all relevant national guidance, other supporting and threat-specific plans (e.g. pandemic flu, CBRN, mass casualties, burns, fuel shortages, industrial action, evacuation, lockdown, severe weather etc.) and policies, and all other supporting documents that enhance the organisation's incident response plan;	X	● Page/ section references in IRP, annexes to plans or standalone plans	Major Incident Plan references included will be included in new versions of IRPs as they are developed	GREEN	RESOLVED				

	NHS Core Standards for Emergency Preparedness, Resilience & Response (EPRR)	Acute trusts	Suggested Minimum Level of Evidence to be submitted to review group	Commentary/ References to Evidence Supplied	Self Assessment	Priority for resolution	Action	Deadline	Review Team Comment	Review Team Assessment
5 . 7	refer to all other associated plans identified by local, regional and national risk registers;	X	● Page/ section references in IRP, annexes to plans or standalone plans	Inside page of Major Incident Plan contains useful other organisational, LRF and regional plans. This will be incorporated into other plans as a standard template. Guidance documents not included	GREEN	RESOLVED				
5 . 8	have been written in collaboration with all relevant partner organisations;	X	● Page/ section references in IRP, annexes to plans or standalone plans	Where necessary action cards and agreed roles and a responsibilities for other organisations have been included Major Incident Plan, Operation Consort Plan. Attendance and cooperation in LRF and LHRP.	GREEN	RESOLVED				
5 . 9	refer to incident response plans used by partners, including LRF plans;	X	● Page/ section references in IRP, annexes to plans or standalone plans	Inside page of Major Incident Plan contains useful other organisational, LRF and regional plans. This will be incorporated into other plans as a standard template. Guidance documents not included	GREEN	RESOLVED				
5 . 10	have been written in collaboration with PHE;	X	● Page/ section references in IRP, annexes to plans or standalone plans	Major Incident Plan makes note to being written in conjunction with Public Health. Further collaboration through LRF and LHRP	GREEN	RESOLVED				
5 . 11	have been written in collaboration with all burns, trauma and critical care networks; and	X	● Page/ section references in IRP, annexes to plans or standalone plans ● Information how to access capabilities	Burn network draft plan developed, flu plan being developed with Trust critical care lead	AMBER	MEDIUM	Network arrangements to be included in reviewed plans	Mar-14		
5 . 12	define how the organisation will meet the Prevent strategy's objectives for health(1. prevent people from being drawn into terrorism and ensure that they are given appropriate advice and support and 2. work with sectors and institutions where there are risks of radicalisation which we need to address, and the wider CONTEST strategy).	X	**Not rated in 2013**	**Not rated in 2013**	**Not rated in 2013**	**Not rated in 2013**	**Not rated in 2013**	**Not rated in 2013**	**Not rated in 2013**	**Not rated in 2013**
	Incident response plans must follow NHS governance arrangements. They must:	X								
5 . 13	be approved by the relevant board;	X	● Page/ section references in IRP, annexes to plans or standalone plans ● Notes from relevant approving Board meeting	Major Incident Plan signed off by Trust Board April 2013 Operation Consort signed off by Trust Executive July 2013	GREEN	RESOLVED				
5 . 14	be signed off by the appropriate Senior Responsible Officer;	X	● Page/ section references in IRP, annexes to plans or standalone plans	As above CEO/Chairman	GREEN	RESOLVED				
5 . 15	set out how legal advice can be obtained in relation to the CCA;	X	● Page/ section references in IRP, annexes to plans or standalone plans	Included in the Major Incident Plan	GREEN	RESOLVED	To be included in relevant policy			
5 . 16	identify who is responsible for making sure the plan is updated, distributed and regularly tested;	X	● Page/ section references in IRP, annexes to plans or standalone plans	Front of plans identifies author and name of the responsible committee/individual for the plan	GREEN	RESOLVED				
5 . 17	explain how internal and external consultation will be carried out to validate the plan;	X	● Page/ section references in IRP, annexes to plans or standalone plans	Reference to BCM policy	GREEN	RESOLVED				
5 . 18	include version controls to be sure the user has the latest version;	X	● Page/ section references in IRP, annexes to plans or standalone plans		GREEN	RESOLVED				
5 . 19	set out how the plan will be published – for example, on a website;	X	● Page/ section references in IRP, annexes to plans or standalone plans	Statement on the front of the Major Incident Plan that it is held electronically on the Intranet	GREEN	RESOLVED				
5 . 20	include an audit trail to record changes and updates;	X	● Page/ section references in IRP, annexes to plans or standalone plans	page 2 of the Major Incident Plan	GREEN	RESOLVED				
5 . 21	explain how predicted and unexpected spending will be covered and how a unique cost centre and budget code can be made available to track costs; and	X	● Page/ section references in IRP, annexes to plans or standalone plans	Requirements agreed. Requires developing and implimenting. Agreed that a new cost code will be established with company credit cards linked to it.	RED	MEDIUM	Process needs to be developed with Finance and Procurement as part of the current major incident plan review.	Mar-14		
5 . 22	demonstrate a systematic risk assessment process in identifying risks relating to any part of the plan or the identified emergency.	X	● Page/ section references in IRP, annexes to plans or standalone plans		RED	MEDIUM	To address with risk manager	Dec-13		
	Staff must be aware of the Incident Response Plan, competent in their roles and suitably trained.	X								
5 . 23	Key staff must know where to find the plan on the intranet or shared drive.	X	● Training plan for staff with a specific role ● Training Needs Analysis for those staff ● Training materials ● Training records	Training includes location of the plan, including Insite, ICC and SharePoint with regular email updates.	GREEN	RESOLVED				
5 . 24	There must be an annual work programme setting out training and exercises relating to EPRR and how lessons will be learnt.	X	● Testing and Exercising schedule ● Details on process for reviewing plans in light of lessons learnt	Training Needs Analysis and Training Programme developed and incorporated into EPRR work plan. Training based on the NOS.	GREEN	RESOLVED				
5 . 25	Key knowledge and skills for staff must be based on the National Occupation Standards for Civil Contingencies. Directors on NHS on-call rotas must meet NHS published competencies.	X	● Training Needs Analysis ● Training schedule ● Training materials ● Training records	Training Needs Analysis and Training Programme developed and incorporated into EPRR work plan. Training based on the NOS.	GREEN	RESOLVED				
5 . 26	It must be clear how awareness of the plan will be maintained amongst all staff (for example, through ongoing education and information programmes or e-learning).	X	● Training Needs Analysis ● Training schedule ● Training materials ● Training records	Training Needs Analysis and Training Programme developed and incorporated into EPRR work plan. Training based on the NOS. e-learning and training materials provided so staff can top up their skills when required.	GREEN	RESOLVED				
5 . 27	It must be clear how key staff can achieve and maintain suitable knowledge and skills.	X	● Training Needs Analysis ● Training schedule ● Training materials ● Training records	Training Needs Analysis and Training Programme developed and incorporated into EPRR work plan. Training based on the NOS.	GREEN	RESOLVED				
	Set out responsibilities for carrying out the plan and how the plan works, including command and control arrangements and stand-down protocols.	X								
5 . 28	Describe the alerting arrangements for external and self-declared incidents (including trigger points, decision trees and escalation/de-escalation procedures)	X	● Page/ section references in IRP, annexes to plans or standalone plans	page 3 UHL Major Incident Plan LRF Major Incident Plan	GREEN	RESOLVED				
5 . 30	Explain how the emergency on-call rota will be set up and managed over the short and longer term.	X	● Provide detail on how this is delivered ● Provide detail on contingency arrangements regarding call-out ● Function assigned to IRP/ ICC Action Card	Action cards within the Major Incident plan plus details on command and control.	GREEN	RESOLVED				

	NHS Core Standards for Emergency Preparedness, Resilience & Response (EPRR)	Acute trusts	Suggested Minimum Level of Evidence to be submitted to review group	Commentary/ References to Evidence Supplied	Self Assessment	Priority for resolution	Action	Deadline	Review Team Comment	Review Team Assessment
5 . 31	Include 24-hour arrangements for alerting managers and other key staff, and explain how contact lists will be kept up to date.	X	● On-call arrangements/ processes, On-call pack, On-call staff lists ● Responsibility assigned to an Action Card ● Admin / support role assigned to maintain systems ● Reports from COMMEX/ regular cascades using contact lists	Communications Tests 9th November 2012, 6th June 2013 (SMS), 21st June 2013. Contact details kept up to date by switchboard through normal procedures. On call contacts are contacted through switchboard almost daily through normal operations.	GREEN	RESOLVED				
5 . 32	Set out the responsibilities of key staff and departments.	X	● Page/ section references in IRP, annexes to plans or standalone plans ● Action Cards	Action Cards within all plans More detailed responsibilities for each department being worked into revised plans	AMBER	MEDIUM	Being developed as part of the Major Incident Plan review. Some old plans currently contain details	Mar-14		
5 . 33	Set out the responsibilities of the appropriate Senior Responsible Officer or nominated Executive Director.	X	● Page/ section references in IRP, annexes to plans or standalone plans ● Action Cards	Action cards within the Major Incident plan plus details on command and control.	GREEN	RESOLVED				
5 . 34	Explain how mutual aid arrangements will be activated and maintained.	X	● Page/ section references in IRP, annexes to plans or standalone plans ● Action Cards		RED	MEDIUM	Some initial discussions with NHS England and other health partners. Details to be finalised and incorporated into the new Major Incident Plan	Mar-14		
5 . 35	Identify where the incident or emergency will be managed from (the ICC).	X	● Page/ section references in IRP, annexes to plans or standalone plans ● Action Cards	Page 11 of Major Incident Plan	GREEN	RESOLVED				
5 . 36	Define the role of the loggist to record decisions made and meetings held during and after the incident, and how an incident report will be produced.	X	● Page/ section references in IRP, annexes to plans or standalone plans ● Action Cards	Action Card	GREEN	RESOLVED				
5 . 37	**Best Practice:** Use an electronic data-logging system to record the decisions made.	X	**Not rated in 2013, unless organisation provides evidence**	Options being considered. Loggist currently trained in using standard log book and best practice	RED	MEDIUM	Research options and submit proposals on an electronic logging system	Jan-14		
5 . 38	**Best Practice:** Use the National Resilience Extranet.	X	**Not rated in 2013, unless organisation provides evidence**	Options being considered	RED	LOW	Dependant on how the NRE is being developed			
5 . 39	Refer to specific action cards relating to using the incident response plan.	X	● Page/ section references in IRP, annexes to plans or standalone plans ● Action Cards	16 Action cards in the Major Incident Plan. All plans have action cards in them for key staff	GREEN	RESOLVED				
5 . 40	Explain the process for completing, authorising and submitting NHS England standard threat-specific situation reports and how other relevant information will be shared with other organisations.	X	● Page/ section references in IRP, annexes to plans or standalone plans ● Action Cards	included in Major Incident plan Annex F	GREEN	RESOLVED		Dec-13		
5 . 41	Explain how extended working hours will apply and how they can be sustained. Explain how handovers are completed.	X	● Page/ section references in IRP, annexes to plans or standalone plans ● Action Cards	On call/shift arrangements ensure that for most roles duties are handed over to someone else after a period of time with hand over sheets. Information and guidance on European Working Time Directive now included in the plan for managers to make an informed decission	GREEN	RESOLVED		Mar-14		
5 . 42	Explain how to communicate with partners, the public and internal staff based on a formal communications strategy. This must take into account the FOI Act 2000, the Data Protection Act 1998 and the CCA 2004 'duty to communicate with the public'. Social networking tools may be of use here.	X	● Page/ section references in IRP, annexes to plans or standalone plans ● Action Cards	Communications Lead action card, Section on Communications and Information sharing during a major incident. Will require updating and further development.	AMBER	MEDIUM	Communications plan to be updated and liaise with LRF coms leads and LRF coms plan	Apr-14		
5 . 43	Have agreements in place with local 111 providers so they know how they can help with an incident	X	● Page/ section references in IRP, annexes to plans or standalone plans ● Action Cards		RED	LOW	Liaise with NHS England and CCGs as to what can be done and whose responsibility it would be.	Jun-14		
5 . 44	Consider using helplines in an emergency. Set up procedures in advance which explain the arrangements. Make sure foreign language lines are part of these arrangements.	X	● Page/ section references in IRP, annexes to plans or standalone plans ● Action Cards	Hotline number and procedure available. Requires minor updating	AMBER	MEDIUM	Telecoms/NTT to confirm details with hotline provider and validate arrangements	Dec-13		
5 . 45	Describe how stores and supplies will be maintained.	X	● Page/ section references in IRP, annexes to plans or standalone plans ● Action Cards		RED	MEDIUM	Liaise with finance and procurement to develop a process	Jun-14		
5 . 46	Explain how specific casualties will be managed – for example, burns, paediatrics and those from certain faiths.	X	● Page/ section references in IRP, annexes to plans or standalone plans ● Action Cards	Some local SOPs not written into the Major Incident Plan	AMBER	MEDIUM	Incorporate into the revised Major Incident Plan	Mar-14		
5 . 47	Explain how VIPs will be managed, whether they are casualties or visiting others who are casualties.	X	● Page/ section references in IRP, annexes to plans or standalone plans ● Action Cards	Operation Consort Plan	GREEN	RESOLVED				
5 . 48	Explain the process of recovery and returning to normal processes.	X	● Page/ section references in IRP, annexes to plans or standalone plans ● Action Cards	Major Incident Plan states to implement a recovery plan no further details	RED	HIGH	Develop recovery arrangements and incorporate into the new major incident plan	Mar-14		
5 . 49	Explain the de-briefing process (hot, local and multi-agency)at the end of an incident.	X	● Page/ section references in IRP, annexes to plans or standalone plans ● Action Cards	BCM Policy outlines the requirement for a debrief. Action cards in Major Incident Plan identify the need to undertake a debrief	GREEN	RESOLVED				
5 . 50	Explain how to support patients, staff and relatives before, during and after an incident (including counselling and mental health services).	X	● Page/ section references in IRP, annexes to plans or standalone plans ● Action Cards	Currently detailed in the Relatives' Reception Centre Plan to be moved to MIP	AMBER	LOW	Incorporate into the revised Major Incident Plan	Mar-14		
	Set out how surges in demand will be managed.	X								
5 . 51	Explain who will be responsible for managing escalation and surges.	X	● Page/ section references in IRP/ Surge Management arrangements, annexes to plans or standalone plans ● Action Cards	Trust Escalation Plan	GREEN	RESOLVED				
5 . 52	Describe local escalation arrangements and trigger points in line with regional escalation plans and working alongside acute, ambulance and community providers.	X	● Page/ section references in IRP/ Surge Management arrangements, annexes to plans or standalone plans ● Escalation framework including trigger points for ambulance, acute and community ● Action Cards	Trust Escalation Plan & LLR Escalation Plan	GREEN	RESOLVED				
	Link the Incident Response Plan to threat-specific incidents	X								
5 . 53	CBRN incidents;	X	● Page/ section references in IRP/ Surge Management arrangements, annexes to plans or standalone plans ● Specific CBRN plans	Trust CBRN Plan	GREEN	RESOLVED				

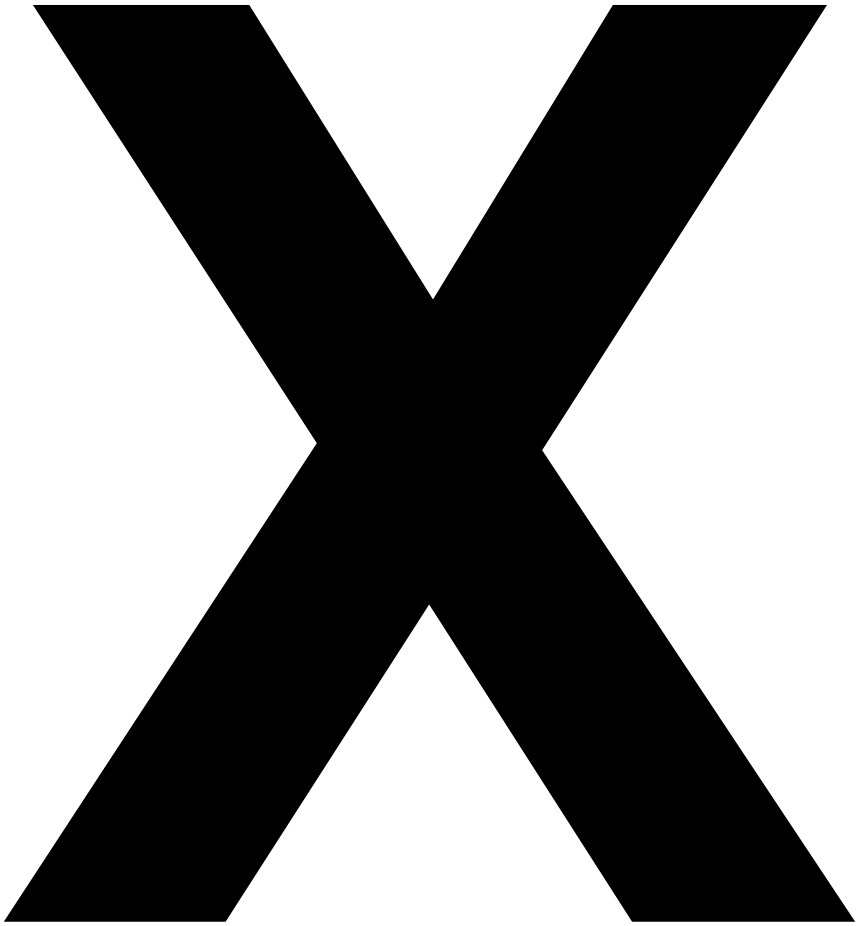
	NHS Core Standards for Emergency Preparedness, Resilience & Response (EPRR)	Acute trusts	Suggested Minimum Level of Evidence to be submitted to review group	Commentary/ References to Evidence Supplied	Self Assessment	Priority for resolution	Action	Deadline	Review Team Comment	Review Team Assessment
5 . 54	mass casualty incidents;	X	● Page/ section references in IRP/ Surge Management arrangements, annexes to plans or standalone plans ● Specific Mass Casualties plans	Major Incident Plan, The old SHA Mass Casualty Framework April 2011 is the only version the Trust has access to.	GREEN	RESOLVED				
5 . 55	pandemic flu;	X	● Page/ section references in IRP/ Surge Management arrangements, annexes to plans or standalone plans ● Specific Pandemic Flu plans	UHL Pandemic Flu Plan (1.9.2009) - Current but being updated	GREEN	RESOLVED				
5 . 56	patients with burns requiring critical care; and	X	● Page/ section references in IRP/ Surge Management arrangements, annexes to plans or standalone plans ● Specific Burns plans	Burn network draft plan developed Nothing specifically available for critical care	AMBER	MEDIUM	Incorporate into the revised Major Incident Plan	Mar-14		
5 . 57	severe weather.	X	● Page/ section references in IRP/ Surge Management arrangements, annexes to plans or standalone plans ● Specific Severe Weather plans	Plan current (1.10.2010) with supplementary checklist	GREEN	RESOLVED				
6	**All NHS organisations must provide a suitable environment for managing a significant incident or emergency (an ICC). This must include a suitable space for making decisions and collecting and sharing information quickly and efficiently.**	X	● Page/ section references in IRP, annexes to plans or standalone ICC plans ● Action Cards							
6 . 1	There must be a plan setting out how the ICC will operate.	X	● Page/ section references in IRP, annexes to plans or standalone ICC plans ● Action Cards	Major Incident Plan section 3.1	GREEN	RESOLVED				
6 . 2	There must be detailed operating procedures to help manage the ICC (for example, contact lists and reporting templates).	X	● Page/ section references in IRP, annexes to plans or standalone ICC plans ● Action Cards	New SOPs to be developed with creation of new ICC	RED	HIGH	Incorporate into the revised Major Incident Plan	Dec-13		
6 . 3	There must be a plan setting out how the Incident Coordination Team will be called in and managed over any length of time	X	● Page/ section references in IRP, annexes to plans or standalone ICC plans ● Action Cards	On call arrangements	GREEN	RESOLVED				
6 . 4	Facilities and equipment must meet the requirements of the NHS England Corporate Incident Response Plan.	X	● Page/ section references in IRP, annexes to plans or standalone ICC plans ● Action Cards ● Provide detail on equipment available within ICC ● Provide detail on the programme for exercising ICC arrangements	Newly developed inline with the requirements where appropriate and feasible	GREEN	RESOLVED				
7	**All NHS organisations and providers of NHS funded care must develop, maintain and continually improve their business continuity management systems. This means having suitable plans which set out how each organisation will maintain continuity in its services during a disruption from identified local risks and how they will recover delivery of key services in line with ISO22301. Organisations must:**	X	● PLEASE SUPPLY ONE COPY OF YOUR BUSINESS CONTINUITY POLICY, BUSINESS CONTINUITY PLAN AND APPENDICES ● Arrangements dealing with site/organisation specific risks (e.g.: flooding) ● Action plan for transition to/ alignment with ISO22301	Business Continuity Policy - currently based on BS25999 Draft templates of local plans - currently being redeveloped Trust Major Incident Plan includes reference to internal incidents - same structure would be applied. PwC Audit report	AMBER	MEDIUM	BCMS is due for review in January 2014. Will undertake a review and update based from the review	Jun-14		
7 . 1	make sure that there are suitable financial resources for their BCMS and that those delivering the BCMS understand and are competent in their roles;	X	● Page/ section references in Business Continuity Management System arrangements/ Business Continuity Policy/ Business Continuity Plan, annexes to plans or standalone plans	Emergency Planning Officer to ensure compliance against EPRR Core Standards. Funding managed within Corporate Operations budget. Training for those undertaking BCMS included on training programme	GREEN	RESOLVED				
7 . 2	set out how finances and unexpected spending will be covered, and how unique cost centres and budget codes can be made available to track costs;	X	● Page/ section references in BC arrangements	Requirements agreed. Requires developing and implimenting	RED	MEDIUM	Process needs to be developed with Finance and Procurement as part of the current major incident plan review.	Mar-14		
7 . 3	develop business continuity strategies for continuing and recovering critical activities within agreed timescales, including the resources required such as people, premises, ICT, information, utilities, equipment, suppliers and stakeholders; and	X	● Page/ section references in BC arrangements	Harder to quantify for an Acute setting, BIAs developed, IM&T plans identify priority order systems. IM&T working towards ISO 22000. Time frames and priorities would be determined by the hospital control team during an incident based on services impacted	RED	LOW	Set out principles/strategy for managing downtime of critical resources	Jun-14		
7 . 4	develop, use and maintain business continuity plans to manage disruptions and significant incidents based on recovery time objectives and timescales identified in the business impact analysis	X	● Page/ section references in BC arrangements	Draft templates of local plans - currently being redeveloped	AMBER	HIGH	Continue on programme of work to develop BCPs	Dec-13		
	Business continuity plans must include governance and management arrangements linked to relevant risks and in line with international standards.	X								
7 . 5	Each organisation's BCMS must be based on its legal responsibilities, internal and external issues that could affect service delivery and the needs and expectations of interested parties.	X	● Page/ section references in BC arrangements	BCM Policy	GREEN	RESOLVED				
7 . 6	Organisations must establish a business continuity policy which is agreed by top management, built into business processes and shared with internal and external interested parties.	X	● Page/ section references in BC arrangements	Agreed by Policy and Guidelines Committee (on behalf of the exec) 18th January 2013	GREEN	RESOLVED				
7 . 7	Organisations must make clear how their plan will be published, for example on a website.	X	● Page/ section references in BC arrangements	Trust policy that all plans and policies are published on Intranet	GREEN	RESOLVED				
7 . 8	The BCMS policy and business continuity plan must be approved by the relevant board and signed off by the appropriate Senior Responsible Officer.	X	● Page/ section references in BC arrangements	Agreed by Policy and Guidelines Committee (on behalf of the exec) 18th January 2013. Emergency Planning Committee sign off prior on behalf of the AEO	GREEN	RESOLVED				
7 . 9	There must be an audit trail to record changes and updates such as changes to policy and staffing.	X	● Page/ section references in BC arrangements	Trust policy	GREEN	RESOLVED				
7 . 10	The planning process must take into account nationally available toolkits that are seen as good practice.	X	● Page/ section references in BC arrangements	References included on page 12 of the Policy	GREEN	RESOLVED				
	Business continuity plans must take into account the organisation's critical activities, the analysis of the effects of disruption and the actual risks of disruption.	X								
7 . 11	Organisations must identify and manage internal and external risks and opportunities relating to the continuity of their operations.	X	● Page/ section references in BC arrangements	BCM Policy para 6.3.1, risks will be managed through the normal trust risk reporting/management structure	GREEN	RESOLVED				
7 . 12	Plans must be maintained based on risk-assessed worst-case scenarios.	X	● Page/ section references in BC arrangements ● Risk assessments/ methodology	Plans developed based on the loss of critical services identified in the BIAs	GREEN	RESOLVED				

	NHS Core Standards for Emergency Preparedness, Resilience & Response (EPRR)	Acute trusts	Suggested Minimum Level of Evidence to be submitted to review group	Commentary/ References to Evidence Supplied	Self Assessment	Priority for resolution	Action	Deadline	Review Team Comment	Review Team Assessment
7 . 13	Risk assessments must take into account community risk registers and at very least include worst-case scenarios for: • severe weather (including snow, Heatwave, prolonged periods of cold weather and flooding); • staff absence (including industrial action); • the working environment, buildings and equipment; • fuel shortages; • surges in activity; • IT and communications; • supply chain failure; and • associated risks in the surrounding area (e.g. COMAH and iconic sites).	X	● Page/ section references in BC arrangements ● Risk registers and arrangements for review	Emergency Planning Committee review CRR and identify any issues/risks to the organisation. No current process to formalise this although work is underway to address. Loss of Business Continuity is on the Corporate Risk Register (Board Assurance Framework).	AMBER	MEDIUM	Document the top 10 risks from the CRR on to DATIX with suitable reference to CRR and NRA.	Nov-13		
7 . 14	Organisations must develop, use and maintain a formal and documented process for business impact analysis and risk assessment.	X	● Page/ section references in BC arrangements	Business Impact assessment outlined in BCM Policy. All CBUs/Services have completed a BIA	GREEN	RESOLVED				
7 . 15	They must identify all critical activities using a business impact analysis. This must set out the effect business disruption may have on the organisation and how this will be overcome, including the maximum period of tolerable disruption.	X	● Prioritised list of critical activities/ services ● Business Impact Analysis methodology	Training materials and training sessions provided	GREEN	RESOLVED				
7 . 16	Organisations must highlight which of their critical activities have been put on the corporate risk register and how these risks are being addressed.	X	● Appropriate risk register	Loss of Business Continuity is on the Corporate Risk Register (Board Assurance Framework). Individual risks need to be included on corporate risk register	AMBER	MEDIUM	incorporated into action 7.13	Nov-13		
	Business continuity plans must set out how the plans will be called into use, escalated and operated.	X								
7 . 17	Organisations must develop, use, maintain and test procedures for receiving and cascading warnings and other communications before, during and after a disruption or significant incident. If appropriate, business continuity plans must be published on external websites and through other information-sharing media.	X	● Page/ section references in BC plans, annexes to plans or standalone plans ● Action Cards	Included in training packages, draft service area action cards with appropriate levels of escalation to notify the Trust of an incident.	AMBER	HIGH	Continue on programme of work to develop BCPs			
7 . 18	Plans must set out: the alerting arrangements for external and self-declared incidents, including trigger points and escalation procedures;	X	● Page/ section references in BC plans, annexes to plans or standalone plans ● Action Cards	No triggers set but principles and points for consideration are detailed and will be declared by the Senior Manager On Call if necessary agencies to contact are contained in the Major Incident Plan.	GREEN	RESOLVED				
7 . 19	the procedures for escalating emergencies to CCGs and the NHS England area, regional and national teams;	X	● Page/ section references in BC plans, annexes to plans or standalone plans ● Responsibility assigned to Action Card	Issues are routinely escalated to NHS England and CCGs however requires further detail in major incident plan but details of key agencies to contact are contained in the Major Incident Plan	AMBER	MEDIUM	Liaise with NHS England and CCGs to ensure process is documented	Dec-13		
7 . 20	24-hour arrangements for alerting managers and other key staff, including how up-to-date contact lists will be maintained;	X	● On-call arrangements/ processes, On-call pack, On-call staff lists ● Responsibility assigned to an Action Card ● Admin / support role assigned to maintain systems ● Reports from COMMEX/ regular cascades using contact lists	Communications Tests 9th November 2012, 6th June 2013 (SMS), 21st June 2013. Contact details kept up to date by switchboard through normal procedures. On call contacts are contacted through switchboard almost daily through normal operations.	GREEN	RESOLVED				
7 . 21	the responsibilities of key staff and departments;	X	● Page/ section references in BC plans, annexes to plans or standalone plans ● Action Cards	Action Cards within all plans More detailed responsibilities for each department being worked into revised plans	AMBER	MEDIUM	Being developed as part of the Major Incident Plan review. Some old plans currently contain details	Mar-14		
7 . 22	the responsibilities of the appropriate Senior Responsible Officer or Executive Director;	X	● Page/ section references in BC plans, annexes to plans or standalone plans ● Action Cards	Action cards within the Major Incident plan plus details on command and control.	GREEN	RESOLVED				
7 . 23	how mutual aid arrangements will be called into use and maintained;	X	● Page/ section references in BC plans, annexes to plans or standalone plans ● Action Cards		RED	LOW	Liaise with NHS England to ensure the process is developed and incorporate into new Major Incident Plan	Dec-13		
7 . 24	where the incident or emergency will be managed from (the ICC);	X	● Page/ section references in BC plans, annexes to plans or standalone plans ● Action Cards	Page 11 of Major Incident Plan	GREEN	RESOLVED				
7 . 25	how the independent healthcare sector may help if required; and	X	● Page/ section references in BC plans, annexes to plans or standalone plans ● Action Cards		RED	LOW	Determine which services are outsourced and what the capabilities of the private providers can assist with.	Dec-14		
7 . 26	the insurance arrangement that are in place and how they may apply.	X	● Page/ section references in BC plans, annexes to plans or standalone plans ● Action Cards	Requirements agreed. Requires developing and implimenting	RED	LOW	Liaise with finance and procurement to clarify	Dec-14		
	Business continuity plans must describe the effects of any disruption and how they can be managed. **Plans must include:**	X								
7 . 27	contact details for all key stakeholders;	X	● Page/ section references in BC plans, annexes to plans or standalone plans	Major Incident plan details key agencies to contact. Further stakeholders to be included. Local plans contain some details	AMBER	LOW	Key stakeholders to be included in local plans when developed	Dec-13		
7 . 28	alternative locations for the business;	X	● Page/ section references in BC plans, annexes to plans or standalone plans	Services are limited by availability of other resources and infrastructure. Would be determined within Hospital Control Team. Some local understanding and arrangements where services can be relocated	AMBER	MEDIUM	Further developed through the development of local plans.	Apr-14		
7 . 29	a scalable plan setting out how incidents will be managed and by whom;	X	● Page/ section references in BC plans, annexes to plans or standalone plans ● Action Cards	Service area action cards detail level of escalation	GREEN	RESOLVED				
7 . 30	recovery and restoration processes and how they will be set up following an incident;	X	● Page/ section references in BC plan, annexes to plans or standalone plans ● Action Cards ● Link to IRP (Standard 5.48) if using these arrangements	Some detail on how services will be restored and what actions to undertake during the recovery included in the service area action cards	AMBER	HIGH	Develop recovery arrangements and incorporate into the new major incident plan			
7 . 31	how decisions and meetings will be recorded during and after an incident, and how the incident report will be compiled;	X	● Page/ section references in BC plan, annexes to plans or standalone plans ● Action Cards ● Sample incident log ● Post exercise/ incident reports, showing lessons identified, with an action plan to address gaps	3.5 of Major Incident Plan	GREEN	RESOLVED				

	NHS Core Standards for Emergency Preparedness, Resilience & Response (EPRR)	Acute trusts	Suggested Minimum Level of Evidence to be submitted to review group	Commentary/ References to Evidence Supplied	Self Assessment	Priority for resolution	Action	Deadline	Review Team Comment	Review Team Assessment
7 . 32	how the organisation will respond to the media following a significant incident, in line with the formal communications strategy;	X	● Page/ section references in BC plan, annexes to plans or standalone plans ● Spokespersons identified and assigned to an Action Card	Communications Lead action card, Section on Communications and Information sharing during a major incident. Will require updating and further development.	AMBER	MEDIUM	Communications plan to be updated and liaise with LRF coms leads and LRF coms plan	Apr-14		
7 . 33	how staff will be accommodated overnight if necessary;	X	● Page/ section references in BC plan, annexes to plans or standalone plans	Draft arrangements for use of hotel (Holiday Inn) and on call rooms. On call rooms are regularly used routinely and Holiday Inn accommodation was used during the cold weather in January 2013.	AMBER	LOW	Arrangements to be developed and formalised with HR.	Nov-13		
7 . 34	how stores and supplies will be managed and maintained; and	X	● Page/ section references in BC plan, annexes to plans or standalone plans		RED	MEDIUM	Liaise with finance and procurement to develop a process	Jun-14		
7 . 35	details of a surge plan to maintain critical services.	X	● Page/ section references in BC plan, annexes to plans or standalone plans	Trust Escalation Plan	GREEN	RESOLVED				
	Business continuity plans must specify how they will be used, maintained and reviewed.	X								
7 . 36	Organisations must use, exercise and test their plans to show that they meet the needs of the organisation and of other interested parties. If possible, these exercises and tests should involve relevant interested parties. Lessons learnt must be acted on as part of continuous improvement.	X	● Testing and Exercising programme / log that complies with national exercising standards ● Post exercise/ incident reports, showing lessons identified, with an action plan to address gaps	Exercising and training program developed	GREEN	RESOLVED				
7 . 37	Plans must identify who is responsible for making sure the plan is updated, distributed and regularly tested.	X	● Page/ section references in BC plan, annexes to plans or standalone plans	Roles outlined in BCM Policy	GREEN	RESOLVED				
7 . 38	Organisations must monitor, measure, analyse and assess the effectiveness of their BCMS against their own requirements, those of relevant interested parties and any legal responsibilities.	X	● Page/ section references in BC plan, annexes to plans or standalone plans ● Reports to Board or Management Teams	Policies reviewed in line with normal trust Policy	GREEN	RESOLVED				
7 . 39	Organisations must identify and take action to correct any irregularities identified through the BCMS and must take steps to prevent them from happening again. They must continually improve the suitability and effectiveness of their BCMS.	X	● Page/ section references in BC plan, annexes to plans or standalone plans ● Business Continuity strategies developed in response to problems identified ● Reports to Board or Management Teams ● Post incident / exercise debrief reports ● Details of expenditure/ investment	Post incident reports developed and action plans implemented. Updated risk assessments where necessary and communicated to the Trust Exec.	GREEN	RESOLVED				
	Business continuity plans must specify how they will be communicated to and accessed by staff. Plans must include:	X								
7 . 40	details of the training provided to staff and how the training record is maintained;	X	● Training Needs Analysis ● Training schedule ● Training materials ● Training attendance records	Training Needs Analysis Training Programme Training Record Materials	GREEN	RESOLVED				
7 . 41	reference to the National Occupation standards for Civil Contingencies and NHS England competencies when identifying key knowledge and skills for staff; (directors of NHS England on-call rotas to meet NHS England published competencies);	X	● Training Needs Analysis ● Training schedule ● Training materials ● Training attendance records	Training Needs Analysis and Training Programme developed and incorporated into EPRR work plan. Training based on the NOS.	GREEN	RESOLVED				
7 . 42	details of the tools that will be used to make sure staff remain aware through ongoing education and information programmes (for example, e-learning and induction training); and	X	● Training Needs Analysis ● Training schedule ● Training materials ● Training attendance records	Training Needs Analysis and Training Programme developed and incorporated into EPRR work plan. Training based on the NOS. e-learning and training materials provided so staff can top up their skills when required.	GREEN	RESOLVED				
7 . 43	details of how suitable knowledge and skills will be achieved and maintained.	X	● Training Needs Analysis ● Training schedule ● Training materials ● Training attendance records	Training Needs Analysis and Training Programme developed and incorporated into EPRR work plan. Training based on the NOS.	GREEN	RESOLVED				
8	**NHS Acute Trusts must also include:**	X								
8 . 1	detailed lockdown procedures;	X	● Page/ section references in IRP, annexes or standalone plans	Available for the LRI	AMBER	MEDIUM	Requires updating and development across all three sites by Interserve	May-14		
8 . 2	detailed evacuation procedures;	X	● Page/ section references in IRP, annexes or standalone plans	Fire Plans - more development required	AMBER	HIGH	Requires updating and development across all three sites			
8 . 3	details of how they will manage relatives for any length of time, how patients and relatives will be reunited and how patients will be transported home if necessary;	X	● Page/ section references in IRP, annexes or standalone plans	Draft relatives' reception centre plan	AMBER	MEDIUM	Plan due to be finalised and agreed with division of Nursing and signed off by Emergency Planning Committee. Police documentation team exercise is being developed to test elements of this plan.	Jan-14		
8 . 4	details of how they will manage fatalities and the relatives of fatalities; and	X	● Page/ section references in IRP, annexes or standalone plans	Draft relatives' reception centre plan	AMBER	MEDIUM	Plan due to be finalised and agreed with division of Nursing and signed off by Emergency Planning Committee. Police documentation team exercise is being developed to test elements of this plan.	Jan-14		
8 . 5	**Best Practice:** reference to the Clinical Guidelines for Major Incidents.	X	● Page/ section references in IRP, annexes or standalone plans		RED	MEDIUM	ED plan to be updated to reflect where appropriate	Mar-14		
8 . 6	explain how the Mobile Privileged Access Scheme (MTPAS) and Fixed Telecommunications Privileged Access Scheme (FTPAS) will be provided across the organisation; and	X	● Detail arrangements for MTPAS enabled telecoms in the service/ invocation arrangements		GREEN	RESOLVED				
19	**Urgent care centres must also:**	X								
19 . 1	outline how they can support NHS organisations affected by service disruption, especially by treating minor injuries to reduce the pressure on emergency departments. They will need to develop procedures for this in partnership with local acute trusts and ambulance and patient care transport providers.	X	● Page/ section references in IRP, annexes or standalone plans ● Commissioning specifications should include provisions for appropriate support ● Acute organisations should be able to demonstrate joint planning, training and exercising with the UCC provider	UCC manages the front door for ambulatory adults arriving at ED. SOPs in place to support the routine admission and treatment of patients.	AMBER	MEDIUM	New front door policy and procedures to be reflected in the new major incident plan	Mar-14		

Total	119
GREEN	76
AMBER	27
RED	16
N/A	0

GREEN	LOW
AMBER	MEDIUM
RED	HIGH
N/A	RESOLVED



Trust Board Paper X

To:	**Trust Board**
From:	Mark Wightman, Director of Marketing and Communications
Date:	28th November 2013
CQC regulation:	

Title:	**Summary of results from November 2013 Reputation Audit**

Author/Responsible Director: Karl Mayes, PPI & Membership Manager / Mark Wightman, Director of Communications and Marketing

Purpose of the Report:
To update the Board with a summary of results from a reputation audit carried out in November 2013

The Report is provided to the Board for:

Decision		Discussion	X
Assurance	X	Endorsement	

Summary / Key Points:

In November 2013 a reputation audit was conducted which sought to assess perceptions of the Trust among its stakeholders. The most positive responses were received from our Trust members and members of the public. Overall, the majority of responses were positive. For example, 81% of respondents were either satisfied or very satisfied with their dealings with Trust staff over the last year.

Public and voluntary sector stakeholders were motivated to work with the Trust although a significant minority did not feel involved in the development of Trust policy and services. There is clearly an opportunity to look at how we recognise and value stakeholder contributions and make more of the high level of motivation among these stakeholders.

When asked about the Trust's reputation across LLR, 57% of our public and voluntary sector stakeholders either agreed or agreed strongly that our reputation was good. However 29% stated that the Trust did not have a good local reputation.

Recommendations:
It is recommended that the reputation audit be repeated bi-annually with a more targeted focus on soliciting public and voluntary sector responses. Comparative data, once available, to form the basis of an action plan.

Previously considered at another corporate UHL Committee?

No

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

Resource Implications (eg Financial, HR):

The reputation audit has been administered by the PPI and membership manager and

Clinical Audit team.
Assurance Implications: The Board are asked to note the outcome of this audit and will be presented with comparative data once the second audit is conducted in May 2014.
Patient and Public Involvement (PPI) Implications: The reputation audit is one of a number of tools and methods by which the Trust seeks to understand the views and perception of patients and the wider public. The data it generates will provide a useful range of issues with which to further engage public stakeholders.
Stakeholder Engagement Implications: As above, the audit directly engages with stakeholders, both to explore their perceptions of the Trust and to identify areas in which stakeholder engagement may improve.
Equality Impact: The audit was distributed across a wide range of stakeholder networks, including many who represent protected characteristic groups as identified by the Equality Act. On this occasion, equality monitoring was not applied to incoming responses. This is a learning point for subsequent audits.
Information exempt from Disclosure: No
Requirement for further review? A repeat audit will be conducted in May 2014 with comparative data presented to the Board thereafter.

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST

REPORT TO: **Trust Board**

REPORT BY: **Karl Mayes, PPI and Membership Manager, Carl Walker, Clinical Audit Manager**

DATE: **November 28th, 2013**

SUBJECT: **Summary of results from November 2013 Reputation Survey**

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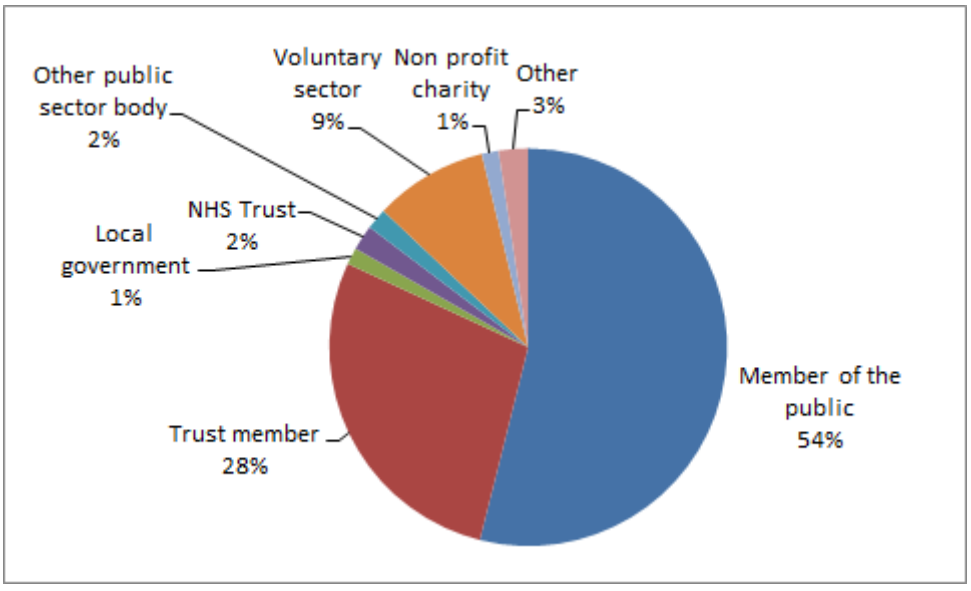
1. Introduction

1.1 In November 2013 a reputation survey was conducted which sought to assess perceptions of the Trust among its key stakeholders. A survey of this nature has been recommended by the NHS Confederation's paper on Reputation management[1]. The survey, which ran for three weeks, was disseminated to voluntary and public sector partner organisations and through patient and public networks (including the Trust's public membership). The reputation survey will be repeated bi-annually to provide the board with an overview of how the Trust is perceived, alongside other feedback already in place such as the Friends & family test etc.

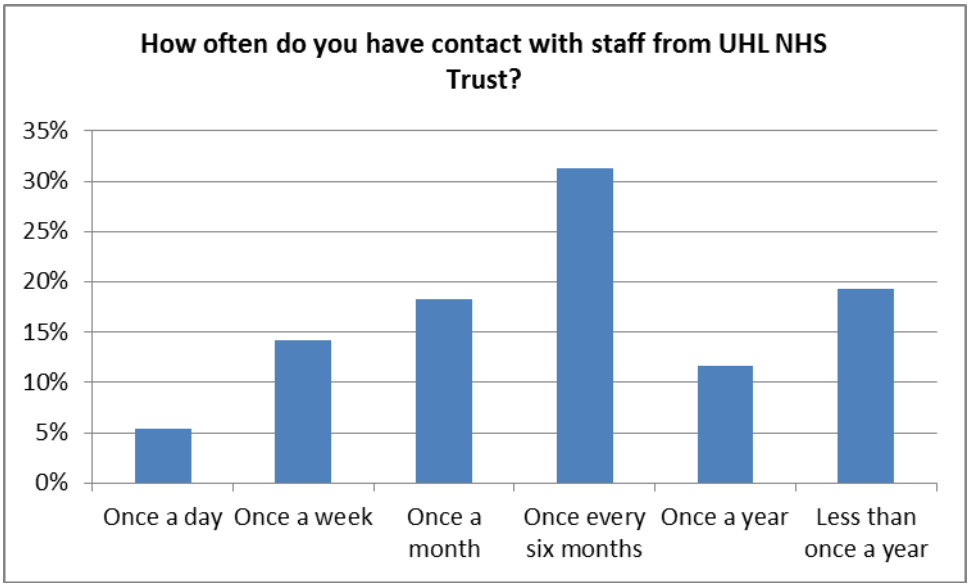
1.2 The survey was sent to a range of individuals and organisations (see Appendix 1.) and a total of 319 valid responses were received. The distribution of respondents (as a percentage of total respondents) may be found in the chart below.



1.3 The majority of responses were from members of the public (53%) and Trust public members (28%). Public (including NHS) and voluntary sector bodies comprised approximately 15% of respondents.

1.4 Contact with the Trust varied among respondents. 62% said that they were in contact once every 6 months or less frequently.

[1] Reputation Management: A Guide for Boards. NHS Confederation (2009).



1.5 Only 14 of the 319 responses had no dealings with trust within the last 12 months and those that did 81% were very satisfied or satisfied with their interactions with staff.

2. Format of the survey

2.1 All respondents were asked a series of questions relating to the Trust's values and the extent to which we are judged to be "living" them. All respondents were also asked to rate our interaction with them and to respond to the "Friends and Family Test" question; "how likely are you to recommend our hospitals to friends and family if they needed care or treatment"?

2.2 Public and voluntary sector partners were then asked a further series of questions which explored in greater detail the way in which the Trust interacts with and is viewed by its stakeholders. As such, the survey generated both a reflection on the Trust as a service provider and as a professional partner.

2.3 The Clinical Audit Team provided support and expertise to develop the reputation survey which was sent out electronically using the department's CRT online survey. The team also helped analyse the response data presented in this document.

2.4 A full breakdown of the results from the survey is provided in Appendix 2 of this paper. To help provide a summary of strengths and areas for development a simple scoring system was applied to the satisfaction questions with 5 valid response options in the survey. A scoring system produced scores with a possible range of 1-5 with a score of 5 being a perfect satisfaction. The scores for each relevant question are shown in the tables below for each section alongside the results of the other questions asked. Responses are ranked, with the most favourable responses ranked first.

3. Results: our values (answered by all respondents)

3.1 The first section of the survey asked how well we live up to our values.

RANK	OUR VALUES AND BEHAVIOUR: As an organisation we are committed to living our values. Looking at the values below, please rate whether you think we are living them:	Satisfaction score
1	We treat people how we would like to be treated	3.71
2	We are one team and we are best when we work together	3.63
3	We do what we say we are going to do	3.57
4	We focus on what matters most	3.52
5	We are passionate and creative in our work	3.39

3.2 Respondents felt we were living our value 'we treat people how we would like to be treated' the most. They were most ambivalent when asked to reflect on the value "we are passionate and creative in our work". While this may indicate that we are not perceived as a particularly creative and passionate organisation; it may equally suggest that our passion and creativity is simply not as visible as it could be.

4. Results: stakeholder / partnership working (answered by all respondents)

4.1 Again, the following questions were asked of all respondents. They aimed to explore day to day interactions with the Trust.

RANK	Below is a list of 6 attributes which we think are important to good stakeholder/partnership working. Could you rate your experience as indicated when considering these:	Satisfaction score
1	Staff that are knowledgeable about their area of work	3.74
2	Staff who treat you with courtesy and respect	3.64
3	Providing accurate and reliable information	3.44
4	Providing timely and appropriate responses	3.23
5	Willing to take your views on board	3.14
6	Is open to challenge	3.06

4.2 The results show that our staff's knowledge about their area of work was deemed to be our strongest attribute. This statement elicited a very positive response with only 10% replying in the negative. This was closely followed by 'Staff who treat you with courtesy and respect' where 87% of responses to this statement were in the positive spectrum (excellent, very good and good).

4.3 The lowest scoring attribute was 'The Trust is open to challenge' with 28% of respondents recording a response of poor or very poor in this area.

5 Working with our stakeholders (answered only by public and voluntary sector respondents)

5.1 The following questions were available to respondents representing public and voluntary sector organisations. As such, responses are more reflective of the quality of our working relationships than that of our service delivery.

RANK	Below are a further four statements about the way in which Leicester's Hospitals work with stakeholders. Please indicate to what extent you agree or disagree with each:	Satisfaction score
1	I am personally motivated to work in partnership with Leicester's	4.17

	Hospitals to achieve their vision	
2	Leicester's Hospitals are fair and equal in their treatment of stakeholders	3.88
3	I feel valued for the contribution I make to the work of Leicester's Hospitals	3.78
4	I feel involved in the development of Leicester's Hospitals policy and services	3.51

5.2 The highest level of satisfaction came in response to the statement 'I am personally motivated to work in partnership with Leicester's Hospitals to achieve their vision'. This elicited a positive response from the majority of respondents with 82% expressing a personal desire to work in partnership with us.

5.3 By contrast, the least positive statement was 'I feel involved in the development of Leicester's Hospitals' policy and services'. 25% of respondents did not agree with this statement while 58% suggested that they did feel involved in our service development and policies.

6. Results: reputation (answered only by public and voluntary sector respondents)

6.1 The following questions focused more specifically on the reputation of Leicester's Hospitals and respondents' experience of doing business with us. We asked;

RANK	REPUTATION:	Satisfaction score
1	When dealing with a member of staff have you been satisfied with their politeness and courtesy?	4.08
2	As an organisation, are we easy to do business with?	3.55
3	Do you think that Leicester's Hospitals have a good reputation outside of the county?	3.32
4	Do you think that Leicester's Hospitals have a good reputation locally (across Leicester, Leicestershire and Rutland)?	3.30

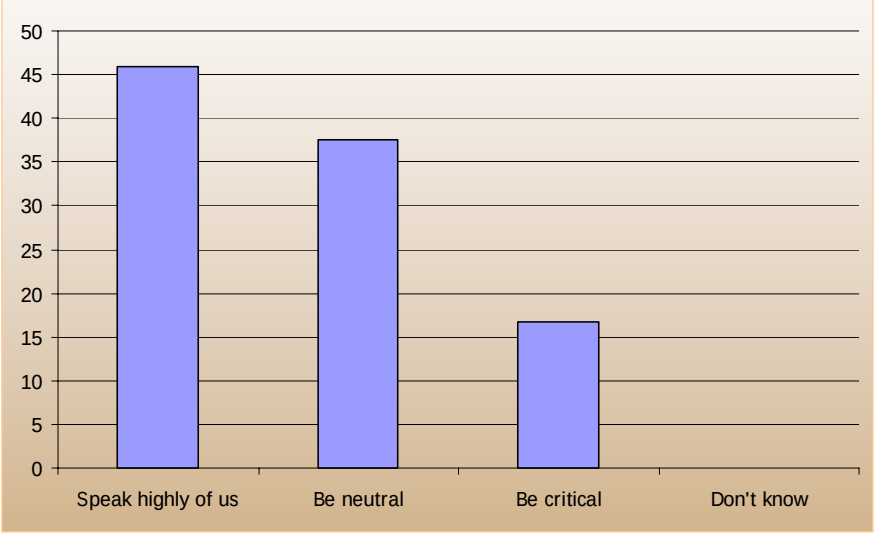
6.2 The highest scoring statement in this section related to the politeness and courtesy of staff. 87% of our stakeholders recorded a positive response to this question with just 4% saying they were dissatisfied with their interaction with our staff.

6.3 When asked if the Trust was easy to do business with, 52% agreed or agreed strongly. 25% provided neutral responses and just over 15% disagreed or disagreed strongly.

6.4 When asked to think about the Trust's reputation across LLR, 57% either agreed or agreed strongly that our reputation was good. However 29% stated that the Trust did not have a good local reputation.

6.5 Reflecting on the Trust's reputation outside of the county, 33% of respondents noted that UHL had a good reputation. 42% did not know about the Trust's wider reputation however, and just over 10% recorded that the Trust did not have a good reputation.

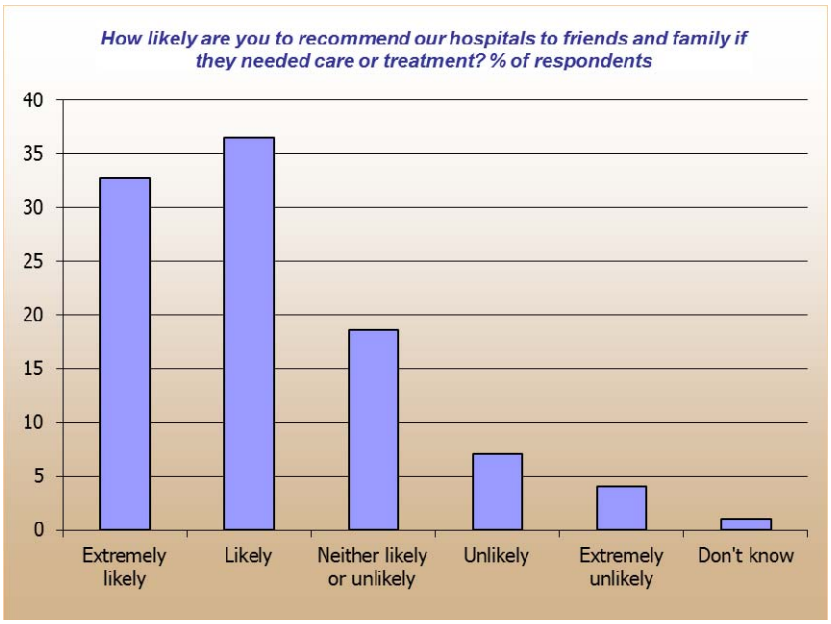
6.6 The final question in this section asked how respondents would speak of the Trust to others. As illustrated in the chart below, 46% of respondents with whom we have a working relationship said they would speak highly of us. 37% said they would be neutral and 17% would speak of the Trust critically.



Which of these comes closest to describing how you would speak about Leicester's Hospitals?

7. Results: the Friends and Family Test (answered by all respondents)

7.1 As noted above, the survey also applied the Friends and Family test to respondents, asking; "how likely are you to recommend our hospitals to friends and family if they needed care or treatment"?

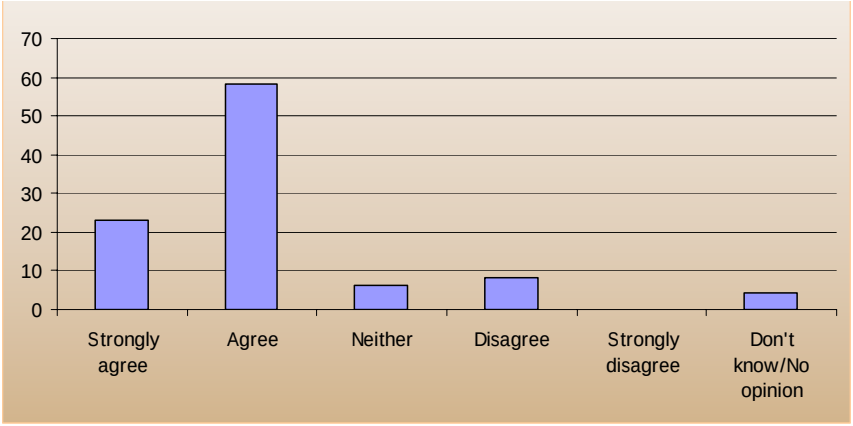


This response equates to a FFT score of 3.1 which is significantly lower than the FFT score for the trust from patients (66 in October). This score should be viewed in the context of 70% of respondents either likely or extremely likely to recommend us. Unfortunately the scoring process for the FFT does not reflect the majority support elicited by this survey.

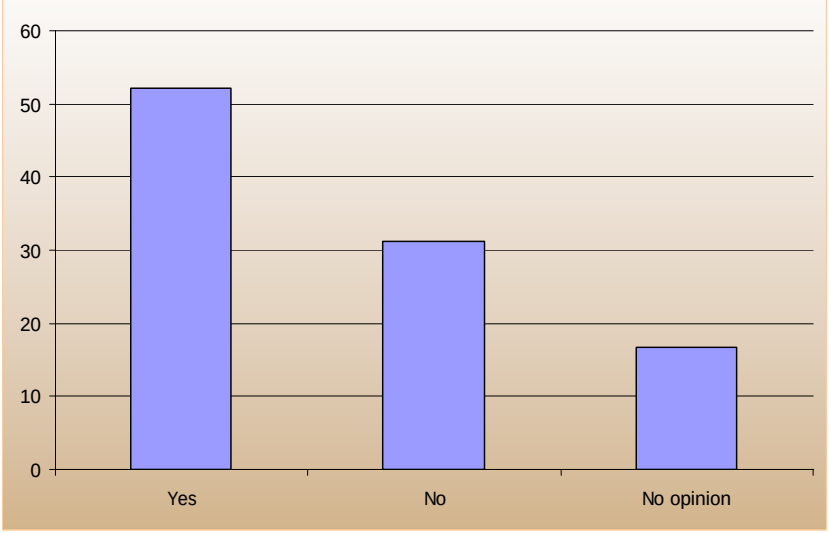
8. Results: communication (answered only by Public and voluntary sector respondents)

8.1 The survey concluded with a reflection on communication with and by Leicester's Hospitals. The results will be helpful in terms of tailoring future communication plans and strategies etc. We asked;

8.1.1 Excluding personal correspondence, do you regularly hear from Leicester's Hospitals?

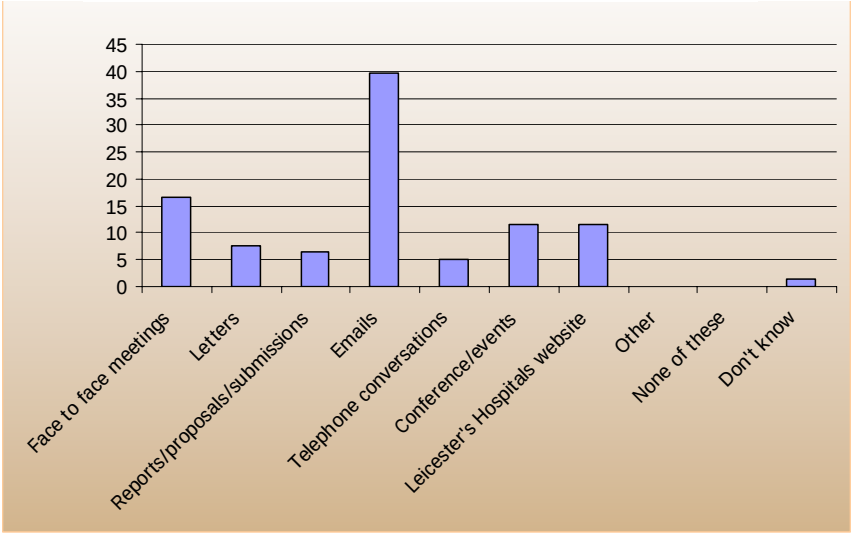


8.1.2 Would you like to hear more from Leicester's Hospitals?



Taking the last two questions together, 80% of respondents felt that they heard regularly from the Trust and 52% would like to hear more. 31% did not wish to hear more from the Trust.

8.1.3 Which form should that communication ideally take? (Please select the most important)



Preferences expressed in response to this question ranged from face to face meetings to conferences and more content on the Trust's web site. However, the majority (40%) said they would prefer communication by email.

9. Summary

9.1 Overall, the majority of responses were positive. For example, 81% of respondents were either satisfied or very satisfied with their dealings with Trust staff over the last year. 70% were either likely or very likely to recommend us to their friends and family if they needed care or treatment.

9.2 In terms of our day to day interaction with stakeholders much of the data from the survey was positive. 83% of respondents felt we were good at providing reliable and accurate information and 72% rated us positively as an organisation that is open to challenge. Naturally the remaining 28% who do not share this view are of concern. Of concern too are the 23% of respondents who rated us poor or very poor on our willingness to take stakeholder views on board.

9.3 Although often a source of complaints to the Trust, experiences of staff attitudes and behaviours were rated highly in the survey. 87% of all respondents felt that staff had treated them with courtesy and respect. Among our public and voluntary sector stakeholders 87% again were satisfied that, when dealing with a member of staff, they were treated with politeness and courtesy. Indeed, just 4% stated that they had been dissatisfied when interacting with staff.

9.4 Focusing specifically on our public and voluntary sector stakeholders we find a high degree of personal motivation to work in partnership with the Trust to achieve its vision (82%). However, 25% recorded that they did not feel involved in the development of Trust policy and services and 29% either responded neutrally or disagreed with the statement "I feel valued for the contribution I make to Leicester's Hospitals". There is clearly an opportunity to look at how we recognise and value stakeholder contributions and make more of the high level of motivation among neighbouring organisations.

9.5 Just over half of our public and voluntary sector stakeholders felt that the Trust was easy to do business with (25% were neutral and 15% disagreed). When asked about how they would speak about the Trust 46% of respondents with whom we have a working relationship said they would

speak highly of us. 37% said they would be neutral and 17% stated that they would speak of the Trust critically.

9.6 In general the survey reveals a number of positive experiences of the Trust and attitudes towards it. However, this does not necessarily translate to a good reputation. When asked about the Trust's reputation across LLR, 57% of our public and voluntary sector stakeholders either agreed or agreed strongly that our reputation was good. However 29% stated that the Trust did not have a good local reputation.

10. NHS Choices ratings: November 2013

10.1 In addition to the Trust's reputation survey, a snapshot of ratings gathered by the NHS Choices web site is shown below. The data is split by hospital site and records service user ratings, staff recommendations, data on response to safety alerts, mortality rate and performance against CQC standards.

User rating by staff safety alerts	Recommended to patient	Responding standards	Mortality Rate national	CQC
Glenfield Hospital				
82 ratings Rate it yourself	55 % of staff who would recommend this organisation	Poor - Some alerts not signed off after deadline	As expected in hospital and up to 30 days after discharge (1.0491)	All standards met Visit CQC profile
Leicester Royal Infirmary				
240 ratings Rate it yourself	55 % of staff who would recommend this organisation	Poor - Some alerts not signed off after deadline	As expected in hospital and up to 30 days after discharge (1.0491)	All standards met Visit CQC profile
Leicester General Hospital				
117 ratings Rate it yourself	55 % of staff who would recommend this organisation	Poor - Some alerts not signed off after deadline	As expected in hospital and up to 30 days after discharge (1.0491)	All standards met Visit CQC profile

User ratings are highest for the Glenfield Hospital and lowest for the Royal Infirmary. 55% of staff would currently recommend the Trust.

11. Conclusion

11. 1 This was the first time that the Trust has undertaken a reputation survey which sought the views of such a wide range of stakeholders (a previous survey was restricted to GPs and other key professional stakeholders). Overall the survey has produced some positive results, with high levels of satisfaction, particularly among our Trust members and the wider public. While public and voluntary sector stakeholders are motivated to work with the Trust, in a significant minority of cases the survey suggests that they do not always feel as involved or valued as they might be.

11.2 While this survey solicited the views of contacts in our partner NHS organisations (LPT, EMAS and the three CCGs), it would be useful to widen the survey and seek the views of a greater number of staff working in those organisations. As such, when the survey is repeated in six months' time a more concerted effort to widen the scope of the survey in these organisations will be undertaken.

11.3 The survey was disseminated to a wide range of community and voluntary sector groups in order to encourage responses across the diversity spectrum. However, this first survey did not apply equality monitoring to responses received. As such, on this occasion, it has not been possible to split results by, for example gender, ethnicity or disability. This is a learning point for future surveys and the PPI and membership manager will be working with the Clinical Audit team to explore how best to achieve this level of monitoring in future surveys.

11.4 The reputation survey will be repeated in May 2014, with results compared to the November 2013 survey.

Karl Mayes
PPI and Membership Manager
November 2013

Carl Walker
Clinical Audit Manager

Appendix 1. Breakdown of survey recipients

The reputation survey was sent out to a range of individuals and groups including;

- Leicester City CCG
- East Leicestershire CCG
- West Leicestershire CCG
- GEM
- EMAS
- LPT
- Local Councillors
- Leicester City Council
- Leicestershire County Council
- Leicester University
- DeMontfort University
- Healthwatch Leicester
- Healthwatch Leicestershire
- Healthwatch Rutland
- UHL Public Members
- UHL Patient Advisors
- UHL Prospective Governors
- Trust Facebook followers
- Trust Twitter followers
- BME Symposium attendees
- Leicester Race Equality Council
- Leicester Chinese Community Centre
- Leicester Mercury Patient's Panel
- Age UK
- Leicestershire Polish Association
- Akwaba Aye
- African Caribbean Citizens Centre
- Leicester Council of faiths
- Local faith / community leaders
- Community Ambassadors
- Leicester City Ethnic Elders group
- Leicestershire Ethnic Elders group
- Action Deafness
- Older People's Engagement Network

Respondents were asked to self identify which of the following groups they were responding on behalf of;

- Local Government
- NHS Trust
- Other public sector body
- Voluntary sector
- Non profit charity
- Trust member
- Member of the public
- Other

Appendix 2 Full results breakdown

1	How often do you have contact with staff from UHL NHS Trust? (317)	Response Breakdown	No of responses	Valid %
		Once a day	17	5%
		Once a week	45	14%
		Once a month	58	18%
		Once every six months	99	31%
		Once a year	37	12%
		Less than once a year	61	19%
2	In the last 12 months, how satisfied have you been with the dealings you have had with staff from Leicester's Hospitals? (317)	Response Breakdown	No of responses	Valid %
		Very satisfied	109	36%
		Satisfied	135	45%
		Neither	26	9%
		Dissatisfied	20	7%
		Very Dissatisfied	13	4%
		No dealings	14	
3	OUR VALUES AND BEHAVIOUR: As an organisation we are committed to living our values. Looking at the values below, please rate whether you think we are living them: : We treat people how we would like to be treated (317)	Response Breakdown	No of responses	Valid %
		Strongly agree	59	19%
		Agree	157	50%
		Neither Agree nor disagree	51	16%
		Disagree	35	11%
		Strongly disagree	10	3%
		Don't know	5	
4	We do what we say we are going to do (318)	Response Breakdown	No of responses	Valid %
		Strongly agree	45	15%
		Agree	150	49%
		Neither	62	20%
		Disagree	38	12%
		Strongly disagree	13	4%
		Don't know	10	
5	We focus on what matters most (317)	Response Breakdown	No of responses	Valid %
		Strongly agree	45	15%
		Agree	120	40%
		Neither Agree nor disagree	85	29%
		Disagree	40	13%
		Strongly disagree	8	3%
		Don't know	19	
6	We are one team and we are best when we work together (318)	Response Breakdown	No of responses	Valid %
		Strongly agree	57	19%

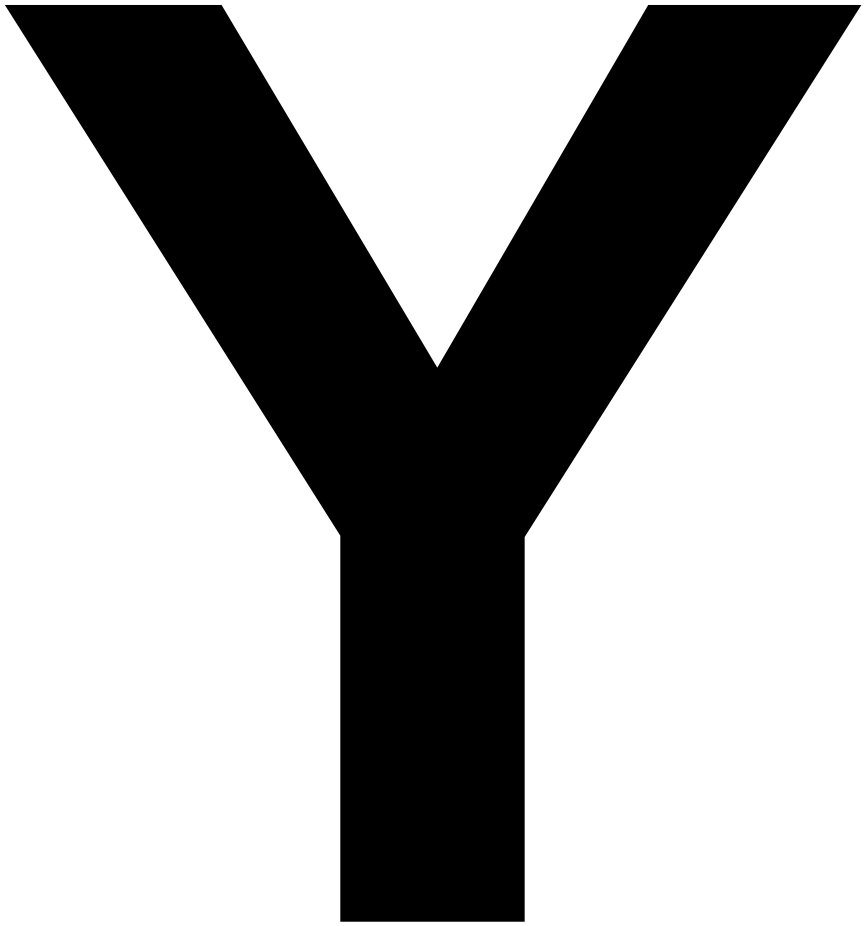
		Agree	133	44%
		Neither Agree nor disagree	65	22%
		Disagree	36	12%
		Strongly disagree	10	3%
		Don't know	17	
7	We are passionate and creative in our work (317)	Response Breakdown	No of responses	Valid %
		Strongly agree	41	14%
		Agree	90	31%
		Neither Agree nor disagree	121	41%
		Disagree	28	10%
		Strongly disagree	14	5%
		Don't know	23	
8	Below is a list of 6 attributes which we think are important to good stakeholder/partnership working. Could you rate your experience as indicated when considering these: : Providing accurate and reliable information (296)	Response Breakdown	No of responses	Valid %
		Excellent	49	17%
		Very good	89	31%
		Good	101	35%
		Poor	35	12%
		Very poor	13	5%
		Don't know	9	
9	Providing timely and appropriate responses (296)	Response Breakdown	No of responses	Valid %
		Excellent	39	14%
		Very good	74	26%
		Good	103	36%
		Poor	49	17%
		Very poor	19	7%
		Don't know	12	
10	Is open to challenge (296)	Response Breakdown	No of responses	Valid %
		Excellent	28	12%
		Very good	47	20%
		Good	92	40%
		Poor	42	18%
		Very poor	23	10%
		Don't know	64	
11	Willing to take your views on board (296)	Response Breakdown	No of responses	Valid %
		Excellent	33	13%
		Very good	61	24%
		Good	97	37%
		Poor	45	17%
		Very poor	23	9%
		Don't know	37	
12	Staff who treat you with courtesy and respect (296)	Response Breakdown	No of responses	Valid %
		Excellent	70	24%

		Very good	90	31%
		Good	94	32%
		Poor	30	10%
		Very poor	7	2%
		Don't know	5	
13	Staff that are knowledgeable about their area of work (296)	Response Breakdown	No of responses	Valid %
		Excellent	74	26%
		Very good	92	33%
		Good	87	31%
		Poor	21	8%
		Very poor	6	2%
		Don't know	16	
14	How likely are you to recommend our hospitals to friends and family if they needed care or treatment? (296)	Response Breakdown	No of responses	Valid %
		Extremely likely	97	33%
		Likely	108	37%
		Neither likely or unlikely	55	19%
		Unlikely	21	7%
		Extremely unlikely	12	4%
		Don't know	3	
15	ABOUT YOU: Are you a: (293)	Response Breakdown	No of responses	Valid %
		Member of the public	158	54%
		Trust member	82	28%
		Local government	4	1%
		NHS Trust	6	2%
		Other public sector body	5	2%
		Voluntary sector	27	9%
		Non profit charity	4	1%
		Other	7	2%
17	Thinking about your role in your own organisation.....are you a: (52)	Response Breakdown	No of responses	Valid %
		Chief Executive/Director	2	4%
		Senior manager	6	12%
		Nurse	1	2%
		Doctor	2	4%
		Officer	1	2%
		Other	21	40%
		Not applicable	19	37%
19	Below are a further four statements about the way in which Leicester's Hospitals work with stakeholders. Please indicate to what extent you agree or disagree with each: : Leicester's Hospitals are fair and equal in their treatment of stakeholders (50)	Response Breakdown	No of responses	Valid %
		Strongly agree	10	24%
		Agree	18	44%

		Neither	11	27%
		Disagree	2	5%
		Strongly disagree	0	0%
		Don't know/No opinion	9	
20	I feel involved in the development of Leicester's Hospitals policy and services (50)	Response Breakdown	No of responses	Valid %
		Strongly agree	11	23%
		Agree	16	34%
		Neither	8	17%
		Disagree	10	21%
		Strongly disagree	2	4%
		Don't know/No opinion	3	
21	I am personally motivated to work in partnership with Leicester's Hospitals to achieve their vision (50)	Response Breakdown	No of responses	Valid %
		Strongly agree	17	37%
		Agree	24	52%
		Neither	2	4%
		Disagree	2	4%
		Strongly disagree	1	2%
		Don't know/No opinion	4	
22	I feel valued for the contribution I make to the work of Leicester's Hospitals (50)	Response Breakdown	No of responses	Valid %
		Strongly agree	14	30%
		Agree	16	35%
		Neither	9	20%
		Disagree	6	13%
		Strongly disagree	1	2%
		Don't know/No opinion	4	
23	REPUTATION: As an organisation, are we easy to do business with? (48)	Response Breakdown	No of responses	Valid %
		Strongly agree	8	18%
		Agree	17	39%
		Neither	12	27%
		Disagree	5	11%
		Strongly disagree	2	5%
		Don't know/No opinion	4	
24	If you have an issue or concern, do you know who in the organisation to talk to? (48)	Response Breakdown	No of responses	Valid %
		Yes	32	73%
		No	12	27%
		No opinion	4	
25	When dealing with a member of staff have you been satisfied with their politeness and courtesy? (48)	Response Breakdown	No of responses	Valid %
		Very satisfied	13	27%
		Satisfied	29	60%
		Neither	4	8%

		Dissatisfied	1	2%
		Very dissatisfied	1	2%
		No opinion	0	
26	Which of these comes closest to describing how you would speak about Leicester's Hospitals? Would you..... (48)	Response Breakdown	No of responses	Valid %
		Speak highly of us	22	46%
		Be neutral	18	38%
		Be critical	8	17%
		Don't know	0	
27	Do you think that Leicester's Hospitals have a good reputation locally (across Leicester, Leicestershire and Rutland)? (48)	Response Breakdown	No of responses	Valid %
		Strongly agree	6	13%
		Agree	21	46%
		Neither	5	11%
		Disagree	9	20%
		Strongly disagree	5	11%
		Don't know/No opinion	2	
28	Do you think that Leicester's Hospitals have a good reputation outside of the county? (48)	Response Breakdown	No of responses	Valid %
		Strongly agree	4	14%
		Agree	12	43%
		Neither	4	14%
		Disagree	5	18%
		Strongly disagree	3	11%
		Don't know/No opinion	20	
29	COMMUNICATION: Excluding personal correspondence, do you regularly hear from Leicester's Hospitals? (48)	Response Breakdown	No of responses	Valid %
		Strongly agree	11	24%
		Agree	28	61%
		Neither	3	7%
		Disagree	4	9%
		Strongly disagree	0	0%
		Don't know/No opinion	2	
30	Would you like to hear more from Leicester's Hospitals? (48)	Response Breakdown	No of responses	Valid %
		Yes	25	63%
		No	15	38%
		No opinion	8	
31	Which form should that communication ideally take? (Please select the most important) (78)	Response Breakdown	No of responses	Valid %
		Face to face meetings	13	17%
		Letters	6	8%
		Reports/proposals/submissions	5	6%
		Emails	31	40%

		Telephone conversations	4	5%
		Conference/events	9	12%
		Leicester's Hospitals website	9	12%
		Other	0	0%
		None of these	0	0%
		Don't know	1	1%



University Hospitals of Leicester NHS
NHS Trust

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST

REPORT BY TRUST BOARD COMMITTEE TO TRUST BOARD

DATE OF TRUST BOARD MEETING: 28 NOVEMBER 2013

COMMITTEE: Audit Committee

CHAIRMAN: Ms K Jenkins, Non-Executive Director

DATE OF COMMITTEE MEETING: 12 November 2013

RECOMMENDATIONS MADE BY THE COMMITTEE FOR CONSIDERATION BY THE TRUST BOARD:

- None

OTHER KEY ISSUES IDENTIFIED BY THE COMMITTEE FOR CONSIDERATION/ RESOLUTION BY THE TRUST BOARD:

- None

DATE OF NEXT COMMITTEE MEETING: 11 February 2014

Ms K Jenkins
25 November 2013

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST
MINUTES OF A MEETING OF THE AUDIT COMMITTEE HELD ON TUESDAY 12 NOVEMBER 2013 AT 10:30AM IN THE BOARD ROOM, VICTORIA BUILDING, LEICESTER ROYAL INFIRMARY

Present:
Ms K Jenkins – Non-Executive Director (Chairman)
Mr I Sadd – Non-Executive Director

In Attendance:
Mr P Cleaver – Risk and Assurance Manager (for Minutes 71/13-72/13 inclusive)
Mrs H Majeed – Trust Administrator
Mr R Manton – Risk and Safety Manager (for Minutes 71/13-72/13 inclusive)
Mr A Seddon – Director of Finance and Business Services
Mr N Sone – Financial Controller
Mr S Ward – Director of Corporate and Legal Affairs

Ms J Clarke – Local Counter Fraud Specialist (East Midlands Internal Audit Services) (from Minute 66/13 – Minute 70/13/2 inclusive)

Mr A Bostock – KPMG (the Trust's External Auditor)
Mr D Sharif – KPMG (the Trust's External Auditor)

Ms J Watson – Senior Internal Audit Manager (the Trust's Internal Auditor)
Ms C Wood – Internal Audit Manager, PwC (the Trust's Internal Auditor)

RESOLVED ITEMS **ACTION**

66/13 PRIVATE DISCUSSIONS WITH BOTH SETS OF AUDITORS

In line with the guidance detailed within paper A, private discussions took place between the Chair and members of the Audit Committee and External and Internal Audit representatives ahead of the start of the formal meeting.

Resolved – that the position be noted.

67/13 WELCOME AND APOLOGIES

The Committee Chair welcomed Mr I Sadd, Non-Executive Director to his first meeting of the Audit Committee.

Apologies for absence were received from Ms R Overfield, Chief Nurse and Mr P Panchal, Non-Executive Director.

68/13 MINUTES

In respect of Minute 57/13 (Report on How the New Processes Outlined in the Risk Management Policy are operating 'Ward to Board'), the beginning of the third sentence to be replaced with 'the Committee Chair queried the reason for selecting an example of a Ward to Board that did not demonstrate the entire process'. **TA**

Resolved – that subject to the above amendment, the Minutes of the meeting held on 10 September 2013 (papers B and B1 refer) be confirmed as a correct record. **TA**

69/13 MATTERS ARISING FROM THE MINUTES

The Committee Chair selected the following key actions from paper C and members reported on progress:-

Minute 52/13/1 – the Director of Clinical Quality to submit a report for noting to the Audit Committee in February 2014 in respect of how patient involvement was being taken into account in clinical audits; **DCQ**

Minute 53/13/2 (ii) – the Local Counter Fraud Specialist advised that an update/clarification from NHS Protect had been requested in respect of fraud trends and an update on this matter would be provided to the Audit Committee in February 2014; **LCFS**

Minute 56/13 (i) – the following wording to be included in the 'progress update' column – the risk assessment relating to implementation of the Trust's new Clinical Divisional structure had been reviewed by the Trust Board twice; **TA**

Minute 58/13/2 – the Internal Audit Manager confirmed that the review of the Trust's 2013-14 reference costs would be factored into the Internal Audit plan for 2014-15, and

Minute 59/13/1 (ii) – an update on mitigation of risks, pending implementation of the agreed actions in Internal Audit reports be an item on the Audit Committee agenda until further notice. **IA/TA**

Resolved – that the matters arising report (paper C) and the actions above, be noted.

70/13 ITEMS FROM THE LOCAL COUNTER FRAUD SPECIALIST

70/13/1 Local Counter Fraud Specialist Progress Report

Paper D summarised the progress made towards the completion of the Trust's 2013-14 counter fraud work plan. Ms J Clarke, Local Counter Fraud Specialist confirmed that there were sufficient days left in the work plan to take forward the outstanding areas of work.

Resolved – that the contents of paper D be received and noted.

70/13/2 Report from the Local Counter Fraud Specialist Progress Report

Resolved – that this Minute be classed as confidential and taken in private accordingly.

71/13 UHL RISK REPORT INCORPORATING THE BOARD ASSURANCE FRAMEWORK (BAF) FOR THE PERIOD 1 AUGUST 2013 – 30 SEPTEMBER 2013

Paper F provided the Audit Committee with an overview of significant risks impacting upon the Trust. There were currently 24 high risks and one extreme risk open on the UHL risk register with one new high risk opened during the reporting period. In the new iteration of the BAF, lead responsibility for risks 4, 5 and 6 would be transferring to the Director of Strategy who had recently taken up her post and the risk scores would be updated further to discussion with her.

Responding to a query from Mr I Sadd, Non-Executive Director in respect of how the Trust ensured that double-counting of risks did not occur, it was noted that the risk register was discussed by the Executive Team (ET) on a monthly basis and if risks related to each other, the ET would take a decision on whether it needed to have a separate entry or whether it could be referenced as a component of another risk. The risks were linked to the Trust's strategic objectives and the risk report/BAF was reviewed prior to being presented to the Trust Board every month.

The Committee Chair queried whether there had been any interruptions to risk reporting following the restructure from Divisions to Clinical Management Groups – the Risk and Assurance Manager confirmed that currently no issues had emerged. The Corporate Risk Team would be meeting with the CMG teams to outline the expectations in relation to risk management and to discuss the levels of support available. Previously, the risk register entries were updated by the Divisional Quality and Safety Managers but this role would now be undertaken by the CMG Heads of Nursing. Responding to a query from the Committee Chair, the Risk and Assurance Manager agreed it would be useful for the Audit Committee to receive an update on suspended risks – i.e. risk entries which were not accompanied by a signed copy of the risk assessment form. **RAM**

The Committee Chair noted a potential discrepancy in the risk score of risk 6 'Failure to achieve FT status' highlighting that different risk scores for the same risk had been provided on page 14 of appendix 1 and page 19 of appendix 2 – it was noted that this might be a 'typographical' error but the Risk and Assurance Manager agreed to look into this. **RAM**

In discussion on some risks where updated information was now available but had not been available at the time of the deadline for submission of Audit Committee papers, the Committee Chair requested that an update was either circulated the day before or on the day of the meeting. **RAM**

The Director of Finance and Business Services highlighted that the issue of nurse vacancies was missing from the BAF. It was noted that nurse vacancies was scheduled to be discussed at the Executive Team meeting on the afternoon of 12 November 2013 and the BAF would be updated accordingly.

The Director of Finance and Business Services provided an example and queried whether the risks on the operational risk register actually reflected significant risks to the Trust or were, in fact, local risks that related to CMGs. In a wider discussion on this matter, it was suggested that a summary report of the operational risks with a score of 15 or above should be included within the cover report of the risk register so that readers could review and consider these. Further trend information on the movement of risk was also to be included in the new format of the BAF. **RAM** **RAM**

<u>Resolved</u> – that (A) the contents of paper F be received and noted, and

(B) the Risk and Assurance Manager be requested to implement the above actions in advance of the November 2013 Trust Board meeting. **RAM/TA**

72/13 IMPLEMENTATION OF THE UHL RISK MANAGEMENT POLICY

Paper G provided assurance that the processes described in the UHL Risk Management policy were being implemented across the Trust. The Corporate Risk Team had already met with 4 Clinical Management Groups (CMGs) and were scheduled to meet with the remaining CMGs giving their teams the opportunity to raise any points of clarification required in relation to the policy.

The Committee Chair noted that there had been no elapsed risk reviews or elapsed action dates during the reporting period and queried whether sufficiently challenging timescales for resolution of risks were being set – in response, the Risk and Assurance Manager advised that actions were set at a local level and there were areas which required further development. He agreed to discuss this with the CMGs and report to the Audit Committee if satisfactory progress was not being made. He suggested that attendance by representatives of the CMGs at the Audit Committee would also help to strengthen the process.

The Committee Chair sought views on how the processes outlined in the policy were operating 'Ward to Board' – the Director of Corporate and Legal Affairs highlighted that

progress had been good but there were still developments to be made noting that this might partly be due to the move to a new management structure.

The Committee Chair requested an update to be provided on the actions being taken to resolve the poor attendance at Risk Awareness training sessions. **RAM**

The Risk and Assurance Manager confirmed that discussions were being held with CMGs and agreed to ascertain who would be responsible/accountable for ensuring risks were reported and escalated, if required. Time-out sessions had already been arranged with some CMGs. **RAM**

Resolved – that (A) the contents of paper G be received and noted, and

(B) the Risk and Assurance Manager be requested to:- **RAM**

- **provide an update to the Audit Committee in February 2014 in respect of the actions being taken to resolve the poor attendance at Risk Awareness training sessions, and**
- **confirm who would be responsible/accountable for ensuring risks were reported and escalated, if required at CMG level.**

73/13 FINANCE – STRATEGIC AND OPERATIONAL ISSUES

73/13/1 Discretionary Procurement Actions

Paper H outlined the discretionary procurement actions for the period September-October 2013 in line with the Trust's Standing Orders. The Committee Chair queried the 'National/International Recruitment of Nurses – reference 13/A/0920' – the Director of Finance and Business Services confirmed that a list of agencies used by UHL were on a national framework and that, as this category of procurement service was in Schedule B, no OJEU type tender was required. In respect of agency rates, the Director of Finance and Business Services made members aware of discussions with neighbouring Trusts (based on established practice in the West Midlands) to seek to agree a consistent approach to agency pay rates. It would be beneficial for Trusts. It would be beneficial for Trusts in the East Midlands to have this arrangement in place but it was noted that it was not a quick process and depended on agreement from all Trusts.

Resolved – that the contents of paper H be received and noted.

73/13/2 Report from the Director of Finance and Business Services

Resolved – that this Minute be classed as confidential and taken in private accordingly.

73/13/3 Implementation of External Audit – Recommendations

The Financial Controller presented paper J, an update on progress against the recommendations raised in External Audit's 2012-13 ISA 260 report as at end of October 2013.

In respect of the recommendation relating to 'Off-Payroll Arrangements' – Members noted that the Director of Human Resources had been reporting on this matter to the Remuneration Committee and agreed that the Remuneration Committee should continue to receive regular updates. The Financial Controller agreed to include this update within his future reports. **FC**

Resolved – that (A) the contents of paper J be received and noted, and

(B) the Financial Controller be requested to update paper J with the information provided above. **FC**

73/13/4 Cash Management Actions

Paper K summarised the cash management actions being taken and also the methodology and assumptions used in the deferral of supplier payments, which was an area of concern raised by the Trust Board at its meeting on 31 October 2013. There were significant pressures on the Trust's cash balances and a full review of the capital programme for the month 7 position was being undertaken. The Committee Chair commented that the risk to achievement of the Trust's strategic objectives if the capital programme was not undertaken as forecasted should be considered and mitigated during the above review. The overriding factor that impacted on cash was the Trust's I&E position and improving this was key to securing longer term liquidity. This matter had been raised with the NHS Trust Development Authority by the Director of Finance and Business Services at their meeting on 11 November 2013.

The Financial Controller confirmed that payments to suppliers were only deferred when this was deemed to be low risk and the Trust prioritised payments to business critical suppliers.

Resolved – that the contents of paper K be received and noted.

73/13/5 2013-14 Financial Position

The Director of Finance and Business Services reported orally and expressed disappointment over the consistent adverse trend against plan highlighting that traction on recovery actions had not been demonstrated. The Committee Chair queried the reason for this issue noting that recovery plans had been in place for some time and were regularly updated. The Director of Finance and Business Services stated the absence of the strategic transitional support, shortfalls against the assumptions made regarding access to the 2% transformation funds and marginal rate deductions and readmission fines were some of the major reasons for the variance. The first round of CMG Performance Management meetings scheduled to be held in November 2013 would be chaired by the Chief Executive and would focus on the projected year-end position and CMGs would need to show the impact of recovery actions.

There had been a significant increase in bank and agency spend. Mr I Sadd, Non-Executive Director queried whether medical locum spend was being reviewed – in response, it was noted that work on 'medical productivity' had been undertaken and a review of Consultant contracts had indicated significant variability. A further review of this would be undertaken but had currently been delayed.

The revised target for CIP was £37.7m (previously £40.4m).

Resolved – that the verbal update be noted.

74/13 ITEMS FROM INTERNAL AUDIT

74/13/1 Internal Audit Progress Report

The Senior Internal Audit Manager presented paper L, a report outlining progress with the implementation of the Internal Audit plan for 2013-14.

In respect of the review of the Trust's self assessment against the Quality Governance Framework. Internal Auditors had discussed with Trust colleagues the most appropriate timing of this review and whether these audit days should instead be used to undertake a review of the Trust's mortality review processes in light of the forthcoming CQC inspection. The Senior Internal Audit Manager advised that a response was awaited noting that the review if undertaken would need to be completed before the end of December 2013.
In respect of the 'Cancer Targets' review – Internal Auditors advised that they had

been informed that there had been significant improvements in meeting the 62 day cancer target and following discussion with the Chief Executive, it was proposed that this review be replaced with a review of the Referral to Treatment target. This change would be reflected in the Internal Audit plan. **IA**

The Committee Chair queried the reason for the wording 'no progress update has been provided' to appear in a number of status update columns. The Senior Internal Audit Manager highlighted that this report had been pulled off from Internal Audit's web based system 'TrAction' and the view was that the Leads had not been using and updating the system appropriately. The Director of Corporate and Legal Affairs advised that this matter had also been discussed at previous Executive Performance Board meetings and the feedback from staff was that they were not able to access the system and that users had encountered technical difficulties. The Internal Audit Manager advised that she had discussed this matter with the Director of Corporate and Legal Affairs and it had been agreed that the Trust Administration office would now drive the process to ensure that the responses/updates were inputted on the system by the Lead Officers.

Mr I Sadd, Non-Executive Director drew members' attention to table 3 of appendix 2 – actions with revised implementation dates. He noted that the revised implementation date of 30 September 2014 for the actions agreed in respect of the 2011-12 bank and agency review and noted the need for immediate actions be put in place so that financial benefit could be obtained in the course of what remained of 2013-14. It was noted that an update on the Bank and Agency review was scheduled to be discussed during the course of the meeting (Minute 74/13/2 (c) below refers).

Resolved – that the contents of paper L, Internal Audit progress report for 2013-14 be received and noted.

74/13/2 Internal Audit Reviews

(a) Business Continuity Management Follow-up Review

Paper M detailed the 2013-14 Internal Audit review regarding business continuity and IT disaster recovery – follow-up report. The Committee Chair expressed concern at the actions still outstanding and requested that an update on this be provided to the Audit Committee in February 2014. **COO**

Resolved – that (A) the contents of paper M be received and noted, and

(B) the Chief Operating Officer be requested to attend the Audit Committee meeting in February 2014 to provide an update on the actions in place to implement the recommendations arising from Internal Audit's 'business continuity' review. **COO**

(b) Facilities Management Review

Paper N provided an update on Internal Audit's review of facilities management. Responding to a query in respect of key performance indicators (KPIs) and whether correct data was being looked at, the Internal Audit Manager advised that one of the recommendations was for UHL to agree the KPIs with NHS Horizons to monitor their performance. It was noted that the current KPIs were probably not the key areas and a review of this was needed. The expected level of validation that should be performed over the information provided by Interserve and the number of audits of performance each month should also be specified. As formal performance measures had not been in place, this recommendation had been rated 'high' risk. UHL would need to monitor whether there was sufficient and appropriate internal resource with capacity to oversee the contract delivery via NHS Horizons.

Resolved – that the contents of paper N be received and noted.

(c) Report from the Internal Audit Manager

Resolved – that this Minute be classed as confidential and taken in private accordingly.

75/13 ITEMS FROM EXTERNAL AUDIT

75/13/1 External Audit Progress Report

Paper O detailed the External Audit progress report. External Auditors advised that planning work for 2013-14 audits was underway and were meetings were being held with key officers at the Trust on a monthly basis to discuss emerging issues that would contribute to the planning approach. The draft External Audit plan 2013-14 focussed on the following areas for the financial statements audits – revenue recognition, creditors, provisions, treatment of new contract arrangements and cash management.

Mr I Sadd, Non-Executive Director noted the importance of the Trust Board's consideration of UHL as a 'going concern' and Mr A Bostock, Trust's External Auditor advised on how the External Auditors would approach its work on the 'Use of Resources' opinion.

Resolved – that the contents of paper O be received and noted.

76/13 MINUTES FOR INFORMATION AND DISCUSSION

76/13/1 Quality Assurance Committee

Resolved – that the Minutes of the Quality Assurance Committee meetings held on 28 August 2013 (paper P refers) and 25 September 2013 (paper P1 refers) be received and noted.

76/13/2 Finance and Performance Committee

Resolved – that the Minutes of the Finance and Performance Committee meetings held on 28 August 2013 (paper Q refers) and 25 September 2013 (paper Q1 refers) be received and noted.

77/13 ANY OTHER BUSINESS

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

78/13 IDENTIFICATION OF KEY ISSUES THAT THE COMMITTEE WISHES TO DRAW TO THE ATTENTION OF THE TRUST BOARD

Resolved – that the following items be brought to the attention of the Trust Board:-

- **confidential Minute 74/13/2 (c) refers – Report by the Internal Audit Manager.** **Chair**

79/13 DATE OF NEXT MEETING

Resolved – that (A) the next meeting of the Audit Committee be held on Tuesday, 11 February 2014 from 10:30am in the Board Room, Victoria Building, Leicester Royal Infirmary, and

(B) it be noted that this meeting would be preceded by a private meeting between the Audit Committee Chair and the Non-Executive Director members at 10:00am, with representatives from Internal and External Audit to attend from 10:15am in the Committee Room, Victoria Building, Leicester Royal Infirmary.

The meeting closed at 1:00pm.

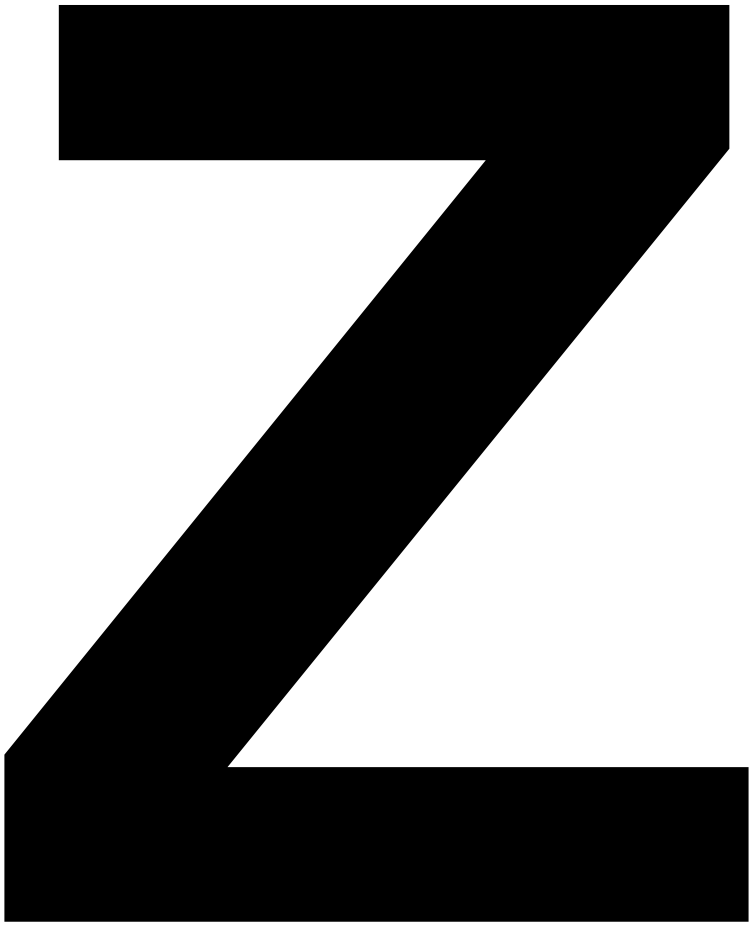
Hina Majeed, **Trust Administrator**

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

Name	Possible	Actual	% attendance
K Jenkins (Chair)	4	4	100%
R Kilner	3	2	66%
I Reid	2	2	100%
P Panchal	2	1	50%
I Sadd	1	1	100%

Attendees

Name	Possible	Actual	% attendance
S Hinchliffe	1	1	100%
A Seddon	4	4	100%
S Ward	4	4	100%
R Overfield	2	1	50%



UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST

Trust Board Bulletin – 28 November 2013

The following reports are attached to this Bulletin as items for noting, and are circulated to UHL Trust Board members and recipients of public Trust Board papers accordingly:-

- **Updated Declarations of Interest** – Lead contact point Mr S Ward, Director of Corporate and Legal Affairs (0116 258 8721) – **paper 1**.

- **Update on Sickel Cell patient experience (Minute 73/13/4 of 28 March 2013 refers)** – Lead contact point Ms R Overfield, Chief Nurse (0116 258 6111) – **paper 2.**

It is intended that these papers will not be discussed at the formal Trust Board meeting on 28 November 2013, unless members wish to raise specific points on the report.

This approach was agreed by the Trust Board on 10 June 2004 (point 7 of paper Q). Any queries should be directed to the specified lead contact point in the first instance. In the event of any further outstanding issues, these may be raised at the Trust Board meeting with the prior agreement of the Chairman.

NAME	POSITION	INTEREST(S) DECLARED
Ms Kate Shields	Director of Strategy	Nil return.

Trust Board Bulletin 28 November 2013 – Paper 2

REPORT TO: Trust Board

REPORT FROM: Liz James Matron, Kate Wilkins/Hilliary Killer Head of Nursing

SUBJECT: Patient Story Update - Improving the patient experience for children with Sickle Cell Disease

DATE: 28 November 2013

Purpose

To present the impact of the changes made to the experience of children admitted with Sickle Cell Crisis.

Background

In March 2013 the Childrens CBU nursing team presented the work being undertaken to improve the experience of children with Sickle Cell Disease, when they are admitted to hospital. This included a personal account by a young person, Sharon, who expressed her frustration that not all staff were aware of the care she needs.

Progress

Since our work began, children and their families are reporting an improvement in their experience of our service, including acute admissions. The service has been re-audited (July 2013) using NICE criteria and demonstrates some improvements. The information below describes how work is continuing to adapt our approach in order to improve the patient experience further.

Staff Training

The multi disciplinary team (MDT) on the Children's Assessment Unit (CAU) have received training through displays, guidance and face-to-face contact. The Specialist Nurse and Consultant for Haematology continue to support learning for the team on CAU.

Individualised Patient Information

- **Alert cards** for urgent treatment are in use and are very effective, some families have also reported using them when presenting at other hospitals.
- **Hand held individualised summary sheets** have been created for every patient and are ready for implementation in November 2013.
- A **service leaflet** has also been printed to provide families with information about what to expect from the team and who to contact for advice and support.

Pain Relief

Intranasal Diamorphine has been successfully introduced in CAU. Sharon (service user) has reported her experience of the service is now “gold standard”. The audit completed in July 2013 shows assessment of pain on admission is of the standard expected however timely administration of appropriate analgesia remains inconsistent. Pre-printed stickers to support prescribing Intranasal Diamorphine are now in use, the effect of which will be reviewed in the next audit (December 2013).

Team Working

The speciality MDT team working remains robust both within UHL and across the East Midlands network. All the patient information above is available on the Sickle Cell and Thalasaemia East Midlands Network website for use by other professionals across the region.

The Specialist Nurse has submitted a poster to the International Forum on Quality and Safety in Healthcare to share our work and its impact on families.

Measurements of Improvement

Monitoring the success of the changes will continue through regular audits and patient feedback. As we learn from our children and their families, we continue to adapt how we deliver care to patients who are admitted in sickle cell crisis in order to address their needs and have prompt delivery of pain control for these young patients, ensuring a consistently high level of care to our patients resulting in a better patient experience