UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST

TRUST BOARD

MEETING TO BE HELD ON THURSDAY 31 OCTOBER 2013 FROM 9.30AM IN SEMINAR ROOMS A & B, CLINICAL EDUCATION CENTRE, LEICESTER GENERAL HOSPITAL

Public meeting commences at 1pm

AGENDA

Please take papers as read

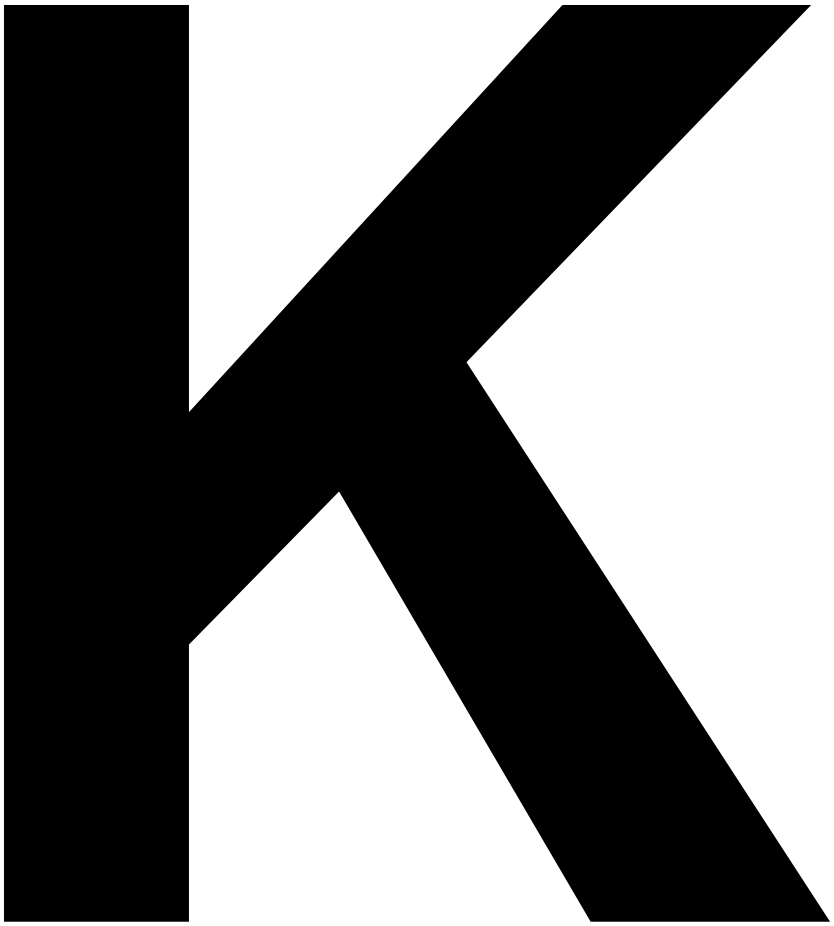
Item no.	Item	Paper ref:	Lead	Discussion time
1.	**EXCLUSION OF THE PRESS AND PUBLIC** It is recommended that, pursuant to the Public Bodies (Admission to Meetings) Act 1960, the press and members of the public be excluded from the following items of business, having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest (items 1-13.			-
2.	**APOLOGIES AND WELCOME** To note that the meeting will be chaired by Mr R Kilner in the capacity of Acting UHL Chairman. To receive apologies from Mr J Adler, Chief Executive, Colonel (Retd) I Crowe, Non-Executive Director, Ms K Jenkins, Non-Executive Director and Professor D Wynford-Thomas, Non-Executive Director. To note that Mr A Seddon, Director of Finance and Business Services will be attending in the capacity of Acting Chief Executive. To note the appointment of Mr I Sadd as UHL Non-Executive Director and to welcome him to his first Trust Board meeting.	**-**	**Acting Chairman**	9.30am – 9.35am
3.	**DECLARATIONS OF INTERESTS** Members of the Trust Board and other persons attending are asked to declare any interests they may have in the business on the agenda (Standing Order 7 refers). Unless the Trust Board agrees otherwise in the case of a non-prejudicial interest, the person concerned shall withdraw from the meeting room and play no part in the relevant discussion or decision.			-
4.	**ACTING CHAIRMAN'S AND ACTING CHIEF EXECUTIVE'S OPENING COMMENTS**	**-**	**Acting Chairman and Acting Chief Executive**	9.35am – 9.55am
5.	**CONFIDENTIAL MINUTES** Confidential Minutes of the 26 September 2013 meeting and 16 September 2013 Trust Board Development Session. *For approval*	**A & A1**	**Acting Chairman**	9.55am – 10am
6.	**MATTERS ARISING** Confidential action log from the 26 September 2013 Trust Board meeting. *For approval*	**B**	**Acting Chairman**	10am – 10.15am
7.	**REPORTS BY THE DIRECTOR OF FINANCE AND BUSINESS SERVICES** *Commercial interests*	**C – C5**	**Director of Finance and**	10.15am – 11.30am

		(C to follow)	**Business Services**	
8.	**REPORTS BY THE DIRECTOR OF HUMAN RESOURCES** *Personal information and prejudicial to the conduct of public affairs*	**D & D1**	**Director of Human Resources**	11.30am – 11.45am
9.	**REPORT BY THE MEDICAL DIRECTOR** *Personal information and prejudicial to the conduct of public affairs*	**E**	**Medical Director**	11.45am – 11.55am
10.	**REPORT BY THE DIRECTOR OF CORPORATE AND LEGAL AFFAIRS** *Personal information and prejudicial to the conduct of public affairs*	**F**	**Director of Corporate and Legal Affairs**	11.55am – 12.05pm
11.	**REPORT BY THE ACTING CHAIR/DIRECTOR OF CORPORATE AND LEGAL AFFAIRS** *Personal information and prejudicial to the conduct of public affairs*	**G**	**Acting Chairman/Director of Corporate and Legal Affairs**	12.05pm – 12.15pm
12.	**REPORTS FROM BOARD COMMITTEES**			12.15pm – 12.20pm
12.1	**FINANCE AND PERFORMANCE COMMITTEE** Confidential Minutes of the 25 September 2013 meeting for noting. *Commercial interests and prejudicial to the conduct of public affairs*	**H**	**Acting Chairman**	
12.2	**QUALITY ASSURANCE COMMITTEE** Confidential Minutes of the 25 September 2013 meeting for noting. *Prejudicial to the conduct of public affairs*	**I**	**Quality Assurance Committee Chair**	
12.3	**REMUNERATION COMMITTEE** Confidential Minutes of the 26 September 2013 meeting for noting. *Prejudicial to the conduct of public affairs*	**J**	**Acting Chairman**	
13.	**ANY OTHER BUSINESS**	**-**	**Chairman**	12.20pm – 12.30pm
Lunch break from 12.30pm to 1pm prior to commencing the public section of the meeting				
14.	**DECLARATION OF INTERESTS**	**-**	**Acting Chairman**	-
	Members of the Trust Board and other persons attending are asked to declare any interests they may have in the business on the public agenda (Standing Order 7 refers). Unless the Trust Board agrees otherwise in the case of a non-prejudicial interest, the person concerned shall withdraw from the meeting room and play no part in the relevant discussion or decision.			
15.	**PRESENTATION BY MR T SANDERS, MANAGING DIRECTOR, WEST LEICESTERSHIRE CCG** • CCG Perspective on Emergency Care and the Collaborative Hub	**verbal**	**Acting Chairman/ Acting Chief Executive**	1pm – 1.20pm
16.	**ACTING CHAIRMAN'S AND ACTING CHIEF EXECUTIVE'S OPENING COMMENTS** • Appointments to Board level Committees	**K**	**Acting Chairman/ Acting Chief Executive**	1.20pm – 1.25
17.	**MINUTES**			
	Minutes of the 26 September 2013 Trust Board meeting. *For approval*	**L**	**Acting Chairman**	1.25 – 1.30m

18.	**MATTERS ARISING**			
	Action log from the 26 September 2013 meeting. *For approval*	**M**	**Acting Chairman**	1.30m – 1.35pm
19.	**REPORTS BY THE ACTING CHIEF EXECUTIVE**			
19.1	**MONTHLY UPDATE REPORT – OCTOBER 2013** *For discussion and assurance*	**N**	**Acting Chief Executive**	1.35pm – 1.45pm
20.	**CLINICAL QUALITY AND SAFETY**			
20.1	**CONTRASTING EXPERIENCES** *For discussion and assurance*	**O** **Presentation**	**Chief Nurse**	1.45pm – 1.55pm
20.2	**CARE QUALITY COMMISSION INTELLIGENT MONITORING** *For discussion and assurance*	**P**	**Medical Director/ Chief Nurse**	1.55pm – 2.10pm
20.3	**UPDATE ON LLR RESPONSE TO FRANCIS, AND UHL RESPONSE TO KEOGH AND BERWICK REVIEWS** *For discussion and assurance*	**Q** **Withdrawn**	**Chief Nurse**	-
20.4	**UHL MORTALITY** *For discussion and assurance*	**R**	**Medical Director**	2.10pm – 2.20pm
20.5	**NURSING WORKFORCE UPDATE** *For discussion and assurance*	**S**	**Chief Nurse**	2.20pm – 2.35pm
20.6	**DEED OF GIFT DONATION FOR SCALP COOLING PACKAGE** *For approval*	**T**	**Director of Marketing and Communications**	2.35pm – 2.40pm
21.	**RISK**			
21.1	**BOARD ASSURANCE FRAMEWORK – UPDATE** *For discussion and assurance*	**U**	**Chief Nurse**	2.40pm – 2.50pm
22.	**HUMAN RESOURCES**			
22.1	**IMPLEMENTATION OF THE CLINICAL MANAGEMENT STRUCTURE** *For discussion and assurance*	**V**	**Director of Human Resources/Chief Operating Officer**	2.50pm – 3pm
23.	**RESEARCH AND DEVELOPMENT**			
23.1	**QUARTERLY UPDATE ON RESEARCH AND DEVELOPMENT** Professor N Brunskill to attend for this item *For discussion and assurance*	**W**	**Medical Director**	3pm – 3.15pm
24.	**QUALITY AND PERFORMANCE** *For assurance*			
24.1	**MONTH 6 QUALITY, PERFORMANCE AND FINANCE REPORT** *For assurance* ***Consideration of this item will be structured as follows:-*** The **Non-Executive Director Chair** of the **Quality Assurance Committee** will be invited to comment verbally on the month 6 position, as considered at the meeting held on 29 October 2013 (the Minutes of which will be presented to the 28 November 2013 Trust Board). Minutes of the 25 September 2013 **Quality Assurance Committee** meeting are also attached for noting and	**X** **X1**	 **Quality Assurance Chair**	3.15pm – 3.45pm

	endorsement of any recommendations. **Ms J Wilson, Non-Executive Director** to be invited to comment verbally on the month 6 position, as considered at the **Finance and Performance Committee** meeting held on 30 October 2013 (the Minutes of which will be presented to the 28 November 2013 Trust Board). Minutes of the 25 September 2013 **Finance and Performance Committee** meeting are also attached for noting and endorsement of any recommendations. **Lead Executive Directors** will then be invited to comment on their respective sections of the month 6 report, specifically:- (a) **Chief Nurse** – patient safety and quality, patient experience, facilities management performance, retail catering and PLACE results; (b) **Medical Director** – quality commitment and mortality rates; (c) **Chief Operating Officer** – operational performance and exception reports, (d) **Director of Human Resources** – staff appraisal, sickness absence and statutory and mandatory training compliance, and (e) **Director of Finance and Business Services** – Month 6 financial performance and 2013-14 financial half year statement.	**X2** **X3** **X4 (to follow)**	**Ms J Wilson, Non-Executive Director** **Lead Executive Directors** **Chief Nurse** **Medical Director** **Chief Operating Officer** **Director of Human Resources** **Director of Finance and Business Services**	
24.2	**EMERGENCY CARE PERFORMANCE AND RECOVERY PLAN** *For discussion and assurance*	**Y**	**Chief Operating Officer**	3.45pm – 3.55pm
24.3	**WINTER PLAN FOR 2013-14** *For discussion and assurance*	**Z**	**Chief Operating Officer**	3.55pm – 4.05pm
24.4	**NHS TRUST OVER-SIGHT SELF CERTIFICATION** *For discussion and approval*	**AA**	**Director of Corporate and Legal Affairs**	4.05pm – 4.10pm
24.5	**PROGRESS AGAINST ANNUAL PLAN PRIORITIES – QUARTER 2 2013-14** *For discussion and approval*	**BB**	**Director of Finance and Business Services**	4.10pm – 4.20pm
25.	**TRUST BOARD BULLETIN – OCTOBER 2013**	**CC**	**-**	-
26.	**QUESTIONS FROM THE PUBLIC RELATING TO BUSINESS TRANSACTED AT THIS MEETING**	**-**	**Acting Chairman**	4.20pm - 4.40pm
27.	**ANY OTHER BUSINESS**	**-**	**Acting Chairman**	4.40pm – 4.45pm
28.	**DATE OF NEXT MEETING**			
	The next Trust Board meeting will be held on **Thursday 28 November 2013** from 9.00am in the Cumulus Room, Diabetes Centre of Excellence, Leicester General Hospital – *note change of venue*. To note that the December 2013 Trust Board meeting has been rescheduled and this meeting will now be held on **Friday 20 December 2013** in Seminar Rooms 2 and 3, Clinical Education Centre, Glenfield Hospital.	**-**		

Kate Rayns, **Trust Administrator**



Trust Board Paper K

To:	**Trust Board**
From:	**ACTING CHAIR/DIRECTOR OF CORPORATE AND LEGAL AFFAIRS**
Date:	**31 October 2013**
CQC regulation:	N/A

Title:	**APPOINTMENT TO BOARD COMMITTEES, ETC**

Author/Responsible Director: Director of Corporate and Legal Affairs

Purpose of the Report: To seek the Board's approval of a number of appointments to Board Committees, etc.

The Report is provided to the Committee for:

Decision	√	Discussion	
Assurance		Endorsement	

Summary / Key Points: The report seeks the Board's approval of a number of appointments to Board Committees, etc arising from the appointment of Mr R Kilner as Acting Chair and Mr I Sadd as Non-Executive Director.

Recommendations: The recommendations are set out in paragraphs 3, 4 and 5 of the report.

Previously considered at another corporate UHL Committee? No

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

Resource Implications (e.g. Financial, HR): N/A

Assurance Implications: N/A

Patient and Public Involvement (PPI) Implications: N/A

Stakeholder Engagement Implications: N/A

Equality Impact: N/A

Information exempt from Disclosure: None

Requirement for further review? On appointment of the substantive Trust Chair.

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST

REPORT TO: **TRUST BOARD**

DATE: **31 OCTOBER 2013**

REPORT BY: **ACTING CHAIR/DIRECTOR OF CORPORATE AND LEGAL AFFAIRS**

SUBJECT: **APPOINTMENT TO BOARD COMMITTEES, ETC**

---

1. This report seeks the Board's approval of a number of appointments to Board committees, etc arising from the appointment of Mr R Kilner as Acting Chair and Mr I Sadd as Non-Executive Director.

2. The proposals set out in this paper have been the subject of discussion between the Acting Chair, Interim Vice-Chair and Senior Independent Director, Non-Executive Directors and Chief Executive.

3. It is **recommended** that:-

(a) Mr R Kilner, Acting Chair:-

- temporarily stand down from membership of the Audit Committee while Acting Chair;

- temporarily stand down from membership of the Empath Board while Acting Chair; and that the Director of Finance and Business Services be appointed temporarily as the Trust's representative on the Empath Board;

(b) Mr I Sadd, Non-Executive Director be appointed to the membership of the Audit Committee, Charitable Funds Committee and Finance and Performance Committee – succeeding Mr P Panchal, Non-Executive Director on this latter Committee;

(c) Mr P Panchal, Non-Executive Director be appointed as Chair of the Charitable Funds Committee (in variance of the existing provision of the terms of reference of that Committee which state that the Trust Chair shall be appointed Chair of the Committee); and that the terms of reference of the Committee be amended accordingly;

(d) Ms K Jenkins, Non-Executive Director be appointed to the membership of the Quality Assurance Committee;

(e) the membership of the Charitable Funds Committee be confirmed as follows:-

Voting Members

Mr P Panchal, Non-Executive Director – Chair
Ms K Jenkins – Non-Executive Director
Mr I Sadd – Non-Executive Director
Chief Nurse

Non-Voting Members

Director of Corporate and Legal Affairs
Director of Marketing and Communications
Financial Controller
Chair of the Medical Equipment Executive
Mr P Burlingham, Patient Advisor

4. For completeness, the Board is also asked to confirm the appointment of the Chief Nurse to the membership of the NHS Horizons Board succeeding the Director of Finance and Business Services.

5. The Trust Board is **recommended** to adopt the proposals set out in this report.

Richard Kilner
Acting Chair

Stephen Ward
Director of Corporate and Legal Affairs

18th October 2013

Paper L

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST

MINUTES OF A MEETING OF THE TRUST BOARD, HELD ON THURSDAY 26 SEPTEMBER 2013 AT 10.15AM IN THE C J BOND ROOM, CLINICAL EDUCATION CENTRE, LEICESTER ROYAL INFIRMARY

Present:
Mr M Hindle – Trust Chairman
Mr J Adler – Chief Executive
Col (Retd) I Crowe – Non-Executive Director
Dr K Harris – Medical Director
Ms K Jenkins – Non-Executive Director
Mr R Kilner – Non-Executive Director (up to and including Minute 251/13/1)
Mr R Mitchell – Chief Operating Officer
Ms R Overfield – Chief Nurse
Mr P Panchal – Non-Executive Director
Mr A Seddon – Director of Finance and Business Services
Ms J Wilson – Non-Executive Director
Professor D Wynford-Thomas, Non-Executive Director

In attendance:
Dr T Bentley – Leicester City CCG Representative (from Minute 242/13)
Ms E Broughton – Acting Head of Midwifery/Lead Nurse, Women's and Children's Division (for Minute 247/13/1)
Professor S Carr – Associate Medical Director, Clinical Education (for Minute 249/13/1)
Mr R Manton – Risk and Safety Manager (for Minute 252/13/1)
Mrs K Rayns – Trust Administrator
Ms E Stevens – Deputy Director of Human Resources (representing the Director of Human Resources)
Mr S Ward – Director of Corporate and Legal Affairs
Mr M Wightman – Director of Marketing and Communications
Ms K Wilkins – Divisional Head of Nursing, Women's and Children's Division (for Minute 247/13/1)

ACTION

230/13 EXCLUSION OF THE PRESS AND PUBLIC

Resolved – that, pursuant to the Public Bodies (Admission to Meetings) Act 1960, the press and members of the public be excluded during consideration of the following items of business (Minutes 230/13 – 241/13), having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest.

231/13 APOLOGIES AND WELCOME

Apologies for absence were received from Ms K Bradley, Director of Human Resources. The Chairman welcomed Ms R Overfield, Chief Nurse to her first meeting of the UHL Trust Board.

232/13 DECLARATIONS OF INTERESTS IN THE CONFIDENTIAL BUSINESS

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

233/13 CHAIRMAN'S AND CHIEF EXECUTIVE'S OPENING COMMENTS

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

234/13 CONFIDENTIAL MINUTES

Resolved – that the confidential Minutes of the Trust Board meeting held on 28 August 2013 be confirmed as a correct record.

235/13 CONFIDENTIAL MATTERS ARISING REPORT

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

236/13 REPORTS BY THE CHAIRMAN AND THE DIRECTOR OF CORPORATE AND LEGAL AFFAIRS

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

237/13 REPORTS BY THE DIRECTOR OF FINANCE AND BUSINESS SERVICES

Resolved – 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.

238/13 REPORTS BY THE DIRECTOR OF HUMAN RESOURCES

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

239/13 REPORT BY THE DIRECTOR OF MARKETING AND COMMUNICATIONS

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

240/13 REPORTS FROM BOARD COMMITTEES

240/13/1 Empath Programme Board

Resolved – 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.

240/13/2 Audit Committee

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

240/13/3 Finance and Performance Committee

Resolved – that the confidential Minutes of the Finance and Performance Committee meeting held on 28 August 2013 be received and noted

240/13/4 Quality Assurance Committee

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

240/13/5 Trust Board Development Session

Resolved – that the confidential Minutes of the Trust Board Development Session held on 15 August 2013 be received and noted.

241/13 CORPORATE TRUSTEE BUSINESS

241/13/1 Charitable Funds Committee

Resolved – 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.

242/13 DECLARATIONS OF INTERESTS IN THE PUBLIC BUSINESS

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

243/13 CHAIRMAN'S AND CHIEF EXECUTIVE'S OPENING COMMENTS

The Chairman welcomed Dr T Bentley, GP and Leicester City CCG Board member to the meeting, advising that Dr Bentley attended UHL Trust Board meetings as a co-opted non-voting representative on behalf of the Leicester City Clinical Commissioning Group (CCG) as UHL's lead Commissioner and that reciprocal arrangements were in place for a UHL clinician to attend the Leicester City CCG Board meetings. He also welcomed Ms R Overfield, Chief Nurse to her first UHL Trust Board meeting and invited Ms Overfield to introduce herself to Board members.

Noting that this would be his last meeting as UHL Chairman, as he was leaving to take up the role of Chairman for the East Midlands Academic Health Science Network (EMAHSN), the Chairman briefed Board members on the arrangements for appointing an Acting Chair and the process for recruiting a substantive Chair.

Members noted that the role of Acting Chair would usually be offered to the Trust's Vice-Chair, but in this instance Ms J Wilson, Non-Executive Director had declined the role in light of her existing commitments as Chair of the Leicestershire and Rutland Probation Trust. Following interviews by a panel consisting of the Chair, Vice-Chair and an independent assessor, the Trust Board had supported the recommendation to appoint Mr R Kilner as Acting Chair with immediate effect. However, due to Mr Kilner's annual leave commitments, Ms Wilson would be assuming the role of Acting Chair from 26 September 2013 for a period of 10 days.

Resolved – that the verbal information provided by the Chairman be received and noted.

244/13 MINUTES

Resolved – that, subject to the addition of the word "femur" in resolution (C) of Minute 223/13/1, the Minutes of the Trust Board meeting held on 29 August 2013 (paper M) be confirmed as a correct record.

245/13 MATTERS ARISING FROM THE MINUTES

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

specific timescale for resolution. In discussion on the matters arising report, the Board noted that none of the items were RAG rated as red and received updated information in respect of the following items:-

(a) item 12 – Minute 227/13(1) – the Director of Marketing and Communications noted that a report on the implementation of the new Clinical Management Group (CMG) structure featured later on the agenda as paper S (Minute 248/13/1 below refers). He briefed the Board on proposals to canvass views from the emerging CMG leadership teams regarding the optimum arrangements for embedding the leadership of patient and public involvement within the CMGs. It was agreed that the outputs from this work would be captured in the next update report on the Trust's clinical management structure, and **DMC**

(b) item 13 – Minute 227/13(2) – the Chairman had considered the question posed at the August 2013 Board meeting regarding the possibility of stakeholders and members of the public contributing to discussions during the course of the meeting, instead of raising their queries at the end of the meeting. He recognised the commitment demonstrated by attendees at UHL's Board meetings but he drew a distinction between a meeting which was "held in public" and a "public meeting". He had also considered the possibility of questions being raised at the start of the meeting, but had determined that this would not be feasible as the Board would not yet have reached a view on the matters in question. He had concluded that this should be a matter for future consideration by the Acting Chair. However, as an exception to the usual process, he suggested that in view of the public interest relating to facilities management issues (as demonstrated at the 19 September 2013 Annual Public Meeting), questions from stakeholders and members of the public would be taken at the end of that agenda item (Minute 251/13/1 below refers). **Acting Chair**

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

246/13 REPORTS BY THE CHIEF EXECUTIVE

246/13/1 Monthly Update Report – September 2013

The Chief Executive introduced paper O, his monthly summary of key issues Noting that separate reports featured elsewhere on the Trust Board agenda in respect of emergency care, financial performance and facilities management service provision, he reported orally on the following issues:-

(i) UHL's designation as host of the East Midlands National Institute for Health Research Clinical Research Network and the process underway to appoint a Clinical Director by the end of December 2013. The Chairman particularly noted the contributions of Professor D Rowbotham, UHL's previous Director of Research and Development in this respect;
(ii) the Caring at its Best annual awards ceremony held on 12 September 2013 which had demonstrated strong links with the Trust's values. He thanked the organisers of this event and the judges for their contributions;
(iii) good attendance at the Annual Public Meeting held on 19 September 2013 – the health fair displays had been well-liked and a wide range of questions had been raised at the end of the meeting;
(iv) publication of Monitor's new Risk Assessment Framework;
(v) the process for recruiting a substantive UHL Chair, confirming that the closing date for applications would be 10 October 2013 and that stakeholder engagement was included within the recruitment process, and
(vi) improved traction noted in respect of the LLR Better Care Together Programme following a Programme Board meeting held on 19 September 2013.

Resolved – that the Chief Executive's monthly update report for September 2013 be

received and noted.

246/13/2 Emergency Floor – Strategic Outline Case (SOC)

Paper P provided an update on the Emergency Floor development at the Leicester Royal Infirmary and the additional requirement to produce an Outline Business Case (OBC) to include all enabling work prior to progressing to the Full Business Case (FBC). Previously, agreement had been reached that the scheme would progress directly from SOC stage to the FBC. In discussion on this report, the Board:-

(a) commended progress with the draft schedule of accommodation and noted opportunities provided by the extended timescale to refine the clinical space requirements;
(b) noted the supportive discussions held with the City and County Overview and Scrutiny bodies and the concerns raised about the practicalities of relocating outpatient activity and providing adequate public transport, site access and car parking facilities at the proposed alternative locations;
(c) queried the impact of the additional project activities on the overall scheme timeline and noted that the FBC would be scheduled for Trust Board approval in June 2014, effectively meaning that the Trust would have to manage with the existing emergency floor accommodation for a further 2 winter seasons;
(d) challenged the alignment with additional bed capacity plans, 5 year bed capacity modelling, length of stay, activity, occupancy and the impact of the predicted left shift in patient activity;
(e) requested a comparison analysis of the existing floor plan and the proposed area, noting that the proposal to provide 8,000m^2 as originally specified in the brief might not be affordable, and
(f) noted the contextual information provided by the Medical Director advising that the total area of the existing accommodation (ED and OPD) on level 1 of the Balmoral building came to 6,200m^2.

Resolved – that the update on the Emergency Floor development (paper O) be received and noted.

247/13 CLINICAL QUALITY AND SAFETY

247/13/1 Patient Story – Women's and Children's Division

The Chief Nurse introduced a 10 minute DVD featuring a patient story from the Neonatal Unit at Leicester Royal Infirmary. Ms E Broughton, Acting Head of Midwifery and Ms K Wilkins, Divisional Head of Nursing attended the meeting for this item. The DVD highlighted the quality of the clinical care provided by the maternity unit and the neonatal unit and the care, compassion and professionalism that this family had been shown throughout their stay at UHL as they came to terms with their baby's condition. In discussion following the DVD, the Board:-

(i) noted the additional learning point for the maternity department to ensure that all parents were routinely offered a follow-up appointment in the event of a traumatic birth experience;
(ii) considered the impact of the new Neonatal facilities in terms of reducing the number of staff vacancies and how this learning might be transferred to other areas;
(iii) reinforced the importance of reviewing both good and bad patient stories at Board level, and
(iv) recognised that this example of patient experience at UHL exemplified the Trust's values and whole team approach, whilst highlighting references to areas such as administrative processes and patient catering which required further improvement.

Resolved – that (A) the patient story from the Women's and Children's Division be received and noted, and

(B) further patient stories be presented to the Trust Board on a quarterly basis to include both positive and negative patient experiences. **CN**

247/13/2 Update on Patient Adviser Recruitment

The Director of Marketing and Communications presented paper R, providing an update on the recent recruitment of 6 additional Patient Advisers, subject to satisfactory Disclosure and Barring checks being completed. Members particularly noted the table provided in figure 1 which detailed the composition of the new Patient Adviser group in terms of their gender, ethnic background, disability, carer status and age. During the discussion on this item, members sought and received assurance that:-

(1) clearly established induction processes and "buddying" arrangements were in place;
(2) efforts would be made to strengthen representation amongst the younger age groups in future, and
(3) further analysis would be undertaken in terms of the geographical spread of where the Patient Advisers lived.

Resolved – that the update on Patient Adviser recruitment be received and noted.

248/13 HUMAN RESOURCES

248/13/1 Implementation of the Clinical Management Structure

Further to Minute 221/13/2 of 28 August 2013, paper S provided a briefing on the introduction and implementation of the new Clinical Management Group (CMG) structure at UHL in shadow form with effect from the beginning of October 2013 and the project management arrangements in place to complete the aligned workstreams over the next 6 weeks. Copies of the project plan, weekly workstream highlight report template, risk assessment and due regard assessment were appended to the report.

The Deputy Director of Human Resources advised that 5 of the 7 CMG Directors had now been appointed and that a Listening into Action event was planned to be held on 30 September 2013 to discuss the changing structures and to ensure that appropriate learning was captured from the existing structure with a particular focus on what had worked well. In discussion on paper S:-

a) Mr R Kilner, Non-Executive Director sought and received assurance that the risk assessment would be updated to include any risks surrounding a loss of focus on CIP delivery plans, although it was noted that appropriate mitigation plans were in place to transfer CIP schemes across from the CBUs into the new CMG structure;
b) Dr T Bentley, CCG representative stressed the importance of effective clinical engagement and noted the assurance provided by the Medical Director that development programmes would be put in place to support the new CMG management teams in their roles;
c) Colonel (Retired) I Crowe, Non-Executive Director queried the scope to establish a "live" populated organisational chart to provide an up-to-date summary of appointments to key positions and their respective start dates. The Board welcomed this suggestion, noting that weekly updates would be helpful;
d) the Chief Executive summarised the arrangements for preserving continuity, transparent hand-off processes for CIP and Divisional financial recovery plans which would now be disaggregated from the Divisions into the CMGs;
e) Professor D Wynford-Thomas, Non-Executive Director sought and received additional information regarding the number of sessions to be allocated to clinical leaders within

their job plans for management duties and the support being made available to them, and

f) Ms K Jenkins, Non-Executive Director requested additional assurance in respect of the timetable for delivery of Annual Operational Plan (AOP) objectives for 2013-14 and whether there were any risks relating to delays in the critical milestones as a result of changes in accountability. In response, the Chief Operating Officer summarised progress with the CMG implementation project plan to date and the governance, reporting and monitoring arrangements in place to ensure that key performance metrics continued to be addressed. In addition, the Medical Director noted the work of cross-cutting Boards, such as the Cancer Board and the Children's Board. which would continue to monitor progress and seek to address any areas of concern.

Resolved – that (A) the update on implementation of UHL's Clinical Management Group structure be received and noted;

(B) a populated organisational structure be published on the Trust's intranet with weekly updates being provided on appointments to key positions, and **DHR**

(C) a further update on progress be provided to the 31 October 2013 Trust Board meeting. **DHR**

248/13/2 Quarterly Update on Workforce and Organisational Development

Further to Minute 170/13/1 of 27 June 2013, the Deputy Director of Human Resources introduced paper T which provided the second quarterly update to the Trust Board in respect of Workforce and Organisational Development issues for the period July to September 2013.

Section 1 of paper T detailed progress against each of the 6 workstreams to support the Trust's Organisational Development priorities. The Board particularly noted the work underway to adopt the national "putting people first" approach to providing safe high-quality patient-centred care and the launch of the Leadership Qualities and Behaviours. The annual Caring at its Best awards evening had been attended by over 450 members of staff and the Listening into Action framework continued to be embedded into the organisation. Appendix 4 identified the development priorities and the key action areas for developing UHL's Leadership into Action Strategy.

Section 2 of the report summarised the Trust's HR operational performance for quarter 2, including staff turnover, sickness, appraisal, corporate induction attendance, workforce profile and pay expenditure. Transformation of HR services and development of the HR service model were outlined within section 3, comprising of workstreams relating to the telephone advice line, dedicated email, preparations for a dedicated HR IT portal and review of HR policies and procedures.

In discussion on paper T, the following comments and queries were raised:-

(a) Dr T Bentley, CCG Representative welcomed the Consultant/General Practitioner Conference Event planned for 5 December 2013 and suggested that this information be cascaded to GPs as early as possible to ensure their availability. The Deputy Director of Human Resources confirmed that a "save the date" email was due to be circulated imminently; **DDHR**

(b) Mr R Kilner, Non-Executive Director challenged whether the number of Facilities staff transferring to Interserve had been stripped out of the Trust's turnover rate and whether the Trust was comfortable with this level of turnover. In response, the Deputy Director of Human Resources confirmed that the Facilities staff had been excluded from this data, but the IM&T staff that had transferred to IBM were still included. She provided assurance that each CBU had complete scrutiny of the turnover rates for their own area

and there were no particular areas causing concern, and

(c) Ms J Wilson, Non-Executive Director commended the report noting that it provided a helpful overall summary of the issues affected UHL's workforce. She sought a view from the Deputy Director of Human Resources on which aspects of the report were considered the most urgent. In response, it was noted that the issues highlighted in section 5.4 of paper T surrounding the recruitment and retention of clinical and nursing staff were most pressing. The Chief Nurse advised that a report on the nursing workforce had been requested by a number of Committees and this was scheduled to be presented to the 31 October 2013 Trust Board meeting. **CN**

Resolved – that (A) the quarterly update on Workforce and Organisational Development (paper T) be received and noted, and

(B) a report on the recruitment and retention of UHL's nursing workforce be presented to the 31 October 2013 Trust Board meeting. **CN**

249/13 MEDICAL EDUCATION

249/13/1 Quarterly Update on Medical Education

Further to Minute 171/13/1 of 27 June 2013, Professor S Carr, Associate Medical Director (Clinical Education) attended the meeting to introduce paper U, the quarterly update on educational issues relating to the Trust and provide some presentation slides detailing progress against the Medical Education Strategy, and providing a focus on current issues and challenges. Copies of the presentation slides were circulated to Board members by email following the meeting.

The Board particularly noted the implications of changes to SIFT and MADEL funding arrangements and that no responses had yet been received in response to the letters circulated in July 2013 to all CBU education leads seeking submission of expenditure reports for SIFT funding resources. It was agreed that these letters would be re-issued to the new CMG medical leads to expedite this matter. In respect of the scorecard, it was suggested that 5 key indicators be selected for future scrutiny by the Board. Plans for improving the education and training facilities were being developed and the accommodation to house the new library/learning centre at the LRI (Odames ward) was expected to become available in February 2014. **AMD, CE**

Resolved – that (A) the quarterly update on Medical Education issues be received and noted (paper U refers);

(B) the Associate Medical Director (Clinical Education) be requested to re-issue the requests for expenditure reports for SIFT resources to the new CMG education leads. **AMD, CE**

250/13 STRATEGY AND FORWARD PLANNING

250/13/1 The NHS Belongs to the People – A Call to Action

The Director of Marketing and Communications introduced paper V, providing a briefing on the above NHS England initiative, noting that many of the pressures highlighted in the report had been known about for the last 3 or 4 years, eg the aging population, the increasing number of people suffering with long-term conditions and the funding gap. He drew members' attention to the information contained on page 23 of the report which highlighted the various ways in which the CCGs would be inviting people to engage with the development of a renewed vision for the health service, through the Better Care Together Programme.

Mr P Panchal, Non-Executive Director voiced his support of the initiative but challenged how

it would be intended to cover the hardest to reach areas of the community in terms of ethnic origin and age groups. The Director of Marketing and Communications provided assurance that the NHS would be able to access all areas of the population through a range of local partners, charities and patient groups.

Resolved – that the briefing note on "The NHS Belongs to the People – A Call to Action" be received and noted (paper V refers).

250/13/2 Update on UHL's Foundation Trust Application

The Chief Executive introduced paper W which updated the Trust Board in respect of UHL's application process for Foundation Trust status. Members particularly noted the information relating to the future of the FT pipeline provided in a recent publication of the Foundation Trust Network. The FT Programme Board had considered this information and agreed that it would be appropriate to continue with all elements of the FT application process as the outputs required were considered to be things which the Trust should be striving towards irrespective of the FT application process.

The Chief Executive voiced his concern that the outputs from the Better Care Together Programme might not align with the current FT timetable (eg the capacity modelling workstream). Ms K Jenkins, Non-Executive Director sought additional information regarding delays with reconfiguration workstreams and whether it would be appropriate to re-align UHL's timetable for submission. In response, the Chief Executive confirmed that there was considered to be sufficient room for manoeuvre within the existing timetable.

Resolved – that the update on progress with UHL's FT application (paper W) be received and noted.

251/13 QUALITY AND PERFORMANCE

251/13/1 Month 5 Quality, Performance and Finance Report

Paper X, the quality, performance and finance report for month 5 (month ending 31 August 2013) advised of red/amber/green (RAG) performance ratings for the Trust, and set out performance exception reports in the accompanying appendices.

Ms J Wilson, Non-Executive Director and Quality Assurance Committee (QAC) Chair briefed Trust Board members on the following items which were considered at the 25 September 2013 QAC meeting:-

- the incidence of pressure ulcers which was behind the trajectory for improvement and the Committee had reviewed a comprehensive action plan for improving compliance;
- fractured neck of femur performance as detailed in the operational performance exception report (appendix 1 to paper X);
- infection prevention issues, including the challenging target for Clostridium Difficile and a confirmed MRSA bacteraemia in September 2013;
- concerns raised regarding the level of nursing vacancies since the Trust's funded establishment had been increased, and
- a review undertaken in respect of the UHL's Patient Led Assessments of the Care Environment (PLACE) results.

The Chief Nurse highlighted key elements from the patient safety, quality and experience and facilities management performance section, particularly noting that:-

a) a zero tolerance approach to pressure ulcers had been agreed as an ambition for the Trust, but she knew of no other Trusts which were meeting this target. In order to improve performance, a review of agency staff usage and documentation audits were

being undertaken. Appropriate documentation of incidents was crucial to ensure that any unavoidable pressure ulcers were appropriately classified as such. She provided her assurance that the action plan already developed appeared to be robust although she intended to include an additional accountability meeting within the investigation process;

b) Clostridium Difficile infection rates had been disappointing for September 2013, although they were within the trajectory and performance was RAG rated as green. She provided assurance that this trend was being scrutinised against the cleaning performance data to see if the 2 issues might be linked;
c) a table-top root cause analysis review had been completed in respect of the MRSA bacteraemia and details of this incident would be made available to Board members upon request;
d) some of the ways in which the Trust could be more creative to support its nurse recruitment programme, including an overseas recruitment programme, an increase in the number of apprentice opportunities for Health Care Assistants and the development of a marketing strategy to attract additional recruits;
e) key differences between the PLACE assessments undertaken and the previous PEAT audit programme;
f) a review of the facilities management key performance indicators currently included in the quality and performance report, noting that these had been selected from an available range of 83 indicators used to monitor all aspects of the service provision. A meeting with NHS Horizons and Interserve had been arranged on 30 September 2013 at which the Chief Nurse would be seeking firm milestones for measured improvements in respect of the KPIs surrounding cleanliness, patient catering and seeking to address concerns around the retail catering pricing structures. **CN**

In discussion on the patient safety, quality, patient experience and facilities management aspect of paper X, the Board:-

1) sought and received additional information surrounding competency standards for agency staff to complete appropriate documentation for incidences of pressure ulcers and the impact of the decision to remove the enhanced payments for nursing staff working in key areas;
2) received confirmation that the Trust would continue to strive towards the zero pressure ulcer ambition;
3) noted the comments raised on a recent CCG-led inspection surrounding delays in obtaining pressure relieving mattresses for patients assessed as requiring such equipment;
4) noted that June 2013 facilities management performance data was being presented to the September 2013 Board meeting and requested that more up-to-date information be provided to future meetings, and **CN**
5) queried whether patient safety had been compromised by the low percentage (37%) of urgent estates requests being responded to within the given timeframe. The Chief Nurse undertook to investigate this and provide feedback outside the meeting. **CN**

Paper X1 provided the Minutes of the QAC meeting held on 28 August 2013 for noting.

The Medical Director reported on 1 prevented “Never Event” in August 2013 and a further potential “Never Event” being investigated for September 2013. Subject to the outcome of the Serious Untoward Incident investigation, a report on the September incident would be presented to the October 2013 QAC and Trust Board meetings. VTE performance had been achieved for the second consecutive month. In respect of fractured neck of femur performance (as detailed in the performance exception report), there were challenges surrounding patients’ fitness for surgery, theatre scheduling capacity, and an increase in the number of cases needing hip replacement surgery as opposed to a pinning procedure – the former requiring laminar flow theatres which were only available on the LGH site.

The Chief Operating Officer briefed the Trust Board on UHL's month 5 operational performance particularly highlighting the following issues by exception:-

(a) Emergency Department performance;
(b) RTT admitted performance – a contract query had been raised by Commissioners and this was still in the process of being resolved. Progress was being made in Orthopaedic and General Surgery, but Ophthalmology performance continued to cause concern. Operational management arrangements were under review and Intensive Support Team intervention was also being progressed;
(c) cancelled operations;
(d) choose and book slot unavailability;
(e) cancer targets had been delivered in July and August and the September performance had been met to date;
(f) delayed transfers of care which would be discussed further under the Emergency Care report (Minute 251/13/2 below refers);

The Deputy Director of Human Resources reported on the Trust's improved appraisal rate which stood at 92.7% against the target of 95%. In respect of staff sickness, the reported July 2013 position had reduced to 3.3% as periods of absence were closed down. The sickness rate for August 2013 stood at 3.5%. The Trust's Health and Wellbeing Board led by Ms N Junkin, HR Business Partner had recently qualified for a DoH award for provision of physical activities programmes for staff and this was due to be celebrated in November 2013. In respect of Statutory and Mandatory Training, the Board noted that current compliance stood at 49% and whilst a detailed trajectory had not been set, it was hoped that 75% compliance would be achieved by the end of March 2014. The Chief Executive commented that the pace of change had improved since the Executive Team had reviewed this compliance issue in some detail.

Mr R Kilner, Non-Executive Director and Chairman of the Finance and Performance Committee reported verbally on that Committee's consideration of the Trust's month 5 financial position at the meeting held on 25 September 2013. Noting that the detailed financial summary was provided within paper X, he drew the Board's attention to the following key issues:-

- financial performance had continued to deteriorate with income below plan and both pay and non-pay above plan. However, a slight improvement in the pay run-rate had been noted against the year to date monthly average;
- positive progress noted with the Outpatients Innovation and Improvement Project and the scope for some additional resources to deliver further benefits;
- the review of UHL's bed base and the identified requirements for 100 additional beds to manage winter pressures for 2013-14;
- a review of UHL's workforce plan and the significant vacancies in terms of the nursing workforce, and
- RTT performance and the lack of an agreed recovery plan with Commissioners.

The Director of Finance and Business Services advised the Board that August was traditionally a non-standard month for financial performance. As expected, income had reduced and the run-rate for pay expenditure had improved as a result of work to improve the balance between bank and agency nursing costs. Some double-running costs had been incurred as a result of the junior doctors' changeover. Key areas of non-pay expenditure were being subjected to additional scrutiny (including theatre consumables, imaging costs, temporary capacity, mobile scanners, security provision in ED, satellite renal services, pathology, high cost therapies and medical devices).

The Divisional recovery plans produced by Planned and Acute Care had been refreshed and these plans would now be migrated into the new CMG structure. Enhanced expenditure controls had been implemented to reduce discretionary spending and improve

procurement catalogue compliance. He commended the Women's and Children's Division for delivering a balanced position, despite a reported £0.6m underperformance on births income against plan. CIP schemes relating to bed reductions had been deemed as inappropriate and approximately £2m of forecast CIP savings had been removed from the plan. The forecast CIP delivery total stood at £37.7m and there was confidence that the £1.5m shortfall would be met with other schemes currently being developed.

The Director of Finance and Business Services introduced a discussion on the facilities management provision reminding members that the Chief Nurse had recently assumed Executive Director accountability for the Lot 1 services and that he would be retaining accountability for the Lot 2 developmental work until the Ms K Shields (previously Caston) took up her post as Director of Strategy on 4 November 2013.

The NHS Horizons Board had considered the August 2013 performance data at its meeting on 25 September 2013 and discussion took place regarding the enactment of financial penalties from the contractual payment schedule for those elements of the contract where performance had been non-compliant. Assurance was provided that appropriate discussions were being held with NHS Horizons and Interserve and that remedial plans were in place to address the underlying service issues.

Mr R Kilner, Non-Executive Director reiterated the significant achievement undertaken on 1 March 2013 to transfer approximately 2,000 members of staff across and that business as usual had been maintained prior to the transformation work commencing. With the implementation of the Steamplicity patient meals system, some issues had arisen regarding the timing of patient meals and the arrangements for delivering meals to the patient bedside. Micro-fibre cleaning systems had been rolled out, coupled with changes to the daily ward cleaning patterns and the associated management of change programme had affected approximately 600 members of staff. A new profile of daily ward cleaning was being trialled on 3 UHL wards currently. Additional Interserve senior management resources were being applied to the contract and further work was underway to assess the assurance provided by Interserve in respect of the deliverability of their recovery plans.

At this point in the meeting, the Chairman invited questions from the public on this important issue as Mr R Kilner, Non-Executive Director would be leaving the meeting before the public questions were taken at the end of the meeting. The following questions and comments were raised:-

(i) a comment on the approach provided by Interserve in response to the media enquiry on the retail catering pricing structure. Mr R Kilner, Non-Executive Director responded by recognising the reputational damage that this had caused and confirming that a more joined-up approach would be embedded now that the Interserve communications officer was being co-located with UHL's communications team;

(ii) comments on the PLACE assessment process which had taken place at a time when staff morale was low during their management of change process. It was noted that during the assessments, some staff had expressed their concerns regarding the management of the contract and had not expected the contract to last for more than 12 months;

(iii) concerns raised that the standard of cleaning in outpatients and some wards had deteriorated further since the PLACE assessments had been carried out. Mr M Woods was requested to provide details of these areas to the Chief Nurse outside the meeting; **Mr M Woods**

(iv) a query raised on the prices of the retail catering and the apparent lack of a scrutiny mechanism to ensure that meals were affordable. Mr R Kilner, Non-Executive Director responded by confirming the contractual arrangements for retail catering and highlighting the level of investment already undertaken in refurbishment of the restaurant areas. A range of meal deals and special offers were being developed to respond to the concerns raised;

(v) a further comment raised regarding the improved quality of the retail catering provision and an expectation that market forces would address the issue of prices (if allowed to do so), and

(vi) a concern raised that the risk of ward contamination might increase if any cleaning duties were to be cut short as a result of the new cleaning schedules. It was agreed that the Chief Nurse would follow up this concern with Mr D Gorrod outside the meeting. **CN**

Resolved – that (A) the quality, performance and finance report for month 5 (month ending 31 August 2013) be noted;

(B) the Chief Nurse be requested to ensure that more timely FM performance data be included in future iterations of the quality and performance reports; **CN**

(C) the Chief Nurse be requested to explore whether any of the delays in processing urgent Estates requests had resulted in any patient quality or safety issues; **CN**

(D) the public comments and any associated actions be noted;

(E) the Minutes of the 28 August 2013 Quality Assurance Committee meeting (paper X1) be received and noted, and

(F) the Minutes of the 28 August 2013 Finance and Performance Committee meeting (paper X2) be received and noted.

251/13/2 Emergency Care Performance and Recovery Plan

Paper Y provided an overview of emergency care performance during August 2013. The Chief Operating Officer apologised for the late circulation of this report and particularly highlighted the graphs on pages 1 and 2 of the report showing performance against the trajectory for compliance with the 4 hour Emergency Department (ED) target and levels of emergency activity. He reported on the implementation of the command and control hub which was co-located next to the ED and recent improvements made in decision making processes, bed management systems, on-call rota and winter planning arrangements.

An unannounced CCG quality, safety and patient experience visit to the ED had taken place on 19 September 2013 and assurance had been provided that staff were working under satisfactory oversight of patient quality and safety standards. On the same date, the Urgent Care Board had supported an accelerated focus on acute medical bed capacity, discharge processes, reducing gaps in ED medical staff rotas and maximising use of community hospital beds and the independent sector.

The Chief Executive commended the fresh approach to improving emergency care performance and he tabled a copy of the draft LLR emergency care priority actions (dated 25 September 2913). Ms J Wilson Non-Executive Director, highlighted action 16 in the tabled paper – to review the internal discharge process to enable discharge earlier in the day – and queried what would be done differently to address this, given that this workstream had been in place now for approximately 2 years and little improvement had been demonstrated to date. In response, the Chief Operating Officer confirmed that managing discharge arrangements across approximately 60 ward areas was challenging, but a targeted approach had been developed to managing the position in 4 or 5 key areas. These ward positions were reported at the site meetings (held 4 times per day from 8.30am) and discharges were progressed in 4 hour blocks throughout the day.

Dr T Bentley, CCG representative confirmed his view that appropriate discharges were in the best interests of the patient and he offered any support that the CCGs could provide in this respect. Ms K Jenkins, Non-Executive Director queried what assurance could be

provided in relation to the tabled paper which did not contain any completion dates or metrics for measuring success. In response, the Chief Operating Officer advised that these actions would be incorporated into the Emergency Care Action Team (ECAT) action plan (appended to paper Y) and monitored accordingly.

Mr P Panchal, Non-Executive Director queried whether clinical engagement had been embedded into the new emergency care arrangements and the Medical Director confirmed that following the initial diagnosis, the Trust had listened to clinicians' views and adapted the recovery plans accordingly. The Chief Operating Officer confirmed that he had not encountered any areas of clinical resistance and it was generally accepted amongst clinicians that the emergency care recovery process needed to be accelerated in order to provide an improved service to patients.

Resolved – that the report on UHL's Emergency Care Performance and Recovery Plan (paper U) and the tabled list of LLR emergency care priority actions be received and noted.

251/13/3 NHS Trust Over-Sight Self Certifications

The Director of Corporate and Legal Affairs introduced UHL's self certification returns for August 2013 (paper Z refers) and welcomed any comments or questions on this report. Ms J Wilson, Non-Executive Director queried whether the response to section 10 would require updating now, given that sustainable compliance with the ED 4 hour target would not be achieved by 30 September 2013. The Medical Director and the Chief Executive explained that UHL had been advised not to formally amend the trajectory for delivering sustainable ED performance, but it was agreed to expand the wording of this section to confirm that regular dialogue was being held with the TDA on this important issue. **CHAIR MAN/ CE**

Subject to the above clarification, the August 2013 self certification against Monitor Licensing Requirements (appendix A), Trust Board Statements (appendix B) and Single Operating Model return (appendix C) were endorsed for signature by the Chairman and Chief Executive and submission to the TDA accordingly.

Resolved – that subject to a clarification regarding ED performance, the NHS Trust Over-Sight Self Certification returns for August 2013 be approved for signature by the UHL Chairman and Chief Executive, and submitted to the TDA as required. **CHAIR MAN/ CE**

252/13 RISK

252/13/1 Board Assurance Framework (BAF) Update

The Chief Nurse presented the latest iteration of UHL's BAF (paper AA) and Mr R Manton, Risk and Safety Manager attended the meeting for this item. In view of the restricted time available at this meeting, the Chairman invited Board members to comment on the 3 risks highlighted for review (risks 9, 10 and 11) and suggested that any remaining issues be highlighted to the Chief Nurse outside the meeting. The Chief Executive suggested that the BAF item be brought forward in the agenda to allow a more detailed discussion at future meetings.

Ms K Jenkins, Non-Executive Director noted that risk 4 – the risk of ineffective organisational transformation – had reached its target score and had been closed. She queried the monitoring arrangements for any of the incomplete actions associated with this risk to maintain the appropriate audit trail. **CN**

Resolved – that (A) the Board Assurance Framework (presented as paper AA) be received and noted;

TA

(B) the Trust Administrator be requested to schedule this item earlier in the agenda at future Board meetings, and

(C) the Chief Nurse be requested to respond to Ms K Jenkins outside the meeting regarding the monitoring arrangements for risk 4 – ineffective organisational transformation. **CN**

253/13 REPORTS FROM BOARD COMMITTEES

253/13/1 Audit Committee

Ms K Jenkins, Non-Executive Director and Audit Committee Chair introduced paper BB, providing the Minutes of the Audit Committee meeting held on 10 September 2013 and seeking Trust Board approval of the 2012-13 Annual Audit Letter (as appended to paper BB).

In respect of Minute 54/13, particular discussion took place regarding the Medical Director's role in fostering greater clinical engagement in clinical coding. The Medical Director highlighted opportunities to improve performance against clinical quality metrics and to maximise the Trust's income through improved accuracy of clinical coding. He provided assurance that the clinicians were enthusiastic to drive such improvements, advising that 2 medical specialties had been selected for a targeted approach as part of the Trust's Quality Commitment workstream "Saving Lives", noting the relationship between accuracy of clinical coding and risk adjustments for mortality and SHMI data. A further report on clinical coding would be presented to the 12 November 2013 Audit Committee meeting. **MD**

The Chief Executive added that clinical coding was also being reviewed under the Improvement and Innovation Framework and the Director of Finance and Business Services reported that the Musculo-Skeletal specialty was keen to engage with this workstream to eliminate clinical variation in their Patient Level Information Costing System (PLICS) data.

Resolved – that (A) the Minutes of the Audit Committee meeting held on 10 September 2013 (paper BB) be received and noted;

(B) the 2012-13 Annual Audit Letter be endorsed, and

(C) a further report on clinical coding be presented to the 12 November 2013 Audit Committee. **MD**

254/13 CORPORATE TRUSTEE BUSINESS

254/13/1 Charitable Funds Committee

Mr P Panchal, Non-Executive Director and Charitable Funds Committee Vice Chair introduced paper CC, providing the Minutes of the Charitable Funds Committee meeting held on 13 September 2013. As this meeting had not been quorate, he sought the Board's approval (as Corporate Trustee) for all of the Committee's recommended items.

Resolved – that (A) the Minutes of the inquorate Charitable Funds Committee meeting held on 13 September 2013 (paper CC refers) be received and noted, and

(B) all recommendations made by the Committee at its meeting on 13 September 2013 (as detailed in paper CC) be endorsed by the Trust Board (as Corporate Trustee). **DFBS**

255/13 TRUST BOARD BULLETIN – SEPTEMBER 2013

Resolved – that the Trust Board Bulletin report containing updated declarations of

interest, quarterly report on Trust sealings and quarterly IM&T update (paper DD) be received for information.

256/13 QUESTIONS AND COMMENTS FROM THE PUBLIC RELATING TO BUSINESS TRANSACTED AT THIS MEETING

The following questions and comments were received regarding the business on the Trust Board meeting agenda:-

(1) a compliment regarding the Annual Public Meeting held on 19 September 2013;

(2) a query regarding the actions taking place in the community to support the discharge process from UHL to community beds. In response, members noted the priority actions identified to support the daily process to match patients to community bed capacity and the Intensive Support Team pilot scheme to improve community bed capacity;

(3) comments from one of the Trust's new Patient Advisers, thanking the Trust for welcoming him to this role, commending the arrangements for supporting public attendance and noting the value of presenting patient stories at the Board meetings;

(4) a query regarding workstreams 1, 3 and 4 of the tabled paper on priority actions to improve emergency care performance and whether an overall Carers' Strategy might be useful led by a Non-Executive Director champion. It was confirmed that the Chief Nurse and the Acting Chairman would be reviewing this proposal which had previously been submitted by email; **CN/ Acting Chair**

(5) a series of questions and comments raised by Mr M Woods, which he agreed to submit by email to the Director of Corporate and Legal Affairs for a more detailed response. These questions broadly related to the following themes:-
- concerns raised by residents in the area close to the LGH if plans for the temporary transfer of outpatient capacity to the Brandon Unit on the LGH site were progressed;
- complimentary comments regarding the quality of UHL's clinical workforce;
- concerns regarding the nursing workforce vacancies and recruitment progress;
- a positive comment relating to the recent Prospective Governors meeting;
- a comment regarding the correlation between pressure ulcers and agency nursing staff working a small number of shifts at the Trust;
- comments regarding the additional delays incurred prior to patient discharge whilst waiting for prescribed medicines or discharge letters, and

(6) a message of thanks to the Chairman for the robust and gentlemanly way in which he had conducted public Board meetings during his tenure as UHL Chairman.

Resolved – that the comments above and any related actions, be noted.

257/13 ANY OTHER BUSINESS

257/13/1 Mr M Hindle – Chairman

Ms J Wilson, Non-Executive Director and Vice-Chair recorded the Board's appreciation of the significant contributions made by Mr M Hindle during his 7 year tenure as UHL Chairman and presented him with a card and a small gift on behalf of Trust Board members. In response the Chairman thanked Board members for their support and wished them well for the future.

Resolved – that the information be noted.

258/13 DATE OF NEXT MEETING

<u>Resolved</u> – that the next Trust Board meeting be held on Thursday 31 October 2013 in Seminar Rooms A & B, Clinical Education Centre, Leicester General Hospital.

<u>The meeting closed at 5.07pm</u>

Kate Rayns,
Trust Administrator

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

Name	Possible	Actual	% attendance	Name	Possible	Actual	% attendance
M Hindle (Chair)	7	7	100	R Mitchell	3	3	100
J Adler	7	7	100	R Overfield	1	1	100
T Bentley*	6	2	33	P Panchal	7	6	85
K Bradley*	7	5	71	I Reid	4	4	100
I Crowe	3	3	100	C Ribbins	4	4	100
S Dauncey	1	1	100	A Seddon	7	7	100
K Harris	7	7	100	J Tozer*	3	2	66
S Hinchliffe	2	2	100	S Ward*	7	7	100
K Jenkins	7	7	100	M Wightman*	7	6	85
R Kilner	7	7	100	J Wilson	7	6	85
				D Wynford-Thomas	7	3	43

* non-voting members

University Hospitals of Leicester NHS Trust

Trust Board Paper M

Progress of actions arising from the Trust Board meeting held on Thursday 26 September 2013

Item No	Minute Reference	Action	Lead	By When	Progress Update	RAG Status*
1	248/13/1	Populated CMG management structure to be published on the Trust's intranet and update report to be provided to the October 2013 Trust Board.	DHR	31.10.13	CMG structure on the intranet is being updated regularly and update report scheduled on the 31 October 2013 agenda.	5
2	248/13/2	Report on UHL's nursing workforce to be provided to the Board in October 2013.	CN	31.10.13	Report scheduled on the 31 October 2013 agenda.	5
3	249/13/1	Letters requesting expenditure reports for SIFT resources to be re-circulated to the new CMG education leads.	MD/AMD	31.10.13	**Verbal report to be provided on 31 October 2013.**	
4	251/13/1(b)	Chief Nurse to ensure that more timely FM performance data be reported to the Trust Board	CN	31.10.13	September 2013 data now being reported to the October 2013 Trust Board.	5
5	251/13/1(c)	Chief Nurse to explore whether any of the delays in processing urgent Estates requests had resulted in any patient quality or safety issues.	CN	31.10.13	**Verbal report to be provided on 31 October 2013.**	
6	252/13/1	Chief Nurse to respond to Ms K Jenkins outside the meeting regarding the monitoring arrangements for risk 4.	CN	31.10.13	**Verbal report to be provided on 31 October 2013.**	

Matters arising from previous Trust Board meetings

Item No	Minute Reference	Action	Lead	By When	Progress Update	RAG Status*
29 August 2013						
7	222/13/2	Consolidated report on the common themes arising from Berwick, Keogh and Francis Reviews to be presented to the September 2013 Trust Board meeting.	MD/CN	~~26.9.13~~ 31.10.13	Report re-scheduled on the 31 October 2013 Trust Board agenda to allow for additional input by the Chief Nurse.	3
8	227/13(1)	Mechanism for Patient and Public Involvement to be clarified within the new Clinical Management Structure.	COO/DHR/DMC	26.9.13	Verbal report provided at the 26 September 2013 meeting. **Arrangements to be clarified on 31 October 2013.**	

** Both numerical and colour keys are to be used in the RAG rating. If target dates are changed this must be shown using ~~strikethrough~~ so that the original date is still visible.*

RAG Status Key:	***5***	***Complete***	***4***	***On Track***	***3***	***Some Delay – expected to be completed as planned***	***2***	***Significant Delay – unlikely to be completed as planned***	***1***	***Not yet commenced***

Item No	Minute Reference	Action	Lead	By When	Progress Update	RAG Status*
9	227/13(2)	Chairman to update the Trust Board on the consideration of opportunities for members of the public to contribute to Trust Board discussions during the course of the meeting.	Chairman	26.9.13	Verbal report provided at the 26 September 2013 meeting. **Decision deferred to the Acting Chairman who will report orally at the 31 October 2013 Trust Board meeting.**	
25 July 2013						
10	194/13	Updated Trust Board calendar of business to be circulated to Trust Board members.	DCLA	~~30.8.13~~ 30.9.13	To be circulated in the light of final decisions being taken on a revised Trust Board Development Programme.	4
11	199/13/1	The results of the Equality Audit to be provided to the Trust Board in December 2013, with any urgent issues being highlighted to the Audit Committee Chair in the interim period.	DHR	30.12.13	To be included in the quarterly Workforce and OD Trust Board update scheduled on the 20 December 2013 Trust Board agenda.	4
27 June 2013						
12	167/13/3	LLR Health Economy Response to Francis Report to be provided to the October 2013 Trust Board meeting.	CE	31.10.13	The Chief Executive has advised that there is unlikely to be a further LLR-wide response to Francis. Further discussion recommended through the CCIG/Chief Officers' Group.	3

** Both numerical and colour keys are to be used in the RAG rating. If target dates are changed this must be shown using ~~strikethrough~~ so that the original date is still visible.*

RAG Status Key:	***5***	***Complete***	***4***	***On Track***	***3***	***Some Delay – expected to be completed as planned***	***2***	***Significant Delay – unlikely to be completed as planned***	***1***	***Not yet commenced***

N

Trust Board Paper N

To:	**Trust Board**
From:	**CHIEF EXECUTIVE**
Date:	**31 October 2013**
CQC regulation:	N/A

Title:	**MONTHLY UPDATE REPORT – OCTOBER 2013**

Author/Responsible Director: Director of Corporate and Legal Affairs

Purpose of the Report: To brief the Board on key issues and identify important changes or issues in the external environment.

The Report is provided to the Committee for:

Decision		Discussion	√
Assurance	√	Endorsement	

Summary / Key Points: The report identifies a number of key Trust issues and important changes or issues in the external environment.

Recommendations: The Board is asked to consider the report, and the impact on the Strategic Direction and Board Assurance Framework (if any) and decide if updates to either are required.

Previously considered at another corporate UHL Committee? No

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

Resource Implications (e.g. Financial, HR): N/A

Assurance Implications: N/A

Patient and Public Involvement (PPI) Implications: N/A

Stakeholder Engagement Implications: N/A

Equality Impact: N/A

Information exempt from Disclosure: None

Requirement for further review? The Chief Executive will report monthly to each public Board meeting.

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST

REPORT TO: **TRUST BOARD**

DATE: **31 OCTOBER 2013**

REPORT BY: **CHIEF EXECUTIVE**

SUBJECT: **MONTHLY UPDATE REPORT – OCTOBER 2013**

---

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

2. For this meeting, the key issues which the Chief Executive has identified and upon which the Acting Chief Executive (on his behalf) will report further, orally, at the Board meeting are as follows:-

(a) emergency care performance, the Trust's winter plan 2013; and the emergency floor development;

(b) the Trust's financial position as at month 6 2013/14;

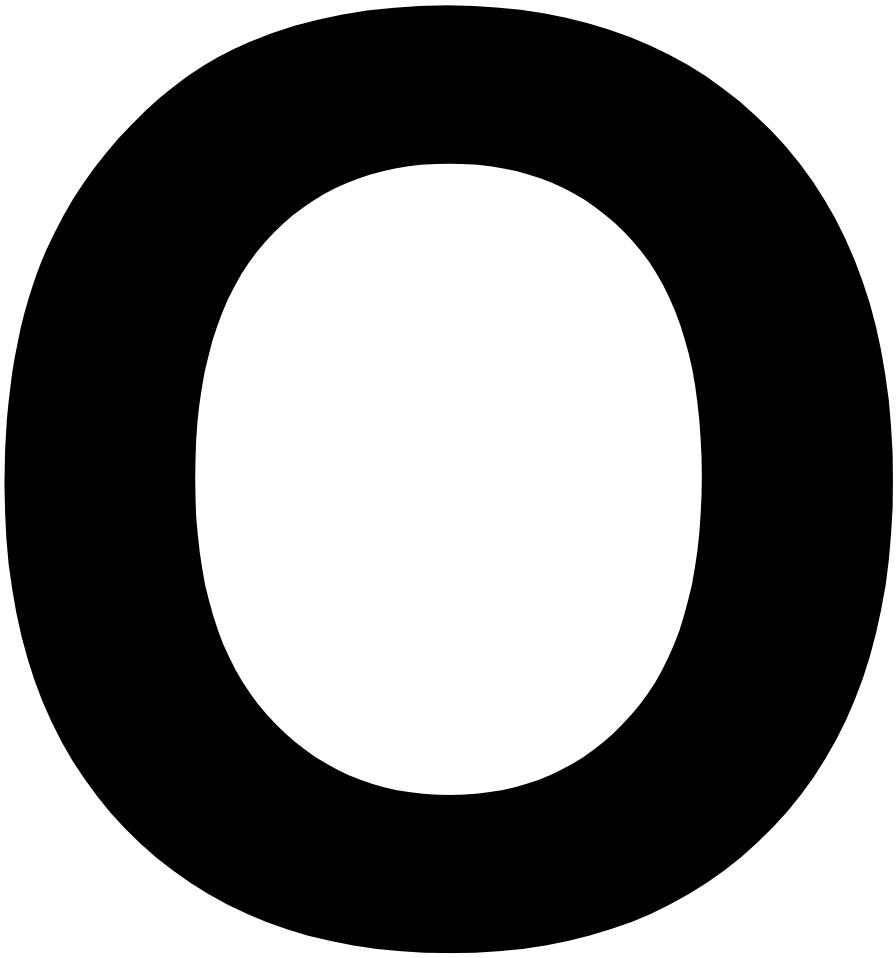
(c) the NHS Trust Development Authority's (TDA) recently published performance rating for the Trust as 'Level 4' – "material issue";

(d) FT status – Monitor has reaffirmed that it will not grant FT status to any further NHS Trusts until it receives robust assurance from the Care Quality Commission that applicants are providing a good quality of care to patients. In consequence, the Trust is to review its FT timeline and will be assisted in this task by Ms Kate Shields, newly appointed Director of Strategy who takes up her post on 4th November 2013. An update will be submitted to the next Board meeting on 28th November 2013;

(e) publication by Monitor and NHS England of "The 2014/15 National Tariff Payment System : A Consultation Notice". This document sets out national prices for services; the operation of national business rules and the efficiency factor and deflators which apply to services under national and local tariffs. There is an efficiency requirement of 4%, which is significantly higher than 2013/14. The document will be taken into account in the development of the draft Trust Annual Operating Plan for 2014/15.

3. The Trust Board is asked to consider the Chief Executive's report and, again, in line with good practice, consider the impact on the Trust's Strategic Direction and decide whether or not updates to the Trust's Board Assurance Framework are required.

John Adler
Chief Executive 16th October 2013



Trust Board Paper O

To:	**Trust Board**
From:	Rachel Overfield
Date:	31st October 2013
CQC regulation:	Outcome 1, 5, 7 and 13

Title:	Role of the Meaningful Activity Facilitator within UHL

Author/Responsible Director:
Carole Ribbins – Director of Nursing

Purpose of the Report:
To provide Trust Board with a brief presentation providing an insight into a new innovative role - Meaningful Activity Facilitator

The Report is provided to the Board for:

Decision		Discussion	x
Assurance		Endorsement	

Summary / Key Points:
There are three full time Meaningful Activity Facilitators currently working on wards 37, 32 and 19 at LRI, which are all wards that predominately care for Older People.

- Their roles are funded through CQUIN and Charitable Funds
- They are part of the Patient Experience Team and support wards over a Monday to Friday period
- Each day a Meaningful Activity Facilitator attends the 'board round', along with the multidisciplinary team where patients with dementia or suspected dementia are referred for meaningful activity support.
- The role focuses on those patients who are exhibiting agitation or distress or requiring additional support at mealtimes or are prone to wandering.
- Data is being collected to provide evidence of impact to patient outcomes and will be available to the Quality Assurance Committee in quarter three.

Background

- This new role is part of the Quality Commitment work stream for Older People
- The role supports people with dementia and their carers in hospital as activity provides cognitive stimulation, supports physical, sensory and psychological well being, as well as reducing vulnerability
- The aim is to improve patient well-being promoting a closer working relationship with carers
- This is achieved through reminiscence, arts and crafts, music therapy, group and individual one to one working, liaising with carers to complete Patient Profiles and 'Memory Lane' – afternoon events

Recommendations: to review role outcomes when data available in January 2014

Strategic Risk Register NA	**Strategic Risk Register** NA

Resource Implications (e.g. Financial, HR) Role supported by Charitable Funds and CQUIN monies. Managed by Patient Experience Team

Assurance Implications NA

Patient and Public Involvement (PPI) Implications Yes

Equality Impact Yes

Information exempt from Disclosure NA

Requirement for further review? To produce a detailed report for QAC - Quarter 3 on impact of role

P

To:	Trust Board
From:	Chief Nurse
Date:	31st October 2013
CQC regulation:	All

Trust Board Paper P

Title:	Care Quality Commission Intelligent Monitoring Report and Impending Inspection

Author/Responsible Director: Director of Clinical Quality/Chief Nurse

Purpose of the Report: To brief the Board on the CQC's new model of surveillance, the results of their first review.

The Report is provided to the Board for:

Decision		Discussion	X
Assurance	X	Endorsement	

Summary / Key Points:

- The Care Quality Commission has developed a new model for monitoring a range of key indicators about NHS acute and specialist hospitals. These indicators relate to the five key questions they will ask of all services – are they safe, effective, caring, responsive and well-led?
- The results of the CQC's intelligent monitoring report (October 2013) identifies that UHL has 5 indicators in the category of risk and 5 at an elevated risk and this places UHL in the risk category of 1 overall.
- UHL will be within the next wave of inspections commencing in January 2014. Further reports will be provided to the Trust Board and the Quality Assurance Committee regarding the detail of this inspection.
- The Trust is already in the process of reviewing our assurance escalation and response systems to ensure those indicators that the CQC are monitoring are captured and reported.

Recommendations:

- The Trust Board are asked to receive the report and note the findings of the CQC surveillance published in the Intelligent Monitoring report on the 24th October and inclusion in wave 2 of the acute hospital inspection programme.

Previously considered at another corporate UHL Committee ?
No

Strategic Risk Register Yes	**Performance KPIs year to date** Q+P Report

Resource Implications (eg Financial, HR)
To be identified

Assurance Implications
CQC Operational Group Monitoring

Patient and Public Involvement (PPI) Implications

CQC Intelligent Monitoring Report in the public domain. Patient and public feedback used in the surveillance and inspection model.
Equality Impact
Information exempt from Disclosure No
Requirement for further review? To be advised

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST

REPORT TO: **Trust Board**

DATE: **31st October 2013**

REPORT FROM: **Chief Nurse**

REPORT BY: **Director of Clinical Quality**

SUBJECT: **Care Quality Commission Intelligent Monitoring Report and Impending Inspection**

1.0 Introduction

1.1 The Care Quality Commission (CQC) has developed a new model for monitoring a range of key indicators about NHS acute and specialist hospitals. These indicators relate to the five key questions they will ask of all services – are they safe, effective, caring, responsive and well-led?

1.2 On Thursday 24th October the CQC published for the first time the results of new surveillance model, also known as the Intelligent Monitoring tool, which sets out a range of information which we hold on each of the 161 acute and specialist Trusts. This information helps the CQC prioritise their inspections.

1.3 At the same time it was announced that the University Hospital's of Leicester (UHL) will be inspected using the new Care Quality Commission model some time between January to March 2014.

1.4 This paper provides details of the CQC's intelligent monitoring report in addition to the impending visit.

2.0 CQC's Intelligent Monitoring Report

2.1 The new reports give the CQC's overall view of every Trust and how they arrive at that view. This helps the CQC to decide when, where, and what to inspect under their new model. The reports draw together a range of information to give the CQC inspectors a clear picture of the areas of care that may need to be followed up.

2.2 The intelligent monitoring system is based on 150 indicators that look at a range of information including patient experience, staff experience and statistical measures of performance. The indicators relate to the five key questions CQC will ask of all services. The indicators are used to raise questions not to make judgements about the quality of care. CQC's judgements will always follow their inspections, which take into account the results of the intelligent monitoring and reports from other organisations.

2.3 The CQC has analysed each of the 150 indicators and identified one of the following levels:

- 'no evidence of risk'
- 'risk'
- 'elevated risk'

2.4 UHL has been identified as having 5 indicators at risk and 5 at an elevated risk.

2.5 An overall summary band for each Trust is then created by reviewing the proportion of indicators that have been identified as 'risk' or 'elevated risk' for each Trust out of all applicable indicators in the model.

2.6 Guidance has been produced by the CQC to explain how they have created a summary view for each NHS Trust as well as indicators definitions for each indicator they explain:-

- how the numerator and denominator have been constructed (for quantitative
- indicators)
- how we have determined 'risk' and 'elevated risk'
- time period of the data source
- data source and links to the original source (where this is available)

The CQC has also produced an additional methodology document, describing the statistical methods they have used.

2.7 The following fields have been calculated for each NHS trust by the CQC and are provided on each Trust level profile:

- **Number of risks**: total number of indicators identified as 'risk' (thresholds and rules for identifying risk are provided in the individual indicator details below).
- **Number of elevated risks:** total number of indicators identified as 'elevated risk' (thresholds and rules for identifying elevated risk are provided in the individual indicator details below).
- **Number of applicable indicators:** a count of the number of indicators that apply to the individual trust
- **Overall risk score:** a weighted sum of (number of risks) + (number of elevated risks x 2).
- **Maximum possible risk score:** the score a trust would receive if they had flagged as elevated risk for every single applied indicator in the model.
- **Proportional Score:** calculated from (overall risk score)/ (maximum possible risk score)
- **Band:** CQC has categorised trusts into one of six summary bands, with band 1 representing highest risk and band 6 with the lowest. These bands have been assigned based on the proportion of indicators that have been identified as 'risk' or 'elevated risk' or if there are known serious concerns (e.g. trusts in special measures) trusts are categorised as band 1. For the trusts assigned a category based on the proportion of indicators, we have used the following thresholds:

  Band 1 ≥ 7.5%
  Band 2 ≥ 5.5%
  Band 3 ≥ 4.5%
  Band 4 ≥ 3.5 %
  Band 5 ≥ 2.5 %
  Band 6 < 2.5 %

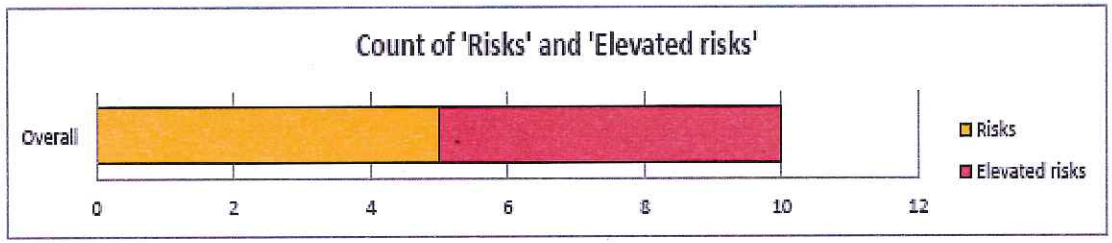
3.0 Results- October 2013

3.1 The CQC intelligent monitoring report- October 2013 is attached at Appendix 1. This can be accessed online at http://www.cqc.org.uk/.

3.2 The Trust summary for October 2013 is as follows:

University Hospitals of Leicester NHS Trust

Trust Summary



Band	1
Number of 'Risks'	5
Number of 'Elevated risks'	5
Overall Risk Score	15
Number of Applicable Indicators	83
Proportional Score	0.09
Maximum Possible Risk Score	166

Elevated risk	Dr. Foster: Deaths in low risk diagnosis groups
Elevated risk	Maternity outlier alert: Puerperal sepsis and other puerperal infections
Elevated risk	A&E waiting times more than 4 hours
Elevated risk	Whistleblowing alerts
Elevated risk	Serious Education Concerns
Risk	Composite indicator: In-hospital mortality - Paediatric and congenital disorders and perinatal mortality
Risk	PROMs EQ-5D score: Groin Hernia Surgery
Risk	TDA - Escalation score
Risk	Composite risk rating of ESR items relating to staff turnover
Risk	Composite risk rating of ESR items relating to staff stability

4.0 Trust Response

4.1 A number (although not all) of the indicators are already monitored and reported in the Quality and Performance Report. These include mortality, A&E waiting times, TDA escalation score and workforce indicators. A number of the indicators have also been subject to detailed reports, and/or presentations at the Trust Board or Quality Assurance Committee.

4.2 A response to each of the indicators identified as elevated risk/risk is detailed below:

- **Dr. Foster: Deaths in low risk diagnosis groups (Elevated Risk)**

  There were 81 patients who died in 2012/13 that were coded as having a 'low risk diagnosis'. The types of diagnosis included in this group are: abdominal pain, transient cerebral ischemia, chest pain, abdominal hernia, normal pregnancy, crushing injury/internal injury. Preliminary review of the data suggests that some patients were subsequently confirmed as having a 'higher risk diagnosis' (stroke, myocardial infarction). Others appeared to have other co-morbidities that significantly affected their outcome (e.g. patient admitted with 'internal injury' also had alcoholic cirrhosis of the liver and oesophageal varices).

  The details of each of the patients in this group are now being cross referenced with the relevant Morbidity and Mortality reviews to ensure that any areas for learning have been acted upon. At the same time, the clinical coding will be checked as one patient was coded with a 'primary diagnosis of abdominal pain' but was admitted to the coronary care unit.

- **Maternity outlier alert: Puerperal sepsis and other puerperal infections (Elevated risk)**

  In August 2013 the CQC wrote to notify UHL of the fact that analysis of maternity indicators undertaken by the Care Quality Commission had indicated that rates of puerperal sepsis and other puerperal infections within 42 days of delivery at our Trust have remained significantly high since the previous alert for this indicator was closed in April 2012.

  A case-note review, the review of audit data regarding serious septic illness and the review of audit data regarding post-caesarean section wound infection all confirmed good clinical outcomes and failed to identify any concerns regarding quality of care. However there were a number of issues identified that need to be addressed.

  These include:

  - A need to improve coding of septic illness diagnoses to more accurately reflect the clinical diagnoses
  - A need to validate and benchmark the data being collected with regard to severe septic illness on our E3 database
  - A need to identify and implement at least one Quality Outcome Indicator to be included as a regular item on our maternity dashboard
  - A review of pathways of care for women after discharge from hospital in conjunction with primary care colleagues

An action plan is being implemented to address these points.

- **A&E waiting times more than 4 hours (Elevated risk)**
  Performance against the 4 hour wait is subject to regular detailed reporting at the Trust Board. It is well recognised that the current Emergency Department is too small, having been designed for around 115,000 patients a year rather than 160,000 that come through the department. A scheme for investment in the Emergency Department has been developed.

  Working with partners a "single front door" process was introduced in July 2013 guiding patients to the most appropriate care.

  Executives across the healthcare community have been meeting on a weekly basis to work on sustainable solutions that will improve performance, patient experience and staff satisfaction.

- **Whistleblowing alerts (Elevated risk)**
  From the reporting period UHL have received three whistle blowing concerns; one in relation to overcrowding in the Emergency Department and two in relation to the cleanliness at the LRI and LGH.

  UHL provided the CQC with a response for each concern raised. The Director of Clinical Quality liaised with the Medical Director, Chief Nurse, Interim Director of Operations and Senior Management team of the Acute Division and Emergency Department to be able to provide a comprehensive response to address the issues raised with regards to standards of care.

  The Lead Nurse Infection Prevention and the Deputy Director of Facilities compiled a response with regards to the standards of cleanliness across the hospital sites.

- **Serious Education Concerns (Elevated risk)**

  We are aware of and are addressing the ongoing issues with medical education. The Medical Director presented a report to the Executive Team on a recent Local Education Training Boards Education Review for Trainee Doctors which focused on areas such as Paediatrics, Obstetrics and Gynaecology, Anaesthetics, Trauma and Orthopaedics, and all Foundation Trainees. This year there are 48 areas of improvement, of which 13 areas are RAG rated red to indicate urgent action being required. Some of the areas of improvement can be categorised into the following areas:

  - Education Resources
  - Identification of Different Levels of Medical Staff
  - Trainee Rotas:
    - Foundation Year 1 doctors working core level doctor rotas is a concern.
    - Doctors advised that they were often required to work longer than the duty rota
    - Excessive hours being worked over consecutive days
  - IT Systems
  - Phlebotomy

- Service Level Induction

A number of these issues have already been resolved by the Trust, for example there are plans for a new library at the LRI site, and there will be an Educational Lead for each Clinical Management Group and implementation of the colour coded ID badge holders and lanyards for Medical Staff.

- **Composite indicator: In-hospital mortality- Paediatric and congenital disorders and perinatal mortality (Risk)**

Better understanding of the methodology is required in order to properly investigate as this is a composite indicator of two groups of patients (paediatric/congenital disorders and perinatal mortality) and different methods are used for creating the outcomes for each of the groups

The 'risk' is associated with the first part of the indicator and not the perinatal mortality. The indicator assessed as at 'risk' is a combined indicator and includes paediatric and congenital disorders plus perinatal mortality.

The Risk only relates to the Paediatric and Congenital Disorders
Within the indicator are 5 main diagnostic groups:

- Cardiac and circulatory congenital anomalies
- Other congenital anomalies
- Genitourinary congenital anomalies
- Digestive congenital anomalies
- Nervous system congenital anomalies

We believe that the group that is alerting is 'other congenital anomalies' and within that group there is a subgroup which is alerting – congenital diaphragmatic hernia (there were 5 deaths in 34 patients).

The Children's Mortality and Morbidity lead for both the LRI and GH has reviewed all paediatric cardiac deaths in 2012 by himself and the PICANET lead. Within this review were 3 of the congenital diaphragmatic hernia patients (2 of the patients died subsequent to being transferred back to their original hospitals). All 3 babies had been accepted for ECMO and known complications of ECMO and subsequently died.

The majority of Trusts where babies are managed with these conditions will only have those babies that require relatively minor operations and specifically in respect of the Congenial Diaphragmatic Hernia babies (closing of the diaphragm area where the hernia is) - so their mortality numbers will be next to 0 whilst because we have ECMO (and subsequently receive the complex babies), our numbers will be substantially higher.

Our congenital anomalies mortality is unlikely to compare favourably with the majority of hospitals in England because we will get babies with the worst type of congenital abnormality, both because we are a cardiac centre but more so because of ECMO (there are only 4 centres in the UK). Our deaths have been reviewed and any learning acted upon and our outcomes are monitored both by PICANET and NICOR (previously CCAD).

- **PROMs EQ-5D score: Groin Hernia Surgery (Risk)**
  UHL's patients reported a similar health gain to the England average for 11/12 (UHL 0.85 England 0.88). For 12/13 the provisional data published on the HSCIC website, shows UHL's performance dropping to 0.39 (England average remains at 0.88). This drop appears to be disproportionate and UHL has requested validation of the data by Quality Health.

- **TDA- Escalation Score (Risk)**
  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):

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

  Confirmation was received from the NHS Trust Development Authority 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.

- **Composite risk rating of ESR items relating to staff turnover (Risk)**

  Using the Electronic Staff Record as its data source, the CQC calculate turnover as the number of leavers in the last 12 months divided by the average headcount in the last 12 months. During 2012/13 specifically, this figure has been distorted by the transfer of 406 facilities and switchboard staff to the employment of Interserve. This quantity equates to approximately three month's turnover. In addition our figures are distorted by the significant numbers of medical trainees who transfer between East Midlands organisations. Each transfer will be recorded as a leaver.

  Turnover rates are regularly monitored and reported to the Board on a monthly basis via the Quality and Performance Report. No specific issues have recently been highlighted. In addition the National Workforce Assurance Tool does not indicate that turnover is a specific issue at the Trust when compared to our peers.

- **Composite risk rating of ESR items relating to staff stability (Risk)**
  The same data set is used by the CQC for staff turnover however the stability index measures the number of employees with greater than 12 months service divided by the number of employees 12 months ago. This is equally distorted by the turnover attributed to the TUPE transfer of facilities staff (98.77% of those transferring had more than 12 months service).

5.0 Wave 2 Inspection Programme

5.1 The CQC has announced that they will be inspecting 19 acute Trusts between January and March 2014. UHL is one of these 19 Trusts. A copy of the letter from Professor Sir Mike Richards (Chief Inspector of Hospitals) to John Adler is attached at Appendix 2).

5.2 The team of over 20 will be headed by a senior NHS Clinician or Executive, working alongside senior CQC Inspectors and they will spend at least 2 days inspecting our sites that deliver acute services and the following eight key service areas: A&E; acute medical pathways including the frail elderly; acute surgical pathways; critical care; maternity; paediatrics; end of life care and outpatients.

5.3 The inspection will result in a rating of one of the following; good, requires improvement or inadequate.

6.0 Conclusion

6.1 The results of the CQC's intelligent monitoring report (October 2013) identifies that UHL has 5 indicators in the category of 'risk' and 5 at an 'elevated risk' and this places UHL in the risk category of 1 overall.

6.2 UHL will be within the next wave of inspections commencing in January 2014. Further reports will be provided to the Trust Board and the Quality Assurance Committee regarding the detail of this inspection.

6.3 The Trust is already in the process of reviewing our assurance escalation and response systems to ensure those indicators that the CQC are monitoring are captured and reported.

7.0 Recommendation

7.1 The Trust Board are asked to receive the report and note the findings of the CQC surveillance published in the Intelligent Monitoring report on the 24th October and inclusion in wave 2 of the acute hospital inspection programme.

Intelligent Monitoring Report

Report on

University Hospitals of Leicester NHS Trust

21 October 2013

Intelligent Monitoring: Report on 21 October 2013

CQC has developed a new model for monitoring a range of key indicators about NHS acute and specialist hospitals. These indicators relate to the five key questions we will ask of all services – are they safe, effective, caring, responsive and well-led? The indicators will be used to raise questions about the quality of care. They will not be used on their own to make judgements. Our judgements will always be based on the result of an inspection, which will take into account our Intelligent Monitoring analysis alongside local information from the public, the trust and other organisations.

What does this report contain?

This report presents CQC's analysis of the key indicators (which we call 'tier one indicators') for University Hospitals of Leicester NHS Trust. We have analysed each indicator to identify two possible levels of risk.

We have used a number of statistical tests to determine where the thresholds of "risk" and "elevated risk" sit for each indicator, based on our judgement of which statistical tests are most appropriate. These tests include CUSUM and z scoring techniques. For some data sources we have applied a set of rules to the data as the basis for these thresholds - for example concerns raised by staff to CQC (and validated by CQC) are always flagged in the model.

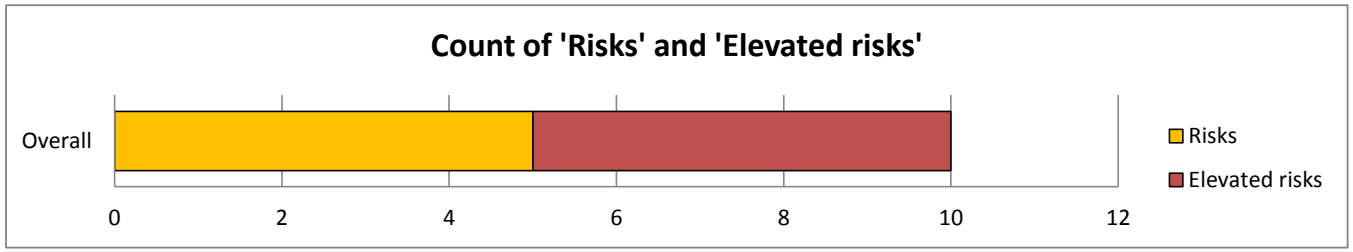
Further details of the analysis applied are explained in the accompanying guidance document.

What guidance is available?

We have published a document setting out the definition and full methodology for each indicator. If you have any queries or need more information, please email enquiries@cqc.org.uk or use the contact details at www.cqc.org.uk/contact-us

University Hospitals of Leicester NHS Trust

Trust Summary



Band	1
Number of 'Risks'	5
Number of 'Elevated risks'	5
Overall Risk Score	15
Number of Applicable Indicators	83
Proportional Score	0.09
Maximum Possible Risk Score	166

Elevated risk	Dr. Foster: Deaths in low risk diagnosis groups
Elevated risk	Maternity outlier alert: Puerperal sepsis and other puerperal infections
Elevated risk	A&E waiting times more than 4 hours
Elevated risk	Whistleblowing alerts
Elevated risk	Serious Education Concerns
Risk	Composite indicator: In-hospital mortality - Paediatric and congenital disorders and perinatal mortality
Risk	PROMs EQ-5D score: Groin Hernia Surgery
Risk	TDA - Escalation score
Risk	Composite risk rating of ESR items relating to staff turnover
Risk	Composite risk rating of ESR items relating to staff stability

University Hospitals of Leicester NHS Trust

Tier One Indicators

Section	ID	Indicators	Observed	Expected	Risk?
Never Events	STEISNE	Never Event incidence	-	-	No evidence of risk
Avoidable infections	CDIFF	Incidence of Clostridium difficile (C.difficile)	86	87.75	No evidence of risk
	MRSA	Incidence of Meticillin-resistant Staphylococcus aureus (MRSA)	3	6.25	No evidence of risk
Deaths in low risk conditions	MORTLOWR	Dr. Foster: Deaths in low risk diagnosis groups	-	-	Elevated risk
Patient safety incidents	NRLSL03	Proportion of reported patient safety incidents that are harmful	0.19	0.28	No evidence of risk
	NRLSL04	Potential under-reporting of patient safety incidents resulting in death or severe harm	2.24	1.49	No evidence of risk
	NRLSL05	Potential under-reporting of patient safety incidents	366.1	235.27	No evidence of risk
Venous Thromboembolism	VTERA03	Proportion of patients risk assessed for Venous Thromboembolism (VTE)	0.94	0.95	No evidence of risk
Mortality: Trust Level	SHMI01	Summary Hospital-level Mortality Indicator	Trust's mortality rate is 'As Expected'	-	No evidence of risk
	HSMR	Dr. Foster: Hospital Standardised Mortality Ratio	-	-	No evidence of risk
	HSMRWKDAY	Dr. Foster: Hospital Standardised Mortality Ratio (Weekday)	-	-	No evidence of risk
	HSMRWKEND	Dr. Foster: Hospital Standardised Mortality Ratio (Weekend)	-	-	No evidence of risk
Mortality	COM_CARDI	Composite indicator: In-hospital mortality - Cardiological conditions and procedures	-	-	No evidence of risk
	COM_CEREB	Composite indicator: In-hospital mortality - Cerebrovascular conditions	-	-	No evidence of risk
	COM_DERMA	Composite indicator: In-hospital mortality - Dermatological conditions	-	-	No evidence of risk
	COM_ENDOC	Composite indicator: In-hospital mortality - Endocrinological conditions	-	-	No evidence of risk
	COM_GASTR	Composite indicator: In-hospital mortality - Gastroenterological and hepatological conditions and procedures	-	-	No evidence of risk
	COM_GENIT	Composite indicator: In-hospital mortality - Genito-urinary conditions	-	-	No evidence of risk
	COM_HAEMA	Composite indicator: In-hospital mortality - Haematological conditions	-	-	No evidence of risk
	COM_INFEC	Composite indicator: In-hospital mortality - Infectious diseases	-	-	No evidence of risk
	COM_MENTA	Composite indicator: In-hospital mortality - Conditions associated with Mental health	-	-	No evidence of risk
	COM_MUSCU	Composite indicator: In-hospital mortality - Musculoskeletal conditions	-	-	No evidence of risk
	COM_NEPHR	Composite indicator: In-hospital mortality - Nephrological conditions	-	-	No evidence of risk
	COM_NEURO	Composite indicator: In-hospital mortality - Neurological conditions	-	-	No evidence of risk
	COM_PAEDI	Composite indicator: In-hospital mortality - Paediatric and congenital disorders and perinatal mortality	-	-	Risk
	COM_RESPI	Composite indicator: In-hospital mortality - Respiratory conditions and procedures	-	-	No evidence of risk
	COM_TRAUM	Composite indicator: In-hospital mortality - Trauma and orthopaedic conditions and procedures	-	-	No evidence of risk
	COM_VASCU	Composite indicator: In-hospital mortality - Vascular conditions and procedures	-	-	No evidence of risk

Section	ID	Indicators	Observed	Expected	Risk?
Maternity and women's health	MATELECCS	Maternity outlier alert: Elective Caesarean section	-	-	No evidence of risk
	MATEMERCS	Maternity outlier alert: Emergency Caesarean section	-	-	No evidence of risk
	MATSEPSIS	Maternity outlier alert: Puerperal sepsis and other puerperal infections	-	-	Elevated risk
Re-admissions	MATMATRE	Maternity outlier alert: Maternal readmissions	-	-	No evidence of risk
	MATNEORE	Maternity outlier alert: Neonatal readmissions	-	-	No evidence of risk
	HESELRE	Emergency readmissions following an elective admission	1909	1724.73	No evidence of risk
	HESEMRE	Emergency readmissions following an emergency admission	7446	7784.56	No evidence of risk
PROMs	PROMS19	PROMs EQ-5D score: Groin Hernia Surgery	0.45	1	Risk
	PROMS20	PROMs EQ-5D score: Hip Replacement	0.97	1	No evidence of risk
	PROMS22	PROMs EQ-5D score: Knee Replacement	1.09	1	No evidence of risk
	PROMS24	PROMs EQ-5D score: Varicose Vein Surgery	Not included	Not included	Not included
Audit	NHFD01	The number of cases assessed as achieving compliance with all nine standards of care measured within the National Hip Fracture Database.	0.55	0.6	No evidence of risk
	SINAP14	Key Indicator 1: Number of patients scanned within 1 hour of arrival at hospital	Not included	Not included	Not included
	SINAP15	Key Indicator 8: Number of potentially eligible patients thrombolysed	Not included	Not included	Not included
Surgical revisions outlier	SURGHIPREV	Surgical revisions outlier alert: Hip revisions	Not included	Not included	Not included
	SURGKNEREV	Surgical revisions outlier alert: Knee revisions	Not included	Not included	Not included
Compassionate care	IPSurTalkWor	Inpatient Survey 2012 Q34 "Did you find someone on the hospital staff to talk to about your worries and fears?"	5.61	-	No evidence of risk
	IPSurSupEmot	Inpatient Survey 2012 Q35 "Do you feel you got enough emotional support from hospital staff during your stay?"	6.91	-	No evidence of risk
Meeting physical needs	IPSurHelpEat	Inpatient Survey 2012 Q23 "Did you get enough help from staff to eat your meals?"	7.02	-	No evidence of risk
	IPSurInvDeci	Inpatient Survey 2012 Q32 "Were you involved as much as you wanted to be in decisions about your care and treatment?"	7.22	-	No evidence of risk
	IPSurCntPain	Inpatient Survey 2012 Q39 "Do you think the hospital staff did everything they could to help control your pain?"	7.85	-	No evidence of risk
Overall experience	IPSurOverall	Inpatient Survey 2012 Q68 "Overall..." (I had a very poor/good experience)	7.77	-	No evidence of risk
	FFTNHSEscore	NHS England inpatients score from Friends and Family Test	-	-	No evidence of risk
Treatment with dignity and respect	IPSurRspDign	Inpatient Survey 2012 Q67 "Overall, did you feel you were treated with respect and dignity while you were in the hospital?"	8.68	-	No evidence of risk
Trusting relationships	IPSurConfDoc	Inpatient Survey 2012 Q25 "Did you have confidence and trust in the doctors treating you?"	8.60	-	No evidence of risk
	IPSurConfNur	Inpatient Survey 2012 Q28 "Did you have confidence and trust in the nurses treating you?"	8.39	-	No evidence of risk

Section	ID	Indicators	Observed	Expected	Risk?
Access measures	AD_A&E12	A&E waiting times more than 4 hours	0.11	0.05	Elevated risk
	RTT_01	Referral to treatment times under 18 weeks: admitted pathway	0.89	0.9	No evidence of risk
	RTT_02	Referral to treatment times under 18 weeks: non-admitted pathway	0.97	0.95	No evidence of risk
	DIAG6WK01	Diagnostics waiting times: patients waiting over 6 weeks for a diagnostic test	0.01	0.01	No evidence of risk
	WT_CAN26	All cancers: 62 day wait for first treatment from urgent GP referral	0.82	0.85	No evidence of risk
	WT_CAN27	All cancers: 62 day wait for first treatment from NHS cancer screening referral	0.96	0.9	No evidence of risk
	WT_CAN22	All cancers: 31 day wait from diagnosis	0.98	0.96	No evidence of risk
	CND_OPS02	The proportion of patients whose operation was cancelled	0.01	0.01	No evidence of risk
	CND_OPS01	The number of patients not treated within 28 days of last minute cancellation due to non-clinical reason	0.1	0.07	No evidence of risk
	AMBTURN06	Proportion of ambulance journeys where the ambulance vehicle remained at hospital for more than 60 minutes	Not included	Not included	Not included
Discharge and Integration	DTC40	Ratio of the total number of days delay in transfer from hospital to the total number of occupied beds	0.04	0.02	No evidence of risk
Reporting culture	NRLS14	Consistency of reporting to the National Reporting and Learning System (NRLS)	6 months of reporting	-	No evidence of risk
	SUSDQ	Data quality of trust returns to the HSCIC	-	-	No evidence of risk
	FFTRESP02	Inpatients response rate from NHS England Friends and Family Test	0.23	0.26	No evidence of risk
Partners	MONITOR01	Monitor - Governance risk rating	Not included	Not included	Not included
	TDA01	TDA - Escalation score	4 Material issue	-	Risk
	NTS12	GMC National Training Survey – Trainee's overall satisfaction	Within Q2/IQR	-	No evidence of risk
Staff survey	STASURBG01	NHS Staff Survey - Percentage of staff who would recommend the trust as a place to work or receive treatment	0.62	0.64	No evidence of risk
	NHSSTAFF04	NHS Staff Survey - KF7. % staff appraised in last 12 months	0.94	0.82	No evidence of risk
	NHSSTAFF06	NHS Staff Survey - KF9. Support from immediate managers	0.65	0.65	No evidence of risk
	NHSSTAFF07	NHS Staff Survey - KF10. % staff receiving health and safety training in last 12 months	0.73	0.74	No evidence of risk
	NHSSTAFF11	NHS Staff Survey - KF15. Fairness and effectiveness of incident reporting procedures	0.63	0.63	No evidence of risk
	NHSSTAFF16	NHS Staff Survey - KF21. % reporting good communication between senior management and staff	0.22	0.27	No evidence of risk

Section	ID	Indicators	Observed	Expected	Risk?
Staffing	ESRSIC	Composite risk rating of ESR items relating to staff sickness rates	-	-	No evidence of risk
	ESRReg	Composite risk rating of ESR items relating to staff registration	-	-	No evidence of risk
	ESRTO	Composite risk rating of ESR items relating to staff turnover	-	-	Risk
	ESRSTAB	Composite risk rating of ESR items relating to staff stability	-	-	Risk
	ESRSUP	Composite risk rating of ESR items relating to staff support/ supervision	-	-	No evidence of risk
	ESRSTAFF	Composite risk rating of ESR items relating to ratio: Staff vs bed occupancy	-	-	No evidence of risk
	FLUVAC01	Healthcare Worker Flu vaccination uptake	0.51	0.48	No evidence of risk
Qualitative intelligence	WHISTLEBLOW	Whistleblowing alerts	-	-	Elevated risk
	GMCconcerns	Serious Education Concerns	-	-	Elevated risk
	Safeguarding	Safeguarding concerns	-	-	No evidence of risk
	SYE	Your Experience	-	-	No evidence of risk
	NHSchoices	NHS Choices	-	-	No evidence of risk
	P_OPINION	Patient Opinion	-	-	No evidence of risk
	CQC_COM	CQC complaints	-	-	No evidence of risk
	PROV_COM	Provider complaints	-	-	No evidence of risk

University Hospitals of Leicester NHS Trust

Appendix of indicators used in the composite mortality indicators

Section	ID	Indicators	Risk?
Cardiological Conditions and Procedures	HESMORT24CU	In-hospital mortality: Cardiological conditions	No evidence of risk
	MORTAMI	Mortality outlier alert: Acute myocardial infarction	No evidence of risk
	MORTARRES	Mortality outlier alert: Cardiac arrest and ventricular fibrillation	No evidence of risk
	MORTCABGI	Mortality outlier alert: CABG (isolated first time)	No evidence of risk
	MORTCABGO	Mortality outlier alert: CABG (other)	No evidence of risk
	MORTCASUR	Mortality outlier alert: Adult cardiac surgery	No evidence of risk
	MORTCATH	Mortality outlier alert: Coronary atherosclerosis and other heart disease	No evidence of risk
	MORTCHF	Mortality outlier alert: Congestive heart failure; nonhypertensive	No evidence of risk
	MORTDYSRH	Mortality outlier alert: Cardiac dysrhythmias	No evidence of risk
	MORTHVD	Mortality outlier alert: Heart valve disorders	No evidence of risk
	MORTPHD	Mortality outlier alert: Pulmonary heart disease	No evidence of risk
Cerebrovascular Conditions	HESMORT21CU	In-hospital mortality: Cerebrovascular conditions	No evidence of risk
	MORTACD	Mortality outlier alert: Acute cerebrovascular disease	No evidence of risk
Dermatological Conditions	HESMORT35CU	In-hospital mortality: Dermatological conditions	No evidence of risk
	MORTSKINF	Mortality outlier alert: Skin and subcutaneous tissue infections	No evidence of risk
	MORTSKULC	Mortality outlier alert: Chronic ulcer of skin	No evidence of risk
Endocrinological Conditions	HESMORT29CU	In-hospital mortality: Endocrinological conditions	No evidence of risk
	MORTDIABWC	Mortality outlier alert: Diabetes mellitus with complications	No evidence of risk
	MORTDIABWOC	Mortality outlier alert: Diabetes mellitus without complications	No evidence of risk
	MORTFLUID	Mortality outlier alert: Fluid and electrolyte disorders	No evidence of risk

Section	ID	Indicators	Risk?
Gastroenterological and Hepatological Conditions and Procedures	HESMORT27CU	In-hospital mortality: Gastroenterological and hepatological conditions	No evidence of risk
	MORTALCLIV	Mortality outlier alert: Liver disease, alcohol-related	No evidence of risk
	MORTBILIA	Mortality outlier alert: Biliary tract disease	No evidence of risk
	MORTGASHAE	Mortality outlier alert: Gastrointestinal haemorrhage	No evidence of risk
	MORTGASN	Mortality outlier alert: Noninfectious gastroenteritis	No evidence of risk
	MORTINTOBS	Mortality outlier alert: Intestinal obstruction without hernia	No evidence of risk
	MORTOGAS	Mortality outlier alert: Other gastrointestinal disorders	No evidence of risk
	MORTOLIV	Mortality outlier alert: Other liver diseases	No evidence of risk
	MORTOPJEJ	Mortality outlier alert: Operations on jejunum	No evidence of risk
	MORTPERI	Mortality outlier alert: Peritonitis and intestinal abscess	No evidence of risk
	MORTTEPBI	Mortality outlier alert: Therapeutic endoscopic procedures on biliary tract	No evidence of risk
	MORTTEPLGI	Mortality outlier alert: Therapeutic endoscopic procedures on lower GI tract	No evidence of risk
	MORTTEPUGI	Mortality outlier alert: Therapeutic endoscopic procedures on upper GI tract	No evidence of risk
	MORTTOJI	Mortality outlier alert: Therapeutic operations on jejunum and ileum	No evidence of risk
Genito-Urinary Conditions	HESMORT31CU	In-hospital mortality: Genito-urinary conditions	No evidence of risk
	MORTUTI	Mortality outlier alert: Urinary tract infections	No evidence of risk
Haematological Conditions	HESMORT28CU	In-hospital mortality: Haematological conditions	No evidence of risk
	MORTDEFI	Mortality outlier alert: Deficiency and other anaemia	No evidence of risk
Infectious Diseases	HESMORT26CU	In-hospital mortality: Infectious diseases	No evidence of risk
	MORTSEPT	Mortality outlier alert: Septicaemia (except in labour)	No evidence of risk
Conditions Associated With Mental Health	HESMORT33CU	In-hospital mortality: Conditions associated with Mental health	Not included
	MORTSENI	Mortality outlier alert: Senility and organic mental disorders	No evidence of risk
Musculoskeletal Conditions	HESMORT36CU	In-hospital mortality: Musculoskeletal conditions	No evidence of risk
	MORTPATH	Mortality outlier alert: Pathological fracture	No evidence of risk
	MORTSPON	Mortality outlier alert: Spondylosis, intervertebral disc disorders, other back problems	No evidence of risk

Section	ID	Indicators	Risk?
Nephrological Conditions	HESMORT30CU	In-hospital mortality: Nephrological conditions	No evidence of risk
	MORTRENA	Mortality outlier alert: Acute and unspecified renal failure	No evidence of risk
	MORTRENC	Mortality outlier alert: Chronic renal failure	No evidence of risk
Neurological Conditions	HESMORT34CU	In-hospital mortality: Neurological conditions	No evidence of risk
	MORTEPIL	Mortality outlier alert: Epilepsy, convulsions	No evidence of risk
Paediatric and Congenital Disorders and Perinatal Mortality	HESMORT32CU	In-hospital mortality: Paediatric and congenital disorders	Risk
	MATPERIMOR	Maternity outlier alert: Perinatal mortality	No evidence of risk
Respiratory Conditions and Procedures	HESMORT25CU	In-hospital mortality: Respiratory conditions	No evidence of risk
	MORTASTHM	Mortality outlier alert: Asthma	No evidence of risk
	MORTBRONC	Mortality outlier alert: Acute bronchitis	No evidence of risk
	MORTCOPD	Mortality outlier alert: Chronic obstructive pulmonary disease and bronchiectasis	No evidence of risk
	MORTPLEU	Mortality outlier alert: Pleurisy, pneumothorax, pulmonary collapse	No evidence of risk
	MORTPNEU	Mortality outlier alert: Pneumonia	No evidence of risk
Trauma and Orthopaedic Conditions	HESMORT37CU	In-hospital mortality: Trauma and orthopaedic conditions	No evidence of risk
	MORTCRAN	Mortality outlier alert: Craniotomy for trauma	No evidence of risk
	MORTFNOF	Mortality outlier alert: Fracture of neck of femur (hip)	No evidence of risk
	MORTHFREP	Mortality outlier alert: Head of femur replacement	No evidence of risk
	MORTHIPREP	Mortality outlier alert: Hip replacement	No evidence of risk
	MORTINTINJ	Mortality outlier alert: Intracranial injury	No evidence of risk
	MORTOFRA	Mortality outlier alert: Other fractures	No evidence of risk
	MORTREDFB	Mortality outlier alert: Reduction of fracture of bone	No evidence of risk
	MORTREDFBL	Mortality outlier alert: Reduction of fracture of bone (upper/lower limb)	No evidence of risk
	MORTREDFNOF	Mortality outlier alert: Reduction of fracture of neck of femur	No evidence of risk
	MORTSHUN	Mortality outlier alert: Shunting for hydrocephalus	No evidence of risk

Section	ID	Indicators	Risk?
Vascular Conditions and Procedures	HESMORT23CU	In-hospital mortality: Vascular conditions	No evidence of risk
	MORTAMPUT	Mortality outlier alert: Amputation of leg	No evidence of risk
	MORTANEUR	Mortality outlier alert: Aortic, peripheral, and visceral artery aneurysms	No evidence of risk
	MORTCLIP	Mortality outlier alert: Clip and coil aneurysms	No evidence of risk
	MORTOFB	Mortality outlier alert: Other femoral bypass	No evidence of risk
	MORTPVA	Mortality outlier alert: Peripheral and visceral atherosclerosis	No evidence of risk
	MORTREPAAA	Mortality outlier alert: Repair of abdominal aortic aneurysm (AAA)	No evidence of risk
	MORTTOFA	Mortality outlier alert: Transluminal operations on the femoral artery	No evidence of risk

Care Quality Commission
Finsbury Tower
103-105 Bunhill Row
London
EC1Y 8TG

Telephone: 03000 616161
Fax: 020 7448 9311
www.cqc.org.uk

John Adler
University Hospitals of Leicester NHS Trust
Trust HQ
Level 3 Balmoral
Leicester Royal Infirmary
Leicester
Leicestershire
LE1 5WW

23 October 2013

Dear Mr Adler

Wave 2 acute hospital inspection programme: January-March 2014

I have now been the Chief Inspector of Hospitals at CQC for three months and we have carried out six acute trust inspections using the new approach that I outlined when I was appointed, with a further 12 scheduled to be inspected by Christmas.

On Thursday (24 October) I will be publishing a list of 19 acute trusts that we will inspect between January and March 2014. This will be the second wave of inspections using this new model and will let us build on the learning and improvements we have made during the 18 inspections in 'wave 1'.

We will be inspecting your trust using the new CQC model as part of this second wave. My colleagues will be in touch within the next fortnight regarding what this means in practical terms and with dates for our planned inspection. I wanted to let you know about your inclusion in 'wave 2' and thought it would be helpful if I gave you an overview of what this new model entails.

The new inspection teams will be large (over 20 people) and will be headed by a senior NHS clinician or executive, working alongside senior CQC inspectors. The teams include professional and clinical staff and other experts, including trained members of the public ('experts by experience'). Many of these are volunteers who came forward when I launched my new approach in July.

The teams will spend at least two full days at the trust inspecting every site that delivers acute services, and eight key service areas: A&E; acute medical pathways including the frail elderly; acute surgical pathways; critical care; maternity; paediatrics; end of life care and outpatients. The teams will look at other services where necessary, and for some trusts in 'wave 2' we will be testing methodology to look at community services provided by acute trusts.

The inspections are a mixture of announced and unannounced and may include inspections in the evenings and weekends, when we know people can experience poor care. Our inspection teams make better use of information and evidence to direct resources where they're most needed. Our analysts have developed new triggers to guide the teams on when, where and what to inspect. Before they inspect, the teams assess a wide range of

quantitative data, including information from our partners in the system, and information from the public.

Each inspection will provide the public with a clear picture of the quality of care in their local hospital, exposing poor and mediocre care and highlighting good and excellent care. We will look at whether the trust and each of the core services are safe; effective; caring; responsive to people's needs and well-led.

I will decide whether hospitals are rated as outstanding; good; requires improvement; or inadequate. If a hospital requires improvement or is inadequate, I will expect it to improve. Where there are failures in care, I will work with my colleagues at Monitor and the NHS Trust Development Authority to make sure that a clear programme is put in place to deal with the failure and hold people to account.

In the first wave of inspections we are piloting ratings at three of 18 trusts. For the second wave every trust will get a rating. Your inclusion in this wave means my inspection of care services at your trust will include ratings of each of the eight core services, and of the trust overall. By the end of 2015 my teams will have inspected and rated all acute hospitals in this way. You can find out more details on our website – visit www.cqc.org.uk and search for 'new acute hospital inspection model'.

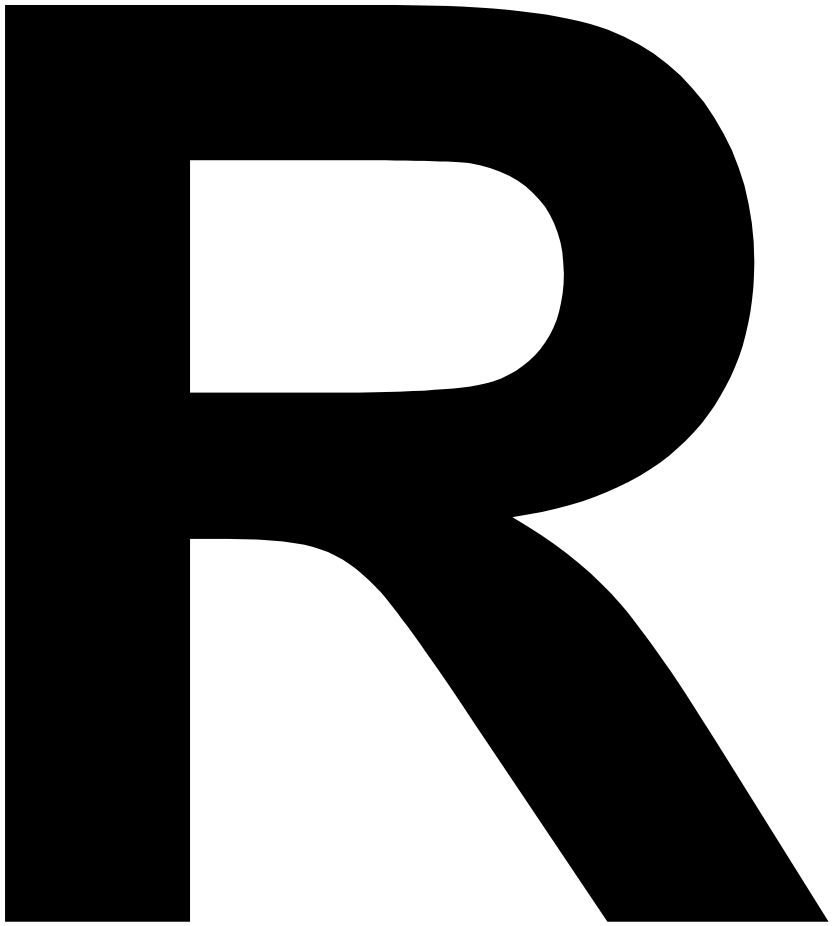
I have made my choices for this second wave of inspections based on our assessment of risk; as follow-ups to the Keogh reviews carried out earlier this year; or depending on where trusts are in the Foundation Trust pipeline (we have considered the views of Monitor and the NHS Trust Development Authority). CQC is publishing details of its 'intelligent monitoring' of NHS trusts tomorrow alongside details of our second wave of acute inspections. You will have received our analysis for your trust and this will be made public on your page on our website tomorrow.

You will receive a follow up from CQC explaining in more detail what this will mean for you and your trust, including the dates on which we intend to inspect. Your CQC regional director should be able to answer general questions about the new model in the meantime, or you can contact Matthew Trainer (London regional director, who is overseeing the national delivery of this programme) at matthew.trainer@cqc.org.uk.

Thank you in advance for your co-operation, and I look forward to working with you in the near future.

Yours sincerely,

Professor Sir Mike Richards
Chief Inspector of Hospitals



University Hospitals of Leicester NHS
NHS Trust

Trust Board Paper R

To:	**Trust Board**
From:	**Kevin Harris, Medical Director**
Date:	**31st October 2013**
CQC regulation:	Outcome 16

Title:	**UHL Mortality Review Report – Saving Lives Update**

Author/Responsible Director:
Kevin Harris, Medical Director
Rebecca Broughton, Head of Outcomes & Effectiveness

Purpose of the Report:

To report the findings of the review of UHL's historical and current mortality performance and what actions have been taken/are in progress to reduce both the Hospital Standardised Mortality Rate (HSMR) and Summary Hospital Mortality Index (SHMI).

The Report is provided to the Board for:

Decision	X	Discussion	X
Assurance	X	Endorsement	

Summary / Key Points:

UHLs mortality in 12/13 as assessed by HSMR was 101, slightly above the average of 100 and "within expected".

The latest SHMI for UHL covering the same time period is 106 which is again "within expected".

UHL's ambition is to significantly better than average and this is one of the key drivers behind the 'Saving Lives' workstream of the Quality Commitment, which aims to save 1000 extra lives over the next 3 years.

Significant progress has been made with the implementation of the Respiratory Pathway, to manage patients with severe respiratory illness like pneumonia.

Within that overall Trust results there are differences between hospitals; in 12/13 the Leicester Royal Infirmary's HSMR was 114, the Leicester General Hospital's was 81 and the Glenfield Hospital's was 82

The Dr Foster Hospital Guide for 2013 will publish both Trust and Site specific mortality rates for 12/13 and this will show the Leicester Royal Infirmary, home to the LLR Emergency Department, as having a 'higher than expected HSMR'.

The reasons for the differences between the sites are discussed and the actions being taken to address this are outlined.

It is of note that in 12/13 64% of the emergency and sickest patients are treated at the LRI compared to15.5% at the GGH and 20.5% at the General

A key priority for the Trust remains that our service redesign ensures that patients receive the right care in the right place at the right time.

This comprehensive report includes:

Mortality Rate Definitions – Section 2.0
Historical Perspective – Section 4.0
Previous Mortality Reviews within UHL – Section 5.0
Current Work-streams to Reduce Mortality – Section 6.0
Current HSMR/SHMI Position – Section 7.0
Dr Foster Hospital Guide 2013 – Section 8.0
Summary – Section 9.0

Recommendations:

Committee members are requested to receive and note the content of this report and to support the recommendations in Section 10.0

Strategic Risk Register	**Performance KPIs year to date**
None	HSMR – 98 SHMI - 106

Resource Implications (eg Financial, HR)

See Section 9.0

Assurance Implications
SHMI - *Accountability Framework for NHS Trust Boards*

Patient and Public Involvement (PPI) Implications

N/A

Equality Impact

N/A

Information exempt from Disclosure
No

Requirement for further review?

Further updates will be provided to the Trust board in the monthly Q+P reports.

University Hospitals of Leicester NHS
NHS Trust

Caring at its best

Review of Hospital Mortality Rates at University Hospitals of Leicester NHS Trust

October 2013

Dr Kevin Harris, Medical Director
Rebecca Broughton, Head of Outcomes & Effectiveness

1. Introduction

1.1 As the primary provider of acute care services to the population of Leicester, Leicestershire and Rutland services, the University Hospitals of Leicester NHS Trust has a responsibility to ensure services are safe and of a high quality.

1.2 Hospital mortality statistics, of which there are a number of different methods, are a commonly used tool for measuring the safety and quality of hospitals. However there are many caveats and limitations on the use of hospital mortality statistics and their interpretation requires great care to ensure a complete understanding of the contributory factors to either a 'higher than the England average' or 'greater than expected' mortality statistic.

2.0 Definitions

Hospital mortality statistics include the Hospital Standardised Mortality Ratio (HSMR), the Summary Hospital Level Mortality Indicator (SHMI) and the crude mortality rate. These are published at different intervals (monthly, quarterly or annually) by a range of organisations and each is calculated using different formulae and definitions and each has its limitations.

2.1 Risk adjusted Hospital Mortality Rates (in hospital deaths)

The most commonly used methodology is the Hospital Standardised Mortality Ratio (HSMR). HSMR is a ratio of the observed number of in-hospital deaths at the end of a continuous inpatient spell to the expected number of in-hospital deaths (multiplied by 100) for 56 diagnosis groups (this equates to about 80% of deaths). The expected deaths are calculated from logistic regression models with a case-mix of: age band, sex, deprivation, interaction between age band and co-morbidities, month of admission, admission method, source of admission, the presence of palliative care, number of previous emergency admissions and financial year of discharge. The HSMR risk adjustment model uses both primary diagnosis and co-morbidities taken from the **'first** episode of care' within an admission spell to calculate the predicted mortality rate.

The HSMR is produced by the commercial company Dr Foster Intelligence and also the Hospital Evaluation Data (hosted by University Hospitals of Birmingham NHS Trust).

Other companies produce their own standardised mortality statistic, usually with their own methodology. One of these is CHKS who produce the Risk Adjusted Mortality Index (RAMI). RAMI uses a similar methodology to the HSMR except it looks across **all** episodes of care to find secondary diagnosis codes (co-morbidities) and also uses the primary diagnosis within the highest Health Resource Group during the admission spell to calculate the risk adjustment. This means that the risk of mortality may be considerably higher than it would have been if the 'primary diagnosis on admission' had been used and subsequently will lead to a lower RAMI than HSMR for the same group of patients.

2.2 Standardised Hospital Mortality Rates (in and out of hospital deaths)

In 2010 a national Steering Group was established by Sir Bruce Keogh with the purpose of developing a consensus view of the key methodological requirements for a practical Hospital Standardised Mortality Ratio. The steering group recommended the use of SHMI and this is has now been widely adopted across the NHS.

The key points about SHMI are that it:

- covers death relating to all admitted patients that occur in all settings, i.e. in and out of hospital, from admission to 30 days post-discharge,

- applies to all NHS acute trust except specialist hospitals

- is the ratio of the Observed number of deaths in a Trust vs. Expected number of deaths over a period of time. The SHMI uses 5 factors to adjust mortality rates: Primary admitting diagnosis; type of admission co-morbidity (Charlson); age and sex.

- crucially it does not adjust for 'palliation' and therefore does not take account of the likelihood that if they are receiving palliative care they are probably being admitted with a terminal illness and their death is unlikely to be preventable.

2.3 Crude Mortality

Crude mortality rates are typically the number of deaths divided by the number of admissions, but these do not take account of the variation in type of illness (and associated risks of mortality) that patients present with to different hospitals and also will obviously be highly dependent upon which type of activity is included in the denominator (day case, elective, short stay etc) so cannot reliably be used to compare hospitals.

2.4 Using Risk Adjustment Mortality data

There is on going debate amongst experts about what factors should be taken into account when estimating how many patients might have been expected to die over a given time period (the risk adjustment model).

Whilst the 'risk adjustments' are supposed to take account of different patient groups and case mix, no model currently produces a perfect risk adjustment. As no two hospitals will admit exactly the same sort of patients, it may not always be appropriate to draw conclusions simply by comparing two hospitals HSMRs or SHMI.

In his 'open letter' to the Secretary of State for Health, Sir Bruce Keogh emphasised "the complexity of using and interpreting aggregate measures of mortality, including HSMR and SHMI" and further went on to note that two completely different lists of outlier trusts were identified when using the HSMR and SHMI to determine which trusts should be in the first wave of reviews. The report also quotes Robert Francis as having said 'it is in my view misleading and a potential misuse of the figures to extrapolate from them a conclusion that any particular number, or range of numbers of deaths were caused or contributed to by inadequate care' (*Review into the quality of care and treatment provided by 14 hospital trusts in England: overview report by Professor Sir Bruce Keogh, 16 July 2013*)

These indicators provide an important and valuable tool for Trusts but it is essential that their meaning is not over interpreted or be seen necessarily by the public as a cause for alarm. Rather a high HSMR should be used as a "smoke alarm" prompting the hospital to undertake further investigation to ensure the factors contributing to that HSMR are fully understood and to make corrective interventions where necessary to ensure patient safety.

Despite these limitations the HSMRs for individual Trusts are routinely published in the annual 'Hospital Guide' produced by Dr Foster Intelligence. In addition the NHS Trusts who underwent the recent "Keogh Reviews" were chosen on the basis of a consistently high HSMR. There is also an increasing focus on those Trusts with a higher SHMI.

3.0 Causes of high mortality statistics

3.1 Mortality statistics are usually reported within the context of a range of values within which a hospital could be by chance alone. Once the value is outside of this range (ie being an "outlier"), it is unlikely that the rate (whether higher or lower) could reasonably be

expected by chance alone. At this stage other factors may be at work and further investigation is required.

3.2 Poor quality care is one potential reason for a high HSMR rate and it is essential that this is immediately considered and investigated. However, this may not always be the reason and to presume so can be premature.

3.3 The explanation for a high HSMR can be complicated and multi-factorial and a consequence of a complex mix of factors including

- case mix (how severely ill patients are when they are admitted to hospital)
- lifestyle choices such as smoking and diet
- disease coding (how accurately the patient's presenting conditions are categorised to one or more standardised disease categories)
- quality of care in primary care and community settings e.g. care homes
- quality of care in hospital
- availability of options to support end of life care e.g. local hospices
- patient choice of where to die
- chance variations

3.4. A high mortality rate or ratio in itself does not necessarily imply that there is any reason for concern about the quality of clinical care at the hospital; rather it is described as a "smoke alarm" that should trigger examination of pertinent factors including clinical care to see whether they can explain the outlying mortality statistic.

3.5 Many factors that cause a hospital to have a high mortality statistic may be outside the direct control or influence of the hospital i.e. lack of hospice beds. This will be particularly relevant for the SHMI indicator which does not include palliative care in its risk adjustment model. Therefore a terminally ill patient will be assessed as having the same risk of mortality as someone who has been newly diagnosed with the same condition.

3.6 It is also important not to view an average (within range) HSMR as automatically acceptable, since within hospitals there may be areas of exceptional care and other less strong areas. In such cases an area with a high HSMR could be masked by better performance in other areas. It is therefore essential that trusts monitor all specialities and looks for the "smoke alarms" which should trigger further investigation.

4.0 Historical perspective

4.1 <u>Early attempts to publish hospital mortality statistics</u>

The first attempt to calculate and compare mortality rates in different hospitals was undertaken by Florence Nightingale in 1853. Her attempts were criticised and the practice was not continued. Some of the criticisms have relevance to today:

(i) there were shortcomings in the formula she chose to use to calculate mortality rates: she divided the number of deaths by the number of beds in the hospital. As a result some hospitals had apparent mortality rates of nearly 100%, which did not convey meaningful information.
(ii) some hospitals with high mortality rates claimed this was something to be proud of, since they were clearly taking care of the sickest patients.
(iii) other hospitals tried to conceal deaths by discharging very sick patients before they died.
(iv) getting hospitals to provide her with comparative statistics proved more difficult than she had anticipated.

4.2 NHS mortality rates

Standardised Hospital Mortality Rates have not been systematically published by the DoH or other National bodies until the introduction of the SHMI.

In 2002/3, the Commission for Health Improvement (CHI) included two mortality related indicators as part of its Star Ratings (Deaths within 30 days of a selected surgical procedure and deaths within 30 days of a heart bypass operation). For both indicators, UHL's performance was always in line with the England average.

The Healthcare Commission annual health check, introduced in 2006/07, replaced the old star rating system and did not include any mortality indicators. When CHI handed over to the Care Quality Commission this continued.

4.3 Publication of the HSMR

Hospital mortality statistics first began to be routinely published in England in 2001 in the Sunday Times as the Dr Foster "Good Hospital Guide" (produced by the Dr Foster Unit at Imperial College London). Three quarters of the hospitals with the lowest HSMRs were in London and the South East (University College London Hospital's HSMR at 68 was the lowest) whilst several hospitals in the Midlands were identified as having the highest HSMRs in the country. This prompted analysis and investigation to understand why the HSMR varied so much across the country.

Of the 152 trusts analysed in the 2007 Hospital Guide 'How healthy is your hospital?' - 56 trusts were listed as having a high mortality rate during 2005/6 (of which UHL was one with an HSMR of 109), 45 had a low mortality rate and 51 had an average mortality rate.

The following year, UHL's HMR had dropped to 89 and UHL was named as being one of the trusts with the 'lowest HSMR' in the 2008 Hospital Guide 'The Health of our Hospitals Revealed'.

The Hospital Guides between 2009 and 20011 did not include Trusts' HSMRs.

4.4 SHMI

SHMI was first published in October 2011 and covered the period 2010/11. Of the 147 trusts with a published SHMI, 79 had a SHMI greater than 100 but most of these were 'within expected' range. UHL's SHMI was106 and fell within the expected range when using the 95% control limits.

(Initially the SHMI was published using both 95% and 99% control limits (the range which determines "within expected"). When using the more sensitive 99.8% control limits more Trusts including UHL become "higher than expected", but this is no longer felt valid and SHMI is now only published using the 95% control limits).

5. 0 Mortality Reviews within UHL

5.1 Clinical Benchmarking

In 2008/09 UHL used the Dr Foster's 'Real Time Monitoring' Tool to report HSMR and 'Post Procedural Mortality' at a Trust level and in 2008/09 UHL's HSMR was 95. The tool was also used to monitor any diagnosis or procedural groups with a 'higher than expected mortality'. There were 8 alerts in 2008/09, and no clinical concerns were identified from any of the alerts reviewed.

During 09/10 UHL after a tendering process for provision of a clinical and activity benchmarking system and from 1st April 2010, UHL commenced a 3 year contract with CHKS (Comparative Health Knowledge System) which replaced Dr Foster's 'Real Time Monitoring' Tool'.

5.2 Mortality & Morbidity Process Review

During 2010/11, the Trust's produced a policy outlining how Mortality and Morbidity (M&M) reviews needed to undertaken and documented by all specialities (prior to this they were undertaken in a variable way). All CBUs were required to ensure that Mortality & Morbidity Review meetings were held in all specialities to an agreed minimum standard with agreed terms of reference. This was set out in UHL's M&M policy.

To inform the M&M review process, monthly reports were generated from the Trust's 'data warehouse' providing details of all in-hospital deaths plus patients who have been coded as having had either a 'misadventure' or 'hospital acquired complication'.

5.3 Elective Mortality Review

For the first Quarter of 10/11, the trust had a 'higher than expected' HSMR rate for its 'elective admissions' during May and June.

A review of case notes identified that a number of patients had been wrongly coded as being 'elective admissions', and this explained the alert. Review of the actual elective admissions did not identify any delays in treatment or inappropriate management with several patients having significant co-morbidity and/or advanced disease.

5.4 Non-Elective Mortality Review

Following an increase in the Trust's Non Elective RAMI during December and January10/11, a review was undertaken by the Medicine and Respiratory CBU Medical Leads, and was reported to the Clinical Effectiveness Committee.

The key finding were:

- an increased number of elderly, frail patients with several co-morbidities had been admitted during those months,
- many with pneumonia which has a recognised high mortality rate and a known 'seasonal variation'

5.4 Quality Account 2011/12

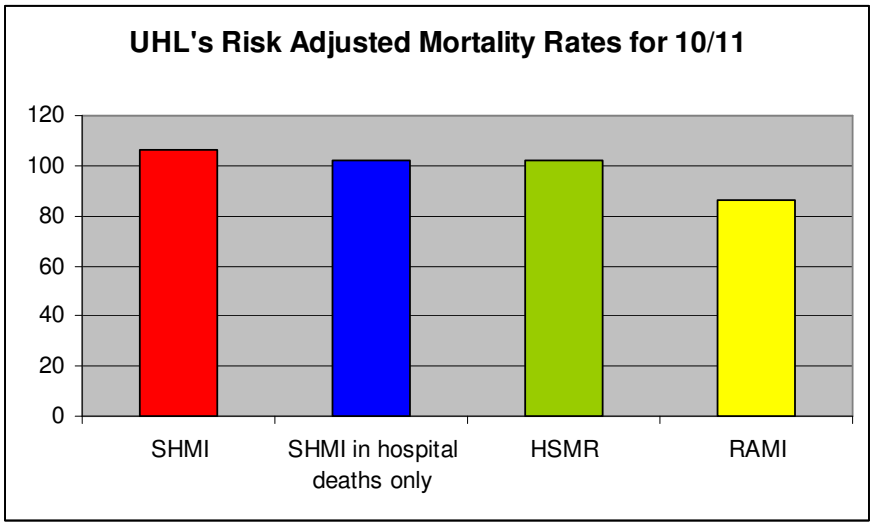
Improving Mortality Rates was one of the Quality Account priorities for 2011/12. At the time the Trust was using CHKS for its clinical benchmarking and UHL's RAMI for 10/11 and for 11/12 was well below the England average

Another Quality Account aim was to look in greater detail at the mortality rates for patients from Black, Minority and Ethnic Groups (BME). 16-18% of UHL admissions are patients from BME groups and most patients are from the Asian/Asian British Group. Using patient demographics data as captured on HISS, the crude mortality rate for UHL patients from a BME group (0.9%) is lower than for 'White British/White Other" (1.7%). CHKS did not include ethnicity in their RAMI tool and benchmarking mortality rates for BME groups was therefore not possible at the time.

5.5 UHL SHMI Review

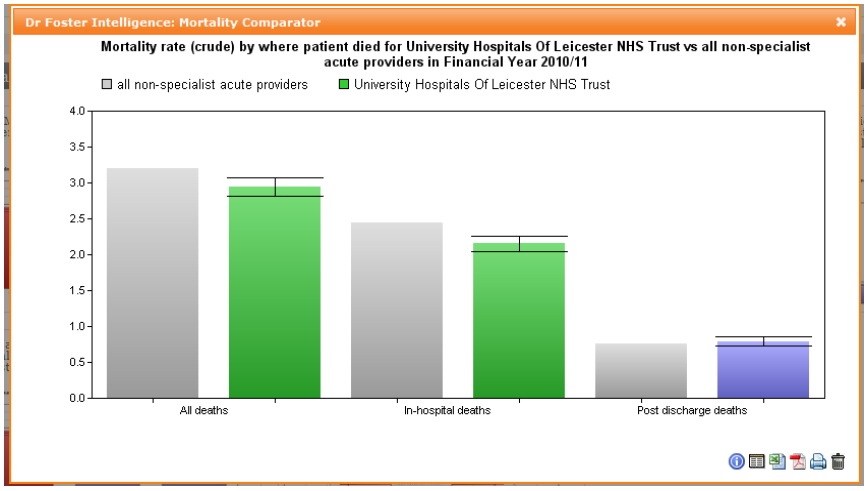
In 2011, the Trust had been routinely reporting RAMI using CHKS risk adjustment model. At that time UHL's RAMI was 86. However during 2011, the HSMR was 102 and subsequently a SHMI of 106 was published.

The main reason for this discrepancy is the use of primary diagnosis in the first episode of care for HSMR and SHMI but the highest HRG for RAMI. For example, if a patient is admitted with a chest infection but later during their hospital stay this develops into pneumonia, they will be given different mortality risks by CHKS than they would have been by Dr Fosters. Dr Fosters will use the 'admission diagnosis of chest infection' for their risk adjustment whilst CHKS will use the subsequent pneumonia diagnosis which is known to have a much higher mortality risk.



5.6 Crude Mortality

Previous reviews of UHL's crude mortality rates have shown that it is lower than other similar sized Trusts. However, since SHMI has been available it is apparent that UHL's 'post discharge' crude mortality rate is higher than the England average.



5.7 Top 10 Diagnosis Groups

Following publication of the SHMI, a review was undertaken of a sample of case notes of deceased patients in 3 of the 'Top 10 Diagnosis Groups' – Urinary Tract Infection; Myocardial Infarction and Gastro-intestinal Bleed.

The aim of the review was two-fold:

- Confirm the type of 'death classification' (as per UHL M&M policy) and whether management was appropriate.
- Confirm whether the diagnosis was correctly coded and also whether the depth of coding in respect of co-morbidities was complete

The main findings of the review were:

Urinary Tract Infection - most patients were frail, very poorly on admission and admitted with symptoms of infection but source unknown and all had multiple co-morbidities. Few patients had positive urine microbiology (a diagnostic requirement for urinary tract infection). The "on admission" diagnosis and associated co-morbidities were poorly documented, making it difficult for the coders to have coded accurately.

Gastrointestinal Bleed - coding of the primary diagnosis was correct in all cases (all patients did have a GI bleed). Co-morbidities were less well captured. Several patients had malignancy or alcoholic liver disease and all had co-morbidities. Some patients were from nursing homes with 2 on 'end of life pathways' prior to admission and all but one of these patients were put onto the 'end of life' pathway post admission.

Myocardial Infarction - Coding of primary diagnosis was correct but documentation of co morbidity was again poor.

5.8 Pneumonia Mortality Review

A review of pneumonia mortality (which is the largest diagnostic group contributing to the Trust's SHMI) was already part of the Pneumonia Local CQUIN Schemes. The specific aim has been to improve the management and outcomes of patients admitted with pneumonia. The overall mortality rate in April 10 had been in line with the national average but there had been a higher rate for patients with less severe pneumonia (CURB score 2). There had been a reduction in the mortality rate for this group at a Trust level but a higher mortality rate for this group remained at the Leicester Royal Infirmary (LRI).

Those patients who had been admitted with pneumonia and subsequently died were also specifically reviewed. This identified a need for improvement with assessment of severity of illness, timing of senior review and prescription of antibiotics particularly at the LRI. Existing Pneumonia Guidelines were actively drawn to the attention of the Junior Doctors by a lead AMU physician and a 'Pneumonia flag" was introduced.

5.9 Out of Hours Admissions

The 2011 (DFI) Hospital Guide focused on mortality rates for patients admitted as an emergency 'out of hours'. As with the majority of Trusts, UHL's HSMR for weekend emergency admissions was higher than for weekday admissions, but it was still 'within expected'.

Potential contributory factors to a worsening mortality rate for emergency patients admitted 'out of hours' include staffing levels, access to diagnostic services and senior review. 24/7 working in the NHS is currently the subject of a national review. In addition other contributory factors could include differences in frailty and acuity of patients admitted 'out of hours' and the out of hours availability out of hours of alternative pathways of care for those on end of life pathways.

5.10 Public Health, LLR CCGs & UHL SHMI Review

Following UHL's internal analysis of SHMI data and case note review, further work in collaboration with the LLR CCGs and Public Health has been undertaken. No correlation between the UHL SHMI and percentage of deaths that occurred outside hospital, the use of palliative care coding or the percentage of elective and non-elective admissions was found. Neither did there appear to be any statistical difference between mortality for City and County patients. Part of the report included findings from analysis of ONS and Hospital Mortality Data which identified that a third of the 'out of hospital deaths' occurred at home, a third were in 'care/nursing homes' and a quarter in community hospitals.

Following presentation of the report to the LLR Cluster and CCG Boards, (Nov 12) an 'LLR overview committee' was established to take a health community approach to understanding what factors most impact on the 'in and out of hospital deaths'.

5.11 November 12 Mortality Review

A 'semi prospective' review of a sample of patients that died in November 12 was undertaken by a single clinician within UHL, including those that died within 30 days of discharge from UHL (ie using the SHMI methodology).

64 sets of notes were reviewed (27% of 238 adult deaths in November). 79% were from Acute care and 21% from Planned. 3 deaths were identified in which although the death was felt to be 'likely' due to the severity of illness on admission not 'all management was appropriate'. The identified deficiencies in management were:

- failure to order an abdominal Xray (in patient with possible bowel obstruction)
- poor handover in between ED juniors/ AMU
- failure to recognise/ understand the significance of abnormal arterial blood gases.

5.12 Boston Consultancy Review

At the beginning of 2013, the Trust commissioned an in-depth analysis of UHL's SHMI and other mortality data by the Boston Consultancy Group. This work identified two groups of patients that appeared to have the greatest impact on the '>100 SHMI':

- Patients admitted at weekends or 'out of hours'
- Patients with a respiratory diagnosis (specifically pneumonia)

These were therefore identified as priorities to be taken forward by the 'Saving Lives Quality Action Group' as part of the Trust's Quality Commitment.

5.13 LLR Patient Care Review

In March 13 an 'interface review' was commissioned by the LLR Mortality Summit, to look at patients who had died following admission to the LRI following a cardiac arrest or admission to the Critical Care Unit and within 30 days of discharge, following transfer to a community hospital or care home (but where the home was not the patient's residence on admission)

The review was carried out by a group of medical staff (both GPs and UHL Consultants) and a group of nursing staff (from Community Nursing Teams and UHL) and examined the standard of care provided. The purpose of the review was not to attribute events to death

nor to establish whether the death was preventable but to ascertain whether the standard of care the patient received from both UHL and primary care was acceptable.

The results of this review are due to be formally reported to the trust at the end of October. Preliminary findings have been shared with the Medical Director and Director of Nursing and most of the areas for improvement are already known to the organisation and have actions in place as part of the Critical Safety Actions workstreams:

Ward Rounds and recording of ward round discussions
Clinical Handover
Following up and acting on results
Responding to Early Warning Scores
Sepsis

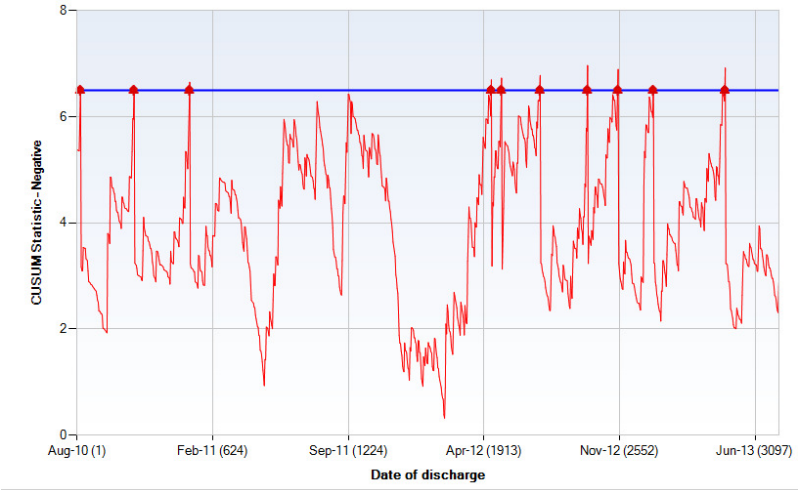
It is also anticipated that the report will identify a need for improvements within LLR for the management of those patients on “end of life pathways”

5.14 Reviews of Dr Foster Alerts

The Dr Foster clinical benchmarking system includes provision of a monthly alert summary report which shows the number of times a diagnosis or procedure has alerted in the CUSUM chart. An alert could be the result of one death in a speciality where this would not be expected (immunisation and screening for example) or several deaths where this would have been expected (cancer pathways for example).

Alerts which have required specific attention include:

i. Other Perinatal Conditions



‘Other perinatal conditions’ and ‘Short gestation’ previously alerted in the Dr Fosters tool in 2009/10 and were thoroughly investigated, with several actions undertaken and reported to the UHL Clinical Outcomes Group in July 2010. Actions included both review of clinical pathways and also addressing identified coding anomalies.

ii. Alerts relating to General/GI surgery in 2013.

All have been investigated by the CBU and the findings were reported to the Planned Care Quality and Safety Board.

The overwhelming majority of patients either had advanced cancer with short expected survivals. The surgical procedures were appropriately performed either for palliation or on

extremely ill patients with an expected high mortality rate even with surgery. All reviews have confirmed that patients died because of their condition rather than as a result of the procedure.

iii. Cardiac related alerts.

There were 2 cardiac related alerts in 12/13 (CABG and Mitral Valve Repair). Both alerts were investigated and related to coding anomalies. All care was appropriate.

iv. 'Fracture of upper limb' or 'other connective tissue injury' alerts.

In these cases the patient's admission was precipitated by a relatively minor injury, but they had an underlying severe medical condition (malignancy, heart failure, dementia) which required them to be admitted rather than managed at home. The coding rules require that the primary diagnosis is taken from 'the reason for admission' with the other condition (malignancy, heart failure, dementia etc) is coded as a 'co-morbidity'.

v. alert for 'Immunisation and Screening for Infectious Diseases' (one patient)

This resulted from the death of a 90 year old patient who was admitted with suspected TB was and discharged to one of the Community Hospitals. The patient was subsequently was admitted to UHL with cholecystitis (unrelated) from which they died. Their primary diagnosis was coded from the first episode of care and not the subsequent re-admission.

6.0 Current workstreams.

6.1 Improvements in Care Actions

The workstreams for the 13/14 Quality Commitment 'Saving 1,000 Extra Lives' are making good progress.

Hospital 24/7 is now being implemented at the LRI and there has been significant progress to ensure 'earlier senior review' and appropriate 'ward round standards' within the Critical Safety Actions.

Further detailed analysis of the respiratory data at the Glenfield Hospital has demonstrated that the increased mortality associated with 'out of hours admissions' is not all accounted for by conditions amenable to medical treatment but could be related to the end of life management of a terminal illness where out of hours there is no alternative to admission. The methodology behind this analysis is now being applied to non-respiratory diagnoses groups across the Trust to see if there are similar findings.

A respiratory pathway has now been implemented (as of 1st July) which should see increased number of patients with primary respiratory conditions admitted directly to Glenfield Hospital. Frailty patients with multiple co-morbidities who need geriatrician input to support their recovery wil continue to be managed by the appropriate clinicians who are based at the Leicester Royal Infirmary. Monitoring has demonstrated that there has been an increase in those patients with respiratory conditions but without co-morbidities going to Glenfield. However it is too early to assess the impact on mortality.

The implementation of the Pneumonia Care Bundle has been supported by the appointment of two Pneumonia Nurses in September. They work across both the LRI and Glenfield sites. The full impact of these changes to the management of respiratory conditions will not be known until after the winter period.

The health community are developing plans to improve the management of 'end of life' and 'Deciding Right' is an integrated approach across Leicester, Leicestershire and Rutland (LLR) to enable adults to make decisions about their care in advance. 'Deciding Right' particularly relates to care for patients who might be nearing the end of life or who are in the advanced stages of a chronic health problem, including those who may lose capacity in the future or have already lost capacity to make decisions about their care. Work has also commenced on a LLR wide Electronic Palliative Care Co-ordination System.

6.2 Improvements to Mortality & Morbidity Process

All specialities hold M&M meetings, but they have different levels of support and the format is not consistent. All elective deaths are reviewed and in those specialities with small number of deaths all patients' case notes are reviewed. However currently only a predefined subset of non elective deaths are reviewed in General Medicine or General Surgery. The M&M leads review the mortality reports which provide coded data but the patients' notes are only retrieved where the coding suggests the death was 'unexpected'.

Mortality reviews are currently only undertaken on those patients that die within the hospital and do not include those that die within 30 days of discharge (ie those that would be included in the SHMI.

Minutes of meetings, including summaries of reviews, are being filed on 'M&M shared drive'. Delays in implementation of Sharepoint has meant that central collation and analysis of the reviews relies on a manual and time consuming process.

A proposal that the Trust should acquire an M&M database which collects data on all deaths (both within hospital and within 30 days of discharge) and could incorporate the death certificate cause of death data is being developed. This would ensure a more standardised approach to the M&M meetings with all deaths being reviewed within all Specialities, and allow more effective and efficient corporate oversight.

6.3 Re-establishing a mortality review committee

Until 2012 UHL had a Clinical Effectiveness Committee chaired by the Medical Director which oversaw both mortality and clinical outcomes. Its work was subsumed into both the governance structures of the Divisions with corporate oversight from the QPMG.

With the current restructuring, the Trust's Governance arrangements have been reviewed and as part of this it has been proposed that a Mortality Review Committee is established to provide improved focus and corporate oversight of the key issues relating to mortality.

Draft Terms of Reference have been written and these will be implemented with the changes to the Trust's Governance structures which have recently been endorsed at a Board Development session.

6.4 Site Reconfiguration

UHL's current/ estate configuration does not provide an optimal basis for the on-going delivery of high quality services. There is currently a lot of work on-going to improve the configuration both within UHL and across the health community. UHL's site reconfiguration program has "improving the delivery of Clinical Quality" as its number one benefit criteria. Specifically any proposal for reconfiguration will only be taken forward after data analysis and clinical opinion support that the change will:

- Minimise clinical risk
- Reduce preventable deaths
- Improve health outcomes

- Facilitate effective Infection Prevention and Control practices

7.0 The current position

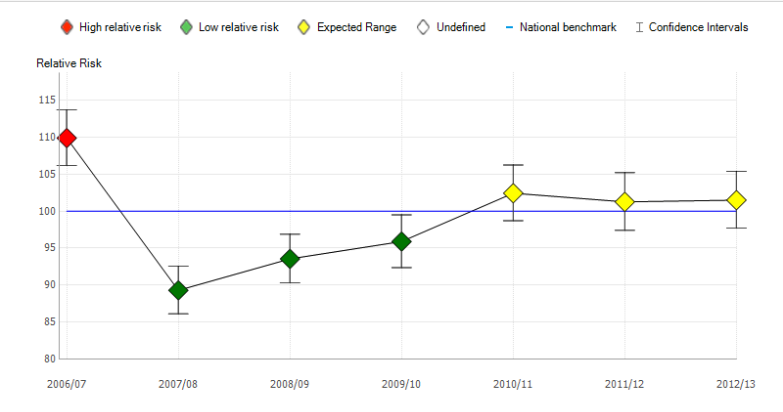
Due to the limitations of the CHKS risk adjustment methodology, the trust is no longer using the RAMI for any of its mortality monitoring. (The CHKS tool is used for market share analysis). UHL subscribes to Dr Fosters and since the beginning of October 2013 has acquired the Hospital Evaluation Data (HED) tool which allows further analysis of mortality data.

The Dr Fosters HSMR and Relative Risk models are being used by the Corporate Medical team to monitor mortality rates at both a Trust and diagnosis group level – specifically by review of the monthly 'Alerts'.

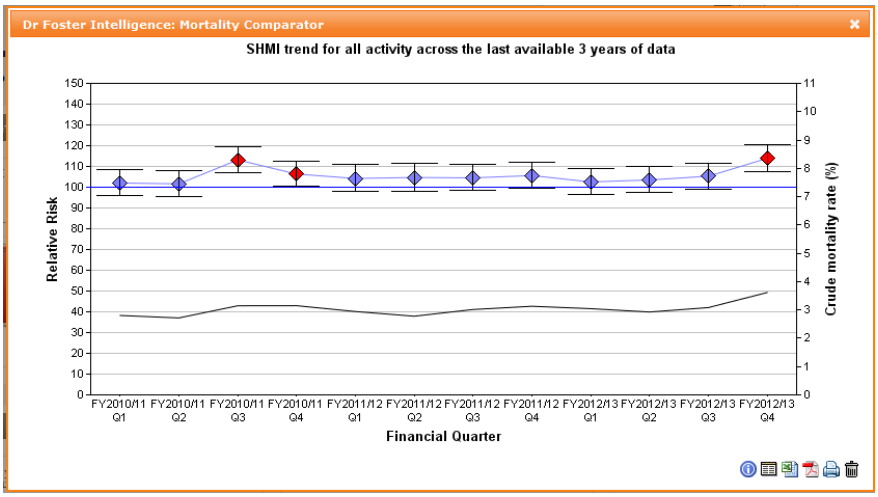
The HED tool includes both HSMR and SHMI data at a patient level. Also, whilst Dr Foster do provide some SHMI analysis at a trust or diagnosis group level, they do not have access to the data until the latest SHMI is published, whereas HED have access to the ONS data and so are able to provide SHMI analysis in the same timescales as they do for HSMR (ie 3 months behind)

7.1 Trust wide HSMR and SHMI

UHL's 3 Year 'Rolling HSMR' between April 2010 and March 2013 is 101.71 (being 102 for 10/11 and101 for both 11/12 and 12/13)



UHL's latest SHMI (covering the time period 12/13) has just been published and is 106 (previous SHMI for Jan to Dec 12 was 105). As can be seen from the chart below, this is because of the increased SHMI for Quarter 4 of 12/13. Although "within expected" range at the 95% control limits if the 99.8% control limits were used this vlue could be "higher than expected".



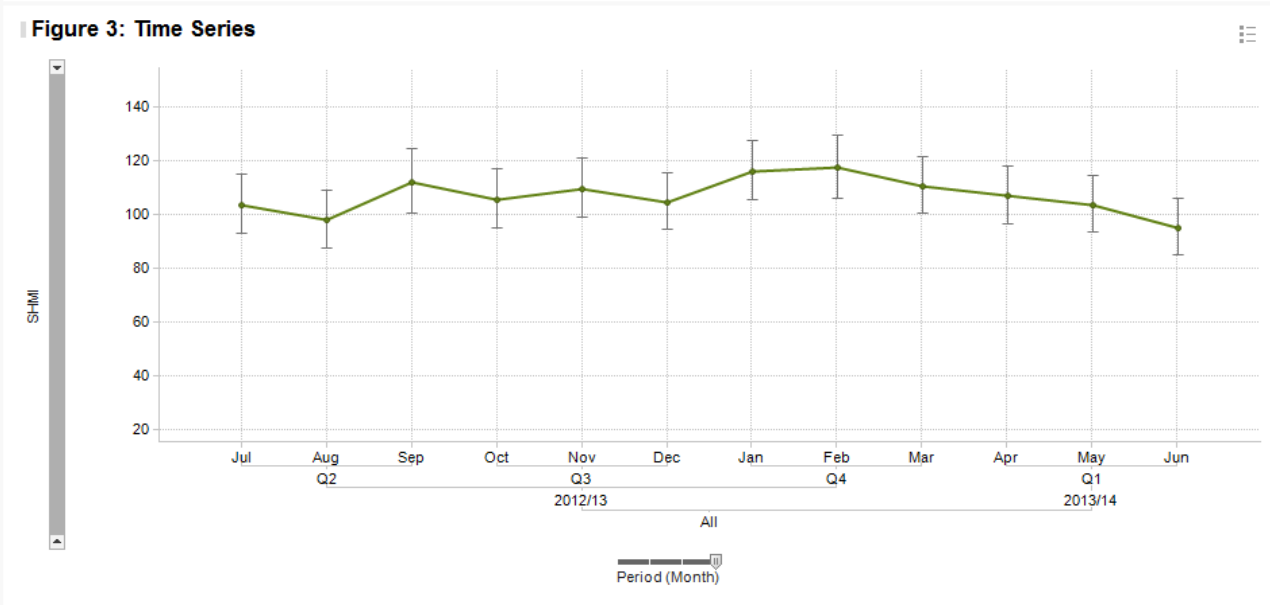
Quarterly SHMI as calculated by Dr Fosters

Therefore, even if the work that is being currently undertaken does reduce our risk adjusted mortality as expected, it is likely that our SHMI will remain above 100 until the 13/14 SHMI period is published next October 14.

The table below shows those months in the 12/13 SHMI which most contributed to the 106 overall figure and as can be seen, the 'out of hospital' SHMI is significantly higher than the 'in-hospital SHMI'. Although previous SHMI values have shown UHL's 'out of hospital deaths' to be higher than the England average, this is the first time they have been 'significantly greater than expected'

Discharge Month	SHMI	Expected number of deaths	Number of observed mortalities	Number of total discharges	Crude mortality rate	Number of mortalities occuring in the hospital	Percentage of mortalities occurring in hospital	SHMI (in hospital)	SHMI (out of hospital)
Q1 Apr-12	111.95	347	388	11310	3.40%	270	69.60%	105.92	128.94
Q2 Sep-12	112.04	307	344	11523	3.00%	241	70.10%	108.01	122.57
Q4 Jan-13	116.33	376	437	11625	3.80%	309	70.70%	111.64	129.17
Feb-13	117.46	335	394	10968	3.60%	272	69.00%	110.32	136.93
Mar-13	110.79	381	422	11965	3.50%	287	68.00%	102.27	134.37

Using the HED tool to calculate UHL's monthly SHMI, there does appear to have been a consistent reduction since February this year, however, it should be noted that this 'spring reduction' has been seen in previous years.

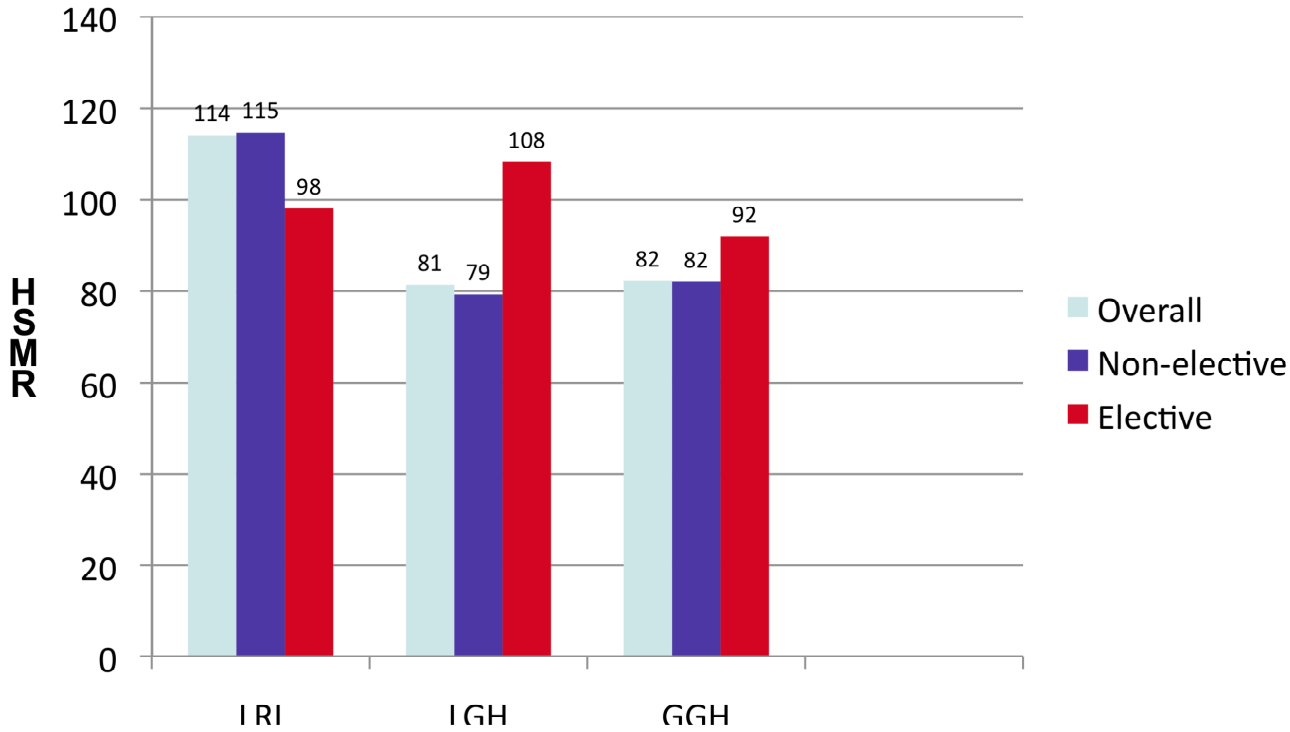


7.2 Site Specific HSMR and SHMI

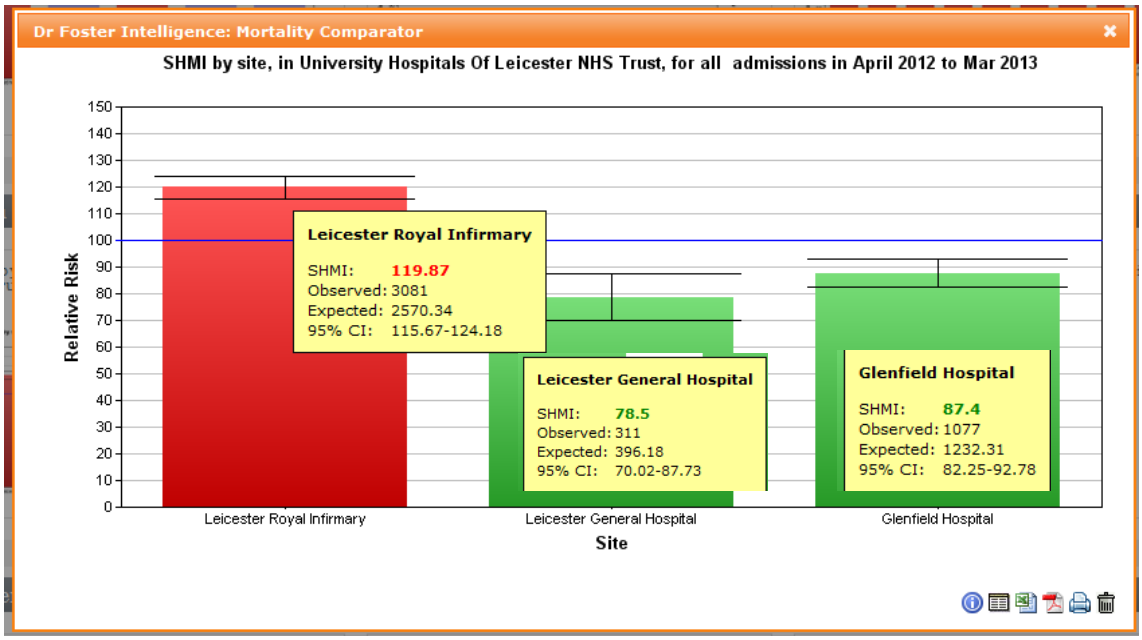
Both the HSMR and SHMI are higher at the LRI than on the other two sites. The 'site specific HSMR' shows that the LRI was 'greater than expected' for 2012/13 (114) and this was predominantly caused by non-elective (emergency) activity (non elective HSMR 115). The site specific elective HSMR for the LRI is within expected and below 100 at 98.

Although the elective mortality at LGH in 2012/13 was above 100 (108) this was "within expected". Cross reference with the UHL M&M process is being undertaken to ensure that all cases were appropriately reviewed and any learning acted upon.

The 13/14 HSMR data is currently showing that the LRI continues to have a higher HSMR than the other 2 sites but this is not currently 'greater than expected' for 'overall HSMR, although this data has not yet been 'rebased'.



The 'site specific' SHMI for the latest SHMI data (as analysed by Dr Fosters) is presented below and shows that the LRI SHMI is 'greater than expected'.

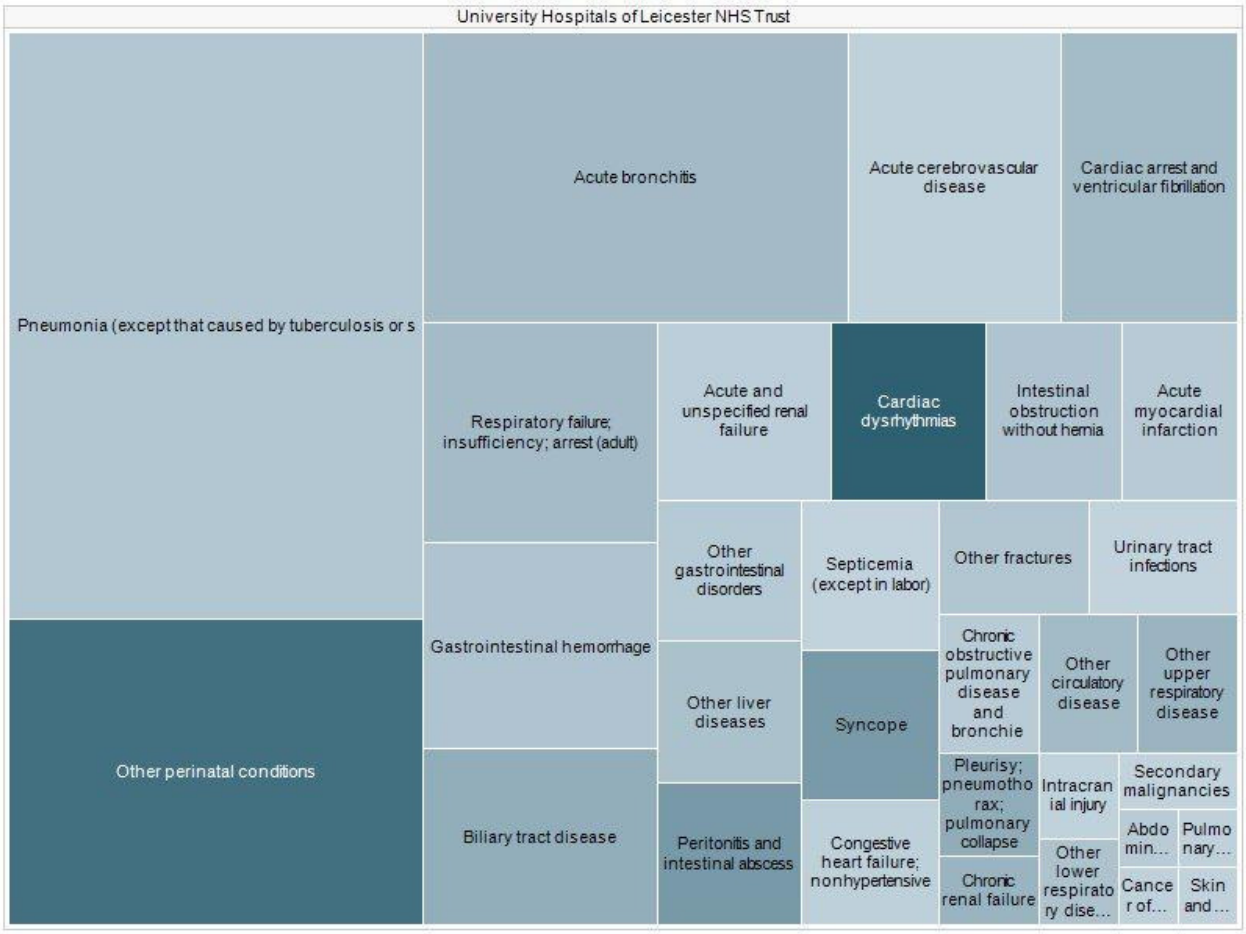


7.3 HSMR by Diagnosis at the LRI

The 'tree chart' below shows which diagnosis groups are most contributing the HSMR either by number of deaths (size of box) or relative risk (depth of blue). It confirms the previous analysis that both respiratory diagnoses and perinatal mortality are the main drivers for the LRI HSMR and as such the current work programs are appropriate

Part of the work being undertaken by the Pneumonia Nurses is to support earlier recognition of pneumonia particualrly at the LRI and to ensure this is clearly documentated so this is then

accurately captured by coding. There appear to be relative differences between LRI and other Trusts which have a proportionatley greater number of patients coded with pneumonia compare to less severe respiratory diagnoses.

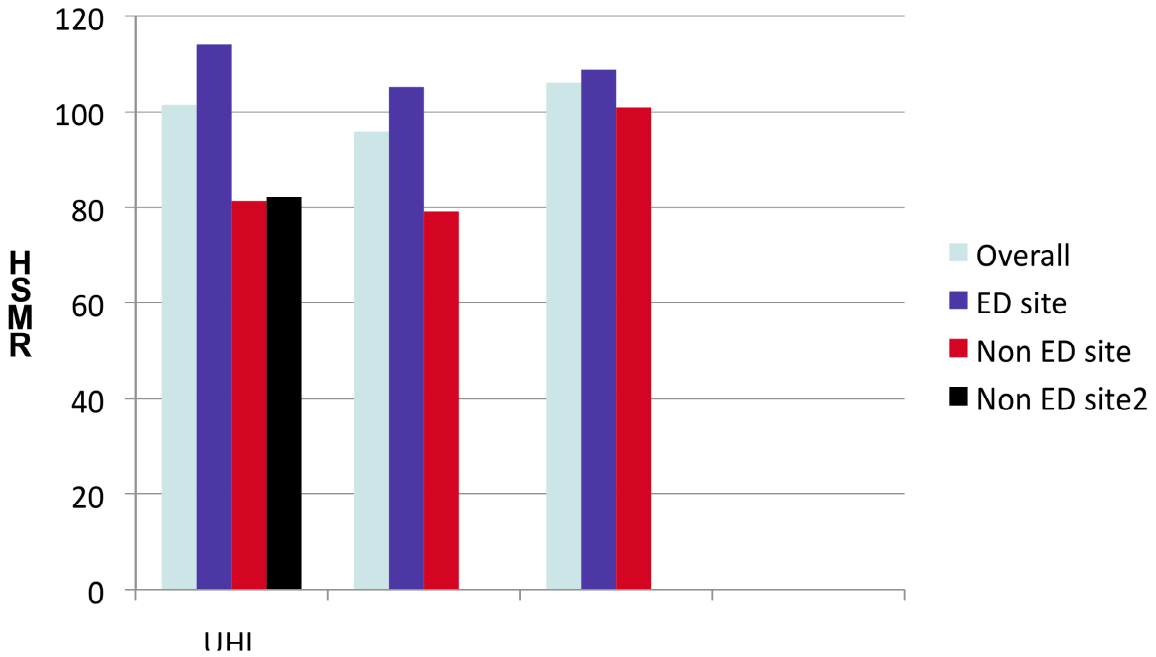


Of note, the LRI Cancer services have a 'lower than expected' HSMR and this has been consistently so for the past 4 years.

7.4 <u>The effect of the Emergency Department at LRI</u>

The LRI is the only one of our sites with an Emergency Department, and as such those patients with the most severe and life threatening conditions present to it. For the most part the most seriously ill patients will not be considered fit to transfer to the other sites within UHL and will be kept at the LRI. One such example is pneumonia which has recognised levels of severity (as measured by the CURB score – 1 to 5) each with its own risk of mortality.

The SHMI and HSMR risk adjustment model cannot adequately correct for how ill the patient is at presentation to hospital and so there will be an intrinsic bias in HSMR against those sites with large Emergency Departments. Evidence from other Trusts with more than one site but only one Emergency Department suggests the Emergency Department site typically has a higher HSMR i.e. it will come as no surprise for most people to know that there is a link between the most poorly patients and mortality.



7.5 Coding at the LRI

The review by the Boston Consulting Group previously identified that the depth of coding was significantly lower at the LRI site than the GGH. It does not seem plausible that the patients at the LRI have fewer co-morbidities than those at GGH but the relevance of this to the LRI HSMR remain to be determined.

Accurate coding is essential and therefore improvements in coding will be underpinned by the use of coding checklists and supporting the structured recording of diagnoses within the notes and the availability of the notes to the coders.

Improving the accuracy and consistency of coding across all areas will be supported by the appointment of the new Coding Supervisor. In addition coding has been proposed as part of the next series of LiA events.

7.6 End of Life

Issues related to 'End of life care' have been a regular theme of most mortality reviews undertaken and also individual M&M reports. A recurring issue is that patients who have (or should have had) an advanced care plan end up being inappropriately sent to UHL.

In the latest National 'End of Life' Profiles, Leicester, Leicestershire and Rutland are all significantly below the England average in respect of deaths in a Hospice and this seems to support the view that many patients are admitted to UHL for 'end of life care'.

One of the primary aims of the 'AMBER care bundle' CQUIN is that patients facing an uncertain recovery, and who are at risk of dying in the next one or two months, have a systematic approach to their care and ideally that where patients have chosen to die at home, the necessary support is provided to meet this choice.

As stated above, a health economy approach to meeting 'end of life' needs is required in order to ensure that similar conversations are had with all such patients and that those decisions are then respected by all health care agencies.

7.4 Perinatal Mortality

Following a series of alerts during 2012, a review in collaboration with both Dr Fosters and the Department of Epidemiology at Leicester University of UHL's perinatal mortality data has been undertaken and it has been confirmed that there are significant differences between Trusts in the way clinical codes are applied in obstetrics. Whether any changes to the way UHL should be applying its coding practice is being examined but it is important to ensure the national Coding Rules continue to be followed.

In the meantime, the Perinatal Death Review Group is continuing to review all deaths and to submit data to the new national MBRACCE database in order that clinical risk adjusted mortality figures can be provided. In addition the Service is undertaking a review of the evidence around effective methods of identifying intrauterine growth retardation (IUGR)

8.0 Dr Foster Hospital Guide 2013

UHL's HSMR has remained above 100 since 2009 and was103 in the 2012 "Inside Your Hospital". Our HSMR will be 101 in this year's Guide – due to be published in November.

It is not yet known what analyses will be published by DFI in November. However it is thought that key themes under consideration for inclusion in this year's Hospital Guide include:

- HSMR (including a three-year version and the Relative Risk based on 100% of deaths)
- SHMI (using 99.8% control limits to determine significance)
- Deaths in low-risk conditions
- Palliative Care Coding Rate
- Case mix Index
- Doctors per bed
- SMRs for AMI, Pneumonia, Stroke, Heart Failure and Broken Hips
- Mortality rates at weekends
- Deaths after Surgery
- HSMR by Hospital Site

A range of the above indicators will also be published at hospital site as well as at Trust level. UHL has been asked to confirm their sites as being LGH, LRI and GGH. A meeting is being held with Dr Fosters on 28th October to review what data will be included in the Guide .

9.0 Summary

UHL's overall mortality is 'within expected' but is not where we want it to be and this is one of the key drivers behind the 'Saving Lives' workstream of the Quality Commitment with good progress being made with the implementation of the Respiratory Pathway.

There are differences in both the HSMR and SHMI between our 3 hospitals which is not surprising given the differences in type of activity and that the Emergency Department for the whole health economy is on one site.

However, whilst not surprising, it is important to work towards improving care provided at the LRI and particularly ensuring the right patients get to the right place at the right time.

10. Recommendations

Note the report and note the workstreams currently underway

Note the progress that has been made to date, but recognise that this work will take time to feed through to an improvement in HSMR and SHMI

Endorse the ongoing work to improve HSMR and SHMI and in particular the workstream aimed at adressing the higher HSMR/SHMI at LRI

Support the work to examine the provision of a dedicated M&M software solution

Endorse the ongoing use of the HED tool by the Trust to support its ongoing analysis and monitoring of HSMR/SHMI

Endorse the approach being undertaken by the Site Reconfiguration Board to underpin the delivery of improved Clinical Quality

S

Trust Board Paper S

To:	Finance and Performance Committee
From:	Rachel Overfield, Chief Nurse
Date:	31 October 2013

Title:	Nursing Workforce Report

Author/Responsible Directors:
Rachel Overfield, Chief Nurse
Maria McAuley, Head of Nursing
Eleanor Meldrum, Assistant Director of Nursing
Louise Gallagher, Workforce Development Manager
Simon Sheppard, Deputy Director of Finance

Purpose of the Report:
The attached paper provides an overview of the nursing workforce position for UHL.

The Report is provided to the Board for:

Decision		Discussion	
Assurance	x	Ratification	

Summary / Key Points:
This paper sets out the current nursing workforce position within UHL including

- Nursing establishment and vacancy levels,
- Bank and agency usage,
- Reasons for expenditure,
- Recruitment plans with trajectories,
- Future monitoring, quality and safety assurance processes in relation to recruitment
- Recommendations

Recommendations:
Finance and Performance Committee members are asked to note the content of this report and provide comment on the position and actions being undertaken.

Strategic Risk Register	**Performance KPIs year to date**

Resource Implications (eg Financial, HR)

Assurance Implications

Patient and Public Involvement (PPI) Implications

Equality Impact

Information exempt from Disclosure

Requirement for further review?
To receive monthly update reports.

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST

MEETING: **TRUST BOARD REPORT**

DATE: **31 October 2013**

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

SUBJECT: **NURSING WORKFORCE REPORT**

1.0 Background

This paper sets out the current nursing workforce position within UHL including

- Nursing establishment and vacancy levels
- Bank and agency usage
- Reasons for expenditure
- Recruitment plans with trajectories
- Future monitoring, quality and safety assurance processes in relation to recruitment
- Recommendations

2.0 Need for Review

A Trust wide review of nurse staffing levels within UHL was undertaken in 2011. In 2013 a further Trust wide review of ward nurse staffing levels was requested by the Chief Executive following the budget setting process for 2013 /14. The review needed to address the following issues:

- Actual budgets for 2013/14 did not reflect budgets set in 2012/13 as these had been set at month 8 out turn
- The 2013/14 budgets did not include the monies required and agreed by the Trust Board following the acuity work completed in 2012
- Budgets needed to include 0.4wte funding for supervisory status for Ward managers

2.1 Agreed Ward Establishments - Nurse to Bed Ratios (N2BR)

Background

The results of a 2007 Trust wide acuity review were triangulated with national staffing recommendations, RCN guidelines, the Association of UK Hospitals (AUKUH) tool and professional judgement of the senior nursing team. The Director of Nursing and Trust Board, at the time, supported the revised N2BR and skill mix for all inpatient beds.

A further acuity review was undertaken in 2012 and the N2BR and skill mix was maintained at similar levels. However it was recognised that the acuity/dependency levels on some wards had changed and an additional £2 million was identified for investment in additional staff for those clinical areas.

The wards requiring extra staffing were in the Medical Specialties CBU, Planned Care and Women's & Children's Division. However the £2 million did not completely fund the financial gap that was identified following the acuity review in 2012.

2.2 Confirmed Nurse to Bed Ratios 2013/14

Table 1
Below confirms the agreed N2BR and skill mix, which the Trust has committed to provide

Ward description	N2BR	Skill mix
Base wards	1.1-1.3	60/40
Specialist wards	1.4-1.6	70/30
Intensive Care	6.6	90/10
High Dependency	3.3	90/10
Children's	1.4	70/30

3.0 Nurse to Bed Ratio Review Methodology

In May 2013 the Deputy Director of Finance and Corporate Head of Nursing designed an 'establishment' spreadsheet that calculated the whole time equivalents with 23% headroom and automatically incorporates 2 days of supervisory time for ward managers. (Appendix 1)

The Corporate Head of Nursing met with every CBU Lead Nurse and Ward Manager who were asked to describe how many staff they needed, by band per shift over the 24 hour period. Matrons were also present at these meetings. The corporate representative was the constant throughout the whole process.

Ward areas were asked, what it was *they needed* to deliver their service safely whilst maintaining quality. This has been challenging in some areas, to move away from the "what have I got" to "what do I want" model.

Completed reviews were sent to the Divisional Head of Nursing and Divisional Finance Manager to undertake a Confirm and Challenge process with the CBU Lead Nurses. The Nurse Establishment reviews were then signed off by Corporate Nursing and Corporate Finance. This process and outcome has also been discussed with the Chief Nurse.

The Director of Nursing and Deputy Director of Finance have also met with Price Waterhouse Coopers to confirm that the approach taken was appropriate and whether Price Waterhouse Coopers could advise on any additional steps which should be added into the review for additional assurance. They advised that we were following best practice and could not add any beneficial steps to the process and commended the UHL approach to this review as best practice.

3.1 Findings for 2013 Review

A financial gap was identified when the N2BR is viewed alongside the planned 2013/14 budgets. This becomes greater when funding for Ward Managers supervisory status 0.4wte (2 days per week) and the costs for additional beds are also included. In addition, the acuity money agreed by the Trust Board in 2012 had not been placed into the planned 2013/14 budgets to address the agreed shortfall to cover the N2BR deficits across the Trust.

Currently the significant nursing premium expenditure, i.e. agency, is trying to cover the gap in manpower created by a failure to issue agreed budgets. It is recognised that this is not sustainable in relation to ensuring patient safety or continuity of care and is not a model the Senior Nursing Team supports to provide a sustainable quality service for patients.

Following the 2013 review a significantly larger gap than that identified in 2012 was present. Whilst answering the question asked 'what do you need to run your ward' it needs to be recognised that this was aspirational and the template used included a variety of shift patterns increasing the overlap significantly resulting in a larger financial gap. It also included extending the existing agreed levels of ward clerks, housekeepers and security. It is recognised that this would be appropriate as part of a further workforce review, but is not currently essential and therefore has been excluded from the revised ratios.

Table 2 below shows the total annual budgets for the areas included in Appendix 3. This now includes setting budgets for additional capacity in Medicine and areas previously identified as income backed.

Table 2

	Existing Budget	Existing additional authorised staffing	Staffing review outcome additional	Phase 1 additional supervisory, acuity, emergency pathway, additional capacity	Existing Budget	Existing additional authorised staffing	Staffing review outcome additional	Phase 1 additional request
Division	**WTE**	**WTE**	**WTE**	**WTE**	**£000s**	**£000s**	**£000s**	**£000s**
Acute	1,232.55	62.85	159.33	95.48	£40,995	£1,981	£5,320	£3,050
Planned	719.42	25.80	120.04	56.67	£22,977	£779	£2,895	£1,736
W&C	459.62	10.00	66.71	33.84	£16,487	£350	£1,737	£1,142
Total	2,411.59	98.65	346.08	185.99	£80,459	£3,111	£9,952	£5,928

Table 3 - demonstrates the breakdown of this investment

Division	Supervisory	Emergency Pathway	Acuity	Additional Capacity inc investments supported by new income	Total
Acute	£432	£430	£570	£1,618	£3,050
Planned	£353	£238	£431	£714	£1,736
W&C	£305		£624	£213	£1,142
Total	**£1,090**	**£668**	**£1,625**	**£2,545**	**£5,928**

In July 2013 the Executive Team, (ratified by the Trust Board) agreed to invest £5.9m into ward nursing budgets to reconcile previous agreements and additional costs associated with additional capacity being opened. This recognises the need to bring N2BR to agreed acceptable levels, fund additional capacity and recognises increasing acuity.

For completeness and assurance a standardised establishment template will be signed off and saved electronically this will be signed and supported by the Head of Nursing, Divisional Finance Lead, Lead Nurse and Ward Sister, for all ward areas to ensure transparency and clarity in relation to funded establishments. This will be reviewed bi-annually. (Appendix 2)

4.0 Summary of New Budgets Following Review versus Budgets Originally Set 2013/14

This is attached for information as Appendix 3

5.0 Vacancies

Vacancies are monitored on a monthly basis and reported to the Chief Nurse. This information is disseminated across the organisation, and shared with our CCG colleagues. Alongside this, the N2BR is monitored on a monthly basis and discussed at QAC and CQRG, any ward areas falling under the recommended N2BR has an associated supporting action plan (Appendix 4)

5.1 Reported Vacancies

Table 4 demonstrates the number of reported vacancies across the Trust for the previous 12 months.

Table 4

Month/Year	Registered Nurse Wte	Non Registered Nurse Wte	Overall Total Wte
September 2012	156	36	192
October 2012	222	64	286
November 2012	198	83	281
December 2012	195	71	266
January 2013	189	62	250
February 2013	166	93	259
March 2013	152	40	192
April 2013	**307**	**132**	**438**
May 2013	268	87	355
June 2013	270	78	348
July 2013	288	50	335
August 2013	313	62	375
September 2013	**394**	**106**	**500**

There was an increase in reported vacancies between March 2013 and April 2013 as establishments were revised upwards based on existing plans, alongside this all unfunded areas/beds have been included, which was not the case previously.

Following the review as detailed above, the budgetary agreement in July 2013 (section 3.0) the Registered Nurse Vacancies have increased by 90wte's, which has increased the vacancies further.

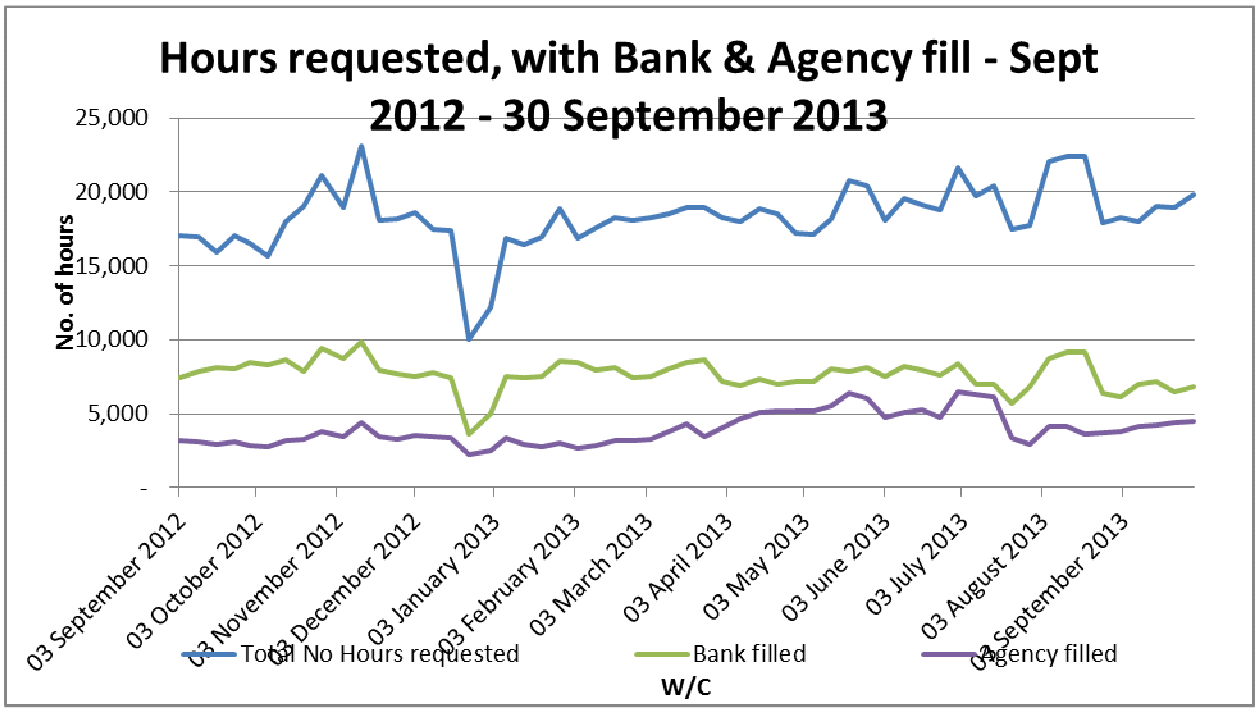
A risk assessment in relation to the amount of RN vacancies within UHL has been completed with input from HRSS and the Quality & Safety team, and is on the Corporate Risk register

To provide assurance and determine in 'real' time ward staffing, workforce measures of actual numbers on shift will be displayed in the ward areas in public from November 2013.

These will be reviewed twice daily by a Corporate senior nurse on behalf of the Chief Nurse. This is in draft and subject to further amendments.

5.2 Bank & Agency

There is a steady increase in the amount of hours requested month on month for temporary staffing.



- There is an increase in nursing requests of approximately 15% since September 2012
- The percentage of bank fill versus agency has decreased, since September 2012
- The percentage of agency fill has increased
- It is clear we are not filling the gap and this poses potential risks.

There is a comprehensive action plan (reviewed regularly at Executive Team) with actions to increase the amount of Nursing Bank staff available, to improve efficiencies in the recruitment process for Bank staff and reduce the agency nursing use/costs whilst protecting ward staffing levels.

Key headlines from the plan are:

- An on-going proactive recruitment campaign for staff, substantive and bank including international recruitment
- A more streamlined recruitment process through the LiA EOP scheme
- Incremental introduction of the Electronic Rostering (ER) system, ensuring transparency in relation to numbers of staff available and working within ward off duties, this compliments and supports the organisations ability to move staff to key areas within CBU's to cover staffing gaps- there are 17 ward units using this system, completion date April 2014

- Upgrade of the current staff bank system to link and connect to the ER system, which supports accountability and responsibility of ward managers in relation to requests for bank staff (if the shift is not vacant on the ward's demand template it cannot be sent to bank) again completed by April 2014

- SMS text message service now active on new Staff Bank system to facilitate direct communication with Bank staff about shift availability and *Employee on Line* to be introduced through October and November which will allow Bank staff to view and book available shifts via smartphones and other mobile electronic devices.
- Educational sessions for ward managers in relation to budget/establishment management
- Exploration of the implementation of weekly pay for bank staff to incentivise staff to join UHL's bank alongside supporting the organisation's ability to compete with nursing agencies.

5.3 Turnover

Turnover figures need to be considered to forecast our future vacancy levels in addition to current gaps in order to pull together meaningful and robust recruitment plans. Turnover rates for Qualified and Unqualified Nursing staff are now monitored at CBU level and are attached for information (Appendix 5)

These figures equate to 24 Qualified Nurses per month and 11 Health Care Assistants per month, a total turnover of 35 staff per month.

These figures represent leavers from UHL and therefore do not include internal moves within UHL which can act disproportionately across the Trust. The figures must also be considered in the national context as this will equally impact on the ability to recruit and retain; for example the high turnover for children's nurses is in the context of a national shortage. Turnover figures need to be taken into consideration when targeting recruitment and retention strategies outlined below.

6.0 Recruitment

The current recruitment plan incorporates a recruitment schedule which is supported by campaigns to attract new applicants to UHL (Appendix 6)

6.1 Advertising

The primary advertising media utilised in UHL is through NHS jobs. As detailed in section 7.1 below we have a dedicated Nursing recruitment page. Therefore when other advertising media are used, all applicants are directed to apply via this web page which allows a prime opportunity to promote the Trust, its achievements and staff benefits.

A number of services have a programme of rolling adverts that are service specific, however at appendix 6 is a proposed summary of the Trust wide Band 5 and 6 and Health Care Assistant recruitment campaigns which are scheduled for 2014. This schedule is currently being reviewed with a view to increasing the number of campaigns throughout the year to 10 Registered Nurse adverts per year, 2 Clearing House cohorts per year and 3 HCA adverts per year.

6.2 Bulk Recruitment to Date

In order to facilitate the requirement for ongoing recruitment of Band 5 Nurses and HCA's, bulk recruitment campaigns have operated throughout the year which involve a collaborative approach to the advertising of and recruitment to posts across the Trust.
In January 2013, this was supported by a Nursing Open Day in which candidates were offered talks and tours of specialty areas across the Trust.

6.3 Job Fairs

UHL has attended RCN Conferences in Manchester (July), London (September) and Glasgow (October) to promote the unique selling points of Leicester and the specialty areas. Within ED, which is a particular recruitment hotspot, 4 candidates have been attracted via this route.

6.4 International Recruitment

Following a tender exercise, four agencies have been commissioned to support the recruitment of Band 5 Nurses internationally. This will involve small teams of senior nurses travelling to Portugal, Ireland, Madrid, Italy and Greece to select candidates for UHL. Robust plans have been put in place to support relocation for successful applicants including access to Trust accommodation, a mentorship/buddying arrangement and orientation to support the settling in process. This will be supported by a dedicated HR resource. The expectation is to recruit 100 plus Registered Nurses, in cohorts of 30 staff, commencing in post January/February 2014.

6.5 HCA Apprentices

UHL is currently undertaking a pilot of Health Care Assistant (HCA) Apprentices and 23 applicants have been offered apprenticeships as HCAs within UHL. The successful candidates will start on the 23rd November with the aim that once they have completed their one year apprenticeship they will be able to feed into the HCA recruitment process in October / November 2014 for a substantive post. Interview panel feedback on the calibre of applicants and the recruitment process has been very positive.

7.0 Attracting Staff to UHL

7.1 Branding and Website

In partnership with our supplier for recruitment marketing, we have designed innovative advertising materials for each specialty which reflect both the overarching UHL values and a brand specific to each specialty. The materials portray UHL staff describing what they value most about Leicester, UHL and the specialty in which they work to give potential applicants an insight into working here. UHL are hosting a recruitment microsite for Band 5 vacancies which features our branded material and enables potential recruits to easily access NHS Jobs.

7.2 Marketing

UHL's materials have been showcased at the RCN events noted in 6.3 In addition innovative social media campaigns have been used such as Google Search and Facebook. These and other advertising media direct applicants to the UHL microsite described above.

To support the latest bulk recruitment campaign, advertising material is displayed on train platforms in key commutable areas such as London, Coventry, Birmingham and Northampton.

7.3 Nursing Homes

Recent 'Band 5' recruitment events have attracted experienced nurses who currently work in nursing homes but want an opportunity to work in a hospital setting. However, because of their lack of acute nursing experience, some of these nurses have not been shortlisted as they lack the pre-requisite experience. To address this shortfall in essential criteria, a development programme to attract these nurses to UHL has been devised within Specialty Medicine to provide the appropriate skills and competencies over a 6 month probationary period. After this time skills will be reassessed and if they meet the required standard, employment contracts will be made permanent. The plans for this course are heavily reliant on the Education and Practice Development team supporting individuals in clinical practice. This could impact on the abilities of the teams to deliver on other recruitment and retention initiatives.

7.4 Local University Employability Event for Student Nurses and Midwives

The Trust is in a fortunate position of having a local university, De Montfort University (DMU) that provides pre-registration nurse and midwifery training. There are two intakes of students a year for adult nursing at DMU (September and January) and two outputs of newly qualified adult nurses (November and March). For children's nursing and midwifery there is only one intake/output a year.

The university offers an employability event for student midwives and nurses in their final semester which UHL has attended. Feedback from the two events held to date has been very positive with the students valuing the opportunity to talk to UHL staff and given assurance that appropriate support and development opportunities will be available to newly qualified nurses and midwives. Subsequent speciality based recruitment events within UHL such as 'Tea with Matron' have also provided the students with additional assurance. Approximately 90% of all students who qualify are retained within Leicestershire with the majority accepting a job in UHL; this equates to on average 200 nurses (adult and child) and midwives a year.

8.0 Retention

8.1 Employment Experience

Providing a good first impression is essential to give confidence to our new starters that they are and will be valued by the organisation. Following feedback received through the HCA induction programme a further review meeting is being arranged to identify themes that can be addressed. This will also provide an opportunity to reinforce expectations of managers regarding local induction needs.

8.2 Induction

8.3 Trust Induction

All new staff to UHL must undertake Trust Induction, the responsibility for the induction process sits with HR, and it is supported by the Corporate and Local Induction Policy (Trust reference B4/2003). At the present time, the organisation and delivery of induction is led by HR Training and Development Manager.

All clinical staff must undertake a two day Trust induction that is run on a monthly basis and consists of a 'General Day One' and a 'Clinical Day Two' covering a welcome to the Trust, values and behaviours and statutory and mandatory training elements. Capacity issues have been highlighted for the clinical day two, specifically relating to the size of the venues to provide clinical training such as Moving and Handling and Resuscitation and lack of trainers available to meet the increased demand.

A review of the programme is being undertaken to look at content and frequency however any changes identified will be in place in the New Year. There will be a wider discussion between the Nursing Directorate, HR and Clinical Skills Unit as to how to accommodate the increase in numbers.

Solutions that have been discussed previously have included the need to employ a small team of dedicated Statutory and Mandatory trainers at around band 3 who can provide Manual Handling and resuscitation training for the Trust induction, along with other hotspot areas and the sourcing of a dedicated on site clinical training venue. Currently UHL is in competition with the Medical School for on site clinical training venues – particularly at the LRI.

8.4 HCA Induction:

In line with the Francis recommendations, it is compulsory for all new HCA's to complete both the Trust and HCA induction prior to commencing in a clinical area. All new HCA's first working day with the Trust is Day One of the Trust induction.

The HCA induction includes four Trust wide days and one speciality / CMG specific day. These days are spread across the first 2-3 weeks with the rest of the time being spent in their Clinical Areas in a supernumerary capacity undertaking their local induction and being orientated to the area and team. The Childrens Hospital HCA's and Maternity Care Assistants follow the same standard but run their own programmes which reflect their specific requirements

New HCA's to the Trust are automatically booked onto HCA induction when a booking is received for the Trust Induction. The HCA induction runs monthly and has a capacity of 35 to 50 places per course depending on the size of the venues.

Parts of the Programme are also compulsory for new Ward Housekeepers to the Trust.

8.5 Preceptorship

UHL has embraced Preceptorship for many years, in 2010 this work was streamlined and standardised to ensure that all Newly Registered Nurses joining the Trust received the same education and support.

Preceptorship includes three core Study days and up to four CMG specific study days over a 6 month period, 4 weeks supernumerary on gaining their PIN number to support the transition from Student to Staff Nurse and comprehensive Administration of Medicines assessment which incorporates a maths exam. A review of the Preceptorship Policy is currently being undertaken to reflect this work and will also incorporate AHP colleagues.

For nurses recruited from the EU the Preceptorship programme will provide a solid foundation of induction and support, it may require some adaptation or bespoke work to meet the specific needs of these staff and this can be done in partnership with the Education and Practice Development teams.

8.6 Internal Education Opportunities

8.7 Nursing and Midwifery Development Pathways

The Assistant Director of Nursing has led the implementation of a Nursing and Midwifery Practice Development Strategy and band specific Nursing and Midwifery Development Pathways for Band 2, to Band 7 nursing staff. The pathways support the continuing development and retention of Registered Nurses and HCA's. These can be accessed in INsite via the following link:

http://insite.xuhl-tr.nhs.uk/index.asp?pgid=53587

These pathways set out the expectations of skills and competencies to be gained by the staff members in their first year in post, with the Band 2 extending to 2-3 years. It is intended that these pathways will be given to new staff within the Trust alongside those new into role and used at appraisals to identify education, training and development needs.

8.8 Structured Education programme for Speciality Medicine

The Assistant Director of Nursing is currently developing a structured and university accredited education and practice development programme for Registered Nurses working within the speciality medicine which will focus on the needs of the older person. The aim of this programme (which will be ready in December) is to attract new starters to this specialty, providing study, personal and professional development opportunities for one day a week for six months (in addition to preceptorship requirements). Early discussions with key nurse education leads within the speciality have identified a programme that includes key issues specific to older people such as continence, dementia, falls, pressure ulcers, nutrition. A service project approach will be used to assess individual nurses' knowledge in practice and this will form the accredited part of the programme.

8.9 HCA VITAL (Virtual Interactive Teaching and Learning)

UHL achieved a successful bid for funds to implement VITAL modules for HCA's. VITAL is a Virtual Interactive Teaching and Learning tool which assesses staff clinical and behavioural knowledge through interactive quizzes online. It is intended that a baseline assessment is completed initially to identify any training needs within the HCA workforce and then staff will be reassessed after the learning. This will be used alongside the development pathways, exact timings and although exact timings need to be agreed, the initial phase will commence during November 2013 within the Speciality Medicine CBU.

9.0 Reward and Recognition Strategy

To support the recruitment and retention of staff a draft Reward and Recognition Strategy is in place. This was developed through two 'listening events' and therefore reflects the views and ideas of our workforce.
There are six core themes, one of which is branding and marketing and the others include pay and reward, benefits, health and wellbeing, learning and development and career progression. Using the 'listening approach' in the development of this strategy a number of specific initiatives have evolved including:

- The introduction of a nursing badge reward system for excellence in the quality of care. Consideration will be given as to whether the badge system will be an effective way of rewarding staff who have achieved their Development Pathway detailed in section 8.7
- Promoting our position as leaders in the field of research in a number of specialty areas
- Offering clarity and publicising career progression routes
- Making staff aware of benefits available either locally or through NHS Discounts.

This initiative will be presented to the Executive Strategy Board in November.

9.1 Recruitment and Retention Premia

As a short term solution to gaps between demand and supply and in areas where the shortage is replicated nationally, the Trust has introduced short term recruitment and retention premia. For nursing to date this has just been within the Emergency Department and has already started to impact on the vacancy fill rates with a vacancy level of 30wte forecasted to reduce to 8wte by December. We are currently evaluating the real value of this approach when taken alongside attrition rates.

9.2 Right Staffing LiA EOP

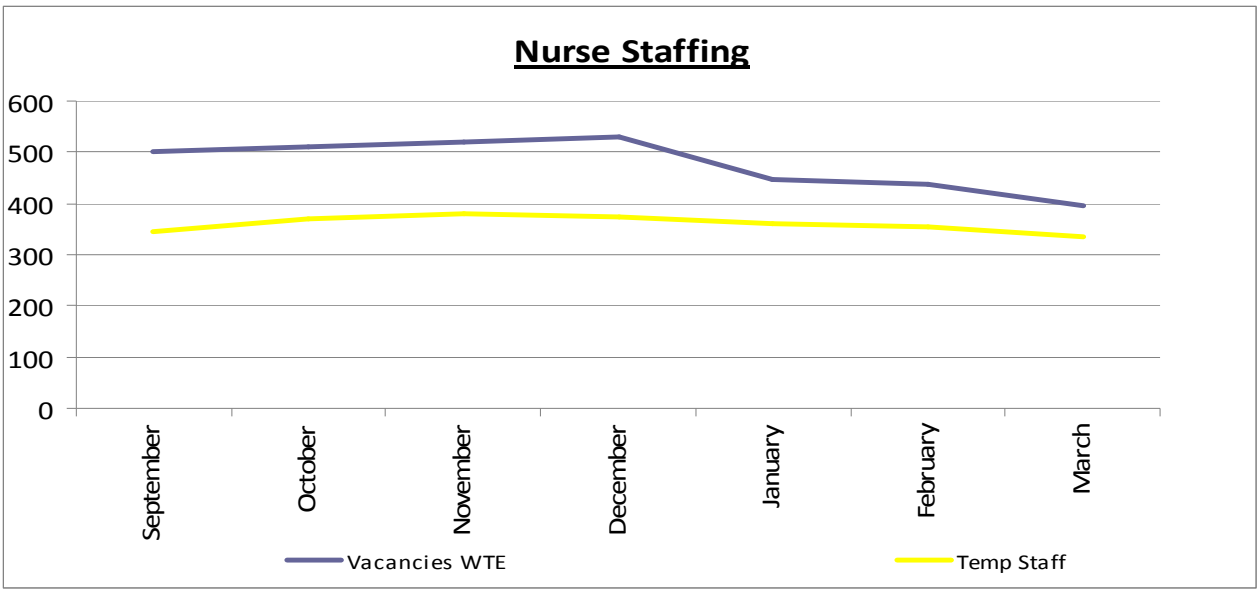
As part of the Listening into Action, enabling our people schemes, there has been intense focus on right staffing with the right skills at the right time, an action plan is in place with key themes and actions will be shared across the organisation on the 6th November.

10 Trajectory

The graph below demonstrates the current nursing vacancy trajectory mapped against the temporary staffing usage. There is a current 'unfilled' risk of 150wte across the Trust. In other words despite every effort to recruit or use temporary staff we still have the equivalent of 150wte or 750 shifts per week unfilled.

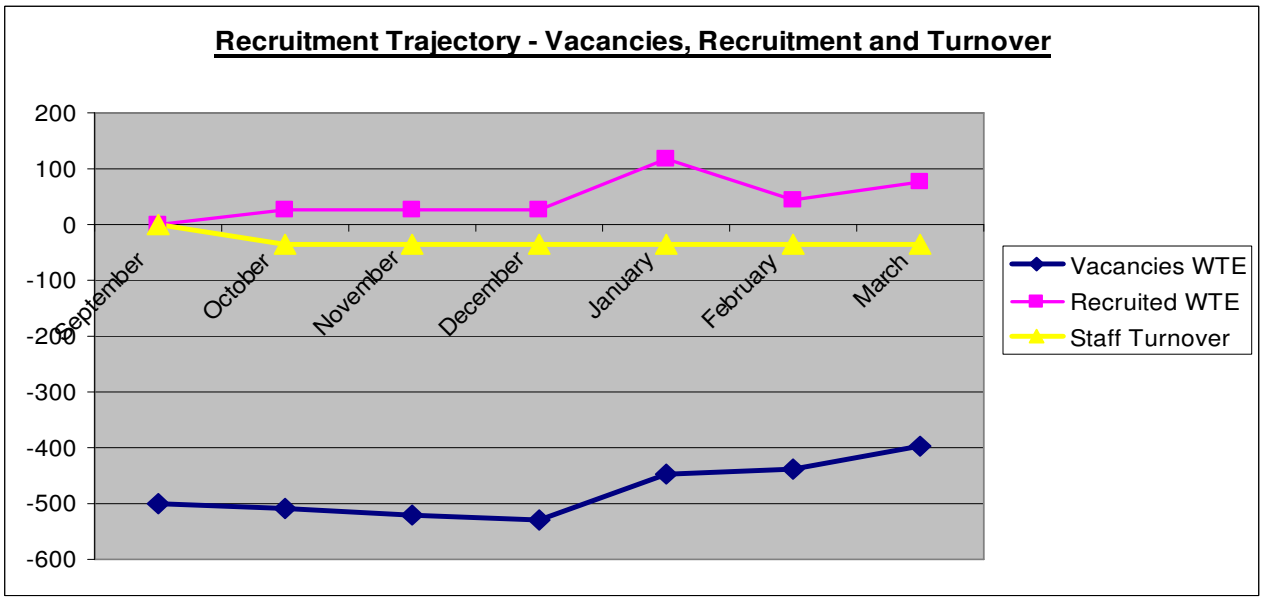
As detailed previously a corporate risk assessment has been completed in collaboration with HRSS, but this needs to be repeated at individual group and ward level. Ultimately assuming recruitment plans progress and turnover of nursing staff remains static; the risk reduces to 50wte by March 2014.

Graph 1



The second graph demonstrates that despite active recruitment plans and assuming that turnover stays at the current rate of 35 staff per month, we will only see an overall increased fill of 100wte. We therefore need to take every opportunity to over recruit based on turnover predictions.

Graph 2



11. Ongoing Monitoring and Support

The attached (Appendix 7) is proposed to be used on a quarterly basis for all wards. The procedure is described within the document but essentially Matrons and Ward Managers are expected to provide evidence that reassures their Head of Nursing that all essential standards are being met. Results are RAG rated and performance reported to group and Trust governance forums as a performance dashboard.

The process, along with more real time measures will be used to identify 'challenged' wards.
Throughout November and December Ward Managers and Matrons have been released from all non – nursing roles to ensure their focus is ensuring safe and effective staffing within their ward areas, along with effective patient flow, which facilitates on-going monitoring and support

11.1. Administrative and Clerical Support

It is evident due to the current nursing vacancies within the clinical areas and the potential risk this poses to patient care, safety and patient flow that enhanced clerical support is necessary for all ward areas, alongside shared secretarial support for ward managers. Roles will be progressed through the Bank office to source these staff for the winter months pending review of permanent investment in the future.

12. Future Reporting

Information on nursing vacancies, bank and agency usage, acuity and 'gaps' will in future be reported in a template format to the following committees, in the following order.

- Nursing Executive Team
- Quality Executive Committee (refreshed QPMG)
- Quality Assurance Committee (TB subgroup)
- Clinical Quality Review Group (CQRG)

It will also be copied for information to the Finance and Performance Committee. This will mean for some committees, data will be less real time than others

13. Recommendations

Trust Board members are asked to note the content of this report and provide comment on the position and actions being undertaken.

Ward & site	

The cover % allowed on this proforma is:	23.00%

Av. Basic Salary	
Band 2	15,194
Band 3	17,127
Band 4	20,433
Band 5	24,194
Band 6	30,434
Band 7	36,600

No. of beds on ward	30
No. of bed spaces on ward	32

Nurse to bed ratio (total)	1.14	Qualified %	70%
Nurse to bed ratio (excluding supervisory time)	1.12	Unqualified %	30%

FOR SHIFTS STARTING ON A WEEKDAY

Days This applies to	Yes/No	Shift Name	Start	Finish	Band 2	Band 3	Band 4	Band 5	Band 6	Band 7	*Total Qual*	*Total Unqual*	Total Staff
Monday	Yes	Early	07:00	15:00	1			1		1	*2*	*1*	3
Tuesday	Yes	Late	12:30	20:30	1			1			*1*	*1*	2
Wednesday	Yes	Night	19:00	07:30	2			3	1		*4*	*2*	6
Thursday	Yes	Long Day	07:00	19:30	1			3	1		*4*	*1*	5
Friday	Yes										*0*	*0*	0
Count	*5*										*0*	*0*	0
											0	*0*	0
											0	*0*	0
											0	*0*	0
											0	*0*	0
WTE Required for Weekday Shift Pattern					**6.60**	**0.00**	**0.00**	**11.20**	**3.07**	**1.00**	***15.27***	***6.60***	**21.87**

FOR SHIFTS STARTING ON A SATURDAY OR SUNDAY

Days This applies to	Yes/No	Shift Name	Start	Finish	Band 2	Band 3	Band 4	Band 5	Band 6	Band 7	*Total Qual*	*Total Unqual*	Total Staff
Saturday	Yes	Early	07:00	15:00	1			1			*1*	*1*	2
Sunday	Yes	Late	12:30	20:30	1			1			*1*	*1*	2
Count	*2*	Night	19:00	07:30	2			3	1		*4*	*2*	6
		Long Day	07:00	19:30	1			3	1		*4*	*1*	5
											0	*0*	0
											0	*0*	0
											0	*0*	0
											0	*0*	0
											0	*0*	0
											0	*0*	0
WTE Required for Weekend Shift Pattern					**2.64**	**0.00**	**0.00**	**4.48**	**1.23**	**0.00**	***5.71***	***2.64***	**8.35**

Combined Shift Pattern WTE Required	**9.24**	**0.00**	**0.00**	**15.68**	**4.29**	**1.00**	***20.97***	***9.24***	**30.21**

Proportion of cover/relief to be built into establishment	**11.50%**	out of	**23.00%**
Proportion of cover/relief to be allowed as bank/agency	**11.50%**	out of	**23.00%**

	Band 2	Band 3	Band 4	Band 5	Band 6	Band 7	TOTAL
WTE FOR SHIFT PATTERN BEFORE COVER	9.24	-	-	15.68	4.29	1.00	**30.21**
BUDGET FOR SHIFT PATTERN BEFORE COVER	222,466	-	-	556,000	194,940	44,681	**1,018,086**
COVER WTE BUILT INTO ESTABLISHMENT	1.06	-	-	1.80	0.49	0.12	**3.47**
BUDGET FOR COVER BUILT INTO ESTABLISHMENT	25,584	-	-	63,940	22,418	5,138	**117,080**
WTE FOR SUPERVISORY / OTHER STAFF				0.40			**0.40**
BUDGET FOR SUPERVISORY / OTHER	-	-	-	14,184	-	-	**14,184**
TOTAL WTE ESTABLISHMENT	**10.30**	**-**	**-**	**17.88**	**4.79**	**1.12**	**34.09**
TOTAL BUDGET ESTABLISHMENT	**248,050**	**-**	**-**	**634,123**	**217,358**	**49,819**	**1,149,350**
COVER WTE AS BANK AND AGENCY	1.06	-	-	1.80	0.49	0.12	**3.47**
COVER BUDGET AS BANK AND AGENCY	25,584	-	-	63,940	22,418	5,138	**117,080**
TOTAL WTE ON BUDGET STATEMENT	**10.30**	**-**	**-**	**17.88**	**4.79**	**1.12**	**34.09**
TOTAL BUDGET ON BUDGET STATEMENT	**273,633**	**-**	**-**	**698,063**	**239,776**	**54,957**	**1,266,430**

SIGN OFF	Date Approved	Signature	Name
Ward Manager			
CBU Lead Nurse			
Divisional Head of Nursing			
Divisional Finance and Performance Manager			

Ward & site	

The cover % allowed on this proforma is:	23.00%

No. of beds on ward	
No. of bed spaces on ward	

Nurse to bed ratio (total)		**Qualified %**	
Nurse to bed ratio (excluding supervisory time)		**Unqualified %**	

Proportion of cover/relief to be built into establishment	23.00%

	Band 2	Band 3	Band 4	Band 5	Band 6	Band 7	TOTAL
WTE FOR SHIFT PATTERN BEFORE COVER							-
BUDGET FOR SHIFT PATTERN BEFORE COVER							-
COVER WTE BUILT INTO ESTABLISHMENT							-
BUDGET FOR COVER BUILT INTO ESTABLISHMENT							-
WTE FOR SUPERVISORY / OTHER STAFF							-
BUDGET FOR SUPERVISORY / OTHER							-
TOTAL WTE ESTABLISHMENT	-	-	-	-	-	-	-
TOTAL BUDGET ESTABLISHMENT	-	-	-	-	-	-	-

SIGN OFF	Date Approved	Signature	Name
Ward Manager			
CBU Lead Nurse			
Divisional Head of Nursing			
Divisional Finance and Performance Manager			

Acute, Planned and W&Cs
Nursing resource templates - Consolidated
Comparison to current budgets (nursing qualified/unqualified) - inpatient wards only

Appendix 3

Division	CBU	CC	Ward	Type of Ward	Beds	13-14 Existing Budgeted staffing WTE	New Budget	Increase / - decrease	13-14 Existing Budgeted staffing £s	New budget	Increase / - decrease	13-14 Existing Budgeted staffing NTBR	Phase 1 NTBR incl supervisory 2 days	Increase / - decrease
						A		E	F		J	K	O	
Acute Care Division	CRR	C29	Clin Dec. Unit - Ward 19 Ggh	Specialist	34	95.65	95.94	0.29	3,038,806	3,048,312	9,506	2.81	2.81	-0.00
Acute Care Division	CRR	C27	Coronary Care Unit - Ggh	Specialist	19	52.31	52.65	0.34	1,852,228	1,863,860	11,632	2.75	2.75	-0.00
Acute Care Division	CRR	S21	Ward 10 Capd	Specialist	18	38.76	38.76	0.00	1,253,965	1,253,965	0	2.15	2.13	-0.02
Acute Care Division	CRR	C20	Ward 15-Respiratory	Base	30	37.95	39.40	1.45	1,158,098	1,203,941	45,843	1.27	1.30	0.03
Acute Care Division	CRR	S04	Ward 15 High Dependency	Specialist	9	27.65	27.65	0.00	1,002,634	1,002,634	0	3.07	3.03	-0.04
Acute Care Division	CRR	S05	Ward 15 Nephrology	Specialist	17	31.69	32.02	0.33	1,046,275	1,056,885	10,610	1.86	1.86	-0.00
Acute Care Division	CRR	C21	Ward 16-Respiratory	Base	30	36.08	36.40	0.32	1,094,480	1,104,381	9,902	1.20	1.20	-0.00
Acute Care Division	CRR	S64	Ward 17 - Capd	Specialist	14	19.64	20.00	0.36	666,033	677,316	11,283	1.40	1.40	-0.00
Acute Care Division	CRR	C23	Ward 17 - Respiratory	Base	25	37.55	37.55	0.00	1,278,957	1,278,957	0	1.50	1.49	-0.02
Acute Care Division	CRR		Ward 17 - Respiratory - HDU	Specialist	5	0.00	3.00	3.00	0	102,510	102,510	0.00	0.52	0.52
Acute Care Division	CRR	C48	Ward 23a	Base	17	22.80	22.46	-0.34	685,968	675,150	-10,818	1.34	1.30	-0.04
Acute Care Division	CRR	C38	Ward 26	Base	15	30.74	30.74	0.00	1,035,120	1,035,120	0	2.05	2.02	-0.03
Acute Care Division	CRR		Ward 26 - HDU	Specialist	5	0.00	0.00	0.00	0	0	0	0.00	-0.08	-0.08
Acute Care Division	CRR	C24	Ward 27	Base	27	30.92	31.45	0.53	1,030,388	1,047,316	16,928	1.15	1.15	0.00
Acute Care Division	CRR	C30	Ward 28 - Cardio	Base	31	34.10	34.50	0.40	1,049,649	1,062,459	12,810	1.10	1.10	0.00
Acute Care Division	CRR	C99	Ward 29 - Resp	Base	25	30.00	30.40	0.40	882,140	894,870	12,730	1.20	1.20	0.00
Acute Care Division	CRR	C35	Ward 31	Base	30	43.98	43.98	0.00	1,515,448	1,515,448	0	1.47	1.45	-0.01
Acute Care Division	CRR		Ward 31 - HDU	Specialist	4	0.00	0.00	0.00	0	0	0	0.00	-0.10	-0.10
Acute Care Division	CRR	C32	Ward 32	Base	17	19.86	20.29	0.43	604,130	617,385	13,255	1.17	1.17	0.00
Acute Care Division	CRR	C31	Ward 33	Base	29	33.73	34.04	0.31	1,089,654	1,099,899	10,245	1.16	1.16	-0.00
Acute Care Division	CRR	C33	Ward 33a	Base	20	25.93	26.40	0.47	772,295	787,311	15,016	1.30	1.30	0.00
Acute Care Division	Specialty Medicine	N61	Brain Injury Unit Lgh	Specialist	7	22.47	21.42	-1.05	716,521	679,722	-36,799	3.21	3.00	-0.21
Acute Care Division	Specialty Medicine	N11	Day Case - Ward 1 Lgh	Base	10	16.52	11.98	-4.54	562,562	433,277	-129,285	1.65	1.16	-0.49
Acute Care Division	Specialty Medicine	N39	Infectious Diseases Unit	Base	18	23.22	23.62	0.40	769,446	782,184	12,738	1.29	1.29	0.00
Acute Care Division	Specialty Medicine	N57	Stroke Unit - Ward 25 & 26 Lri	Specialist	36	60.28	58.12	-2.16	1,989,749	1,914,809	-74,939	1.67	1.60	-0.07
Acute Care Division	Specialty Medicine	N36	Ward 23 Lri	Specialist	28	35.48	39.56	4.08	1,123,061	1,256,122	133,062	1.27	1.40	0.13
Acute Care Division	Specialty Medicine	N24	Ward 24 Lri	Specialist	27	33.30	38.61	5.31	1,035,038	1,203,730	168,692	1.23	1.42	0.18
Acute Care Division	Specialty Medicine	N56	Ward 3 Lgh	Base	21	24.30	27.54	3.24	808,872	911,858	102,986	1.16	1.29	0.14
Acute Care Division	Specialty Medicine	N31	Ward 31 Lri - Med	Specialist	30	34.60	42.30	7.70	1,125,011	1,376,130	251,119	1.15	1.40	0.24
Acute Care Division	Specialty Medicine	N92	Ward 34 Lri	Base	26	28.66	35.66	7.00	932,710	1,151,900	219,191	1.10	1.36	0.25
Acute Care Division	Specialty Medicine	N26	Ward 36 Lri	Specialist	28	33.00	39.48	6.48	1,033,715	1,243,473	209,758	1.18	1.40	0.22
Acute Care Division	Specialty Medicine	N33	Ward 37 Lri	Specialist	24	41.44	34.00	-7.44	1,301,093	1,058,635	-242,459	1.73	1.40	-0.33
Acute Care Division	Specialty Medicine	N38	Ward 38 Lri	Base	28	32.68	36.32	3.64	1,061,925	1,178,812	116,888	1.17	1.28	0.12
Acute Care Division	Specialty Medicine	N60	Ydu Wakerley Lodge Lgh	Specialist	8	19.20	19.20	0.00	629,900	629,900	0	2.40	2.35	-0.05
Acute Care Division	Emergency	N15	Admissions Unit (15/16) Lri	Specialist	56	119.38	115.71	-3.67	3,599,291	3,481,642	-117,648	2.13	2.06	-0.07
Acute Care Division	Emergency	N44	Emergency Decisions Unit Lri	Specialist	15	28.13	28.13	0.00	857,921	857,921	0	1.88	1.85	-0.03
Acute Care Division	Emergency	N99	Ward 33 Lri	Specialist	24	30.55	48.07	17.52	1,051,713	1,598,619	546,906	1.27	1.99	0.71
Planned Care Division	Cancer	B21	Ward 41	Specialist	22	30.20	33.40	3.20	996,096	1,103,788	107,692	1.37	1.50	0.13
Planned Care Division	Cancer	B24	BMTU (includes Hambleton Suite)	Specialist	5	15.20	15.10	-0.10	613,539	609,706	-3,833	3.04	2.94	-0.10
Planned Care Division	Cancer	B02	OAU	Specialist	8	9.85	12.25	2.40	279,833	366,239	86,406	1.23	1.48	0.25
Planned Care Division	Cancer	B01	Ward 39	Base	19	23.00	24.40	1.40	748,510	793,801	45,291	1.21	1.26	0.05
Planned Care Division	Cancer	B06	Ward 40	Base	19	22.63	24.40	1.77	733,732	790,393	56,661	1.19	1.26	0.07
Planned Care Division	GI	W64	Ward 22-LRI	Base	30	35.84	36.24	0.40	1,085,796	1,096,879	11,083	1.19	1.19	0.00
Planned Care Division	GI	W74	SACU	Level 1	6	16.26	16.66	0.40	624,508	640,845	16,337	2.71	2.71	0.00
Planned Care Division	GI	W63	Ward 8SAU/TRIAGE	Specialist	30	39.80	45.20	5.40	1,194,905	1,346,647	151,742	1.33	1.49	0.17
Planned Care Division	GI	W71	Ward 22-LGH	Base	20	26.16	26.46	0.30	877,655	887,484	9,829	1.31	1.30	-0.00
Planned Care Division	GI	S75	Ward 26-LGH	Base	25	26.66	27.96	1.30	886,183	923,928	37,745	1.07	1.10	0.04
Planned Care Division	GI	W73	Ward 27-LGH	Base	20	24.87	24.47	-0.40	799,342	786,332	-13,010	1.24	1.20	-0.04
Planned Care Division	GI	W72	Ward 28-LGH	Specialist	25	33.53	35.33	1.80	1,113,953	1,170,027	56,074	1.34	1.40	0.06
Planned Care Division	GI	W70	Ward 29-LGH_+TRIAGE	Specialist	27	38.65	38.25	-0.40	1,239,936	1,226,377	-13,559	1.43	1.40	-0.03
Planned Care Division	GI	W69	Ward 23-LGH	Base	15	13.85	16.85	3.00	504,505	597,808	93,303	0.92	1.10	0.17
Planned Care Division	GI	N29	Ward 29-LRI	Base	28	34.20	36.80	2.60	1,170,392	1,223,938	53,546	1.22	1.30	0.08
Planned Care Division	GI	N30	Ward 30-LRI	24 x base, 4 x specialist	28	32.01	39.61	7.60	1,039,629	1,289,319	249,690	1.14	1.40	0.26
Planned Care Division	MSK	Y24	Ward 14-LGH	Base	20	23.30	23.70	0.40	762,733	775,871	13,138	1.17	1.17	0.00
Planned Care Division	MSK	Y20	Ward 16-LGH	Base	20	16.68	22.48	5.80	492,555	684,417	191,862	0.83	1.10	0.27
Planned Care Division	MSK	Y22	Ward 19-lgh	Base	24	24.42	26.82	2.40	772,775	848,178	75,403	1.02	1.10	0.08
Planned Care Division	MSK	Y23	ward 18-lgh	Base (day case)	15	11.85	13.25	1.40	333,026	371,944	38,918	0.79	0.86	0.07
Planned Care Division	MSK	Y13	Ward 17-LRI	Specialist	30	38.64	43.04	4.40	1,155,333	1,292,141	136,809	1.29	1.42	0.13
Planned Care Division	MSK	Y14	Ward 18-LRI	Specialist	30	37.58	42.38	4.80	1,127,097	1,259,257	132,161	1.25	1.40	0.15
Planned Care Division	MSK	Y16	Ward 32-LRI	Specialist	24	38.38	38.78	0.40	1,154,478	1,166,443	11,965	1.60	1.60	0.00
Planned Care Division	SPS	W79	Ward 23A	Base	14	16.89	17.29	0.40	551,044	563,858	12,814	1.21	1.21	0.00
Planned Care Division	SPS	W23	Kinmonth	3 x Level 1, 11 x specialist	14	25.37	25.77	0.40	799,495	812,016	12,521	1.81	1.81	0.00
Planned Care Division	SPS	W13	Ward 7	Base	29	29.88	35.08	5.20	899,635	1,052,993	153,358	1.03	1.20	0.17
Planned Care Division	SPS	W43	Ward 21	Base	28	33.72	34.12	0.40	1,019,897	1,032,370	12,473	1.20	1.20	0.00
Womens & Childrens Division	Womens	X57	Ward 31	Base	23	27.88	30.00	2.12	948,268	1,018,836	70,568	1.21	1.29	0.07
Womens & Childrens Division	Womens	X62	Ward 11	Daycase - Surgical	6	8.81	11.52	2.71	257,071	333,315	76,244	1.47	1.85	0.39
Womens & Childrens Division	Womens	X51	GAU	Admissions unit	14	25.33	27.73	2.40	814,980	891,118	76,138	1.81	1.95	0.14
Womens & Childrens Division	Womens	X13	NNU - LGH	Specialist	12	32.65	33.05	0.40	1,280,684	1,295,934	15,250	2.72	2.72	0.00
Womens & Childrens Division	Womens	X10	NNU - LRI	Specialist	28	91.01	95.41	4.40	3,633,854	3,806,170	172,316	3.25	3.39	0.14
Womens & Childrens Division	Childrens	D13	CICU	ITU	6	37.78	40.18	2.40	1,458,941	1,547,929	88,988	6.30	6.63	0.33
Womens & Childrens Division	Childrens	D17	Ward 27	Childrens	12	22.91	25.81	2.90	855,529	956,313	100,784	1.91	2.12	0.21
Womens & Childrens Division	Childrens	D40	Ward 28	Childrens	18	25.68	26.08	0.40	734,296	745,409	11,113	1.43	1.43	0.00
Womens & Childrens Division	Childrens	C41	Ward 30	Childrens	13	17.17	18.57	1.40	590,643	635,086	44,443	1.32	1.40	0.08
Womens & Childrens Division	Childrens	C61	PICU	ITU	7	40.67	43.07	2.40	1,642,716	1,733,317	90,601	5.81	6.10	0.29
Womens & Childrens Division	Childrens	D51	Ward 14	Childrens	19	27.85	28.25	0.40	959,511	972,896	13,385	1.47	1.47	0.00
Womens & Childrens Division	Childrens	D41	Ward 10	Childrens	20	24.41	27.30	2.89	690,056	771,583	81,527	1.22	1.35	0.12
Womens & Childrens Division	Childrens	D12	Ward 12	Childrens	12	26.98	28.60	1.62	877,140	925,800	48,660	2.25	2.35	0.10
Womens & Childrens Division	Childrens	D11	Ward 11	Childrens	26	27.91	31.91	4.00	961,358	1,097,958	136,600	1.07	1.21	0.14
Womens & Childrens Division	Childrens	D14	CAU	Childrens	15	22.58	25.98	3.40	782,072	897,262	115,190	1.51	1.71	0.20
Acute Care Division - Extra Capacity	Specialty Medicine	N84	Fielding Johnson - Medicine		20	24.60	32.00	7.40	430,886	672,325	241,439	1.23	1.58	0.35
Acute Care Division - Extra Capacity	Specialty Medicine	N51	Ward 19 Lri		30	26.82	42.40	15.58	909,672	1,389,622	479,950	0.89	1.40	0.51
Acute Care Division - Extra Capacity	Specialty Medicine	N52	Ward 2 Lgh		21		27.70	27.70		897,058	897,058	0.00	1.30	1.30
				TOTAL	1,684	2,463.01	2,649.00	185.99	80,459,053	86,387,388	5,928,335			

Appendix 4

	Sepember 2013		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	Sept RAG Rating	August RAG Rating	Budgeted Qualified %age	Budgeted Unqualified %age	
C20	Ward 15	30	36.00	0.82	0.00	1.31	1.20	Base			60.4%	39.6%	
C21	Ward 16	30	34.12	2.81	0.07	1.21	1.14	Base			63.4%	36.6%	
C23	Ward 17 - Respiratory	30	35.24	1.75	0.00	1.35	1.17	Base			75.0%	25.0%	
C24	Ward 27	27	30.63	0.31	0.00	1.16	1.13	Base			61.9%	38.1%	
C27	Coronary Care Unit - Ggh	19	49.15	0.15	0.00	2.77	2.59	Specialist			75.6%	24.4%	
C29	Clin Dec. Unit - Ward 19 Ggh	25	81.79	0.33	0.00	3.84	3.27	Specialist			62.9%	37.1%	
C30	Ward 28 - Cardio	31	34.21	2.33	0.00	1.11	1.10	Base			60.0%	40.0%	
C31	Ward 33	29	31.63	1.50	0.00	1.17	1.10	Base			70.2%	29.8%	
C32	Ward 32	17	18.49	4.60	0.00	1.19	1.10	Base			74.7%	25.3%	
C33	Ward 33a	20	23.84	1.94	0.09	1.32	1.19	Base			64.2%	35.8%	
C35	Ward 31	34	41.15	0.82	0.00	1.29	1.21	Base			76.9%	23.1%	
C38	Ward 26	15	27.82	1.11	0.00	2.05	1.85	Specialist			76.5%	23.5%	
C48	Ward 23a	17	19.76	0.73	0.00	0.89	1.16	Specialist			45.2%	54.8%	
C99	Ward 29 - Resp	25	36.91	19.00	0.00	1.22	1.48	Base			61.3%	38.7%	
S04	Ward 15 High Dependency	9	25.26	1.80	0.00	3.07	2.81	Specialist			85.9%	14.1%	
S05	Ward 15 Nephrology	18	28.16	2.12	0.00	1.78	1.56	Specialist			63.1%	36.9%	
S21	Ward 10 Capd	18	35.42	0.27	0.41	2.15	1.97	Specialist			60.9%	39.1%	
S64	Ward 17 - Capd	14	20.60	0.60	0.21	1.43	1.47	Specialist			70.3%	29.7%	
N15	Admissions Unit (15/16) Lri	54	108.71	9.35	14.07	2.14	2.01	Specialist			60.0%	40.0%	
N99	Ward 33 Lri	24	44.37	9.24	5.59	0.00	1.85	Base					
N44	Emergency Decisions Unit Lri	16	19.35	0.13	3.71	1.76	1.21	Specialist			66.8%	33.2%	
N24	Ward 24 Lri	27	35.57	1.38	1.38	1.43	1.32	Base			60.0%	40.0%	
N26	Ward 36 Lri	28	33.73	2.85	6.65	1.41	1.20	Base			60.0%	40.0%	
N31	Ward 31 Lri - Med	30	40.68	1.36	0.46	1.41	1.36	Base			60.0%	40.0%	
N33	Ward 37 Lri	24	37.77	3.63	3.47	1.42	1.57	Base			60.0%	40.0%	
N36	Ward 23 Lri	28	35.22	2.89	0.98	1.41	1.26	Base			60.0%	40.0%	
N38	Ward 38 Lri	28	33.97	2.00	3.62	1.30	1.21	Base			60.0%	40.0%	
N39	Infectious Diseases Unit	18	23.83	3.25	0.82	1.31	1.32	Specialist			60.0%	40.0%	
N51	Ward 19 Lri	30	39.98	1.59	4.62	1.41	1.33	Specialist			60.0%	40.0%	
N52	Ward 2 Lgh	21	23.04	4.61	10.23	1.32	1.10	Specialist			60.0%	40.0%	
N56	Ward 8 Lgh	15	27.35	4.00	0.00	1.84	1.82	Specialist			60.0%	40.0%	
N57	Stroke Unit - Ward 25 & 26 Lri	36	63.12	1.55	11.13	1.61	1.75	Specialist			70.0%	30.0%	
N60	Ydu Wakerley Lodge Lgh	8	18.10	0.31	0.00	2.40	2.26	Specialist			60.0%	40.0%	
N61	Brain Injury Unit Lgh	7	19.19	2.06	0.00	3.06	2.74	Specialist			70.0%	30.0%	
N84	Fielding Johnson - Medicine	20	26.44	6.87	4.44	1.60	1.32	Base			60.0%	40.0%	
N92	Ward 34 Lri	26	35.60	2.65	2.78	1.37	1.37	Base			60.0%	40.0%	
B01	Onc Ward East	19	23.86	1.40	2.88	1.28	1.26	Base			65.8%	34.2%	
B02	Osbourne Assessment Unit	6	8.63	0.82	0.00	2.04	1.44	Specialist			67.0%	33.0%	
B06	Onc Ward West	19	28.95	8.25	0.38	1.28	1.52	Base			72.5%	27.5%	
B21	Haem Ward	22	28.70	0.49	1.19	1.52	1.30	Specialist			71.5%	28.5%	
B24	Bmtu	5	13.75	0.52	0.00	3.02	2.75	Specilaist			96.7%	3.3%	
N29	Ward 29 Lri	28	36.76	9.00	0.00	1.31	1.31	Base			60.0%	40.0%	
N30	Ward 30 Lri	30	34.54	0.78	0.00	1.32	1.15	Base			60.0%	40.0%	
S75	Ward 26 Lgh	25	33.84	11.00	0.00	1.12	1.35	Base			65.7%	34.3%	
W63	Sau - Lri	30	37.07	0.66	0.00	1.51	1.24	Specialist			56.3%	43.7%	
W64	Ward 22 - Lri	30	34.86	2.80	0.00	1.21	1.16	Base			63.3%	36.7%	
W70	Ward 29 - Lgh	27	34.11	0.44	0.00	1.42	1.26	Base			58.1%	41.9%	
W71	Ward 22 - Lgh	20	24.94	0.30	0.00	1.32	1.25	Base			61.8%	38.2%	
W72	Ward 28 - Lgh	25	29.80	1.21	0.00	1.41	1.19	Base			62.4%	37.6%	
W73	Ward 20 - Lgh	20	22.99	1.34	0.00	1.22	1.15	Base			60.8%	39.2%	
W74	Sacu - Lgh	6	15.21	0.26	0.00	2.78	2.54	Specialist			68.4%	31.6%	
C60	Itu Gh	19	112.19	0.00	0.00	6.60	5.90	ITU			92.3%	7.7%	
A10	Itu Lri	15	91.38	0.00	0.15	6.74	6.09	ITU			89.0%	11.0%	
A11	Itu Lgh	8	55.58	0.05	0.00	7.46	6.95	ITU			95.2%	4.8%	
Y13	Ward 17 Lri	30	38.91	0.34	0.09	1.37	1.30	Base			57.8%	42.2%	
Y14	Ward 18 Lri	30	40.04	0.39	0.25	1.41	1.33	Base			55.2%	44.8%	
Y16	Ward 32 Lri	24	37.92	1.05	0.15	1.62	1.58	Specialist			56.3%	43.7%	
Y22	Ward 18 Lgh	17	24.13	0.13	0.00	1.58	1.42	Base			59.4%	40.6%	
W13	Ward 7 - Lri	29	32.11	1.58	0.00	1.19	1.11	Base			57.6%	42.4%	
W23	Kinmouth Unit	14	22.22	0.50	0.00	1.81	1.59	Specialist			65.1%	34.9%	
W43	Ward 21 - Lri	28	30.64	4.49	0.00	1.20	1.10	Base			60.9%	39.1%	
W79	Ward 23 - Ggh	14	15.85	0.00	0.00	1.20	1.13	Base			65.5%	34.5%	
C41	Childrens Ward 30	13	15.66	0.00	0.00	1.43	1.20	Specilaist			80.3%	19.7%	
C61	Paediatric Itu	6	37.93	0.07	0.50	7.18	6.32	ITU			100.0%	0.0%	
D11	Ward 11	12	25.11	0.00	0.00	2.66	2.09	Specialist			69.1%	30.9%	
D12	Ward 12	5	19.86	0.00	0.00	5.72	3.97	Specialist			83.1%	16.9%	
D13	Children'S Intensive Care Unit	6	36.97	0.00	1.00	6.70	6.16	ITU			94.7%	5.3%	
D14	Children'S Admissions Unit	9	21.05	0.00	2.00	2.89	2.34	Specialist			68.6%	31.4%	
D17	Ward 27 - Childrens	9	23.60	0.00	0.00	2.87	2.62	Specialist			82.4%	17.6%	
D40	Ward 28 - Childrens	14	18.42	0.25	0.00	1.86	1.32	Specilaist			73.6%	26.4%	
D41	Ward 10	14	21.24	0.15	0.00	1.95	1.52	Specilaist			68.9%	31.1%	
D51	Ward 14	19	26.88	0.00	0.00	1.49	1.41	Specilaist			70.8%	29.2%	
X10	Neo-Natal Unit (Lri)	24	84.51	0.00	0.00	3.98	3.52	Specialist			87.0%	13.0%	
X13	N.I.C.U. (Lgh)	12	28.75	0.00	0.00	2.75	2.40	HDU			64.8%	35.2%	
X34	Ward 5 Obstetrics (Lri)	26	39.64	0.00	0.00	1.54	1.52	Specialist			59.9%	40.1%	
X35	Ward 6 Obstetrics (Lri)	26	40.86	0.00	0.00	1.65	1.57	Specilaist			63.4%	36.6%	
X37	Lgh Delivery Suite & Ward 30	32	106.48	0.00	0.00	3.56	3.33	HDU			76.4%	23.6%	
X51	Gau	20	25.19	0.62	0.00	1.57	1.26	Base			69.6%	30.4%	
X57	Lgh Ward 31 Gynae	21	26.47	0.00	0.00	1.43	1.26	Base			62.6%	37.4%	

Turnover Figures

Appendix 5

	Qualified Nurses	Healthcare Assistants
CBU	**LTR Headcount %**	**LTR Headcount %**
358 Cancer Services & Clinical Haematology	9.55	12.50
358 Childrens Services	10.76	13.24
358 Corporate Medical	7.69	N/A
358 Corporate Nursing	5.88	0.00
358 Emergency Care	6.01	16.67
358 GI Medicine / Surgery	7.45	9.94
358 Human Resources & Training	13.64	N/A
358 ITAPS	7.36	6.38
358 Imaging	26.32	0.00
358 Musculo-Skeletal Services	9.88	9.35
358 Pathology	0.00	N/A
358 Professional Services	0.00	2.50
358 Renal, Respiratory & Cardiac	7.58	7.94
358 Research	0.00	0.00
358 Specialist Surgery	10.32	9.23
358 Specialty Medicine	6.87	6.93
358 Womens & Perinatal Services	7.88	8.85
UHL	**7.97%**	**8.94%**

Recruitment Plan with dates 2014

Month	Staff Grade	Advert date	Closing date	Interview date
January 2014	Registered Nurses Band 5's and 6's	**06.01.14**	**19.01.14**	**04.02.13**
February 2014	Registered Nurses Band 5's and 6's	**03.02.14**	**16.02.14**	**04.03.14**
March 2014 (avoid Easter)	Health Care Assistants	**03.03.14**	**16.03.14**	**02.04.14**
April 2014	Registered Nurses Band 5's and 6's	**31.03.14**	**13.04.14**	**29.04.14**
May 2014	Registered Nurses	**05.05.14**	**18.05.14**	**03.06.14**
June 2014	Health Care Assistants	**02.06.14**	**15.06.14**	**02.07.014**
July 2014	Clearing house	**TBC**	**TBC**	**TBC**
August 2014	Health Care Assistants	**04.08.14**	**17.08.14**	**02.09.14**
September 2014	Registered Nurses Band 5's and 6's	**01.09.14**	**14.09.14**	**30.09.14**
October 2014	Registered Nurses Band 5's and 6's	**29.09.14**	**12.10.14**	**28.10.14**
November 2014	Registered Nurses Band 5's and 6's	**03.11.14**	**16.11.14**	**02.12.14**
December 2013	Clearing House	**TBC**	**TBC**	**TBC**
January 2014	Registered Nurses Band 5's and 6's	**07.01.15**	**20.01.15**	**29.01.15**

University Hospitals of Leicester NHS Trust

Report To: Executive Strategy Board

Report From: Rachel Overfield, Chief Nurse

Date: 1 October 2013

Title: Ward Performance System (Criteria for Wards on Special Support)

---

1. Introduction

The purpose of this paper is to describe the intended approach to maintaining ward performance and systematically addressing poor performance at an early stage using early warning systems.

The approach utilises much of what is already in place but will require some remodelling of metrics, data collection and IT support.

The approach has been discussed with and enthusiastically agreed by the Nursing Executive Team.

2. Real Time Metrics/Dashboard

In order to determine in 'real' time ward safety and performance, the following types of metrics are required and need to be viewed alongside each other:

- Safety measures, eg harm events; infection rates
- Experience/satisfaction scores – patient and staff
- Experience outcomes eg pain control
- Workforce measures eg nurse to bed ratio; trained to untrained; actual numbers on shift; sickness absence

Whilst most of these metrics are already collected via electronic systems they are not routinely available in real time via a dashboard.

Recommendation One:
To establish a ward quality dashboard as soon as possible to be used as an early warning system that things are starting to go wrong. The vast majority of Trusts now have these in place and are beginning to make them routinely visible to the public.

3. Standard Ward Audit Day

There are a plethora of audits completed by nurses around ward based care. Currently these are completed on various days/intervals. This is complicated for Senior Nurses to organise and audit results are reported ad hoc and therefore there is unlimited ability to triangulate results to be able to form a comprehensive view of a ward's performance.

Recommendation Two:

To move towards a monthly ward audit day (safety thermometer day) and focus nursing leadership/corporate resources on that day.

4. Ward Performance Review

Collecting the right data against agreed standards/metrics is only part of the process. There is no plan currently in place that reviews all ward performance information as part of a formal process.

The attached (Appendix 1) is proposed to be used on a quarterly basis for all wards (Maternity, Theatre, Critical Care etc to follow). The procedure is described within the document but essentially Matrons and Ward Managers are expected to provide evidence (data, audits, feedback etc) that convinces their Head of Nursing that all essential standards are being met. Results are RAG rated and performance reported to group and Trust governance forums as a performance dashboard.

The process, along with more real time measures will be used to identify 'challenged' wards.

Recommendation Three:
To adopt the attached ward performance review approach.

5. Process for Identifying and Supporting Challenged Wards

The dashboard, results of audits and ward performance review outcomes will generate sufficient real time and trend information to identify early where wards are beginning to struggle. The attached (Appendix 2) describes how this information will be used to assist wards and ensure minimum standards are maintained.

Recommendation Four:
To adopt the approach as described.

6. Communication the Ward Performance Process

With Executive Strategy Board's support, the intention is to share this paper at Nursing Executive Team and Quality and Performance Management Group this week for adoption immediately.

The process will then be communicated to the organisation via usual standard routes.

7. Recommendations

Executive Strategy Board members are asked to agree the recommendations contained within this paper.

University Hospitals of Leicester NHS

NHS Trust

Caring at its best

Ward Review Tool

Ward/Area: _____

Ward Sister: _____

Matron: _____

Clinical Management Group: _____

Date and Time of Review _____

Introduction

This information describes the Trust's Ward Review Process.

The Review is designed to ensure all wards can identify their standard of care in order to ensure it is safe, effective and of high quality to guarantee we are providing the best we can for our patients.

General Principles

- The Review will be completed on a quarterly basis.
- The Review will be undertaken by the relevant Head of Nursing or Midwifery – with the Chief Nurse/Director of Nursing involved when necessary for assurance purposes.
- Ward Matrons and Ward Sisters must be in attendance with any other team reps they decide to bring.
- The outcome of the Review will form part of the Clinical Management Group (CMG) Performance Review.

The Process

- Individual review dates are scheduled through CMG Management Team.
- A minimum of two to four week's notice will be given to allow for information to be collated.
- A schedule of Review dates will be circulated to the relevant departments a minimum of two weeks by the CMG.
- The Matrons and Ward Sisters will be required to produce a remedial action plan to address any short falls identified within three weeks of the date of the review. A copy of this must be sent to the Head of Nursing for monitoring and for the ward/area file.
- 'Special measures' will be applied to wards significantly failing to meet the required standards.
- Results will be presented on a quarterly basis by the Head of Nursing to the Nursing Executive Team.

Scoring

A RAG rating will be applied to each objective:

Green = Fully embedded in care/clinical practice
Amber = Work in progress to implement/results poor suggests not embedded in clinical practice
Red = Failure to or no attempt to implement objective/lack of knowledge in this objective

For each objective essential criteria have been identified. 'Failure to meet an element in a key criteria is deemed a failure of that objective and is RAG rated red. In the event of this occurring the Ward Manager will be given 3 weeks to provide a detailed action plan agreed with their Matron identifying how the elements will be met. Upon receipt of a satisfactory action plan the Head of Nursing will move the RAG to amber pending the next ward review.

Abbreviations

CQC	Care Quality Commission
CQUIN	Commissioning for Quality and Innovation
DOL	Deprivation of Liberties
EOL	End of Life
FBC	Fluid Balance Chart
HIA	High Impact Action
IP	Infection Prevention
MDT	Multi Disciplinary Team
MUST	Malnutrition Universal Screening Tool
NHSLA	NHS Litigation Authority
NSI	Nurse Sensitive Indicators
PILS	Patient Information Liaison Service
PDR	Personal Development Review
PLACE	Patient Led Assessment of the Care Environment
SSI	Surgical Site Infection
ST	Safety Thermometer
PPI	Patient and Public Involvement
PES	Patient Experience Survey
CDiff	Clostridium Difficile
VIP	Visual Infusion Phlebitis
ALOS	Average Length of Stay
VRE	Vancomycin Resistant Enterococci
FFT	Friends and Family Test
MRSA	Methicillin-resistant Staphylococcus aureus

Ward/Area Demographics

Ward/Area	
Ward Speciality/CMG	
Number of Bed	
Number of Funded Beds	
Number of Beds Open	
Funded Nurse established – IP figures Ratio Information for the Quarter	
Summary of key issues for the quarter NB in relation to quality of care and/patient experience	

Overall Objective RAG Rating	

Objective 1
Matrons and Ward Sisters are responsible for ensuring the patient environment is clean and Infection Prevention procedures are in place.
CQC Outome: 8
Essential Criteria: 1a, 1b, 1d and 1e

Link to CQUIN

	Standard	Evidence Required	R	A	G	N/A	Comments/Evidence Produced/Results

1a	The Ward Matron and Ward Sister can give evidence and articulate the wards Infection Prevention and control risks/issues to include:
	• RCAs undertaken for MRSA bacteraemias
	• RCAs Cdiff periods of increased incidence and deaths
	• Outcomes of RCAs and lessons learnt
	• Infection Prevention and control practices issues relating to:
	  • Decontamination and fabric of the ward environment
	  • Decontamination and integrity of equipment
		• Infection Control Reports (previous quarter)
		• Risk register
		To include:
		- Number of patients identified with MRSA bacteraemias
		- Number of patients identified with post 48 hr MRSA
		- Number of patients identified with Cdiff
		- Outbreaks/increased incidence of infection/ward closures
		- Number of catheter associated urinary tract infections (CAUTIs)
		- VRE
		- MRSA screening rates (to include 28 days screens)
		• Isolation risk assessments undertaken					

1b	The Ward Matron and Ward Sister can produce the action plan that mitigates these risks.	• Copy of the action plan					
1c	The Ward Matron and Ward Sister can produce evidence that staff attend Infection Prevention mandatory training in line with Trust policy.	• Mandatory Training record					
1d	PLACE inspection audits are completed monthly and red actions are being resolved.	• Record of dates • Action plan					
1e	The Ward environment and equipment are cleaned regularly as per the cleaning book.	• Audit of daily completion • Audit of national cleanliness standards					

NB: Audit and % to go green

Overall Objective RAG Rating	

Objective 2
Matrons and Ward Managers will ensure all patients will have their essential care needs met.
CQC Outcomes: 1, 4 and 5
Essential Criteria: 2a, 2f

	Standard	Evidence Required	R	A	G	N/A	Comments/Evidence Produced/Results
2a	Matrons and Ward Managers will have in place robust systems for meeting patients Nutritional and Hygiene needs, specifically: • Protected Meal Times • MUST Assessment – initial and reassessment within 24 hrs to base ward • Patients being fed appropriately • Red trays and Red beakers in use • Staff are aware of how to access facilities to feed patients out of hours • Patients are assisted to eat • Patients have choice of meal • Appropriate escalation when poor nutrition is identified	• Meals observation audit • MUST audit evidence that MUST is re-assessed • Evidence that patient has been weighed • Assess patient weight for avoidable weight loss • Review patient food diary • Matron weekly audit and action plans					
2b	All patients will have their toilet and hygiene needs met.	• FFT • PSS results (previous quarter) • Matrons audit • Observation of patients					
2c	100% of patients must have a pain assessment upon admission.	• Nursing metrics (by Matrons)					
2d	All patients identified at risk of pain have an appropriate plan of care.	• Nursing metrics (by Matrons)					
2e	All patients report that their pain was well controlled.	• Nursing metric scores for Pain results (previous quarter)					
2f	All patients have been included in care rounding as required by their needs.	• Audit • Matrons Audit					

Overall Objective RAG Rating	

Objective 3
Matrons and Ward Sisters are responsible for ensuring nursing care is delivered with due regard to Compassion in Practice of those in their care.
CQC Outcomes: 1 and 4
Essential Criteria: 3a

	Standard	Evidence Required	R	A	G	N/A	Comments/Evidence Produced/Results
3a	Matrons and Ward Sisters can demonstrate and articulate that they are meeting their patients' needs in relation to the 6Cs examples: • Patients are nursed in same sex bays • Ward staff do their best to maintain patients dignity and privacy, eg privacy screens, covering patients, not talking over patients • Patients can readily access information for their individual needs • Patients can access toilet and bathroom facilities without walking by or through patients of the opposite sex. • All ward signage complies with same sex accommodation legislation	• Same sex breach report • Incidence reports • Ward philosophy • Copy ward information leaflet • Produce assessment • Up to date KHWD board • FFT					
3b	Wards who have implemented Amber Care Pathway can demonstrate compliance against pathway	• Audits Palliative Care Team					
3c	Matrons and Ward Sisters can demonstrate evidence of the 6Cs in practice.	• Patient feedback • Quality audits • Competence framework • Staff with Hospital badge • KHWD Boards (RT2C) • Complaints and PILS • Compliments					

Overall Objective RAG Rating	

Objective 4
Matrons and Ward Sisters ensure systems are in place to maximise patient experience by the way they communicate with patients and their relatives.
CQC Outcomes: 1, 4 and 5
Essential Criteria: 4d

	Standard	Evidence Required	R	A	G	N/A	Comments/Evidence Produced/Results
4a	KHWD Boards are up to date: • Material is current • Material is relevant • Positive message	• Matrons Audit • CMG spot audits					
4b	Staff make patients and visitors feel welcome.	• FFT • PSS (previous quarter) • CQC mock audit • Matrons audit					
4c	All patients receive appropriate information regarding what to expect during their hospital experience.	• Information leaflets on ward					
4d	Matrons and Ward Sisters can demonstrate evidence that they are responsive to user feedback from patients and carers.	• Caring at its Best Public facing Dashboards on display with corresponding of action plan • Message to Matron results and actions visible • Evidence that the Patient Experience Survey results and FFT results are actioned monthly • Data from PILS • Compliment cards loaded onto sharepoint and visible					
4e	Matrons and Ward Sisters must produce evidence that patients are enabled to complete PES.	• PES • Patient Experience surveys available for patients, relatives and carers to freely access on wards. • PES box easily accessible to patients fostering anonymous feedback • Caring at its Best Public Dashboards and PES results visible with action plans					

		(previous quarter) • Matrons audit results					
4f	Matrons and Ward Sisters must produce evidence of effective communication with all patient groups.	• FFT action plan • PSS (previous quarter) • Matrons audit results					

NB Remember need more on Dementia)

Overall Objective RAG Rating	

Objective 5
Matrons and Ward Sisters will ensure the needs of the vulnerable person are recognised and met.
CQC Outcomes: 7 and 4
Essential Criteria: 5a

	Standard	Evidence Required	R	A	G	N/A	Comments/Evidence Produced/Results
5a	Matrons and Ward Sisters will be able to demonstrate and articulate that all staff and patients know how to raise concerns about children and adults at risk, or who are, being harmed or abused. In accordance with local policy and procedures	• Evidence that staff and patients know how to raise safeguarding alerts • Copies of any safeguarding incident and investigation reports • Exception reports where safeguarding policies have not been followed and actions taken					
5b	All staff to access the relevant level of training : • Safeguarding Adults and Children • Deprivation of Liberty • Mental Capacity • Consent	• Staff Training Records • Outcome of site visit inspections from CCGs where appropriate					
5c	Matrons and Ward Sisters can produce evidence that safeguarding risks have been considered in complaints, staff disciplinary. Serious untoward incident and DATIX report reviews	• Outcome reports which include safeguarding investigations • Complaint responses which include safeguarding investigation summary • Evidence that the recommendations from safeguarding incidents and serious case reviews are implemented					
5d	Matrons and Ward Sisters can produce evidence of involvement of Patients and carers in safeguarding investigations	• Quality Audits • Observation of Care • PPS (previous quarter) • Completion of the Patient Profile for all relevant patients • Patient Experience Surveys completed by carers and relatives • Flexible visiting for carers and relatives					
5e	Matrons and Ward Sisters can produce evidence of any actions taken in their areas to minimise the risk	• Actions taken to ensure patient care is monitored					

	of neglect whilst being cared for by the Trust	• Systems in place 24hrs to review patient care • Systems to address poor standards of practice • Evidence that patients detained under the mental health act (where applicable) are provided with information regarding their rights					
5f	Developmental Standard Matrons and Ward sisters can demonstrate progress towards raising awareness of • Prevent • Domestic Abuse initiatives	• Evidence of initiatives taken to address these areas of practice					

Overall Objective RAG Rating	

Objective 6
Matrons and Ward Sisters will ensure harm free care is delivered.
CQC Outcomes: 9
Essential Criteria: 6d and 6i

	Standard	Evidence Required	R	A	G	N/A	Comments/Evidence Produced/Results
6a	There is a ward based risk register identifying clinical and non clinical risks.	• Copy produced at review • Evidence of escalation to CMG					
6b	Matrons and Ward Sisters can articulate their top 3 patient safety issues and describe what they are doing to mitigate risk.	• Discuss at review • Safety Cross					
6c	100 % patients must have a Waterlow score on admission > 6 hours.	• Quality audit results (previous quarter)					
6d	Matrons and Ward Sisters must be aware of wards 'incident' trends with appropriate action plan. NB: to include SSI where appropriate.	• Feedback from Risk • Local Record (copy produced at Review)					
6e	Matrons and Ward Sisters must produce evidence that early warning systems are in place to promote safety.	• EWS					
6f	Matrons and Ward Sisters must produce evidence of number of staff completing mandatory resus training.	• Local record • Copy produced at Review					
6g	Matrons and Ward Sisters must produce evidence that emergency equipment check completed daily, i.e. crash trolley or equivalent and O2 suction.	• Local record • Copy produced at Review					
6h	Matrons and Ward Sisters can demonstrate effective systems are in place for the safe storage and administration of medicines.	• Omissions Audit • CD check • Storage audit – CQUIN					
6i	ST results.	• Awareness of Ward score for Harm Free Care					
6j	Dementia care.	• Assessment • Staff understanding of patient needs					
6k	Matrons and Ward Sisters can demonstrate compliance with blood transfusion policy.	• Mandatory training record • Incident reporting					
6l	Matrons and Ward Sisters must provide evidence that their staff are competent in the use of relevant	• Mandatory training record					

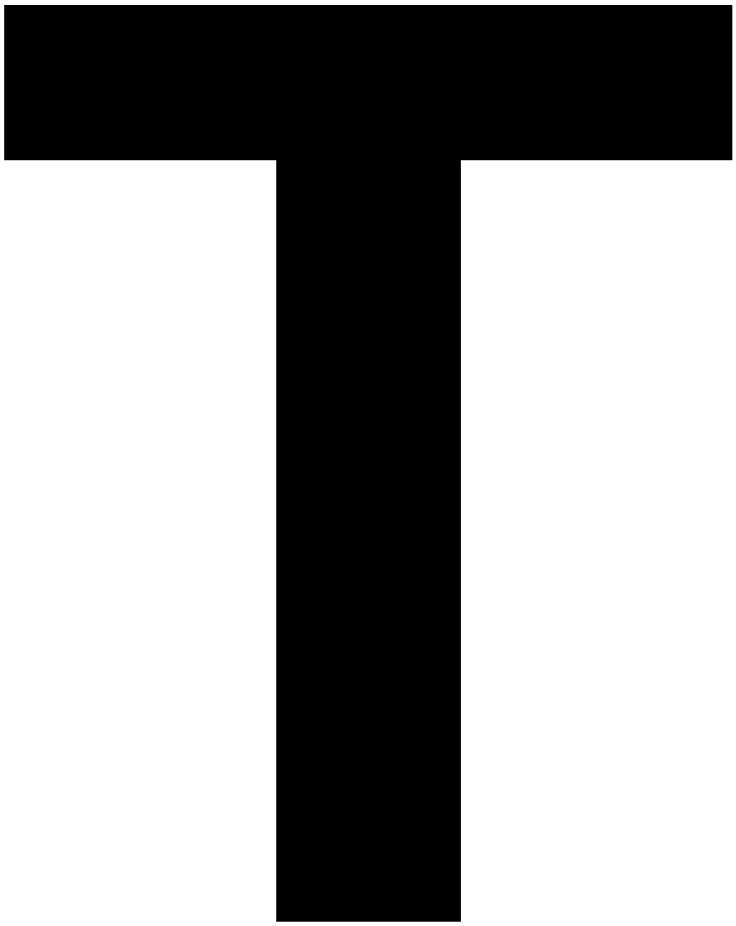
	medical devices.						
6m	All Ward Sisters must have knowledge of rate of: • Falls • Tissue Damage And be able to demonstrate number of pressure ulcer free days.	• Quality audit (previous quarter) • Safety Cross • Action plans / lessons learnt from previous incidents					
6n	All patients identified at risk of developing pressure lesions must have an appropriate plan of care.	• Quality audit					
6o	100% patients have a falls assessment upon admission > 48 hours.	• Quality audit					
6p	All patients identified at risk of falls have an appropriate plan of care identifying preventative measures.	• Quality audit results (previous quarter)					
6q	Matrons and Ward Sisters must be able to present and discuss ward dashboard results and appropriate action.	• Dashboard • Demonstrates understanding and knowledge					

Overall Objective RAG Rating	

Objective 7
Matrons and Ward Sisters will make effective use of all resource and is able to effectively manage the workforce.
CQC Outcomes: 12, 13 and 14
Essential Criteria: 7a and 7c

	Standard	Evidence Required	R	A	G	N/A	Comments/Evidence Produced/Results
7a	Finance meetings at least monthly.						
7b	Human Resources meetings to discuss actions and support required to manage sickness absence or performance reviews.						
7c	Evidence of daily Matron visits and audits are available to review Evidence that the appropriate of volunteers support in the clinical environment has been carried out and that all volunteers are supported and encouraged on the ward	Evidence of volunteers folder is accessible and completed Staff are aware of volunteer roles and the structures to support volunteers in the area.					
7d	Matrons and Ward Sisters can demonstrate effective budget knowledge, understanding and management and ensuring all usage will not exceed budget.	• Mitigation • Finance reports • Bank utilisation reports • Quota report • Maternity leave • Vacancies • Risk assessment					
7e	Matrons and Ward Sisters will have detailed knowledge of the wards sickness absence data and be able to evidence appropriate management of annual target.	• Internal measures board • Local record • Evidence of management					
7f	Matrons and Ward sisters will have detailed knowledge of the wards appraisal data and achieve the CMG target.	• KHWD board • Local record • Training plan: - Actual - Predicted					
7g	A recent assessment of staffing needs has been completed and rostering practices are according to	• Production of local evidence • Real time nursing summary visible					

	policy.	• Bi-annual review of staffing needs • Live on electronic rostering, adherence to set KPI's					
7h	A Matron cluster meeting at least monthly; a Ward Team meeting is held at least monthly; CMG triumvirate at least monthly.	• Minutes of meeting					
7i	Matrons and Ward Sisters can produce a current practice education audit to include evidence that all mentors meet NMC requirements.	• List of mentors and the date of their update • Results of Practice Education Audit Tool • Identify name of wards education link nurse					
7j	The ward is able to demonstrate that they are providing a quality learning environment for students.	• Results of Practice Education Audit Tool • Student information on ward notice board					
7k	Matrons and Ward Sisters can produce evidence that all staff can access clinical supervision/preceptorship.	• List of supervisors • Dates of clinical supervision • Minutes of ward meetings					
7l	Matrons and Ward Sisters can produce evidence staff are competent to care for their patient group.	• Training needs analysis • Training plan: - Predicted - Actual • Production of plan • Evidence of training in the last quarter • Development pathways					
7m	Matrons and Ward Sisters can produce evidence that 100% of new staff have a local induction.	• Copy of induction data and record of completion					
7n	Matrons and Ward Sisters can produce evidence mandatory training attendance meets Trust target, i.e. no less than 95% compliant.	• Mandatory training report					
7o	Matrons and Ward Sisters can produce evidence that all healthcare students are supported to meet their educational requirements in the time frame required, i.e. pre-reg, trainee Assistant Practitioners, HCAs and apprentices.	• Local record • Feedback Practice Learning Leads • Feedback from students • Local audit					
7p	Matrons and Ward Sisters can demonstrate new qualified staff and new starters complete a period of Preceptorship.	• Local record • Feedback from Education teams • Feedback from staff • Local audit					



Trust Board Paper T

To:	**Trust Board**
From:	**Mark Wightman Director of Marketing and Communications**
Date:	**31 October 2013**
CQC regulation:	**All Applicable**

Title:	Deed of Gift for scalp cooling caps.

Author/Responsible Director: Honor Gascoigne, (Macmillan Project Manager) / Mark Wightman

Purpose of the Report: To gain the support of the Board for a proposal to accept a gift from the national Breast Cancer Charity, Walk the Walk, which would enable the Chemotherapy service to purchase 'scalp cooling caps' which are designed to reduce hair loss for patients undergoing chemotherapy.

The Report is provided to the Board for:

Decision		Discussion	
Assurance		Endorsement	X

Summary / Key Points:

The 'Walk the Walk' charity have made a commitment to provide hospitals throughout the UK with the means to purchase scalp cooling equipment to ensure patients receiving chemotherapy can receive effective scalp cooling treatment as a way of minimising hair loss following chemo. In order to achieve this they have teamed up with Paxman Coolers to provide a comprehensive package of equipment and support with no cost to the hospitals taking part. UHL has been offered up to £250,000 in order to be part of the scheme. Walk the Walk will commit their funds through a Deed of Gift, which requires Trust Board to pass a resolution to allow the Chairman to use the Trust seal and thus 'approve' the gift.

Recommendations:

UHL due process in the case of a Deed of Gift requires use of the Trust Seal. Standing Orders require a Trust Board resolution authorising use of the Trust Seal before the Seal can be applied to the Deed and that the Chairman and Director of Corporate and Legal Affairs (or his Deputy) attest/witness the Deed. Therefore, the Board are invited to comment on this proposal and to resolve that the Chairman may authorise the Deed' confirming that we are delighted to accept the offer of funding for this important addition to the service we offer to our patients.

Previously considered at another corporate UHL Committee?

NO

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

Resource Implications (eg Financial, HR):

No resource implications have been highlighted

Assurance Implications:
Patient and Public Involvement (PPI) Implications:
Stakeholder Engagement Implications:
Equality Impact:
Information exempt from Disclosure: No
Requirement for further review? 2018 / on the anniversary of the end of the 5 year contract

Deed of Gift donation for Scalp Cooling Package

Summary: The Walk the Walk charity have made a commitment to provide hospitals throughout the UK with the means to purchase scalp cooling equipment to ensure patients receiving chemotherapy can receive effective scalp cooling treatment. In order to achieve this they have teamed up with Paxman Coolers to provide a comprehensive package of equipment and support with no cost to the hospital. UHL has been offered up to £250,000 in order to be part of the scheme. Walk the Walk will commit their funds through a Deed of Gift, which requires Trust Board to pass a resolution to allow the Chairman to sign.

Background: Cancer chemotherapy treatment affects rapidly dividing cells and at any given time, 90% of human hair follicles are in the actively dividing phase. Hair loss frequently occurs due to partial or total atrophy of the hair root bulb, causing constriction of the hair shaft, which then breaks off easily.

Scalp cooling works by lowering the temperature of the head and scalp immediately before, during and after the administration of chemotherapy. This in turn reduces the blood flow to the hair follicles, thus preventing or minimising the damage, meaning that hair loss is not inevitable.

The caps are soft, flexible and provide a snug, close fit around the patient's head. Coolant passes through the cap extracting heat from the patient's scalp. Inline temperature sensors ensure the cap maintains the scalp at an even, constant temperature. The model on offer, The Orbis II, can provide cooling for one or two patients simultaneously with each cap working independently.

The system consists of a small compact refrigeration unit containing a coolant which is circulated at -4°C through coolant lines to specially designed cooling caps. The coolant lines are supported by an adjustable arm providing maximum patient comfort.

Current Status: A less sophisticated scalp cooling process whereby caps are cooled in a freezer is currently available in UHL, mainly to patients receiving chemotherapy after breast cancer.

CMG Support : Dr Samreen Ahmed, lead clinician for the chemotherapy suite has given her full support to the use of the Orbis II system, advising that they are far more effective than the current cool caps. Michael Nattrass, Angharad Rastrick and the Oncology Clinical Nurse specialists are also aware and supportive of the proposal. In addition, Dr Paul Spiers, in his capacity as Chair of the Medical Equipment Committee has also been informed.

Key Considerations: It is proposed that 15 (to be confirmed) Orbis 11 units are purchased which will allow for a broader range of patients to be offered the opportunity to use a scalp cooling cap and as the cap has to be worn for 30 minutes following the chemotherapy, for patients to be able to move to a waiting area to complete the process.

Proposal: The package includes the following:

- Supply of sufficient numbers of scalp cooling systems to meet current and future demands by patients for scalp cooling.

- A fully comprehensive 5 year service & maintenance contract which includes an annual service of the equipment as well as cover and support for any technical breakdowns that may occur during the contract period.

- Funds to cover the replacement of cooling caps and any other parts during the first 5 years.

- A comprehensive user training and support package which includes re-training sessions every 6 months to ensure continuity in use of equipment.

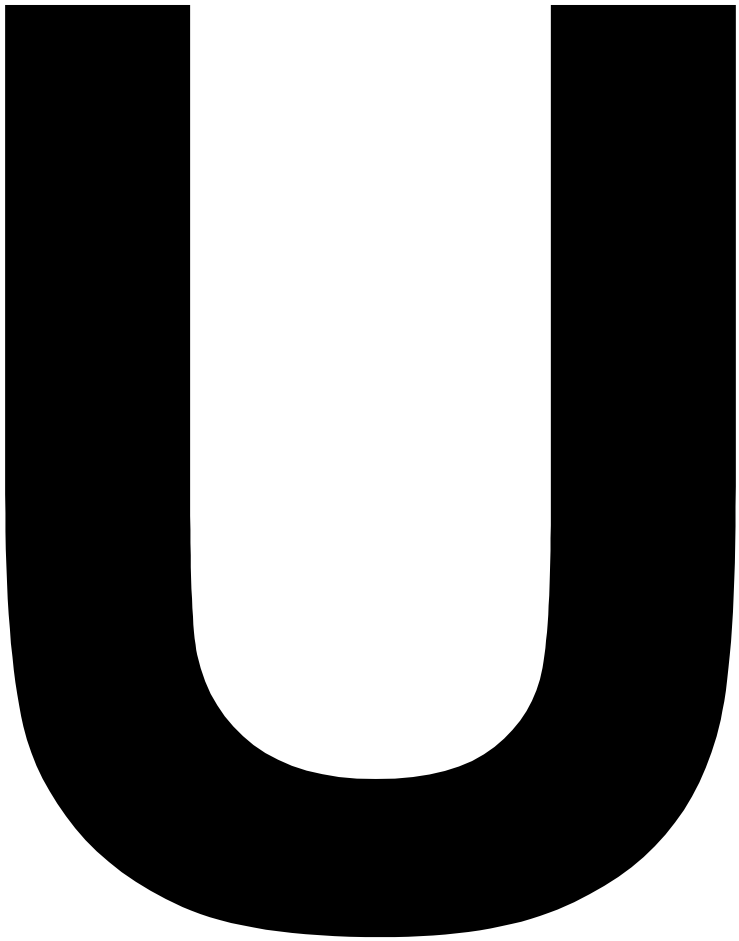
- During the 5th year of the contract the trust can apply for further funding to cover extended warranty, training needs and purchase of additional cooling caps/parts.

Funding for the package is provided by Walk the Walk, (WTW) in the form of a Deed of Gift 'contract' which is to be signed by the NHS trust and returned to WTW. Upon receipt of the signed contract WTW will forward the funds with which to purchase the package from Paxman Coolers. Upon receipt by Paxman Coolers of a confirmed purchase order, arrangements will be made to deliver the equipment and carry out user training.

Recommendations:
UHL due process in the case of a Deed of Gift requires use of the Trust Seal. Standing Orders require a Trust Board resolution authorising use of the Trust Seal before the Seal can be applied to the Deed and that the Chairman and Director of Corporate and Legal Affairs (or his Deputy) attest/witness the Deed. Therefore, the Board are invited to comment on this proposal and to resolve that the Chairman may authorise the Deed' confirming that we are delighted to accept the offer of funding for this important addition to the service we offer our patients.

More information on the charity and their aims can be found on their website - www.walkthewalk.org

ENDS



University Hospitals of Leicester NHS
NHS Trust

To:	**Trust Board**
From:	**Chief Nurse**
Date:	**31 October 2013**
CQC regulation:	Outcome 16 – Assessing and Monitoring the Quality of Service Provision

Trust Board Paper U

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

Author/Responsible Director: Chief Nurse

Purpose of the Report:
The report provides the Board with an updated Board Assurance Framework (BAF) and oversight of extreme and high risks within the Trust. The report includes:-

a) A copy of the BAF as of 30 September 2013.
b) An action tracker to monitor progress of BAF actions
c) A summary diagram of risk movements from the previous month.
d) Suggested parameters for scrutiny of the BAF.
e) An extract from the UHL risk register showing extreme and high risks within UHL.

The Report is provided to the Board for:

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

Summary :

- There have been no changes to BAF risk scores during the reporting period.
- Board members are invited to review the following BAF risks.
  Failure to exploit the potential of IM&T (risk owner – DFBS).
  Failure to enhance education and training culture (risk owner MD).
  Failure to achieve financial sustainability (risk owner DFBS).
- There have been no new high risks have opened on the UHL risk register during September 2013.

Recommendations:
Taking into account the contents of this report and its appendices the Board are invited to:

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

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

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

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

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

(f) Note the organisational risks detailed within appendix five.

Strategic Risk Register Yes	**Performance KPIs year to date** N/A
Resource Implications (eg Financial, HR) N/A	
Assurance Implications: Yes	
Patient and Public Involvement (PPI) Implications: Yes	
Equality Impact N/A	
Information exempt from Disclosure: No	
Requirement for further review? Yes. Monthly review by the Board	

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST

REPORT TO: **TRUST BOARD**

DATE: **31 OCTOBER 2013**

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

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

---

1. INTRODUCTION

1.1 This report provides the Board with:-

a) A copy of the Board Assurance Framework (BAF) as of 30 September 2013.
b) An action tracker to monitor progress of BAF actions.
c) A summary diagram of BAF risk score to show any changes in BAF risk scores from the previous month.
d) Parameters for Board scrutiny of the BAF.
e) An excerpt for the UHL risk register showing all current extreme and high risks within UHL.

2. BAF POSITION AS OF 30 SEPTEMBER 2013

2.1 A copy of the BAF is attached at appendix one with changes to narrative since the previous version shown in red text.

2.2 The progress of actions associated with the BAF is monitored by reference to the action tracker attached at appendix two.

2.3 During this reporting period there have been no changes to BAF risk scores as evidenced in appendix three.

2.4 To provide an opportunity for more detailed review three BAF risks will be presented on a monthly basis for Board members to review against the areas listed in appendix four. These risks will be presented in their numerical sequence and the risks below are presented for review against the parameters outlined in appendix four:

Failure to exploit the potential of IM&T (risk owner – DFBS).
Failure to enhance education and training culture (risk owner MD).
Failure to achieve financial sustainability (risk owner DFBS).

3 EXTREME AND HIGH RISK REPORT.

3.1 As described in the UHL Risk Management Policy the Board will receive notification of any extreme/ high risks that have opened during the reporting period and, in addition, a quarterly excerpt from the UHL risk register to show all currently open extreme/ high risks. The Board are therefore asked to note:

a. No new high risks have opened during September 2013.

b. There are a total of 24 high risks and one extreme risk listed on the UHL risk register, details of which can be found at appendix five.

4. RECOMMENDATIONS

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

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

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

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

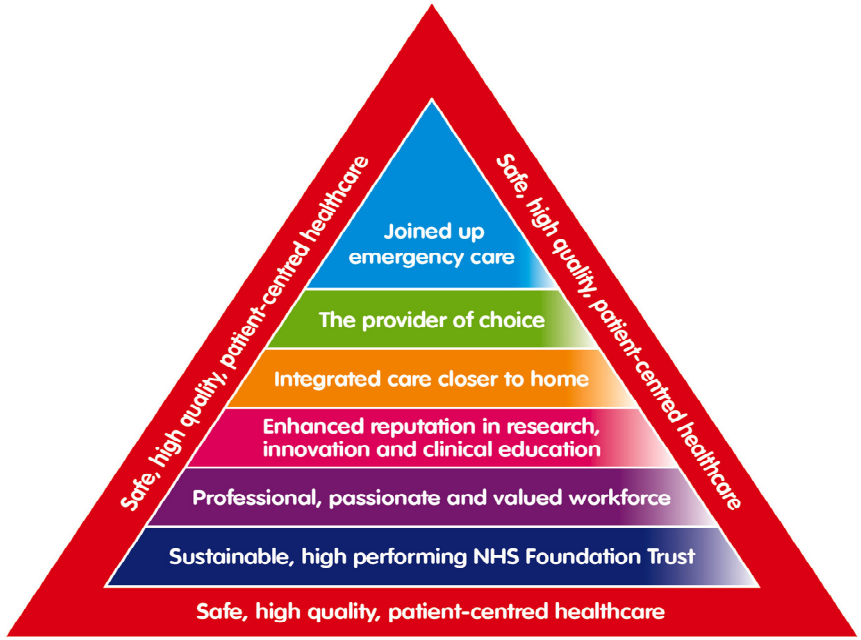
(d) identify any gaps in assurances about the effectiveness of the controls in place to manage the principal risks and consider the nature of, and timescale for, any further assurances to be obtained;

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

(f) Note the organisational risks detailed within appendix five.

Peter Cleaver,
Risk and Assurance Manager,
23 October 2013.

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST – BOARD ASSURANCE FRAMEWORK SEPTEMBER 2013



PERIOD: SEPTEMBER 2013

RISK TITLE	STRATEGIC OBJECTIVE	CURRENT SCORE	TARGET SCORE
Risk 1 – Failure to achieve financial sustainability	g - To be a sustainable, high performing NHS Foundation Trust	25	12
Risk 2 – Failure to transform the emergency care system	b - To enable joined up emergency care	25	12
Risk 3 – Inability to recruit, retain, develop and motivate staff	f - To maintain a professional, passionate and valued workforce e - To enjoy an enhanced reputation in research, innovation and clinical education.	16	12
Risk 4 – Ineffective organisational transformation	a - To provide safe, high quality patient-centred health care c - To be the provider of choice d - To enable integrated care closer to home	12	12
Risk 5 – Ineffective strategic planning and response to external influences	a - To provide safe, high quality patient-centred health care c - To be the provider of choice g - To be a sustainable, high performing NHS Foundation Trust	12	12
Risk 6 – Failure to achieve FT status	g - To be a sustainable, high performing NHS Foundation Trust	16	12
Risk 7 – Failure to maintain productive and effective relationships	c - To be the provider of choice d - To enable integrated care closer to home f - To maintain a professional, passionate and valued workforce	15	10
Risk 8 – Failure to achieve and sustain quality standards	a - To provide safe, high quality patient-centred health care c - To be the provider of choice	16	12
Risk 9 – Failure to achieve and sustain high standards of operational performance	a - To provide safe, high quality patient-centred health care	12	12
Risk 10 – Inadequate reconfiguration of buildings and services	a - To provide safe, high quality patient-centred health care	12	9
Risk 11– Loss of business continuity	g - To be a sustainable, high performing NHS Foundation Trust	9	6
Risk 12 – Failure to exploit the potential of IM&T	a - To provide safe, high quality patient-centred health care d - To enable integrated care closer to home	9	6
Risk 13 - Failure to enhance education and training culture	e – To enjoy an enhanced reputation in research, innovation and clinical education	12	6

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

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

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST – BOARD ASSURANCE FRAMEWORK SEPTEMBER 2013

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

Principal Risk (What could prevent the objective(s) being achieved)	**What are we doing about it?** **(Key Controls)** What control measures or systems we have in place to assist secure delivery of the objective (describe process rather than management group)	**Current Score I x L**	**How do we know we are doing it?** **(Key Assurances of controls)** Provide examples of recent reports considered by Board or committee where delivery of the objectives is discussed and where the board can gain evidence that controls are effective.	**What are we not doing?** **(Gaps in Controls C) / Assurance (A)** What gaps in systems, controls and assurance have been identified?	**How can we fill the gaps or manage the risk better?** **(Actions to address gaps)**	**Target Score I x L**	**Timescale** When will the action be completed?
Failure to achieve financial sustainability including:	Overarching financial governance processes including PLICS process and expenditure controls. Revised variance analysis and reporting metrics especially for the ETPB Self-assessment and SLM baseline exercise completed and project manager identified Finalised SLM Action plan Full information has now been received on UHL allocations from all the no-recurrent funding streams including transformation monies. This information is being incorporated into the financial forecasts.	5X5=25	Monthly /weekly financial reporting to Exec Team Performance Board, F&P Committee and Board. Cost centre reporting and monthly PLICS reporting. Monthly confirm and challenge processes at CBU and Divisional level. Annual internal and external audit programmes. Monthly meetings with the NTDA and the CCG Contract Performance Meeting	(c) SLM programme not fully implemented	ESB will continue to meet every 6 weeks to ensure implementation of SLM across the Trust (expected Mar 2014) (1.19)	4x3=12	Mar 2014 DFBS
Failure to achieve CIP.	Strengthened CIP governance structure including appt of Head of CIP programme		Progress in delivery of CIPs is monitored by CIP Programme Board (meeting fortnightly) and reported to ET and Board.	(c) Under-delivery of CIP programme (£1.6m adverse to plan M5)			

Locum expenditure.	Workforce plan to identify effective methods to recruit to 'difficult to fill' areas Reinstatement of weekly workforce panel to approve all new posts. STAFFflow for medical locums saving £130k of every £1m expenditure Financial Recovery plans developed by Acute and Planned Care Non Contractual Payments are discussed at monthly Divisional meetings Confirm and Challenge Meetings All Divisions (by CBU) have produced premium spend trajectories and associated plans until March 2014 Weekly Staff Bank data reports are issued for medical and nursing (qualified and unqualified) staff Action plan to increase bank staff capacity and drive down agency nurse expenditure.		The use of locum staff in 'difficult to fill' areas is reported to the Board on a monthly basis via the Quality and Performance report. A reduction in the use of such staff would be an assurance of our success in recruiting substantive staff to 'difficult to fill' areas. Increase in contracted staff numbers of medical and nursing professions of 234wte since Mar 12. Saving in excess of £0.6m 5 weeks after 'go live' date Monthly Q&P report to TB Monthly confirm and challenge meetings Non contractual payments (premium spend) are reported monthly to the Finance and Performance Committee A weekly report is presented to ET. Weekly meetings with HoNs and DHR to monitor progress.				
Loss of income due to tariff/tariff changes (including referral rate for emergency admissions – MRET)	Contract meetings with Commissioners Negotiations with Commissioners concluded at a transactional level.		Monthly /weekly financial reporting to Finance and Performance (F&P) Committee and Board.	(c) Failing to manage marginal activity efficiently and effectively.	Ongoing discussions with commissioners about planned re-investment of the MRET deductions. (1.11)		Review Oct 2013 DFBS

Ineffective processes for Counting and Coding.	Clinical coding project.		Ad-Hoc reports on annual counting and coding process. PbR clinical coding audit Jan 2013 (final report received 29 May 2013). IG toolkit audit (sample of 200 General Surgery episodes).	(c) Error rates in audit sample could be indicative of underlying process issues (c) Error rates identified as: Primary diagnoses incorrect 8.0% › Secondary diagnoses incorrect 3.6%. › Primary procedure incorrect 6.4% › Secondary procedure incorrect 4.5%.	Re-establishing clinical coding improvement team under John Roberts. Initial action plan in place (1.6)		Review Oct 2013 COO
Loss of liquidity.	Liquidity Plan.		Monthly /weekly financial reporting to Finance and Performance (F&P) Committee and Board. Detailed cash management plans presented at August 2013 F&P committee				
Lack of robust control over pay and non-pay expenditure.	Pay and Non-pay recovery action plan in place and monitored monthly Catalogue control project.		Monthly /weekly financial reporting to Finance and Performance (F&P) Committee and Board. Non-pay management plan presented at July F&P committee Ongoing Monitoring via F&P Committee.				
Commissioner fines against performance targets.	Contract meetings with Commissioners and negotiations with Commissioners concluded at a transactional level. Divisions have developed plans and trajectories to reduce admission rates that are monitored at monthly C&C meetings.		Monthly /weekly monitoring of action plans, key performance target, and financial reporting to Finance and Performance (F&P) Committee and Board.				
Use of readmission monies.	Contract meetings with Commissioners Negotiations with Commissioners concluded at a transactional level Ownership of readmissions work streams in divisions clarified		Monthly /weekly financial reporting to Finance and Performance (F&P) Committee and Board.				

Ineffective organisational transformation.	See risk 4		See risk 4.	See risk 4.	See risk 4.		

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST – BOARD ASSURANCE FRAMEWORK SEPTEMBER 2013

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

Principal Risk (What could prevent the objective(s) being achieved)	**What are we doing about it?** **(Key Controls)** What control measures or systems we have in place to assist secure delivery of the objective (describe process rather than management group)	**Current Score I x L**	**How do we know we are doing it?** **(Key Assurances of controls)** Provide examples of recent reports considered by Board or committee where delivery of the objectives is discussed and where the board can gain evidence that controls are effective.	**What are we not doing?** **(Gaps in Controls C) / Assurance (A)** What gaps in systems, controls and assurance have been identified?	**How can we fill the gaps or manage the risk better?** **(Actions to address gaps)**	**Target Score I x L**	**Timescale** When will the action be completed?
Failure to transform emergency care system leading to demands on ED and admissions units continuing to exceed capacity.	Health Economy has submitted response plan to NHSE requirements for an Emergency Care system under the A&E Performance Gateway Reference 00062.	5x5=25	Once plan agreed with NTDA, it will be circulated to the Board	No gaps	No actions	4x3=12	
	Emergency Care Action Team formed. Chaired by Chief executive to ensure Emergency Care Pathway Programme actions are being undertaken in line with NHSE action plan and any blockages to improvement removed. Development of action plan to address key issues		Action Plan circulated to the Board on a monthly basis as part of the Report on the Emergency Access Target within the Quality and Performance Report	Gaps described below	Actions described below		
	A new plan has been submitted detailing a clear trajectory for performance improvement and includes key themes from plan: Single front door		Project plan developed by CCG project manager Risks from 'single front door' to be escalated via ECAT and raised with CCG Managing Director as required	No gaps	No actions		
	ED assessment process is being operated.		Forms part of Quality Metrics for ED reported daily update and part of monthly board performance report	No gaps	No actions		
	Recruitment campaign for continued recruitment of ED medical and nursing staff including fortnightly meetings with HR to highlight delays and solutions in the recruitment process.		Vacancy rates and bank/agency usage reported to Trust Board on a monthly basis Recruitment plan being led by HR and monitored as part of ECAT	(c) Difficulties are being encountered in filling vacancies within the emergency care pathway. Agency and bank requests continue to increase in response to increasing sickness rates, additional capacity, and vacancies. (c) Staffing vacancies for medical and nursing staff remain high.	Continue with substantive appts until funded establishment is achieved (2.7)		Review Nov 2013 COO

	Formation of an EFU and AFU to meet increased demand of elderly patients		'Time to see consultant' metric included in National ED quarterly indicator.	No gaps	No actions		
	Maintenance of AMU discharge rate above 40%		Reported to Operational Board twice monthly and will be included in Emergency Care Update report in Quality and Performance Report.	No gaps	No actions		
	New daily MDT Board Rounds on all medical wards and medical plans within 24hrs of admission		Reported to Operational Board twice monthly and will be included in Emergency Care Update report in Quality and Performance Report.	No gaps	No actions		
	EDDs to be available on all patients within 24 hours of admission. Review built in to daily discharge meetings to check accuracy of EDDs (from 2/09/13).		Monitored and reported to Operational Board twice monthly and will be included in Emergency Care Update report in Quality and Performance Report.	No gaps	No actions		
	Maintain winter capacity in place to allow new process to embed		All winter capacity beds are to be kept open until the target is consistently met	No gaps	No actions		
	DTOCs to be kept to a minimal level		Forms part of the Report on Emergency Access in the Quality and Performance Report.	(c) Lack of availability of rehabilitation beds for increasing numbers of patients.	CCG/LPT to increase capacity by use of Intermediate Care Services (2.9)		Review Oct 2013 CO O

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST – BOARD ASSURANCE FRAMEWORK SEPTEMBER 2013

RISK NUMBER/ TITLE:	**RISK 3 – INABILITY TO RECRUIT, RETAIN, DEVELOP AND MOTIVATE STAFF**
LINK TO STRATEGIC OBJECTIVE(S))	**e. - To enjoy an enhanced reputation in research, innovation and clinical education** **f. - To maintain a professional, passionate and valued workforce**
EXECUTIVE LEAD:	Director of Human Resources

Principal Risk (What could prevent the objective(s) being achieved)	**What are we doing about it?** **(Key Controls)** What control measures or systems we have in place to assist secure delivery of the objective (describe process rather than management group)	**Current Score I x L**	**How do we know we are doing it?** **(Key Assurances of controls)** Provide examples of recent reports considered by Board or committee where delivery of the objectives is discussed and where the board can gain evidence that controls are effective.	**What are we not doing?** **(Gaps in Controls C) / Assurance (A)** What gaps in systems, controls and assurance have been identified?	**How can we fill the gaps or manage the risk better?** **(Actions to address gaps)**	**Target Score I x L**	**Timescale** When will the action be completed?
Inability to recruit, retain, develop and motivate suitably qualified staff leading to inadequate organisational capacity and development.	Leadership and talent management programmes to identify and develop 'leaders' within UHL.	4x4=16	Development of UHL talent profiles.	No gaps identified.	No actions required.	4x3=12	
			Talent profile update reports to Remuneration Committee.	No gaps identified.	No actions required.		
	Substantial work program to strengthen leadership contained within OD Plan.			No gaps identified.	No actions required.		
	Organisational Development (OD) plan.		A central enabler of delivering against the OD Plan work streams will be adopting, 'Listening into Action' (LiA) and progress reports on the LiA will be presented to the Trust Board on a quarterly basis.	No gaps identified.	No actions required.		
	A central enabler of delivering against the OD Plan work streams will be adopting, 'Listening into Action (LiA). A Sponsor Group personally led by our Chief Executive and including, Executive Leads and other key clinical influencers has been established.		Progress reports on the LiA will be presented to the Trust Board on a quarterly basis.	No gaps identified. No gaps identified.	No actions required. No actions required.		
	Staff engagement action plan encompassing six integrated elements that shape and enable successful and measurable staff engagement		Results of National staff survey and local patient polling reported to Board on a six monthly basis. Improving staff satisfaction position.	No gaps identified.	No actions required.		
			Staff sickness levels may also provide an indicator of staff satisfaction and performance for staff sickness rates are 3.5% for M5	No gaps identified	No actions required.		

	Appraisal and objective setting in line with UHL strategic direction. Local actions and appraisal performance trajectories agreed with Divisions and Directorates Boards		**Appraisal rates reported monthly to Board via Quality and Performance report.** **Month 5 appraisal rate = 92.79% -**	No gaps identified.	No actions required.		
	Summary of quality findings communicated across the Trust; to identify how to improve the quality of the appraisal experience for the individual and the quality of appraisal meeting recording.		Results of quality audits to ensure adequacy of appraisals reported to the Board via the quarterly workforce and OD report.	No gaps identified.	No actions required.		
			Appraisal Quality Assurance Findings reported to Trust Board via OD Update Report June 2013 Quality Assurance Framework to monitor appraisals on an annual cycle (next due March 2014).	No gaps identified.	No actions required.		
	Workforce plan to identify effective methods to recruit to 'difficult to fill areas). Divisions and Directorates 2013/14 Workforce Plans.		The use of locum staff in 'difficult to fill' areas is reported to the Board on a monthly basis via the Quality and Performance report. Reduction in the use of such staff would be an assurance of our success in recruiting substantive staff.	No gaps identified.	No actions required.		
	Reward /recognition strategy and programmes (e.g. salary sacrifice, staff awards, etc).			(a) Reward and recognition strategy requires revision to include how we will provide assurance that reward and recognition programmes are making a difference to staffing recruitment/ retention/ motivation.	Revise and launch reward and recognition strategy. (3.1) Development of Pay Progression Policy for Agenda for Change staff (3.3) Consult and implement pay progression policy (3.6) Implementation of Recruitment and Retention Premia for ED staff (3.4)		Jan 2014 DHR Oct 2013 DHR **Nov 2014 DHR** **Oct 2013 DHR**

	UHL Branding – to attract a wider and more capable workforce. Includes development of recruitment literature and website, recruitment events, international recruitment. This includes a recently held nurse recruitment day (Jan 2013). Reporting and monitoring of posts with 5 or less applicants.		Evaluate recruitment events and numbers of applicants. Reports issued to Nursing Workforce Group (last report 4 Feb). Report to Workforce and OD Committee in March. Positive feedback from nurse recruitment day on 26 Jan 2013. Future reporting will be to the Board via the quarterly workforce an OD report. Quarterly report to senior HR team and to Board via quarterly workforce and OD report	(a) Better baselining of information to be able to measure improvement. (c) Lack of engagement in production of website material.	Take baseline from January and measure progress now that there is a structured plan for bulk recruitment. Identify a lead from each professional group to develop and encourage the production of fresh and up to date material. (3.2)		Dec 2013 DHR
	Statutory and mandatory training programme for 9 key subject areas in line with National Core Skills Framework		Monthly monitoring of statutory and mandatory training uptake via reports to TB and ESB against 9 key subject areas (currently 49% at M5)	(c) Compliance against the 9 key subject areas is 49% (M5) due to lack of capacity for face to face training. (a) Potentially there may be inaccuracies of training data within the e-UHL system	Ensure Statutory and Mandatory training is easy to access and complete with 75% compliance by reviewing delivery mode, access and increasing capacity to deliver against specific subject areas (3.5) Update e-UHL records to ensure accuracy of reporting on a real time basis		**Mar 2014 DHR** Mar 2014 DHR

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST – BOARD ASSURANCE FRAMEWORK SEPTEMBER 2013

RISK NUMBER/ TITLE:	**RISK 4 – INEFFECTIVE ORGANISATIONAL TRANSFORMATION**
LINK TO STRATEGIC OBJECTIVE(S)	**a. - To provide safe, high quality patient-centred health care.** **c. - To be the provider of choice.** **d. - To enable integrated care closer to home**
EXECUTIVE LEAD:	Chief Executive (via Director of Strategy)

Principal Risk (What could prevent the objective(s) being achieved)	**What are we doing about it?** **(Key Controls)** What control measures or systems we have in place to assist secure delivery of the objective (describe process rather than management group)	**Current Score I x L**	**How do we know we are doing it?** **(Key Assurances of controls)** Provide examples of recent reports considered by Board or committee where delivery of the objectives is discussed and where the board can gain evidence that controls are effective.	**What are we not doing?** **(Gaps in Controls C) / Assurance (A)** What gaps in systems, controls and assurance have been identified?	**How can we fill the gaps or manage the risk better?** **(Actions to address gaps)**	**Target Score I x L**	**Timescale** When will the action be completed?
Failure to put in place a robust approach to organisational transformation, adequately linked to related initiatives and financial planning/outputs	Development of Improvement and Innovation Framework	4x3=12	Monthly progress reports to Exec Strategy Board and F&P Committee. Approval of framework and operational arrangements due at Trust Board June 2013. Thereafter monitoring of overall Framework will be via IIF Board and F&P Ctte and monitoring of financial outputs (CIPs) will be via CIP Delivery Board, Exec Performance Board and F&P Ctte.	None identified	Not applicable	4x3=12	N/A

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST – BOARD ASSURANCE FRAMEWORK SEPTEMBER 2013

RISK NUMBER / TITLE	**RISK 5 - INEFFECTIVE STRATEGIC PLANNING AND RESPONSE TO EXTERNAL INFLUENCES**
LINK TO STRATEGIC OBJECTIVE(S)	**a. - To provide safe, high quality patient-centred health care.** **c. - To be the provider of choice.** **e. - To enjoy an enhanced reputation in research innovation and clinical education.** **g. - To be a sustainable, high performing NHS Foundation Trust**
EXECUTIVE LEAD:	Chief Executive (via Director of Strategy)

Principal Risk (What could prevent the objective(s) being achieved)	**What are we doing about it?** **(Key Controls)** What control measures or systems we have in place to assist secure delivery of the objective (describe process rather than management group)	**Current Score I x L**	**How do we know we are doing it?** **(Key assurances of controls)** Provide examples of recent reports considered by Board or committee where delivery of the objectives is discussed and where the board can gain evidence that controls are effective.	**What are we not doing?** **(Gaps in Controls C) / Assurance (A)** What gaps in systems, controls and assurance have been identified?	**How can we fill the gaps or manage the risk better?** **(Actions to address gaps)**	**Target Score I x L**	**Timescale** When will the action be completed?
Failure to put in place appropriate systems to horizon scan and respond appropriately to external drivers. Failure to proactively develop whole organisation and service line clinical strategies	Appointment of Strategy Director	4x3=12	Plan agreed by Remuneration Committee	None identified	Not applicable	4x3=12	N/A
	Allocation of market intelligence responsibility to Director of Marketing and Communications		Agreed by Remuneration Committee	None identified	Not applicable		N/A
	Co-ordinated approach to business intelligence gathering and response via Business Strategy Support Team ESB forward plan reflecting a 12 month programme aligned with: • the development of the IBP/LTFM • the reconfiguration programme • the development of the next AOP • The TB Development Programme The TB formal agenda		Regular reports to TB reflecting progress of 12 month programme	None identified	Not applicable		

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST – BOARD ASSURANCE FRAMEWORK SEPTEMBER 2013

RISK NUMBER/ TITLE:	**RISK 6 – FAILURE TO ACHIEVE FT STATUS**
LINK TO STRATEGIC OBJECTIVE(S)	**g. - To be a sustainable, high performing NHS Foundation Trust.**
EXECUTIVE LEAD:	Chief Executive

Principal Risk (What could prevent the objective(s) being achieved)	**What are we doing about it?** **(Key Controls)** What control measures or systems we have in place to assist secure delivery of the objective (describe process rather than management group)	**Current Score I x L**	**How do we know we are doing it?** **(Key Assurances of controls)** Provide examples of recent reports considered by Board or committee where delivery of the objectives is discussed and where the board can gain evidence that controls are effective.	**What are we not doing?** **(Gaps in Controls C) / Assurance (A)** What gaps in systems, controls and assurance have been identified?	**How can we fill the gaps or manage the risk better?** **(Actions to address gaps)**	**Target Score I x L**	**Timescale** When will the action be completed?
Failure to meet the requirements of the FT application process in terms of service quality, strategy, financial resilience and governance	FT Programme Board provides strategic direction and monitors the FT application programme.	4x4=16	Monthly progress against the FT programme is reported to the Board to provide oversight.	No gaps identified.	No actions required.	4x3=12	
	FT Workstream group of Executive and operational Leads to ensure delivery of IBP and evidence to support HDD1 and 2 processes.		Feedback from external assessment of application progress by SHA (readiness review meeting Dec 2012).	No gaps identified.	No actions required.		
	FT application project plan / project team in place FT Integrated Development Plan		Reports to FTPB and Trust Board	No gaps identified	Not applicable		N/A
	Progression of Better Care Together Programme which underpins the UHL service strategy and LTFM.		Economic modelling incorporated into the Trust Reconfiguration Strategic Outline Case (SOC) structure and process.				
			Regular reports to Exec Strategy Board and Trust Board Various inputs from Exec Team to BCT work.	(c)Need to identify clear BCT Exec Lead	Director of Strategy to be lead. Ad hoc cover to continue until appointment in place. (6.10)		Oct 2013 CEO
			Feedback and recommendations from the independent reviews against the Quality Governance Framework and the Board Governance Framework.	(c) Independent reports identify a number of recommendations.	Action plans to be developed to address recommendations from independent reviews. (6.11)		Nov 2013 CEO
	Monitoring of KPIs in particular in relation to financial position and key operational performance indicators.		Monthly reports to Executive Performance Board, F&P Committee and Trust Board	None identified.	Not applicable		N/A
			Achievement against the new TDA Accountability Framework is reported to the Trust board and the TDA on a monthly basis.	None identified	Not applicable		N/A

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST – BOARD ASSURANCE FRAMEWORK SEPTEMBER 2013

RISK NUMBER/ TITLE:	**RISK 7– FAILURE TO MAINTAIN PRODUCTIVE AND EFFECTIVE RELATIONSHIPS**
LINK TO STRATEGIC OBJECTIVE(S)	**c. - To be the provider of choice.** **d. - To enable integrated care closer to home.** **f. – To maintain a professional, passionate and valued workforce.**
EXECUTIVE LEAD:	Director of Marketing and Communications

Principal Risk (What could prevent the objective(s) being achieved)	**What are we doing about it?** **(Key Controls)** What control measures or systems we have in place to assist secure delivery of the objective (describe process rather than management group)	**Current Score I x L**	**How do we know we are doing it?** **(Key Assurances of controls)** Provide examples of recent reports considered by Board or committee where delivery of the objectives is discussed and where the board can gain evidence that controls are effective.	**What are we not doing?** **(Gaps in Controls C) / Assurance (A)** What gaps in systems, controls and assurance have been identified?	**How can we fill the gaps or manage the risk better?** **(Actions to address gaps)**	**Target Score I x L**	**Timescale** When will the action be completed?
Failure to maintain productive relationships with external partners/ stakeholders leading to potential loss of activity and income, poor reputation and failure to retain/ reconfigure clinical services.	Stakeholder Engagement Strategy. Regular meetings with external stakeholders and Director of Communications and member of Executive Team to identify and resolve concerns. Regular stakeholder briefing provided by an e-newsletter to inform stakeholders of UHL news. Leicester, Leicestershire and Rutland (LLR) health and social care partners have committed to a collaborative programme of change known as the 'Better Care Together' programme.	5X3=15	Twice yearly GP surveys with results reported to UHL Executive Team. Latest survey results discussed at the April 2013 Board and showed increasing levels of satisfaction… a trend which has now continued for 18 months. Anecdotal feedback from partners and soft intelligence indicates that relations with key organisations and individuals are improving under new UHL leadership.	(a) No surveys currently undertaken to identify relationship issues with wider group of stakeholders e.g. CCGs / LAT / Social Care / Universities etc.	Extend the surveys into wider group of stakeholders to complement the 'soft intel' (7.2)	5X2=10	Oct 2013 DMC

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST – BOARD ASSURANCE FRAMEWORK SEPTEMBER 2013

RISK NUMBER/ TITLE:	**RISK 8 – FAILURE TO ACHIEVE AND SUSTAIN QUALITY STANDARDS**
LINK TO STRATEGIC OBJECTIVE(S)	**a. – To provide safe, high quality patient-centred health-care**
EXECUTIVE LEAD:	Chief Nurse (with Medical Director)

Principal Risk (What could prevent the objective(s) being achieved)	**What are we doing about it?** **(Key Controls)** What control measures or systems we have in place to assist secure delivery of the objective (describe process rather than management group)	**Current Score I x L**	**How do we know we are doing it?** **(Key Assurances of controls)** Provide examples of recent reports considered by Board or committee where delivery of the objectives is discussed and where the board can gain evidence that controls are effective.	**What are we not doing?** **(Gaps in Controls C) / Assurance (A)** What gaps in systems, controls and assurance have been identified?	**How can we fill the gaps or manage the risk better?** **(Actions to address gaps)**	**Target Score I x L**	**Timescale** When will the action be completed?
Failure to achieve and sustain quality standards leading to failure to reduce patient harm with subsequent deterioration in patient experience/ satisfaction/ outcomes, loss of reputation and deterioration of 'friends and family test' score.	Standardised M&M meetings in each speciality.	4x4=16	Routine analysis and monitoring of out of hours/weekend mortality at CBU and Divisional Boards.	No gaps.	No action needed.	4x3=12	
	Systematic speciality review of "alerts" of deterioration to address cause and agree remedial action. Corporate oversight via QPMG, QAC and by exception to ET and TB.		Quality and Performance Report and National Quality dashboard presented to ET and TB. Currently SMHI "within expected" (i.e. 105).	(a) UHL risk adjusted perinatal mortality rate below regional and national average.	Women's CBU to work with Dr Foster and other trusts to better understand risk adjustment model (8.2).		Jan 2014 MD
	Robust implementation of actions to achieve Quality Commitment (save 1000 extra lives in 3 years).		SHMI remains "within expected" (i.e. 105).	(a) LLR mortality review requires independent analysis.	Analysis of mortality review by Public Health (8.9).		Nov 2013 MD
	Agreed patient centred care priorities for 2013-14: - Older people's care - Dementia care - Discharge Planning		Quality Action Group meets monthly. Achievement against key objectives and milestones report to Trust board on a monthly basis. A moderate improvement in the older people survey scores has been recorded.	No gaps identified.	No action needed.		
	Multi-professional training in older peoples care and dementia care in line with LLR dementia strategy.		Quality Action Group monitoring of training numbers and location.	No gaps identified.	No action needed.		
	Protected time for matrons and ward sisters to lead on key outcomes.		Divisional/CBU reporting on matron activity and implementation or supervisory practice.	(c) Present vacancy levels prevent adoption of supervisory practice.	Active recruitment to ward nursing establishment so releasing ward sister –for supervisory practice (8.5).		Sep 2014 CN
	To promote and support older peoples champions network and new dementia champions network.		Monthly monitoring of numbers and activity.	No gaps identified.	No action needed.		

	Targeted development activities for key performance indicators - answering call bells - assistance to toilet - involved in care - discharge information		Monthly monitoring and tracking of patient feedback results. Monthly monitoring of Friends and Family Test reported to the TB (69.6% at M5).				
	Quality Commitment 2013 – 2016: • Save 1000 extra lives • Avoid 5000 harm events • Provide patient centred care so that we consistently achieve a 75 point patient recommendation score		Quality Action Groups monitoring action plans and progress against annual priority improvements. A Quality Commitment dashboard has been developed to present updates to the TB on the 3 core metrics for tracking performance against our 3 goals. These metrics will be tracked up to 2015. Impressive drops in fall numbers have been observed in Datix reports and in the Safety Thermometer audit.				
	Relentless attention to 5 Critical Safety Actions (CSA) initiatives to lower mortality.		Q&P report to TB showing outcomes for 5 CSAs. 4CSAs form part of local CQUIN monitoring. RAG rated green at end of quarter 1. M&M CSA removed from CQUIN monitoring due to full implementation For Quarter 1 the CSA programme saw a 50% reduction in SUIs against the same period last year.	(c) Lack of a unified IT system in relation to ordering and receiving results means that many differing processes are being used to acknowledge/respond to results. Potential risk of results not being acted upon in a timely fashion.	Implementation of Electronic Patient Record (EPR). (8.10)		2015 CIO
	NHS Safety thermometer utilised to measure the prevalence of harm and how many patients remain 'harm free' (Monthly point prevalence for '4 Harms'). Monthly meetings with operational/clinical and managerial leads for each harm in place.		Monthly outcome report of '4 Harms' is reported to Trust board via Q&P report. The total number of harms recorded in UHL (i.e. old and new) increased very slightly, from 96harms in July to 101 harms in August (i.e. 93.5%). New DoH definitions may see an increase in harm attributed to UHL to encourage closer working between primary and secondary care.	(a) Some data may not be accurate due to complex DoH definitions of each harm in relation to whether it is community or hospital acquired.	UHL to be part of the DH review in to the use of the Safety Thermometer tool (8.11)		Review Dec 2013 CN

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST – BOARD ASSURANCE FRAMEWORK SEPTEMBER 2013

RISK NUMBER/ TITLE:	**RISK 9 – FAILURE TO ACHIEVE AND MAINTAIN HIGH STANDARDS OF OPERATIONAL PERFORMANCE**
LINK TO STRATEGIC OBJECTIVE(S)	**a. - To provide safe, high quality patient-centred health-care** **c. - To be the provider of choice.** **g. - To be a sustainable, high performing NHS Foundation Trust.**
EXECUTIVE LEAD:	Chief Operating Officer

Principal Risk (What could prevent the objective(s) being achieved)	**What are we doing about it?** **(Key Controls)** What control measures or systems we have in place to assist secure delivery of the objective (describe process rather than management group)	**Current Score I x L**	**How do we know we are doing it?** **(Key Assurances of controls)** Provide examples of recent reports considered by Board or committee where delivery of the objectives is discussed and where the board can gain evidence that controls are effective.	**What are we not doing?** **(Gaps in Controls C) / Assurance (A)** What gaps in systems, controls and assurance have been identified?	**How can we fill the gaps or manage the risk better?** **(Actions to address gaps)**	**Target Score I x L**	**Timescale** When will the action be completed?
Failure to achieve and sustain operational targets leading to contractual penalties, patient dissatisfaction and poor reputation.	Referral to treatment (RTT) backlog plans (patients over 18 weeks) and operational performance of 90% (for admitted) and 95 % (for non-admitted.	4x3=12	Key specialities will go onto weekly performance meetings with COO Weekly patient level reporting meeting for all key specialties Monthly Q&P report to Trust Board showing 18 week RTT performance Daily RTT performance and prospective reports to inform decision making	(c) 85.7% admitted RTT performance (M5). Backlog plans require further development in line with review of demand and capacity in key specialties. (a) No external assurance of recovery plans (c) Capacity issues created by emergency demand causes cancellations of operations.	Further development of backlog plans. RTT revised plans submitted to commissioners 11/9/13 awaiting formal acceptance. (9.8) NHS Intensive Support team will be invited into UHL to review capacity and demand assumptions and provide assurance to recovery plans (9.9) Re-configuration of surgical beds to create a 'protected area' for surgical patients or by use of independent sector. (9.2)	4x3=12	Oct 2013 COO Oct 2013 COO Nov 2013 COO
	Transformational theatre project to improve theatre efficiency to 80 -90%.		Monthly theatre utilisation rates. Theatre Transformation monthly meeting. Transformation update to Board.	No gaps identified.	No actions required.		
	Emergency Care process redesign (phase 1) implemented 18 February 2013 to improve and sustain ED performance.		Monthly report to Trust Board in relation to Emergency Dept (ED) flow (including 4 hour breaches).	See risk number 2.	See risk number 2.		

	Cancer 62 day performance - Tumour site improvement trajectory agreed and each tumour site has developed action plans to achieve targets. Senior Cancer Manager appointed Lead Cancer Clinician appointed		Cancer action board established and weekly meetings with all tumour sites represented Monthly trajectory agreed and Cancer action plan agreed with CCGs in June 2013 and reported and monitored at Executive Performance board. Chief Operating Officer receives reports from Cancer Manager and 62 day performance included within Monthly Q&P report to Trust Board.	(c) Gaps identified in provision of Imaging 7 day turnaround from request to report	Action plan to resolve Imaging issues to be developed and submitted to Commissioners who have expressed support in principle (9.7)		Review Oct 2013 COO

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST – BOARD ASSURANCE FRAMEWORK SEPTEMBER 2013

RISK NUMBER/ TITLE:	**RISK 10 – INADEQUATE RECONFIGURATION OF BUILDINGS AND SERVICES**
LINK TO STRATEGIC OBJECTIVE(S)	**a. - To provide safe, high quality patient-centred health care**
EXECUTIVE LEAD:	Director of Finance and Business Services

Principal Risk (What could prevent the objective(s) being achieved)	**What are we doing about it?** **(Key Controls)** What control measures or systems we have in place to assist secure delivery of the objective (describe process rather than management group)	**Current Score I x L**	**How do we know we are doing it?** **(Key Assurances of controls)** Provide examples of recent reports considered by Board or committee where delivery of the objectives is discussed and where the board can gain evidence that controls are effective.	**What are we not doing?** **(Gaps in Controls C) / Assurance (A)** What gaps in systems, controls and assurance have been identified?	**How can we fill the gaps or manage the risk better?** **(Actions to address gaps)**	**Target Score I x L**	**Timescale** When will the action be completed?
Inadequate reconfiguration of buildings and services leading to less effective use of estate and services.	Clinical Strategy.	3x4=12		(a) Key measures to demonstrate success of strategy and reporting lines not yet identified.	Key measures for gauging success of strategy to be developed by specialties as part of their 'mini-IBPs' and will be monitored via divisional and directorate boards. (10.1)	3X3=9	Dec 2013 MD
	Estates Strategy including award of FM contract to private sector partner to deliver an Estates solution that will be a key enabler for our clinical strategy in relation to clinical adjacencies.		Facilities Management Collaborative (FMC) will monitor against agreed KPIs to provide assurance of successful outsourced service.	(c) Estates plans not fully developed to achieve the strategy. (c) The success of the plans will be dependent upon capital funding and successful FT application.	Ensure success of FT Application (see risk 6 for further detail). (10.2) Secure capital funding. (10.3)		Apr 2015 CEO Dec 2013 DFBS
	Divisional service development strategies and plans to deliver key developments.		Progress of divisional development plans reported to Service Reconfiguration Board.	No gaps identified.	No actions required.		
	Service Reconfiguration Board.		Monthly ET Strategy session to provide oversight of reconfiguration.	No gaps identified.	No actions required.		
	Capital expenditure programme to fund developments.		Capital expenditure reports reported to the Board via Finance and Performance Committee.	No gaps identified.	No actions required.		
	Managed Business Partner for IM&T services to deliver IT that will be a key enabler for our clinical strategy. IM&T incorporated into Improvement and Innovation Framework.		IM&T Board in place.	No gaps identified.	No actions required.		

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST – BOARD ASSURANCE FRAMEWORK SEPTEMBER 2013

RISK NUMBER/ TITLE:	**RISK 11 – LOSS OF BUSINESS CONTINUITY**
LINK TO STRATEGIC OBJECTIVE(S))	**g. - To be a sustainable, high performing NHS Foundation Trust.**
EXECUTIVE LEAD:	Chief Operating Officer

Principal Risk (What could prevent the objective(s) being achieved)	**What are we doing about it?** **(Key Controls)** What control measures or systems we have in place to assist secure delivery of the objective (describe process rather than management group)	**Current Score I x L**	**How do we know we are doing it?** **(Key Assurances of controls)** Provide examples of recent reports considered by Board or committee where delivery of the objectives is discussed and where the board can gain evidence that controls are effective.	**What are we not doing?** **(Gaps in Controls C) / Assurance (A)** What gaps in systems, controls and assurance have been identified?	**How can we fill the gaps or manage the risk better?** **(Actions to address gaps)**	**Target Score I x L**	**Timescale** When will the action be completed?
Inability to react /recover from events that threaten business continuity leading to sustained downtime and inability to provide full range of services.	Major incident/business continuity/ disaster recovery and Pandemic plans developed and tested for UHL/ wider health community. This includes UHL staff training in major incident planning/ coordination and multi agency involvement across Leicestershire to effectively manage and recover from any event threatening business continuity. Tailored training packages for service area based staff.	3x3=9	Annual Emergency planning Report identifying good practice presented to the Governance and Risk Management Committee July 2012. Training Needs Analysis developed to identify training requirements for staff supported by appropriate training packages for Senior Managers on Call External auditing and assurances to SHA, Business Continuity Self-Assessment, June 2010, completed by Richard Jarvis Completion of the National Capabilities Survey, November 2013 completed by Aaron Vogel. Results will be included in the annual report on Emergency Planning and Business Continuity to the QAC. Audit by Price Waterhouse Coopers LLP Jan 2013. Results being compiled and will be reported to Trust Board (date to be agreed). Documented evidence from key critical suppliers has been collected to ensure that contracts include business continuity arrangements.	(c) On-going continual training of staff to deal with an incident. (a) Do not consider realistic testing of different failure modes for critical IT systems to ensure IT Disaster Recovery arrangements will be effective during invocation. (c) No clear definition of what makes a critical supplier and how a loss would impact on the Trust. No plan as to how we would manage a loss.	Training and Exercising events to involve multiple CBUs/Divisions to validate plans to ensure consistency and coordination (11.13). Determine an approach to delivering a physical testing of the IT Disaster Recovery arrangements which have been identified as a dependency for critical services. Include assessment of the benefits of realistic testing of arrangements against the potential disruption of testing to operations. (11.2) Develop a plan and a better understanding of how a loss of critical suppliers will affect the Trust (11.12)	2x3=6	Aug 2014 COO Review Oct 2013 CIO Oct 2013 COO

	Emergency Planning Officer appointed to oversee the development of business continuity within the Trust.		Outcomes from Price Waterhouse Coopers LLP audit identified that there is a programme management system in place through the Emergency Planning Officer to oversee. A year plan for Emergency Planning has been developed. Production/updates of documents/plans relating to Emergency Planning and Business Continuity aligned with national guidance have begun. Including Business Impact Assessments for all CBUs. Plan templates for CBUs now include details/input from Interserve	(c) not all the critical suppliers questioned provided responses (c) contracts aren't assessed for their potential BC risk on the Trust (c) Local plans for loss of critical services not completed due to change over of facilities provider (c) Plans have not been provided by Interserve as to how they would respond or escalate issues to the Trust.	Further work required to develop escalation plans and response plans for Interserve. (11.11)		Oct 2013 COO
	New policy to identify key roles within the Trust of those responsible for ensuring business continuity planning /learning lessons is undertaken.		Minutes/action plans from Emergency Planning and Business Continuity Committee. Any outstanding risks/issues will be raised through the Chief Operating Officer.	No gaps identified.	No actions required.		
			New Policy on InSite Emergency Planning and Business Continuity Committee ensures that processes outlined in the Policy are followed, including the production of documents relating to business continuity within the service areas. 3 incidents within the Trust have been investigated and debrief reports written, which include recommendations and actions to consider. Issues/lessons feed into the development of local plans and training and exercising events.				

			Head of Operations and Emergency Planning Officer are consulted on the implementation of new IM&T projects that will disrupt users access to IM&T systems	(c)Do not always consider the impact on business continuity and resilience when implementing new systems and processes.	Further processes require development, particularly with the new Facilities and IM&T providers to ensure resilience is considered/ developed when implementing new systems, infrastructure and processes. (11.8)		Review Oct 2013 COO
				(a) Lack of coordination of plans between different service areas and across the CBUs.	Training and Exercising events to involve multiple CBUs/Divisions to validate plans to ensure consistency and coordination. (11.10)		Aug 2014 COO

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST – BOARD ASSURANCE FRAMEWORK SEPTEMBER 2013

RISK NUMBER/ TITLE:	**RISK 12 FAILURE TO EXPLOIT THE POTENTIAL OF IM&T**
LINK TO STRATEGIC OBJECTIVE(S))	**a. - To provide safe, high quality patient-centred health care.** **d. - To enable integrated care closer to home**
EXECUTIVE LEAD:	Director of Finance and Business services

Principal Risk (What could prevent the objective(s) being achieved)	**What are we doing about it?** **(Key Controls)** What control measures or systems we have in place to assist secure delivery of the objective (describe process rather than management group)	**Current Score I x L**	**How do we know we are doing it?** **(Key Assurances of controls)** Provide examples of recent reports considered by Board or committee where delivery of the objectives is discussed and where the board can gain evidence that controls are effective.	**What are we not doing?** **(Gaps in Controls C) / Assurance (A)** What gaps in systems, controls and assurance have been identified?	**How can we fill the gaps or manage the risk better?** **(Actions to address gaps)**	**Target Score I x L**	**Timescale** When will the action be completed?
Failure to integrate the IM&T programme into mainstream activities	Managed Business Partner for IM&T services to deliver IT that will be a key enabler for our clinical strategy. IM&T now incorporated into Improvement and Innovation Framework	3x3=9	IM&T Board in place. Quarterly reports to Trust Board	No gaps identified	No actions required	3x2=6	
	Engagement with the wider clinical communities (internal) including formal meetings of the newly created advisory groups/ clinical IT. Improved communications plan incorporating process for feedback of information		CMIO(s) now in place, and active members of the IM&T meetings The joint governance board monitors the level of communications with the organisation	No gaps identified	No actions required		
	Engagement with the wider clinical communities (External). UHL CMIOs are added as invitees to the meetings, as are the clinical (IM&T) leads from each of the CCGs		UHL membership of the wider LLR IM&B board	No gaps identified	No actions required		

Benefits are not well defined or delivered	Appointment of IBM to assist in the development of an incentivised, benefits driven, programme of activities to get the most out of our existing and future IM&T investments Initial engagement with key members of the TDA to ensure there is sufficient understanding of technology roadmap and their involvement. The development of a strategy to ensure we have a consistent approach to delivering benefits Increased engagement and communications with departments to ensure that we capture requirements and communicate benefits Standard benefits reporting methodology in line with trust expectations		Minutes of the joint governance board, the transformation board and the service delivery board Benefits are part of all the projects that are signed off by the relevant groups	(c) the delivery programme is dependent on TDA approvals for some elements (c) ensure that all divisions/CBUs have the approach to IM&T benefits as part of delivery projects (a) production of a standard report on the delivery of benefits	TDA approvals documentation to be completed (12.8)		Oct 2013 CIO

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST – BOARD ASSURANCE FRAMEWORK SEPTEMBER 2013

RISK NUMBER/ TITLE:	**RISK 13 – FAILURE TO ENHANCE MEDICAL EDUCATION AND TRAINING CULTURE**
LINK TO STRATEGIC OBJECTIVE(S)	**e - To enjoy an enhanced reputation in research, innovation and clinical education.**
EXECUTIVE LEAD:	Medical Director

Principal Risk (What could prevent the objective(s) being achieved)	**What are we doing about it?** **(Key Controls)** What control measures or systems we have in place to assist secure delivery of the objective (describe process rather than management group)	**Current Score I x L**	**How do we know we are doing it?** **(Key Assurances of controls)** Provide examples of recent reports considered by Board or committee where delivery of the objectives is discussed and where the board can gain evidence that controls are effective.	**What are we not doing?** **(Gaps in Controls C) / Assurance (A)** What gaps in systems, controls and assurance have been identified?	**How can we fill the gaps or manage the risk better?** **(Actions to address gaps)**	**Target Score I x L**	**Timescale** When will the action be completed?
Failure to implement and embed an effective medical training and education culture with subsequent critical reports from commissioners, loss of medical students and junior doctors, impact on reputation and potential loss of teaching status.	Medical Education Strategy and Action Plan	4x3 = 12	Strategy approved by the Trust Board Strategy monitored by Operations Manager and reviewed monthly in Full team Meetings.	(c) Lack of engagement/awareness of the Strategy with CBUs.	Meetings to discuss strategy with CBUs (13.1)	3x2 = 6	Dec 2013 MD
	UHL Education Committee		Professor Carr reports to the Trust Board	(c) Attendance at the Committee could be improved.	Relevance of the committee to be discussed at CBU Meetings (13.2)		Dec 2013 MD
				(c) Communication to trainees needs to be improved	Doctors in Training Committee needs to be established along with terms of reference (13.3)		Nov 2013 MD
	Education and Patient Safety		Reports submitted to the Education Committee Terms of reference and minutes of meetings	(c) Improved trainee representation on Trust wide committees (c) Improve engagement with other patient safety activities/groups	Build relationships with CBU Quality Leads. Establish links with LEG/QAC and QPMG. (13.4)		Dec 2013 MD

	Quality Monitoring		Quality dashboard for education and training monitored monthly by Operations Manager, Quality Manager and Education Committee. Education Quality Visits to CBUs Monitor progress against the Education Strategy and GMC Training Survey results	(a) Information is from diverse sources – the collation of information needs to be established (a) Lack of engagement with CBUs to share findings from the dashboards (a) Do not currently ensure progress against strategic and national benchmarks (c) Inadequate educational resources	Introduce exit surveys for trainees Communicate feedback from the GMC training survey and LETB Visits via the Dashboard. (13.5) Attend CBU management meetings and liaise with CBUs. (13.6) Monitor UHL position against other trusts nationally. (13.7) New Library/learning facilities to be developed at the LRI .(13.8)		Dec 2013 MD Dec 2013 MD Review Oct 2013 Oct 2013 MD
	Educational project teams to lead on education transformation projects		Project team meets monthly	(c) Implementation of the project within Acute Medicine needs to be improved.	Dr Hooper in post for Acute Medicine to implement project. (13.9)		Feb 2014 MD
	Financial Monitoring		SIFT monitoring plan in place	(c) Poor engagement with CBUs in relation to implication of SIFT	Need to engage with the CBUs to help them understand the implication of SIFT and their funding streams. (13.10)		Dec 2013 MD

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST

Appendix 2

ACTION TRACKER FOR THE 2013/14 BOARD ASSURANCE FRAMEWORK (BAF)

Monitoring body (Internal and/or External):	Executive Team
Reason for action plan:	Board Assurance Framework
Date of this review	**September 2013**
Frequency of review:	Monthly
Date of last review:	August 2013

REF	ACTION	SENIOR LEAD	OPS LEAD	COMPLETION DATE	PROGRESS UPDATE	STATUS
1	**Failure to achieve financial sustainability**					
1.6	Re-establishing clinical coding improvement team under John Roberts. Initial action plan in place.	COO	ADI	Review ~~August~~ October 2013	Delay in completion due to resubmission of job descriptions to evaluation pane. Restructure of clinical coding team on track to be completed by September. Use of agency coders to reduce coding backlog. Clinical leads identified in Acute and Planned Care Division.	3
1.9	Finalised SLM Action plan approved by ESB is awaited.	DFBS		~~July~~ ~~August~~ September 2013	**Complete.** Initial actions have been approved by ESB.	5
1.11	Ongoing discussions with commissioners about planned re-investment of the MRET deductions.	DFBS		Review October 2013	The previous timescale for completion was optimistic and a revised timescale for completion of discussions and resolution of the issue has been provided.	3
1.17	Seek clarification from CCGs as to the status of the transformation bids	CEO		September 2013	On track.	4
1.18	Update bed capacity/ required bed base criteria in winter plan to meet fluctuations in activity	DFBS		September 2013	**Complete.** Bed modelling completed	5
1.19	ESB will continue to meet every 6 weeks to ensure implementation of SLM across	DFBS		March 2014	On track.	4

Status key:	5	Complete	4	On track	3	Some delay – expect to completed as planned	2	Significant delay – unlikely to be completed as planned	1	Not yet commenced	0	Objective Revised

REF	ACTION	SENIOR LEAD	OPS LEAD	COMPLETION DATE	PROGRESS UPDATE	STATUS
	the Trust (expected Mar 2014)					
2	**Failure to transform the emergency care system**					
2.7	Continue with substantive appts until funded establishment within ED is achieved.	COO	Head of Ops	Review ~~Sept~~ Nov 2013	On track.	4
2.9	CCG/LPT to increase capacity by use of Intermediate Care Services.	COO	Head of Ops	~~August~~ Review October 2013	DTOCs reduced but not at level required yet. Additional community beds in City (24) and East (24) to start in Oct 2013. Additional 19 IP beds for LPT also in process of being put in place	3
3	**Inability to recruit, retain, develop and motivate staff**					
3.1	Revise and re-launch UHL reward and recognition strategy.	DHR	DDHR	~~October 2013~~ January 2014	A draft strategy is in place which has been further developed through 2 LiA events in September. The next stage is consultation on the final draft before approval by Executive colleagues. The launch of the strategy is anticipated launch date for the strategy is January 2014. the action completion date has been amended to reflect this.	4
3.2	Take baseline from January and measure progress in relation to the success of recruitment events now that there is a structured plan for bulk recruitment. Identify a lead from each professional group to develop and encourage the production of fresh and up to date material.	DHR	DDHR	December 2013	On track.	4

Status key:	5	Complete	4	On track	3	Some delay – expect to completed as planned	2	Significant delay – unlikely to be completed as planned	1	Not yet commenced	0	Objective Revised

REF	ACTION	SENIOR LEAD	OPS LEAD	COMPLETION DATE	PROGRESS UPDATE	STATUS
3.3	Development of Pay Progression Policy for Agenda for Change staff.	DHR	DDHR	October 2013	Presentation of proposal to Executive Strategy Board on 1st October. Comments received and work to finalise a Policy for consultation with staff side underway.	4
3.4	Implementation of Recruitment and Retention Premia for ED staff.	DHR	DDHR	~~September~~ October 2013	Partial completion. R and R premia approved by Remuneration Committee and in place for band 5 Nurses. ED Consultants have received communication and further work progressing in terms of job planning. Deadline for completion extended until October 13.	4
3.5	Ensure Statutory and Mandatory training is easy to access and complete with 75% compliance by reviewing delivery mode, access and increasing capacity to deliver against specific subject areas.	DHR	ADLOD	March 2014	On track.	4
3.6	Consult and implement Pay Progression Policy	DHR	DDHR	November 2014	On track.	4
3.7	Update e-UHL records to ensure accuracy of reporting on a real time basis	DHR		March 2014	On track	4
4	**Ineffective organisational transformation**					
5	**Ineffective strategic planning and response to external influences**					
6	**Failure to achieve FT status**					
6.10	Director of Strategy to be Exec lead for BCT. Ad hoc cover to continue until appointment in place.	CEO		October 2013	Recruitment of DS in progress. Interim arrangements in place.	4

Status key:	5	Complete	4	On track	3	Some delay – expect to completed as planned	2	Significant delay – unlikely to be completed as planned	1	Not yet commenced	0	Objective Revised

REF	ACTION	SENIOR LEAD	OPS LEAD	COMPLETION DATE	PROGRESS UPDATE	STATUS
6.11	Action plans to be developed to address recommendations from independent reviews.	CEO	DCLA	~~Review July~~ ~~September~~ November 2013	Document sourced from Sandwell and West Birmingham NHS Trust that will serve to complement our existing policy for responding to external recommendations and requirements. The Director of Clinical Quality will now work to merge these two documents and provide a revised UHL policy. Deadline extended to reflect the timeline for this work. Completion date has slipped as policy now needs to take account of organisational restructuring. Deadline extended to November 2013	3
7	**Failure to maintain productive and effective relationships**					
7.2	Extend the surveys into wider group of stakeholders to complement the 'soft intel'.	DMC		~~September~~ October 2013	Survey will take place during September as planned	4
8	**Failure to achieve and sustain quality standards**					
8.2	Women's CBU to work with Dr Foster and other trusts to better understand risk adjustment model related to the national quality dashboard.	MD		January 2014		4
8.5	Active recruitment to ward nursing establishment so releasing ward sister for supervisory practice.	CN		September 2014	On going recruitment process in place and is likely to take 12 -18months. Deadline extended to reflect this.	4
8.9	Analysis of mortality review by Public Health.	MD		~~September~~ November 2013	There has been a delay on the part of Public Health in relation to the analysis of results. This is now expected in November 2013. Action deadline extended to reflect this.	3
8.10	Implementation of Electronic Patient Record (EPR)	CIO		2015		4

Status key:	5	Complete	4	On track	3	Some delay – expect to completed as planned	2	Significant delay – unlikely to be completed as planned	1	Not yet commenced	0	Objective Revised

REF	ACTION	SENIOR LEAD	OPS LEAD	COMPLETION DATE	PROGRESS UPDATE	STATUS
8.11	UHL to be involved in the DH review in to the use of the Safety Thermometer tool	CN		Review Dec 2013	Timescale DH dependent	4
9	**Failure to achieve and sustain high standards of operational performance**					
9.1	On-going work on ward processes in Acute to free up capacity to recover RTT target.	COO		~~June 2013~~ ~~July 2013~~	Action 9.1 has been amalgamated with action 9.2 following review of risk	0
9.2	Re-configuration of surgical beds to create a 'protected area' for surgical patients or by use of independent sector.	COO	HO/DM Planned	November 2013	On track.	4
9.7	Action plan to resolve Imaging issues to be developed.	COO		~~July~~ ~~August~~ October 2013	Imaging plan has required significant level of detail and review by cancer action board and COO before submission. Commissioners have supported request for funds to deal with imaging backlog	3
9.8	Further development of backlog plans. RTT revised plans submitted to commissioners 11/9/13 awaiting formal acceptance.	COO		~~August~~ ~~September~~ End of October 2013	RTT plans initially submitted to commissioners, however these required further work and have been re-submitted and awaiting formal sign off. Currently failure to agrere notice in place with commissioners , pending agreed recovery plan being developed with support from Intensive suppoitrt team	4
9.9	NHS Intensive Support team will be invited into UHL to review capacity and demand assumptions and provide assurance to recovery plans.	COO		~~September~~ End of October 2013	On track. Intensive support team on site at Trust 6th Oct , terms of reference agreed , initial capacity and demand work will be completed by 25th Oct	4

Status key:	5	Complete	4	On track	3	Some delay – expect to completed as planned	2	Significant delay – unlikely to be completed as planned	1	Not yet commenced	0	Objective Revised

REF	ACTION	SENIOR LEAD	OPS LEAD	COMPLETION DATE	PROGRESS UPDATE	STATUS
10	**Inadequate reconfiguration of buildings and services**					
10.1	Key measures for gauging success of clinical strategy to be developed by specialties as part of their 'mini-IBPs' and will be monitored via divisional and directorate boards.	MD		December 2013	On track.	4
10.2	Ensure success of FT Application (see risk 6 for further detail).	CEO		April 2015	On track.	4
10.3	Secure capital funding to implement Estates Strategy.	DFBS		~~May 2013~~ December 2013	Work underway on capital planning around reconfiguration – SOC due for completion in Dec '13 / Jan '14 which will be the key vehicle to agree availability of capital funding.	4
11	**Loss of business continuity**					
11.2	Determine an approach to delivering a physical testing of the IT Disaster Recovery arrangements which have been identified as a dependency for critical services. Include assessment of the benefits of realistic testing of arrangements against the potential disruption of testing to operations.	COO	CIO	~~September~~ October 2013	Testing programme hasn't been developed but it is part of the work that IBM are doing to achieve ISO 22000. Currently awaiting update from CIO. Review in October 2013	3
11.8	Further processes require development, particularly with the new Facilities and IM&T providers to ensure resilience is considered/ developed when implementing new systems, infrastructure and processes.	COO	EPO	~~July~~ ~~August~~ Review October 2013	Work with IM&T has been completed. Emergency Planning and Head of Ops are consulted as part of the change board approval process. Delays have been encountered developing agreed processes with Interserve. Progress will be reviewed during October 2013.	3

Status key:	5	Complete	4	On track	3	Some delay – expect to completed as planned	2	Significant delay – unlikely to be completed as planned	1	Not yet commenced	0	Objective Revised

REF	ACTION	SENIOR LEAD	OPS LEAD	COMPLETION DATE	PROGRESS UPDATE	STATUS
11.9	Emergency Planning Officer and Divisional BCM leads will ensure that business continuity plans developed are coordinated between service areas/CBUs/Divisions.	COO	EPO/ Divisional BCM leads	September 2013	**Complete.** This is now actively managed by the Emergency Planning Officer and will become a continual process.	5
11.10	Training and Exercising events to involve multiple CBUs/Divisions to validate plans to ensure consistency and coordination.	COO	EPO	August 2014	BCM training and exercising programme has been developed.	4
11.11	Further work required to develop escalation plans and response plans for Interserve.	COO	EPO	October 2013		4
11.12	Develop a plan and a better understanding of how a loss of critical suppliers will affect the Trust	COO	EPO	October 2013		4
11.13	Training and Exercising events to involve multiple CBUs/Divisions to validate plans to ensure consistency and coordination	COO	EPO	August 2014		4
12	**Failure to exploit the potential of IM&T**					
12.6	Refine the proposal around benefits reporting to ensure we have a standard reporting methodology and that it is in line with trust expectations.	CIO		September 2013	**Complete**	5
12.8	TDA approvals documentation to be completed	CIO		October 2013	On track	4
13	**Failure to enhance education and training culture**					
13.1	To improve CBU engagement facilitate meetings to discuss Medical Education Strategy and Action Plans with CBUs.	MD	AMD	December 2013	On track.	4

Status key:	5	Complete	4	On track	3	Some delay – expect to completed as planned	2	Significant delay – unlikely to be completed as planned	1	Not yet commenced	0	Objective Revised

REF	ACTION	SENIOR LEAD	OPS LEAD	COMPLETION DATE	PROGRESS UPDATE	STATUS
13.2	Relevance of the UHL Education Committee to be discussed at CBU Meetings in an effort to improve attendance.	MD	AMD	December 2013	On track.	4
13.3	Doctors in Training Committee needs to be established along with terms of reference to ensure more effective communication to Juniors.	MD	AMD	November 2013	On track.	4
13.4	Build relationships with CBU Quality Leads and establish links with LEG/QAC and QPMG in an effort to improve engagement with other patient safety activities/groups.	MD	AMD	December 2013	On track.	4
13.5	Introduce exit surveys for trainees and communicate feedback from the GMC training survey and LETB Visits via the Dashboard.	MD	AMD	December 2013	On track.	4
13.6	Attend CBU management meetings and liaise with CBUs in an effort to improve engagement of CBUs.	MD	AMD	December 2013	On track.	4
13.7	Monitor UHL position against other trusts nationally to ensure progress against strategic and national benchmarks.	MD	AMD	Review October 2013	On track.	4
13.8	New Library/learning facilities to be developed at the LRI to help resolve inadequate educational resources.	MD	AMD	October 2013	On track.	4
13.9	Dr Hooper in post for Acute Medicine to implement project and improve Acute Medicine progress.	MD	AMD	February 2014	On track.	4
13.10	Need to engage with the CBUs to help them understand the implication of SIFT and their funding streams.	MD	AMD	December 2013	On track.	4

Status key:	5	Complete	4	On track	3	Some delay – expect to completed as planned	2	Significant delay – unlikely to be completed as planned	1	Not yet commenced	0	Objective Revised

REF	ACTION	SENIOR LEAD	OPS LEAD	COMPLETION DATE	PROGRESS UPDATE	STATUS

Key to initials of leads

CEO	Chief Executive Officer
DFBS	Director of Finance and Business Services
MD	Medical Director
AMD	Assistant Medical Director
COO	Chief Operating Officer
DHR	Director of Human Resources
DDHR	Deputy Director of Human Resources
ACN	Acting Chief Nurse
ADLOD	Asst Director of Learning and Organisational Development
DMC	Director of Marketing and Communications
CIO	Chief Information Officer
CMIO	Chief Medical Information Officer
EPO	Emergency Planning Officer
HPO	Head of Performance Improvement
HO	Head of Operations
CD	Clinical Director
DM	Divisional Manager
DDF&P	Deputy Director Finance and Procurement
FTPM	Foundation Trust Programme Manager
HTCIP	Head of Trust Cost Improvement Programme
ADI	Assistant Director of Information
FC	Financial Controller
ADP&S	Assistant Director of Procurement and Supplies
HoN	Head of Nursing
TT	Transformation Team
CN	Chief Nurse

Status key:	5	Complete	4	On track	3	Some delay – expect to completed as planned	2	Significant delay – unlikely to be completed as planned	1	Not yet commenced	0	Objective Revised

BAF RISK SCORE MAP – SEPTEMBER 2013

Likelihood ↓	Consequence				
	1	2	3	4	5
	Insignificant	Minor	Moderate	Major	Extreme
5 Almost Certain					1. Financial sustainability ● 2. Emergency care system ●
4 Likely			10. Reconfiguration of buildings and services ●	3. Recruit, retain, develop and motivate staff ● 6. FT status ● 8. Achieve and sustain quality standards ●	
3 Possible			11. Business continuity ● 12. IM&T ●	4. Organisational transformation ● 13. Education and training culture ● 9. Operational performance ● 5. Strategic planning and response to external influences ●	7. Productive and effective relationships ●
2 Unlikely					
1 Rare					

Key

● - No change in score from previous month.

⇧ - Risk score increased from previous month

⇩ - Risk score decreased from previous month

◈ - New risk

AREAS OF SCRUTINY FOR THE UHL BOARD ASSURANCE FRAMEWORK (BAF)

1) Are the Trust's strategic objectives S.M.A.R.T? i.e. are they :-

- **S**pecific
- **M**easurable
- **A**chievable
- **R**ealistic
- **T**imescaled

2) Have the main risks to the achievement of the objectives been adequately identified?

3) Have the risk owners (i.e. Executive Team) been actively involved in populating the BAF?

4) Are there any omissions or inaccuracies in the list of key controls?

5) Have all relevant data sources been used to demonstrate assurance on controls and positive assurances?

6) Is the BAF dynamic? Is there evidence of regular updates to the content?

7) Has the correct 'action owner' been identified?

8) Are the assigned risk scores realistic?

9) Are the timescales for implementation of further actions to control risks realistic?

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST

UHL RISKS SCORING 15 OR ABOVE FOR THE PERIOD ENDING 30 SEPTEMBER 2013

REPORT PRODUCED BY: UHL RISK AND ASSURANCE MANAGER

Key

Red	Extreme risk (risk score 25)
Orange	High risk (risk score 15 - 20)
Yellow	Moderate risk (risk score 8 - 12)
Green	Low risk (risk score below 8)
⮝	Risk score increased from initial risk score
⮟	Risk score decreased from initial risk score
★	New risk since previous reporting period
⇔	No Change in risk score since previous reporting period

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST

UHL RISKS SCORING 15 OR ABOVE FOR THE PERIOD ENDING 30 SEPTEMBER 2013

REPORT PRODUCED BY: UHL RISK AND ASSURANCE MANAGER

Key

Red	Extreme risk (risk score 25)
Orange	High risk (risk score 15 - 20)
Yellow	Moderate risk (risk score 8 - 12)
Green	Low risk (risk score below 8)
▲	Risk score increased from initial risk score
▼	Risk score decreased from initial risk score
★	New risk since previous reporting period
⇔	No Change in risk score since previous reporting period

Division	Directorate	Risk Title	Opened	Description of Risk	Risk subtype	Controls in place	Impact	Likelihood	Current Risk Score	Action summary	Target Risk Score	Risk Movement	Div/Exec Director	Strategic risk No.
Acute	Emergency Care	Overcrowding in ED	14/05/2013	1. Fire: Inability to evacuate safely; Burns / Respiratory harm; Damage to Property; Loss of Emergency Medical Service; Disruption to other services; Loss of life, contact injuries, crushing and panic injuries. 2. Patients in close proximity alongside each other on trolleys: Cross infection//contamination staff/patients/visitors; Loss of patient privacy and dignity; Loss of confidentiality of medical information; Poor patient and family experience; Inability/Difficulty accessing patients for medical examination/Emergency Situations; Medical and nursing staff adopting unnatural postures to carry out patient examination treatment and care; Increased manual handling of patients and movement of trolleys; Transmission of infections to patients/staff and others. Increased length of stay, additional illness to treat; Increased risk of needle-stick incidents; Increased risk of damage to equipment (collision, dropping, body fluids). 3. Staff shortages (high patient:nurse/doctor ratio): Inability to provide patient care and meet personal care needs;	Patients	Close adherence to UHL Escalation policies Regular risk stratification of patient dependency level and infection risk to maximise use of all possible floor space Adherence to ED internal Minimal Professional Standards when possible, and alerting senior staff when these are breached New expanded Majors Assessment Bay area (March 2013) Restructuring of acute flow processes by Right Place, Right Time consultancy firm 2013	Extreme	Almost Certain	25	Develop business case for new emergency floor and implement - 31/12/2013 Review of medical bed base to maximise opportunities for outflow - 30/10/2013 Explore further opportunities for reducing ED attendances and reducing BB presentations to ED - 31/12/2013 Further review of escalation policies to include decanting of ED patients as soon as agreed thresholds of over-crowding are reached - 30/10/2013 Align staffing model to patient flow to maximise patient turnaround - 31/03/2014	9	⇔	PR/COO	2

Division	Directorate	Risk Title	Opened	Description of Risk	Risk subtype	Controls in place	Impact	Likelihood	Current Risk Score	Action summary	Target Risk Score	Risk Movement	Div/Exec Director	Strategic risk No.
Acute	Professional services	Risk to the production of aseptic pharmaceutical products	03/05/2007	**Causes** Provision of aseptically prepared chemotherapy is being undertaken from a temporary rental unit. Temporary nature and age of facility indicates high probability of failure. Arrangements for segregation of in-process and completed items is inadequate leading to high possibility of error. Current temporary unit is outside the range of the department's temperature monitoring system. Failure of refrigerated storage will remain undetected outside working hours, and has already occurred. Planning permission for temporary unit only valid until August 2012 Contingency arrangements are insufficient and could only provide for the very short term. Project is already 6 months behind schedule Storage, receipts and dispensing facility for dose-banded chemotherapy and other outsourced items purchased. Alternative arrangements will need to be found when unit is refurbished **Consequences** Failure of Current Temporary Facility; Inability to provide 50% of current chemotherapy products for adult services. Inability to provide chemotherapy for paediatric services. Substantial delay in re-establishing service provision from alternative supplier Limitations of treatments that can be sourced from an alternative supplier. Inability to support research where aseptic compounding required. High cost of sourcing required products from alternative supplier at short notice. Increase in datix incidents pertaining to the Aseptic Unit.	Business	Planned servicing & maintenance of existing facility being undertaken. Constant environmental monitoring of facility in place. Alternative preparation facility being maintained as contingency although only adequate for short term contingency and not recommended for preparation of chemotherapy. N.B. this option may be lost depending on the outcome of the business case for a permanent solution for the aseptic dispensing service. Contingency arrangement for supply from external source currently being pursued. Business Case for new unit (refurbishment of facility within the Windsor building) has been presented and approved by the commercial exec board in 2011. Facilities are working with Pharmacy and commercial architects in order to finalise plans and get refurbishment started.	Extreme	Likely	20	Complete unit in operation - due 31/12/2013	3	⇔	PR/ CN & MD	8

Division	Directorate	Risk Title	Opened	Description of Risk	Risk subtype	Controls in place	Impact	Likelihood	Current Risk Score	Action summary	Target Risk Score	Risk Movement	Div/Exec Director	Strategic risk No.
Planned Care	Specialist Surgery	Delayed roll out of outsourced Transcription process, unavailability of skilled workforce and flexible workers	12/10/2012	**Causes:** -Reduction in secretarial skilled staffing due to previous MoC process -Delays in recruitment process preventing appointment to posts in a timely manner. -Use of DICT8 not delivering anticipated efficiencies. -High turnover of staff on fixed-term contracts that leave when substantive posts become available. -Bank and agencies cannot supply adequate numbers of staff to fill vacancies **Consequences:** -Outcomes missing from system. -Outcome slips filed in incorrect locations. -Patient notes may not contain relevant documentation. -Extensive delays in referral letter process (current backlog of approximately 11000 letters in -Ophthalmology, 3000 letters in ENT, 2000 letters in Breast Care) may lead to: Longer waiting times for treatment. -Increased number of complaints. -Adverse impact on reputation of specialty/Trust. -Insufficient staff to cope in cases of IT system failures. -H&S risk to staff due to numbers of patient notes stored inappropriately increasing the risk of slips, trips, and falls hazards. -Existing staff under increased stress due to increased work -Additional costs for overtime/ agency staff.	Patients	Stress audits performed Regular team meetings to provide support for A&C staff Staff training Temporary agency staff recruited 2 ops managers Weekly team meetings New Head of Service Outsourcing activity to private sector Significant number of vacancies filled in supporting A+C ENT typing outsourced to DICT8. Ophthalmology using ICE and template letters for referrals. Overtime and additional hours worked by existing staff. Trajectories developed and monitored in relation to addressing backlog. Urgent cases given priority for typing. Time allowed for 'protected typing' whenever possible. Involvement of UHL Health and safety team to help address staff safety issues. Additional racking for notes sourced and installed. ENT commenced using DICTATE IT	Major	Almost certain	20	Recruit to vacant service manager post - 31/10/2013 Recruit addition medical staffing - 31/10/2013	8	⇔	AF/DHR	3

Division	Directorate	Risk Title	Opened	Description of Risk	Risk subtype	Controls in place	Impact	Likelihood	Current Risk Score	Action summary	Target Risk Score	Risk Movement	Div/Exec Director	Strategic risk No.
Women's & Children's	Women's	Lack of Capacity in maternity services	28/09/2007	**Causes** Continuing increase to the birth-rate in Leicester . The number of maternity beds has decreased. Consultant cover for Delivery Suite is 60 hours a week with long term business plans to increase the hours in accordance with Safer Childbirth Recommendations **Consequences** Midwifery staffing levels are not in accordance with national guidance however are in line with regional averages Transfer of activity between the LGH and LRI occurs on a frequent basis with Leicestershire having to close to maternity admissions on a number of occasions Increase in incidents reported where there has been a delay in elective CS, IOL and augmentation due to lack of beds Staff frequently go without meal breaks Increased waiting time in MAC and therefore increased risk of a clinical adverse outcome to both mother and baby	HR	Length of postnatal stay in hospital as short as possible. Community staff prepare women for early discharge home if straightforward delivery. Extra triage room on Delivery Suite, LRI completed July 2012 Triage and admission areas in acute units to ensure no category x women sitting on delivery suite Use of Escalation Plan to inform staff on actions required if capacity is high Capacity is managed between the two acute units by temporarily transferring care if one site is busy Liaison with neighbouring maternity hospitals if high risk of closure of Leicestershire Maternity Hospitals Prioritisation of both elective and 'emergency' work according to clinical urgency and need On call Manager On call SOM Funded midwife places increased to 1:32 Escalation and contingency plans in place Relocation of all elective gynaecology beds to LGH	Extreme	Likely	20	Relocation of MAC services out of Delivery Suite on both sites to PAS in order to increase the capacity of Delivery Suite - due 14/10/2013 Increase ward capacity on LRI site by having EL CS women on level 1 - due 14/10/2013 Gynae theatres to be refurbished to accommodate EL CS at LRI - due 14/10/2013	12	⇔	IS/DHR	3

Division	Directorate	Risk Title	Opened	Description of Risk	Risk subtype	Controls in place	Impact	Likelihood	Current Risk Score	Action summary	Target Risk Score	Risk Movement	Div/Exec Director	Strategic risk No.
Women's & Children's	Women's	Unavailability of USS and not meeting National Standards for USS in Maternity	10/10/2008	Failure to diagnose abnormality which we would normally expect to diagnose due to changes in National standards. The potential for other consequences are apparent.	Quality	Detailed scan pro-forma US performed by suitable trained staff Self audit Use of regular pre-booked agency sonographers Daily review of outstanding requests to monitor the situation Access to consultants for second opinion if suspicious re possible abnormality All ultrasound machines now of suitable specification and replaced 5 yearly Incident report forms Update 18.10.12 Continued use of Agency Sonographers Continued 'extra' lists by Fetal Med Consultants Additional u/s machine in place but next step is need for additional scan room - this is built in to the interim solution for Maternity (phase 1) and should be converted by April 2013	Extreme	Likely	20	Create further USS space or utilise existing space out of hours to increase capacity - due 30/10/13 Extra scan room to be included as part of the interim solution (LGH) - due 30/10/13 Recruitment of further sonographer - due 30/10/13	6	⇔	IS/DHR	3
Acute	Imaging & Medical Physics	There is a risk of a backlog of unreported images	28/07/2009	**Causes** Backlog of unreported images on PAC'S (Plain Film, CT, MRI) which could lead to a major clinical risk incident and a potential for litigation and adverse media publicity. Royal College Radiologists guidelines state that all images should be reported IRMER require all images involving ionising radiation to be clinically evaluated **Consequences** Risk of suboptimal treatment Potential for patient dissatisfaction / complaint Potential for litigation	Patients	Ongoing reporting by radiologists and reporting radiographers Allocation of CT/MRI examinations to a intended radiologist or specialty group House keeping done by clerical and superintendents to ensure images are visible on PACS. Outsourcing overdue reporting to medica.	Maior	Likely	16	Recruitment to radiology vacancies - 01/01/2014 Train more reporting radiographers - due 30/06/2014	6	⇔	PR?DHR	3

Division	Directorate	Risk Title	Opened	Description of Risk	Risk subtype	Controls in place	Impact	Likelihood	Current Risk Score	Action summary	Target Risk Score	Risk Movement	Div/Exec Director	Strategic risk No.
Acute	Imaging & Medical Physics	No out of hours nursing support for interventional radiology procedures	17/06/2011	**Causes** There is not a radiology nurse present to support radiologists and radiographers undertake interventional radiological procedures out of normal working hours. **Consequences** Procedures undertaken out of hours are by their nature 'urgent' and thus the patients are likely to be sick/unstable and require a high level of nursing/medical care. These patients do not have the usual level of service that would be available to them during normal hours and thus the RCR recommendations for interventional radiology are not followed. The radiographer must cover the roles of nurse, runner and radiographer their urgent nature the patients are unstable, monitoring is basic as at best there may be a nurse accompanying the patient from the ward but they are unfamiliar with the environment and the procedure. Moving the patient can be difficult, the patient often has a lot of drips etc and needs pat sliding, there can be just 3 people to do this which may cause injury to staff or patient. No scrub assistant for the radiologist, they often do not have a registrar either so procedure can be challenging, this Post procedure the radiographer is alone to see the patient	Patients	Nurse requested from ward, radiographers trained in patient monitoring. Manual handling training, slide-sheets, use of porter and escort nurse to transfer. Registrar to assist radiologist when able. Radiographer request the doctor stays until patient leaves. Closes the main doors if alone cleaning up. Out of hours procedures are currently undertaken by a Consultant Radiologist, with support from a radiographer. If required additional support may be available from the radiology SPR on duty and/or ward nursing/medical staff looking after the patient (as per the UHL Escort Policy). This support is not always available and may not be to the same specialist level as that given by a nurse familiar with the procedures. Due to clinical commitments elsewhere in the Trust the radiology SPR may not be available and likewise case mix and staffing levels in other clinical area may restrict the availability of non-imaging staff. Prior to April 08 the out of hours SPR cover meant there were 2 SPR'S available at all times; one at the LRI and one between the LGH and Glenfield. In April	Major	Likely	16	Further recruitment required due to recent sickness and resignations 01/11/2013	3	⇔	PR/DHR	3

Division	Directorate	Risk Title	Opened	Description of Risk	Risk subtype	Controls in place	Impact	Likelihood	Current Risk Score	Action summary	Target Risk Score	Risk Movement	Div/Exec Director	Strategic risk No.
Corporate	Operations	Failure of UHL BT to fully comply with BCSH guidance and BSRs may adversely impact on patient safety and service delivery	22/12/2006	**Causes:** Failure to implement electronic tracking for blood and blood products to provide full traceability from donor to recipient At UHL blood is tracked electronically up to the point of transfer of blood from local fridge to patient with a manual system thereafter which is not 100% effective (currently approximately 1 - 2% (approx 1200 units) of all transfusion recording is non-compliant = 98% compliance). Non-compliance with blood transfusion policies resulting in incorrect identification processes resulting in sample identification and labeling error resulting in wrong blood cross-matched and / or provided for patient (last incident of ABO incompatibility by wrong transfusion approx. 4 years ago (yr 2008); approximately 6 near misses per year). New British Committee for Standards in Haematology (BCSH) guidelines require 2 samples from a patient where manual pre-transfusion compatibility testing is performed. An electronic system would require only 1 sample. Critical report received from MHRA in relation to UHL having no credible strategy for compliance with Blood Safet **Consequences:** Potential loss of blood bank licence (via MHRA) with severe Financial penalty for non-compliance. Delay in timely supply of blood and blood components for n Increased potential for 'Never event' (i.e. wrong transfusion) Potential loss of Trust's good reputation via publication of c Inefficiencies in service delivery.	Quality	Policies and procedures in place for correct patient identification and blood/ blood product identification to reduce risk of wrong transfusion. Paper system provides a degree of compliance with the regulations. Training and competency assessment for UHL staff involved in the transfusion process including e-learning and induction training with competency assessment for key staff groups. Fortnightly monitoring and reporting system to CBU Managers in relation to blood/ blood product traceability performance.	Major	Likely	16	Submit briefing paper to UHL Executive Team and EMPATH. 31/10/13 IM&T project approval. 30/10/13 Obtain Board approval for funding. 31/10/13 Develop implementation plan for electronic tracking system. 30/11/13 Complete SOP's and quality documentation. 31/1/14 Training within clinical areas. 31/1/14 Implement system start date - tba	4	⇔	RM/COO	9

Division	Directorate	Risk Title	Opened	Description of Risk	Risk subtype	Controls in place	Impact	Likelihood	Current Risk Score	Action summary	Target Risk Score	Risk Movement	Div/Exec Director	Strategic risk No.
Corporate	Operations	Risk of inaccuracies in clinical coding	02/08/2011	**Causes** Casenote availability HISS constraints (HRG codes not generated) High workload (coding per person above national average) Inaccuracies / omissions in source documentation (e.g. case notes may not include co-morbidities, high cost drugs may not be listed) Inability to provide training to large groups of coders due to lack of time and financial constraints **Consequences** Loss of income (PbR) Outlier for CHKS/HSMR data Non- optimisation of HRG Loss of Trust reputation	Economic	Coding improvement project initiated April 2011. Project Board commenced September 2011 (PID, project plan and highlight report agreed). Electronic coding implemented February 2012 and to be upgraded November 2012 - HRG code generated. Will aid with audit, implementation of local policies and performance management. Task and finish groups completed in Divisions review improvements in coding using PeRL, PLICs, CHKS and medicode (encoder). New process for medical records retrieving notes. Due to changes in recording and payment of EDU and CAU episodes number of episodes coded has reduced. Shifts from day case to outpatient will reduce workload. Lead clinicians identified and Trust wide communication to move coding closer to the clinician. Tick lists introduced in both the ward area and discharge letter. Bank staff and overtime authorised to meet deadline. Scorecard developed to demonstrate improvements and benchmark against other Trusts. 3 year refresher programme completed November 2011. Quarterly updates/briefings to be led by Asst Director of Information - commenced April 2012. Team restructure Annual External Audit Internal Audit - commences November 2013 Audit Committee updates	Major	Likely	16	Succession Planning for Coding Manager - 31/12/13 Coding Improvement Board - 31/12/13 2013/14 PbR Audit - 22/01/14 CIP - to increase income for Trust by £1.5m - 31/03/14 Review the priority of this risk after go live with the encoder as all actions will have been taken - 31/03/14	8	⇔	JR/DFBS	1

Division	Directorate	Risk Title	Opened	Description of Risk	Risk subtype	Controls in place	Impact	Likelihood	Current Risk Score	Action summary	Target Risk Score	Risk Movement	Div/Exec Director	Strategic risk No.
Planned Care	Cancer, Haematology, Oncology	Current Typing Backlog.	20/02/2013	Current typing backlog sits at 8-10 weeks (Sept 2013) **Causes** Shortage of staff following A&C review Volume of correspondence **Consequence** Delay in communication with GP delayed referrals potential delays in treatment	Quality	-Agency / bank staff -monitoring position	Major	Likely	16	Progress outsourcing as soon as practically possible - 31/10/13 Identify issues arising from outsourcing - 31/10/13 Continue to bring in extra staff from the Bank and Agencies where possible - 31/10/13 Monitor backlogs and accuracy of typing - 31/10/13 Move Oncology to Dictate IT ASAP - 31/10/13	6	▲	AF/DHR	3

Division	Directorate	Risk Title	Opened	Description of Risk	Risk subtype	Controls in place	Impact	Likelihood	Current Risk Score	Action summary	Target Risk Score	Risk Movement	Div/Exec Director	Strategic risk No.
Planned Care	Intensive Care, Theatres, Pain Management, Sleep	Risk of unplanned loss of theatre and/or recovery capacity at the LRI	28/06/2013	**Causes:** 1. The Theatre and Recovery estate and supporting plant(s) are old, unsupported from a maintenance perspective and not fit for purpose. There is recent history of unplanned loss of surgical functionality at the LRI site due to plant failure, problems with sluice plumbing and ventilation. 2. In addition, the poor quality of the floors, walls, doors, fittings and ceilings mean an unfit working environment from a working life, infection prevention and patient experience perspectives. 3. There is insufficient electricity and medical gas outlets per bed. 4. Aged electrical sockets resulting in actual and potential electrical faults - fire in theatres at LRI (Theatre 4) in July 2013. **Consequences:** 1. Periodic failure of the theatre estate (ventilation etc) so elective operating has to stop 2. Risk of complete failure of the theatre estate so elective and emergency operating has to stop 3. Increase risk of patient infections 4. Poor staff morale working in an aged and difficult working environment 5. Difficulty in recruiting and retaining specialised staff (the 6. Poor patient experience - our most vulnerable patients a 7. May impair delivery of life support technologies	HR	1. Regular contact with plant manufacturers to ensure any possible maintenance is carried out 2. Use of limited charitable funds available to purchase improvements such as new staff room chairs and anaesthetic stools 3. TAA building work has started 4. Plan to develop full business case for new recovery build 2013 - start 2014 5. 5S'ing events taking place within the theatre transformation project frame work 6. Compliance with all IP&C recommendations where estate allows 7. Purchase of new disposable curtains for recovery area, reducing infection risk and improving look of environment	Major	Likely	16	TAA Build - due 15/12/13 Recovery re-build - due 01/12/14 Replacement of all theatre corridor floors and doors - due 31/12/14 (Date changed as no funding for works) Completion of ITAPS nursing recruitment plan - regular monitoring Integration of ITAPS LiA pilot to underpin improvements in staff morale, pulse check and theatre transformation work - due 06/11/13 Capital investment and refurbishment of LRI theatres - plan in place and commenced - due 01/12/15	4	⇔	AF/DFBS	10

Division	Directorate	Risk Title	Opened	Description of Risk	Risk subtype	Controls in place	Impact	Likelihood	Current Risk Score	Action summary	Target Risk Score	Risk Movement	Div/Exec Director	Strategic risk No.
Planned Care	Intensive Care, Theatres, Pain Management, Sleep	Risk of unplanned loss of theatre, recovery or Critical Care capacity across UHL due to insufficient nursing staffing	28/06/2013	**Causes:** Locally, ITU and theatre nursing staff have been historically difficult to recruit and retain. Turnover regularly negates recruitment efforts and the effects of a poor working environment in a high stress and risk area has meant difficulties in resolving the issue previously. **Consequences:** 1. Increased overtime and waiting list payments required to run the core service 2. Tired and unmotivated staff in post 3. Poor staff morale working in an aged and difficult working environment 4. Difficulty in recruiting and retaining specialised staff (theatre and Critical care) due to poor working environment and low staff morale in general 5. Reduction in critical care capacity across UHL 6. Inability to respond to increases in demand in theatre, recovery and critical care capacity 7. Elective patient cancellations including cancer patients 8. Critical Care alternatives becoming the norm for high level of care patients e.g. Kinmonth, overnight PACU and specialty "HDU's". 9. Poor patient and carer experience for some of our sickest patients	HR	1. Use of Bank and Agency staff with block contracts for consistency and cost effectiveness. 2. Regular team and leadership meetings/training events 3. Rolling adverts in place 4. International recruitment with HRSS and relevant agencies commenced 5. Exit interviews used regularly and in line with trust policy to understand issues exacerbating higher than wanted turnover of staff	Major	Likely	16	1. Small works to improve current current ITU environment and footprint - full Business Case to be forwarded to Commercial Executive - 30/11/2013 2. Continuation of monthly rolling adverts - monthly monitoring 3. MOC to standardise ITU shift patterns - regular monitoring 4. Introduction of electronic rostering to standardise shift patterns and maximise efficient use of theatre, recovery and ITU staff - due 31/12/13	4	⇔	AF/DHR	3

Division	Directorate	Risk Title	Opened	Description of Risk	Risk subtype	Controls in place	Impact	Likelihood	Current Risk Score	Action summary	Target Risk Score	Risk Movement	Div/Exec Director	Strategic risk No.
Planned Care	Intensive Care, Theatres, Pain Management, Sleep	Insufficient Staffed Level 3 Critical Care Beds	26/06/2012	**Causes:** Critical care occupancy has continued to rise through 2010/11 to 2011/12 resulting in elective cancellations and a lack of physical space to facilitate working more efficiently and effect infection prevention practice. UHL Critical care bed occupancy for 2010/11 was 91.07% and 97.7% for 2011/12 (ICNARC). The Intensive Care Society recommendations are 70% to enable flexibility to respond as an emergency provider. **Consequences:** Lack of Level 3 beds resulting in elective cancellations. This equals 127 @ month 11. Delayed ITU discharges to specialty based wards	Patients	Reallocation of Level 3 beds flexibly across UHL to meet demand Reallocation wherever possible of nursing staff across Critical Care areas in UHL to meet demand Daily SITREP report for critical care distributed throughout the Division and end users of the service stating occupancy, staffing, bed capacity and delayed discharges. Presence of ITU senior nursing staff at Trust's operational bed meeting @ 08.30 daily Bed management policy in place for ITU and all specialties with differing responsibilities for each area. Escalation policy in place inclusive of ITU, PACU and elective users of critical care Ability to escalate to bank/overtime/agency to open extra level 3 capacity as required Presence of ITU senior nursing staff at Trust's weekly theatre activity meeting to plan ahead for elective activity Access to web based system for critical care capacity across the central England network to exercise transfers of Level 3 patients if no capacity available in UHL On 03/04/13, it was announced that Critical Care had been successful with the commissioners in their bid to expand the Critical Care bed base. Nursing rec	Major	Likely	16	Continue with rolling advert continuous until vacancy filled. To review international recruitment potential - meeting 30/11/13. Remove at the end of November 2013 the support given to PICU - 30/11/13	12	⇔	AF/COO	9

Division	Directorate	Risk Title	Opened	Description of Risk	Risk subtype	Controls in place	Impact	Likelihood	Current Risk Score	Action summary	Target Risk Score	Risk Movement	Div/Exec Director	Strategic risk No.
Planned Care	Specialist Surgery	Follow up backlogs and capacity issues in Ophthalmology and ENT	12/06/2013	**Causes:** -lack of capacity within services -Junior Doctor decision makers resulting in increased follow-ups -Follow-ups not protocol led -No partial booking -non adherence to 6/52 leave policy -clinic cancellation process unclear, inadequate communication and escalation **Consequences:** -backlog of patients to be seen -risk of high risk patients not being seen/delayed -poor patient outcome -increased complaints	Patients	Recruited team leaders to ENT Outpatient efficiency work ongoing Full recovery plan for ophthalmology in process	Major	Likely	16	Enforcing 6/52 leave policy - 31/10/13 Agree management plan with clinicians to address backlogs - 31/10/13 Clinical care, joint commissioning groups to support backlog clearance - 31/10/13 Develop condition specific follow up protocols - 31/10/13 Business case development to address any capacity gap - 31/10/13	8	⇔	AF/DHR	3

Division	Directorate	Risk Title	Opened	Description of Risk	Risk subtype	Controls in place	Impact	Likelihood	Current Risk Score	Action summary	Target Risk Score	Risk Movement	Div/Exec Director	Strategic risk No.
Women's & Children's	Children's	PICU/ECMO/ Wd 30 Capacity	05/03/2013	**Causes** The demand for PICU beds currently outweighs capacity. There is an establishment of 6.5 beds but due to vacancies and long-term sickness/maternity leave the unit is currently only able to run at maximum capacity of 6 beds and on specific days only 5 beds (depending on the overall ECMO activity across adults and children). In addition to NHS activity the Trust has contracted to provide cardiac surgery for a cohort of Libyan children. At the time that the contract was developed (Nov-December 2012) it was assessed that there would be sufficient capacity to operate on one child per week without impacting on NHS Activity. However, the current staffing and long-term profile of patients on PICU has resulted in pressures on both NHS work and the delivery of the Libyan contract. Currently there are vacancies for 5.82 wte qualified and 1 wte unqualified nurse within the Childrens' cardio respiratory services, which cover PICU, ward 30 and the COPD. The ECMO services has vacancies of qualified staff. **Consequences** Balancing the demand for PICU beds between NHS contrac Unsafe staffing levels, therefore unable to provide the recor Staff from PICU are moved to cover ward shifts to ensure m Elective surgery cases have to be cancelled on the day of t Nurses without the key ITU or paediatric skills may be used Children's medication can be delayed. Communication with parents is not optimum. Staff miss breaks in order to facilitate care. There has been an increase in staff sickness levels and mo There are an increased number of complaints being receive	Patients	No further Libyan patients are being operated on until agency staff can be recruited to support their PICU stay or until the patient flow changes on PICU to allow week-end operating which does not compromise week-day operating or access to PICU. Active Recruitment in progress Educational team cover clinical shifts Cardiac Liaison Team cover Outpatient clinics Overtime, bank & agency staff requested Lead Nurse, Matron and ECMO Co-ordinator cover clinical shifts Children's Hospital & Adult ICU staff cover shifts The beds on Ward 30 have been reduced from 13 to 10 PICU beds are closed where necessary	Major	Likely	16	Income from the Libyan Ministry of Health programme will be used to fund agency nursing staff to open an additional PICU bed - 30/04/2014 Recruitment of suitably trained/experienced agency PICU nurses - 30/04/2014	8	▲	IS/DHR	3

Division	Directorate	Risk Title	Opened	Description of Risk	Risk subtype	Controls in place	Impact	Likelihood	Current Risk Score	Action summary	Target Risk Score	Risk Movement	Div/Exec Director	Strategic risk No.
Acute	Cardiac, Renal & Respiratory	Inappropriate environment and infection prevention Renal Transplant	25/10/2011	**Causes** Insufficient side room capacity Inadequate space in existing side room for haemodialysis and line procedures. Insufficient en suite facilities in side rooms Vascular access and % of patients with dialysis catheters Procedure room on ward 10 not fit for purpose Inappropriate areas used for renal biopsy on ward 17 Inadequate drug preparation areas Inadequate domestic storage areas No separate facility for isolating patients in ward 10/17 DCU Movement of patients to accommodate admissions or haemodialysis in another area **Consequences** Poor compliance with cannula care Challenges in maintaining integrity of commode lids using Chlorclean Infection prevention risk Transportation of contamination through patient occupied areas (15N/A)	Patients	Preventing Transmission of Infection including Isolation Guidelines (DMS 47699) MRSA Screening policy Weekly MRSA audits undertaken by IP Team Local Infection Prevention Group Communication of IP issues regular agenda item on local meetings Link Nurse Network Daily side room list Monthly Nursing Metrics audits Monthly HII audits Monthly Environment audits Recent refurbishment and upgrade of ward 15N/A accommodation Steam cleaning post CDT patients Vascular access being monitored by CQUIN & EMRN Medically led Vascular Access coordination Expert specialty trained competent staff Use 'cohort facility' as required Ongoing competency based programme for the training and implementation of ANTT	Extreme	Possible	15	Development of renal relocation plan - 31/01/2017 Walkabout with Infection Prevention Team to review risk likelihood and report recommendations to CBU Board - 25/10/13.	15	⇔	PR/DFBS	10
Acute	Cardiac, Renal & Respiratory	Harborough Lodge environment stops staff safely delivering haemodialysis	16/08/2012	**Causes:** Insufficient space to: Safely carry out dialysis procedures Safely carry out manual handling procedures Safely carry out emergency procedures Maintain patient privacy & dignity Poor state of repair of within clinical areas **Consequences:** Cross contamination/infection Manual handling injury to staff/patient/visitor Poor patient experience Negative reputation of Trust Complaints	Patients	Specialist haemodialysis trained and competency assessed staff Haemodialysis/other clinical policies Annual manual handling training Annual infection prevention training Infection prevention policy Infection prevention audits Environment audits Curtains at each bed space Minimum cleaning standards	Extreme	Possible	15	UHL undertake Duty of Care review and produce recommendations - 30/10/2013	5	⇔	PR/DHR	3

Division	Directorate	Risk Title	Opened	Description of Risk	Risk subtype	Controls in place	Impact	Likelihood	Current Risk Score	Action summary	Target Risk Score	Risk Movement	Div/Exec Director	Strategic risk No.
Acute	Imaging & Medical Physics	No comprehensive out of hours on call rota for consultant Paediatric radiologists	29/06/2009	**Causes** There are Consultant Radiologists on call however there are not sufficient numbers to provide an on call service. Registrars are available but they have variable experience **Consequences** Delays for patients requiring Paediatric radiological investigations. Sub-optimal treatment Paediatric patients may have to be sent outside Leicester for treatment Potential for patient dissatisfaction / complaints Consultants are called in when they are not officially on call and they take Lieu time back for this, resulting in loss of expertise during the normal working day.	Patients	There are Consultant Radiologists on call however there are not sufficient numbers to provide an on call service. Registrars are available but they have variable experience. Non Paediatric radiology consultants are not able to perform or interpret Paediatric radiological interventions.	Moderate	Almost certain	15	Review Paediatric service to determine the employment of further Consultants - due 26/10/13	2	⇔	PR/CN &MD	8

Division	Directorate	Risk Title	Opened	Description of Risk	Risk subtype	Controls in place	Likelihood	Impact	Current Risk Score	Action summary	Target Risk Score	Risk Movement	Div/Exec Director	Strategic risk No.
Acute	Imaging & Medical Physics	Lack of planned maintenance for medical equipment maintained by Medical Physics	14/05/2009	**Causes:** Lack of Medical Physics technical staff No mechanism to ensure that the revenue consequences of maintenance are identified and funding given to Medical Physics to perform this maintenance. **Consequences:** Potential for equipment to perform out of specification leading to increased risk of patient/ staff harm. Equipment failure due to non-replacement / maintenance of limited life parts Failure to meet statutory requirements for electrical safety testing of medical equipment. Increased risk of patient complaints / claims Potential for adverse media attention and risk to the reputation of the Trust May impact upon successful outcome of future NHSLA assessments Possibility of non-compliance with CQC Outcome 11 May attract attention of Medicines and Healthcare products Regulatory Agency (MHRA) Low morale / unreasonable pressure on Medical Physics technical staff.	Statutory	Some critical equipment is being maintained under service agreements set up with supplier. Medical Physics team are targeting "High" risk equipment as a first priority. Trust wide project team has been assembled to categorise the risk rating of equipment categories for both Maintenance and training needs - work from this team will eventually lead to many of the recommended actions being possible Identified all critical equipment and maintenance needs through the risk assessment process Reviewed the Medical Devices policy Site wide audit of medical devices Standardise medical equipment wherever possible Trust wide communication about future of medical device management issued. Develop robust mechanism to ensure the revenue consequences of maintenance for medical equipment purchases are identified - 30/9/13 - completed	Moderate	Almost certain	15	Develop process to allow appropriate funding for Medical Physics to ensure programmed maintenance can be performed - 01/04/14 Secure funding to increase current staff base for Medical Physics technical staff or outsource maintenance contracts - 01/04/14 Quantify the shortfall in maintenance provision from existing resources and identify to the Trust (to enable Trust decision on corrective to be made) - 30/11/13 Establish infusion pump libraries at LGH and LRI - 1/4/14	6	⇔	MW/CEO	6

Division	Directorate	Risk Title	Opened	Description of Risk	Risk subtype	Controls in place	Impact	Likelihood	Current Risk Score	Action summary	Target Risk Score	Risk Movement	Div/Exec Director	Strategic risk No.
Corporate	Communications	Failure to achieve Foundation Trust (FT) status	30/04/2007	Public opinion does not support our FT application; Failure of the Trust to persuade the public about the benefits and importance of FT status. Failure to engage staff / public re: FT / Strategic Direction; Disengagement of members / public from the process. Disengagement of staff from the process. Public perception may be of a ""failing"" Trust. We will be required by Monitor to show that staff and the public / stakeholders are aware of and support the Trust's Strategic Direction and FT Trust application. The consultation fails to generate sufficient responses / poor demographic representation among responders; Consultation document / communications do not reach sufficient numbers of people / organisations. Responses do not reflect the diversity of the population.	Public	FT programme Board meets regularly to drive and monitor progress on FT application. FT programme leads meet weekly to keep application on track. Dedicated FT Programme Manager in post, supported by the Trust's strategy team. Consultation Document and supporting communication clearly sets out aspirations and benefits. Communications and Engagement strategy established for FT consultation and strategic direction. FT consultation will be supported and monitored by Membership Engagement Services (MES) Regular briefings to members of staff/ public/ members/ stakeholders. Bi - monthly Prospective Governor meetings established Consultation Strategy specifically targets a wide demographic range of groups / organisations Risk monitored at Board level in Board Assurance Framework.	Moderate	Almost certain	15	Consultation and Engagement actions - 31/12/13	6	⇔	MW/DHR	3
Corporate	Communications	Loss of charity funder	01/10/2011	Loss of (up to) £300k income to Charity from WRVS as a result of single FM supplier contract award. The Charity currently has no recovery plan for such a loss of income. The WRVS funding covers a number of posts within the Trust which would be put at risk.	Economic	The Charitable Funds Committee monitors income and expenditure at bi-monthly meetings. A reduction or cessation of funding is manageable if necessary. Currently awaiting outcome of discussions between WRVS and Interserve.	Moderate	Almost certain	15	To review options for developing new income streams for the Charity (Charity 5 year Plan); to review the funded posts to determine their future viability - due 29/11/13	8	⇔	JC/ DFBS	12
Corporate	IMT	PACS - Breast Care Service	26/05/2011	Breast Care Service : Need to improve D.R. capability by providing local storage to Reporting Work Station, so that the service can be sustained in the event of a PACS outage. This could potentially be achieved by adding extra disk capacity to their local Reporting work Station.	Patients	IM&T and Imaging IT support are currently in the process of determining whether to move the current archive server process to new hardware to mitigate the risk, or defer to a possible managed service provider.	Extreme	Possible	15	The Board has approved the transition to a 'managed service provider'. Contact the service now that it is being managed by Accenture to see if the risk can be downgraded - also asked if they want to invest in a local DR solution - 01/10/2013	2	⇔	KH/ CN & MD	8

Division	Directorate	Risk Title	Opened	Description of Risk	Risk subtype	Controls in place	Impact	Likelihood	Current Risk Score	Action summary	Target Risk Score	Risk Movement	Div/Exec Director	Strategic risk No.
Corporate	Medical Directorate	Personal safety awareness training may be ineffective due to oversubscription and potential discontinuation of contract with LPT	30/08/2013	**Causes** Withdrawal of LPT personal safety awareness training provision. No in-house training function due to period of transition in relation to security management. Lack of personal safety awareness training focus within the Trust. **Consequences** Inability to fulfil current training demand within UHL leading to: Non-compliance with statutory and mandatory training policy requirements. Staff and patient safety compromised. Non-compliance with NHS Protect standards. Reputational issues - public expectation.	Quality	Agreed extension to contract with LPT until end of October 2013. There is a level of security awareness amongst staff who have previously received personal safety awareness training. Security personnel have received appropriate refresher training for 2013.	Moderate	Almost certain	15	Assess feasibility of internal appointment of personal safety awareness trainer using current security training budget - 31/10/13. Arrange for personal safety awareness training to be provided by LPT up to the end of December to reduce the backlog, subject to trainer and venue availability - 31/10/13. Review of Statutory & Mandatory training provision (including personal safety awareness training and potential e-learning package for level 1) to help achieve compliance - 30/11/13.	4	⇔	KH/DHR	3

Division	Directorate	Risk Title	Opened	Description of Risk	Risk subtype	Controls in place	Impact	Likelihood	Current Risk Score	Action summary	Target Risk Score	Risk Movement	Div/Exec Director	Strategic risk No.
Corporate	Medical Directorate	Risk of user error associated with non-standardisation of manual and automated external defibrillators	16/12/2009	**Causes:** Medical staff using the defibrillator will rotate to other sites within the Trust Different make / model of defibrillator used at LGH site (Zoll defibrillators as opposed to Medtronic LifePak 20) Defibrillator training at LRI/ Glenfield hospital uses Lifepak defibrillators for practical element of training but purely illustrates the differences between Zoll and Lifepak. This includes how to turn on, how to activate manual mode (2-stage activation), and location of 'shock' button. Defibrillator training at LGH hospital uses Zoll defibrillator for practical element of training but purely illustrates the differences between Zoll and Lifepak. This includes how to turn on, how to activate manual mode (finding release button and opening manual door), and location of 'shock' button. **Consequences:** Potential for unsuccessful defibrillation attempt Potential for injury to the patient (death) Potential to disrupt the advanced life support universal algorithm Non-compliance with recommendations of the CPR Standards for Clinical Practice and Training	Patients	Defibrillation training Defibrillator will give automated instructions (depending on clinical setting)	Extreme	Possible	15	Funding available for purchase - 30/11/13 Standardise make/ model of defibrillator across the Trust - 31/12/13 Installation of new defibs - 31/12/13	5	⇔	KH/ CN & MD	8

Division	Directorate	Risk Title	Opened	Description of Risk	Risk subtype	Controls in place	Impact	Likelihood	Current Risk Score	Action summary	Target Risk Score	Risk Movement	Div/Exec Director	Strategic risk No.
Corporate	Nursing	Failure to manage Category C documents on UHL Document Management system (DMS)	14/03/2011	**Causes** Lack of resource at Divisional/ directorate level Lack of resource in CASE team Delays in the development of 'SharePoint' that would enable automatic reminders for expired documents to be generated for the document authors. **Consequences** DMS does not contain the most recent versions of all category C documents Staff may be following incorrect guidance (clinical or non-clinical) May not be able to demonstrate compliance with NHSLA ARMS	Quality	Acting Head of Outcomes has discussed the problems with Clinical Business Units (CBUs) to identify which documents can be managed by the CBUs Reminders to be manually generated by the CASE team (one day a week only)	Moderate	Almost certain	15	Use of bank staff or redeployed staff for 3 - 6 months to update information on DMS and migrate to 'SharePoint' - 31/10/13	9	⇔	SH/ CN &MD	8