Trust Board Paper V

To:	Trust Board
From:	Kate Bradley, Director of Human Resources
Date:	31st October 2013

Title:	Implementation of the Clinical Management Group Structures

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

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

The Report is provided to the Board for:

Decision		Discussion	
Assurance	√	Ratification	

Summary / Key Points:

The purpose of this paper is to provide an update on the work that has been completed and that continues in relation to the implementation of the new CMG structure from the beginning of October 2013.

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

A revised risk assessment has now taken place and is attached at **appendix 1** which includes risk analysis on financial and business risk around CIP Delivery.

The new CMG names are confirmed as;

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

Appointments have taken place at the senior CMG levels and any remaining gaps are in active recruitment. A revised structure chart showing recent appointments including Deputy CMG managers is attached at **appendix 2.**

The next phases include Education, Quality and Safety, HR & Finance and planning is detailed within the relevant section.

The paper also details the CMG performance management and development framework being put into place and the key next steps and timescales. This includes a 'Setting the Direction' session with CMG Directors and leaders on 1st November 2013.

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

Strategic Risk Register A comprehensive risk assessment has been produced which includes CIP risk.	**Performance KPIs year to date** N/A
Resource Implications (eg Financial, HR) Managerial, Human Resources, Finance, Communications.	
Assurance Implications	
Patient and Public Involvement (PPI) Implications	
Equality Impact - A due regard assessment has been completed.	
Information exempt from Disclosure Yes	
Requirement for further review? Updates will be provided through Executive Team.	

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST

MEETING: **TRUST BOARD REPORT**

DATE: **31st OCTOBER 2013**

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

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

1.0 INTRODUCTION

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

1.2 A detailed project plan covering each of the key work-streams was created and members of the Executive Team were assigned a lead role for the relevant work-stream. This group have met twice weekly since the end of August to determine next steps, ensure work is completed and that any subsequent decisions and actions are agreed and taken forward appropriately.

1.3 A key area of focus has been the production of a comprehensive risk assessment to ensure that any potential risks created or exacerbated by the introduction of CMGs are identified and actions to mitigate against these risk. An updated Risk assessment is attached at **Appendix 1**. This has been updated since the last Trust Board to include risks around cost improvement programme delivery.

2.0 BACKGROUND

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

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

3.0 CURRENT POSITION

3.1 Throughout September and October individual meetings were held with all senior colleagues who are affected by the move to CMGs. Following these meetings letters have been sent to colleagues informing them of the nature of change and confirming movements at senior CMG team levels. Attached at **Appendix 2** is the current structure including new appointments, which now includes Deputy Manager appointments.

3.2 Next steps are concerned with the way that the Trust will support the effective working of the new CMGs. Specifically, how the CMGs will be supported by corporate functions such as Human Resources (HR) and finance; how quality and safety issues and reporting will be managed in the new structure and how the Trust will ensure assurance and performance

processes to make sure that we are on track to deliver our objectives at CMG and Trust level, along with completing recruitment activity and confirming appointments in the remaining gaps.

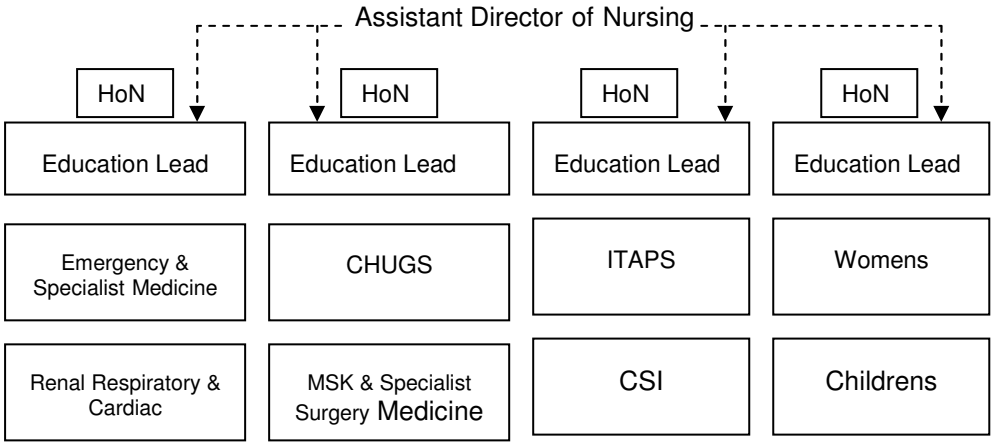
The plans are summarised in the sections below.

4. EDUCATION

4.1 Each CMG will have a medical education lead that will be responsible for helping the CMG deliver its medical educational requirements, working in conjunction with Professor Sue Carr, Director of Medical Education.

4.2 As regards nurse education; it has been agreed by the Nursing Executive Team (NET) that the education and practice development structure should remain the same as the posts can all be aligned to individual CMGs with the exception of the four Education Leads. The NET has advised that each lead will be responsible for nurse education and practice development for two CMGs that have similar clinical affinities (figure 1). The Education Leads will be responsible to one named Head of Nursing and professionally accountable to the Assistant Director of Nursing, Eleanor Meldrum.

Figure 1 – CMG Education and Practice Development Structure



4.3 The 3.0 wte administrative posts supporting the education teams within the CBUs will continue supporting the education teams and will be line managed by each Education Lead

4.4 Existing job descriptions for the Education Leads will be changed to reflect the changes in line management and professional accountability. There are no changes to banding as the responsibilities of the posts remain the same.

5 QUALITY AND SAFETY

5.1 The Quality and Safety teams are currently within the Corporate Nursing structure and the three divisions. The essential portfolio for these teams includes:-

- Incident reporting and investigating, including the writing of final investigation reports and monitoring of action plans;
- Preparation for high risk inquests;
- Investigation of complaints, concerns, G.P. and CCG concerns and preparation of written responses;
- Ombudsman investigations;

- Meeting safety requirements within the Quality Schedule;
- Meeting CQC Standards in relation to Quality and Safety.

Activity within all areas has always been high, but this has significantly increased since the publication of the Francis report into Mid Staffs, which made many recommendations in relation to the Quality and Safety agenda. At the same time the national trend for formal complaints is moving upwards and this is likely to continue for some time due to rising expectations and public awareness, whilst the scope of what constitutes a Serious Untoward Incident, (SUI) has expanded, again increasing the workload for quality and safety colleagues.

All of the above speak to the need for a review of leadership, training, information and transparency in quality and safety matters.

The current Quality and Safety structures are different within the three divisions and do not easily transfer to the seven Clinical Management Groups.

It is recognised that duplication and multiple hand-offs create inefficiencies in the current systems and there is no capacity to "flex" our Quality and Safety resource to meet the unpredictable demands of the quality and safety agenda and activity.

5.2 Different demands and activity: The activity across the seven CMGs differs significantly, with a greater burden on some CMGs and relatively less on others.

In light of this and bearing in mind that we want to create the ability to flex the quality and safety team so that they can focus on areas of greatest need, we are proposing that there is a strengthened central function to undertake the following elements of Quality and Safety.

- SUI investigation and RCA management
- Complaint and Ombudsman case management
- High risk Inquest preparation

Other functions such as those below will be managed within the CMGs by the Head of Nursing and Clinical Director teams.

- CAS follow-up
- CQC outcomes follow-up
- Risk Register management

5.3 Following discussions with senior staff from each CMG (excluding Women's and Children's), the current Quality and Safety Managers and Senior HR Project Lead for Transformation, it became clear that there were concerns about leaving the administration for quality and safety within the CMGs. The proposal therefore to centralise all of the quality and safety function was considered by the Executive Team on the 22nd October 2013 and accepted.

5.4 Work is now being continued by the Director of Safety and Risk, Senior Patient Safety Manager and the HR Lead for Transformation to progress the management of change from the current arrangements to the new structure.

6 **HR AND FINANCE:** To support the work of the CMGs the corporate HR and Finance have adjusted their structures to ensure there is a designated lead and team for each CMG.

The "interim" finance support to the CMG's will be based on a principle of one Finance Manager for each CMG and will take place with immediate effect. These leads will be supported by a number of Service Accountants. A further management of change process will follow to progress the permanent arrangements.

7 **PERFORMANCE AND ASSURANCE PROCESSES**

The introduction of the new CMG structure requires a review of our current meeting and performance management arrangements. As is currently the case it is proposed that there will be a Trust Executive Team, a Trust Performance Board and a Strategy Board, however

the executives and senior management at each of these meetings will change slightly to reflect the different agendas under discussion. All CMG Directors will be members of all three groups, thereby significantly altering the balance of membership towards clinical staff.

7.1 CMG Performance Management and Development

The current 'Confirm and Challenge' cycle will be replaced by the following approach:

> ***Monthly Performance meeting*** – held between the senior CMG team (i.e. Director, General Manager, Head of Nursing and relevant leads) and the Chief Operating Officer (Chair), Director of Finance, Chief Nurse, Medical Director and Director of HR. This meeting will have a standard agenda covering quality, performance, finance and workforce.

> ***Quarterly Development meeting*** – held between the senior CMG team (as above) plus their Heads of Service and the Chief Executive (Chair), Chief Operating Officer, Director of Finance, Chief Nurse, Medical Director, Director of HR, Director of Strategy and Director of Marketing and Communications. This meeting will focus on service planning, strategic development, horizon scanning etc.

This will ensure that we maintain strong grip on performance issues whilst at the same time making sure that we dedicate time to discussing development and strategy with a wider group of CMG leaders.

7.2 Assurance and Governance Structures

Once we have the CMG cycle described above in place the main focus will be around a Trust-wide assurance structure, including a more robust structure within which specialist governance committees can operate. Our Chief Nurse, Rachel Overfield, is working on this with colleagues and proposals are being developed.

7.3 Assurance and Escalation Framework

Work has been ongoing as part of the Foundation Trust work programme on the development of an assurance and escalation framework. The above structures should readily be able to form part of that framework, which will be in place before Christmas.

7.4 Timescales for implementation of the new performance and assurance structure

The revised membership of the Executive Team/ Executive Strategy Board/ Executive Performance Board will come into effect for the November cycle of meetings. The first round of CMG Performance meetings should also be held in November, with the first Development meetings taking place in November / December.

8 'Setting the Direction'

A CMG Directors 'Setting the Direction' day is being held on the 1st November with key CMG leaders and the Exective Team to discuss roles and responsibilities; expectations; the quality commitment and working together.

9 KEY TIMESCALES

We continue to move at pace and we are still looking to complete this work by the **18th of November**. The key dates and considerations between now and then are;

1. CMGs officially came in to existence on **Monday 7 October 2013**.
2. As described above work is well underway on the supporting structures like Finance, HR and quality and safety and how they are represented / work with the new CMGs and this is looking to complete by **31st October**.
3. The next level of appointments, i.e. Deputy CMG managers is now concluded. Next steps are being confirmed with the Senior CMG teams, although it is worth noting that on the whole we do not envisage any substantial change to these leadership positions below the Deputy Managers at Service and Operational Manager levels.
4. The CMG Director adverts for professional services and MSK/ Specialist Surgery closed on **13 October** and interviews / appointments are being arranged.

10 CONCLUSION

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

APPENDICES

Appendix 1 – Revised Risk Assessment
Appendix 2 - New Structure Chart

UHL RISK ASSESSMENT FORM				Local Ref. No.	
Title of risk (i.e. There is a risk of/that… resulting in…)	There is a risk that the restructure to seven Clinical Management Groups may, in the short-term, adversely impact upon quality and performance targets.				
Division/Directorate	***Operations***	***Unit***	***All***	***Site***	***All***
Department/Ward	***All***	***Date of Assessment***	***16/09/2013***	***Assurance Source*** (Refer to Datix for reference)	***Risk Assessment***

Description of the risk: List the causes **and the** consequences **of the risk** (Copy & paste to add rows where necessary)

Currently the UHL is organised around 3 clinical divisions; Women's and Children's, Planned Care and Acute Care. The two larger divisions are equivalent in their size, complexity, staff numbers and budgets to large District General Hospitals but they do not have the same clinical, nursing and operational management resource that a large DGH has.

It is proposed that the three Divisions and 12 Clinical Business Units are disestablished and are replaced with seven Clinical Management Groups (CMGs).

The seven new CMGs are:

- Cancer, Haematology, GI Medicine and Surgery
- Emergency and Specialist Medicine
- Musculoskeletal and Specialist Surgery
- Clinical Support Services, Imaging, Medical Physics and Empath
- Cardiac, Renal and Respiratory
- Theatres, Anaesthesia, Pain and Sleep, (ITAPS)
- Women's and Children's

The new structure will provide three key benefits:

1. A simpler structure with fewer layers will support improved working from the Executive Team through to service provision and vice versa. Management visibility will improve with increased clinical engagement and quicker and more effective decision making.

2. Smaller management units, in terms of income, expenditure and staff numbers which will support improved operational 'grip' and clearer management accountability.

3. Improved parity between the comparative size of the units. Currently Women's and Children's is 40% the size of the Acute Care Division. In the proposal, the smallest CMG is 60% the size of the largest CMG.

The proposal is to secure the CMG Management senior posts by the beginning of October and then to work with these teams to ensure their structures are effective to meet the CMG's needs. Any structural changes beneath the CMG management level would follow the UHL Management of Change Policy and consultation would take place with staff and Staff Side. Timescales are subject to review in the light of consultation requirements and the new structure should be fully complete by the 18th of November.

Causes of the Risk Title (hazard)	**Consequences of Risk Title** (harm / loss event)
Current Clinical Divisions are equivalent to large DGHs but they do not have the same clinical, nursing and operational management resource.	Divisional staff may be unsure of their reporting lines and governance structures and therefore may be dips in performance as new structures 'bed-in', in particular around perceived 'lower priority' issues (e.g., incident reporting, CAS, and complaints reporting timescales)
The current management structure does not support effective working nor the level of operational grip required to manage a complex, multi-site, tertiary, teaching Trust.	Information held on Trust reporting databases will require migration to take account of the changes (e.g. Datix: risk register, complaints, claims, incidents, e-UHL, etc).
	Requirement to update UHL policies/ procedural documents to reflect management changes.

	Short-term additional staff stress and potential for increased short-term sickness in the management teams of the existing Divisions and CBUs, as well as those staff who interface with Divisions and CBUs (e.g. Corporate Directorates).
	Business risk including finance and non-achievement of CIPs.
	Mismanagement of patient care

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

The vast majority of staff will be unaffected by this change in terms of day to day working. Effective communication of rationale and changes within and external to clinical divisions (e.g. CEO meetings with divisional managers and divisional staff, local team meetings, briefings in Trust magazine, messages on InSite, UHL PC desktop messages, media briefings).
Role descriptions have been produced for the CMG roles detailed in the new structure and local managers to support staff through change management using established HR processes.
CBUs will remain intact including monitoring and scrutiny of financial (CIP) performance
Performance monitoring against KPIs in place via normal mechanisms including ET/Committees/TB.

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

Risk subtype: Consequence descriptor: select highest score for Datix (Delete subtype if not applicable)	Consequence (C)	x	Likelihood (L)	=	Current Risk Rating
Patients (mismanagement of patient care with long-term effects)	4	x	1 (ie probability <0.1%)	=	4
Quality (treatment or service has significantly reduced effectiveness)	3	x	2	=	6
HR (short-term low staffing level that temporarily reduces service quality) (<1 day)	1	x	3	=	3
Statutory (critical report)	4	x	2	=	8
Reputation (media coverage)	2	x	2	=	4
Business (key objectives not met)	4	x	2	=	8

Action Plan ***List of actions that can be taken to further control the risk*** **(Copy & paste to add rows where necessary)**

Action Plan	Assigned to	Start date	Due date	Completed date	Cost £
CMG officially come in to existence	CMG Directors	Sept 13	7/10/13	7/10/13	
Complete the whole process	Exec Team / CMGs	Sept 13	18/11/13		
Trust reporting and information Databases to be migrated to ensure data previously assigned to Clinical Divisions is assigned to the correct CMG	Operations Directorate / Corporate Directorates / CMGs	Oct 13	18/11/13		
Trust reporting and information Databases to be migrated to ensure data previously assigned to Clinical Divisions is assigned to the correct CMG	Operations Directorate / Corporate Directorates / CMGs	Oct 13	18/11/13		
Continued monitoring and review of performance and proposals for more effective working, when necessary, to be managed at CMG director level and via cross-CMG meetings with outcomes reported to Trust Senior Committees (ET, TB etc)	CMG Directors	Oct 13	Review weekly (ET) & monthly (TB)		
CMG structures to be developed and vacancies to be recruited in to	CMG Senior Management Teams	Sept 13	18/11/13		
CMG top teams to create their new names for the CMGs	CMG Directors	Oct 13	14/10/13		

Corporate supporting structures to be updated (including finance, HR and quality and safety)	CMG Directors	Oct 13	31/10/13		
CBUs will continue to be accountable body for; quality, performance, finance, education, Research and Development and workforce until formal handover to CMG. Exec directors will support and monitor this handover process	Divisonal Directors / CBU Managers / Exec team	Oct 13	18/11/13		
Review how performance and quality issues are monitored and reported (i.e. through weekly /monthly meetings such as ET & the 'Quality and Performance Management Group Meeting')	Exec Team / CMG Senior Management Teams	Oct 13	Review at ET/ QPMG		
Update senior manager on call rota	Jane Edyvean & Sarah Taylor	Oct 13	21/10/13		
LIA workshops to ensure colleagues have the opportunity to share their thoughts on what has worked well in the current structure so we can build on the strengths going forward	LIA Manager	Oct 13	Oct/Nov/ Dec 13		
Development session with CMG Directors/leads re 'Setting Direction' to agree roles, expectations; quality and working together.	Exec team	1st November 13	Nov 13		

Target Risk Rating (with the proposed actions listed above in place)

Risk subtype: Consequence descriptor (Delete subtype if not applicable)	Consequence (C)	x	Likelihood (L)	=	Target Risk Rating
Patients (mismanagement of patient care with long-term effects)	4	x	1 (i.e. probability <0.1%)	=	4
Quality (treatment or service has significantly reduced effectiveness)	3	x	2	=	6
HR (short-term low staffing level that temporarily reduces service quality) (<1 day)	1	x	2	=	2
Statutory (critical report)	4	x	2	=	8
Reputation (media coverage)	2	x	2	=	4
Business (key objectives and financials not met)	4	x	2	=	8

Risk Assessment Approval ***(prior to the entry being input on to Datix)***

Risk Assessor name	Richard Mitchell, COO	**Signature**		**Initial Date**	16/09/13
Line Manager name	Chief Executive	**Signature**		**Date**	

NOTE: This Risk Assessment form must be approved by the clinical division / corporate directorate board prior to being entered on to the Datix risk register

Approved by: name	Trust Board (Sept 2013)	**Signature (to confirm)**	See TB action notes/ minutes	**Date**	26/09/13

Risk Review Details

1st Review Date	Risk Assessment reviewed at TB - 26/09/13: RA updated to include impact on achievement of CIPs / business risks including finance (control measures in place to mitigate this risk) and further actions included.

Scoring Guidance:

Consequence score (impact of cause / hazard) and example of descriptors					
Risk Subtype	1	2	3	4	5
	Insignificant	**Minor**	**Moderate**	**Major**	**Extreme**
PATIENTS (Consequence on the safety of patients physical/ psychological harm)	Minimal injury requiring no/minimal intervention or treatment.	Minor injury or illness, requiring minor intervention Increase in length of hospital stay by 1-3 days	Moderate injury requiring professional intervention Increase in length of hospital stay by 4-15 days RIDDOR/agency reportable incident An event which Consequences on a small number of patients	Mismanagement of patient care with long-term effects Increase in length of hospital stay by >15 days	Incident leading to death Multiple permanent injuries or irreversible health effects An event which Consequences on a large number of patients
INJURY Consequence on the safety of staff or public physical/ psychological harm)	Minimal injury requiring no/minimal intervention or treatment. No time off work	Minor injury or illness, requiring minor intervention Requiring time off work for <3 days	Moderate injury requiring professional intervention Requiring time off work for 4-14 days RIDDOR/agency reportable incident	Major injury leading to long-term incapacity/disability Requiring time off work for >14 days	Incident leading to death Multiple permanent injuries or irreversible health effects
QUALITY Quality/ complaints/ audit	Peripheral element of treatment or service suboptimal Informal complaint/ inquiry	Overall treatment or service suboptimal Formal complaint (stage 1) Local resolution Single failure to meet internal standards Minor implications for patient safety if unresolved Reduced performance rating if unresolved	Treatment or service has significantly reduced effectiveness Formal complaint (stage 2) complaint Local resolution (with potential to go to independent review) Repeated failure to meet internal standards Major patient safety implications if findings are not acted on	Non-compliance with national standards with significant risk to patients if unresolved Multiple complaints/ independent review Low performance rating Critical report	Totally unacceptable level or quality of treatment/ service Gross failure of patient safety if findings not acted on Inquest/ombudsman inquiry Gross failure to meet national standards
HUMAN RESOURCES (Human resources/ organisational development/ staffing/ competence)	Short-term low staffing level that temporarily reduces service quality (< 1 day)	Low staffing level that reduces the service quality	Late delivery of key objective/ service due to lack of staff Unsafe staffing level or competence (>1 day) Low staff morale Poor staff attendance for mandatory/key training	Uncertain delivery of key objective/service due to lack of staff Unsafe staffing level or competence (>5 days) Loss of key staff Very low staff morale No staff attending mandatory/ key training	Non-delivery of key objective/service due to lack of staff Ongoing unsafe staffing levels or competence Loss of several key staff No staff attending mandatory training /key training on an ongoing basis
STATUTORY (Statutory duty/ inspections)	No or minimal Consequence or breech of guidance/ statutory duty	Breech of statutory legislation Reduced performance rating if unresolved	Single breech in statutory duty Challenging external recommendations/ improvement notice	Enforcement action Multiple breeches in statutory duty Improvement notices Low performance rating Critical report	Multiple breeches in statutory duty Prosecution Complete systems change required Zero performance rating Severely critical report
REPUTATION (Adverse publicity/ reputation)	Rumors Potential for public concern	Local media coverage – short-term reduction in public confidence Elements of public expectation not being met	Local media coverage – long-term reduction in public confidence	National media coverage with <3 days service well below reasonable public expectation	National media coverage with >3 days service well below reasonable public expectation. MP concerned (questions in the House) Total loss of public confidence
BUSINESS (Business objectives/ projects)	Insignificant cost increase/ scheduled slippage	<5 per cent over project budget Scheduled slippage	5–10 per cent over project budget Scheduled slippage	Non-compliance with national 10–25 per cent over project budget Schedule slippage Key objectives not met	Incident leading >25 per cent over project budget Schedule slippage Key objectives not met
ECONOMIC (Finance	Small loss	Loss of 0.1–0.25 per cent of budget	Loss of 0.25–0.5 per cent of budget	Uncertain delivery of key objective/Loss of	Non-delivery of key objective/ Loss of >1 per

including claims)	Risk of claim remote	Claim less than £10,000	Claim(s) between £10,000 and £100,000	0.5–1.0 per cent of budget Claim(s) between £100,000 and £1 million Purchasers failing to pay on time	cent of budget Failure to meet specification/ slippage Loss of contract / payment by results Claim(s) >£1 million
TARGETS (Service/ business interruption)	Loss/interruption to service of >1 hour	Loss/interruption to service of >8 hours	Loss/interruption to service of >1 day	Loss/interruption to service of >1 week	Permanent loss of service or facility
ENVIRONMENT (Environmental Consequence)	Minimal or no Consequence on the environment	Minor Consequence on environment	Moderate Consequence on environment	Major Consequence on environment	Catastrophic Consequence on environment

How to assess likelihood:

When assessing 'likelihood' it is important to take into consideration the controls already in place. The likelihood score is a reflection of how likely it is that the risk described will occur with the current controls. Likelihood can be scored by considering:

- The frequency (i.e. how many times will the adverse consequence being assessed actually be realised?) or
- The probability (i.e. what is the chance the adverse consequence will occur in a given reference period?)

Likelihood and Risk score

The risk score is calculated by multiplying the consequence score by the likelihood score.

	← Consequence →				
Likelihood	**1**	**2**	**3**	**4**	**5**
↓	**Insignificant**	**Minor**	**Moderate**	**Major**	**Extreme**
1 Rare This will probably never happen/recur. Or Not expected to occur for years. Or Probability: <0.1%	**1**	**2**	**3**	**4**	**5**
2 Unlikely Do not expect it to happen/recur but it is possible it may do so. Or Expected to occur at least annually. Or Probability: 0.1-1%	**2**	**4**	**6**	**8**	**10**
3 Possible Might happen or recur occasionally. Or Expected to occur at least monthly. Or Probability: 1-10%	**3**	**6**	**9**	**12**	**15**
4 Likely Will probably happen/recur but it is not a persisting issue. Or Expected to occur at least weekly. Or Probability: 10-50%	**4**	**8**	**12**	**16**	**20**
5 Almost certain Will undoubtedly happen/recur, possibly frequently. Or Expected to occur at least daily. Probability: >50%	**5**	**10**	**15**	**20**	**25**

RISK RATING (SCORE)	*ACTION REQUIRED*
Low (1 – 6)	-Acceptable risk requiring no immediate action. Review annually.
Moderate (8 – 12)	-Action planned within six months; commenced within 6 months. Review in 3 months. Place on risk register.
High (15 – 20)	-Action planned within three months; commenced within 3 months. Review at monthly intervals. Place on risk register.
Extreme (25)	-Action planned and implemented ASAP. Review weekly. Place on risk register.

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST – MANAGEMENT STRUCTURE

16 October 2013

Acting Chairman
Richard Kilner

Chief Executive
John Adler

Executive Directors

Medical Director
Kevin Harris

Deputy Medical Directors
Andrew Furlong
Pete Rabey
Associate Director s
Beverley Collett (Clinical Effectiveness)
Nigel Brunskill (Research and Development)
Sue Carr, (Clinical Education)
Jaydip Banerjee (Clinical Quality & Improvement)
Steve Jackson (Chief Medical Information Officer)
Tim Bourne (Chief Medical Information Officer)
Assistant Medical Directors
Sanjay Agrawal (Senior Medical Development)
Peter Furness (Enhanced Appraisal & Revalidation)
Andrew St John (Primary Care Services)
Assistant Director of Research & Development
David Hetmanski

Director of Finance & Business Services
Andrew Seddon

Deputy Director of Finance
Simon Sheppard
Dept Head
Lucy Wall(acting)
Head of Procurement
Andrea Smith
Financial Controller
Nick Sone

Chief Information Officer
John Clarke

Head of Projects and Programmes
Liz Simons

Head of Operations
Dave Smith

Chief Nurse
Rachel Overfield

Director of Nursing
Carole Ribbins
Assistant Director Of Nursing
Eleanor Meldrum
Julia Ball
Lead Nurse Infection Prevention & Control
Liz Collins
Director Safety & Risk
Moira Durbridge
Director of Clinical Quality
Sharron Hotson

Managing Director NHS Horizons
Andrew Chatten

Deputy Managing Director
Andy Powell

Assistant Director
Nigel Bond

Chief Operating Officer
Richard Mitchell

Head of Operations
Phil Walmsley
Head of Performance Improvement
Charlie Carr

Associate Directors of the Trust Board

Director of Strategy
Kate Shields (wef 4/11/13)

Heads of Improvement and Innovation
Debra Mitchell
Suzanne Khalid
Head of Planning and Business Development
Helen Seth
Head of Information
John Roberts
Programme Manager FT Application
Helen Harrison
Head of Strategic Projects
Nicky Topham/
Rachel Griffiths

Director of Human Resources
Kate Bradley

Deputy Director
Emma Stevens
Head of Service Occupational Health
Anne De Bono
LiA Lead
Michelle Cloney
Assistant Director of Learning and OD
Bina Kotecha
Senior Project Manager
Pete Rogers

Director of Corporate & Legal Affairs
Stephen Ward

Assistant Director

Steve Murray

Director of Marketing & Communications
Mark Wightman

Head of Communications
Tiffany Jones

Head of Services for GP's
Liz Sahu

Head of Fundraising
Tim Diggle

Non Executive Directors

Ian Crowe
Kiran Jenkins
Richard Kilner
Prakash Panchal
Ian Sadd
Jane Wilson
Prof David Wynford-Thomas

CLINICAL MANAGEMENT GROUP STRUCTURE

Cancer, Haematology, Palliative Medicine, GI Medicine and Surgery

CMG Clinical Director
John Jameson
CMG Deputy Clinical Director
Nicky Rudd
CMG General Manager
Jo Fawcus
CMG Deputy General Manager
Michael Nattrass
CMG Head of Nursing
Georgina Kenney
CMG Deputy Head of Nursing
Kerry Johnston
CMG Human Resources Lead
Clare Blakemore
CMG Finance Lead
Sab Esat
CMG Quality & Safety Lead
TBC
CMG Education Lead
TBC
CMG Research & Development Lead
TBC

Emergency and Specialist Medicine

CMG Clinical Director
Catherine Free
CMG Deputy Clinical Director
TBC
CMG General Manager
Jane Edyvean
CMG Deputy General Manager
TBC
CMG Head of Nursing
Gill Staton
CMG Deputy Head of Nursing
Lisa Lane/Kerry Morgan
CMG Human Resources Lead
Kalwant Khaira
CMG Finance Lead
Raj Rughani
CMG Quality & Safety Lead
TBC
CMG Education Lead
TBC
CMG Research & Development Lead
TBC

Musculoskeletal and Specialist Surgery

CMG Clinical Director
TBC
CMG Deputy Clinical Director
Kevin Boyd
CMG General Manager
Sarah Taylor
CMG Deputy General Manager
Chris Lyon
CMG Head of Nursing
Nicola Grant
CMG Deputy Head of Nursing
Kerry Pape
CMG Human Resources Lead
Joanne Tyler Fantom
CMG Finance Lead
Ryggs Gill
CMG Quality & Safety Lead
TBC
CMG Education Lead
TBC
CMG Research & Development Lead
TBC

Professional Services, Imaging, Medical Physics and EMPATH

CMG Clinical Director
TBC
CMG Deputy Clinical Director
TBC
CMG General Manager
Nigel Kee
CMG Deputy General Manager
Chris Shatford
CMG Head of Nursing
Jeanette Halborg
CMG Human Resources Lead
Joanne Tyler Fantom
CMG Finance Lead
Tony Maton
CMG Quality & Safety Lead
TBC
CMG Education Lead
TBC
CMG Research & Development Lead
TBC

Cardiac, Renal and Respiratory

CMG Clinical Director
Nick Moore
CMG Deputy Clinical Director
Leon Hadjinkolaou
CMG General Manager
Luci Blackwell (Sam Leak Nov 13)
CMG Deputy General Manager
Faye Gordon
CMG Head of Nursing
Sue Mason
CMG Deputy Head of Nursing
Jo Bayes
CMG Human Resources Lead
Clare Blakemore
CMG Finance Lead
Lorraine Bentley
CMG Quality & Safety Lead
TBC
CMG Education Lead
TBC
CMG Research & Development Lead
TBC

Critical Care, Theatres, Anaesthetics, Pain and Sleep (ITAPS)

CMG Clinical Director
Paul Spiers
CMG Deputy Clinical Director
TBC
CMG General Manager
Monica Harris
CMG Deputy General Manager
Dale Travis
CMG Head of Nursing
Jo Hollidge
CMG Human Resources Lead
Kalwant Khaira
CMG Finance Lead
Paul Gowdridge
CMG Quality & Safety Lead
TBC
CMG Education Lead
TBC
CMG Research & Development Lead
TBC

Women's and Children's

CMG Clinical Director
Ian Scudamore
CMG Deputy Clinical Director
Andy Currie
CMG General Manager
David Yeomanson
CMG Deputy General Manager
TBC
CMG Head of Nursing
Kate Wilkins
Hilliary Killer
CMG Deputy Head of Nursing
Elizabeth Aryeetey
CMG Head of Midwifery
Jane Porter
CMG Human Resources Lead
Tina Larder
CMG Finance Lead
Stuart Shearing
CMG Quality & Safety Lead
TBC
CMG Education Lead
TBC
CMG Research & Development Lead
TBC

W

Trust Board Paper W

To:	Trust Board
From:	Medical Director
Date:	22nd October 2013
CQC Regulation:	

Title	**R&D in UHL: Quarterly report**

Author/Responsible Director: **Director of R&D/Medical Director**

Purpose of the Report: **To inform the board of current activity and challenges in R&D**

The Report is provided to the Board for:

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

Summary / Key points:
UHL has an extensive R&D portfolio and is recognised nationally and international for excellence in many of its areas. This report is a high level summary of R&D activities in UHL and considers current challenges

Recommendations:
The Board is invited to consider this summary and recommend contents and format of future reports.

Previously considered at another corporate UHL Committee?
No

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

Resource Implications (eg Financial, HR);

Assurance Implications:

Patent and Public Involvement (PPI) Implications:

Stakeholder Engagement Implications:
Equality Impact:
Information exempt from Disclosure:
Requirement for further review: Quarterly

1. Introduction

1.1. The R&D Committee is an executive committee and the Board receives formal quarterly R&D reports.

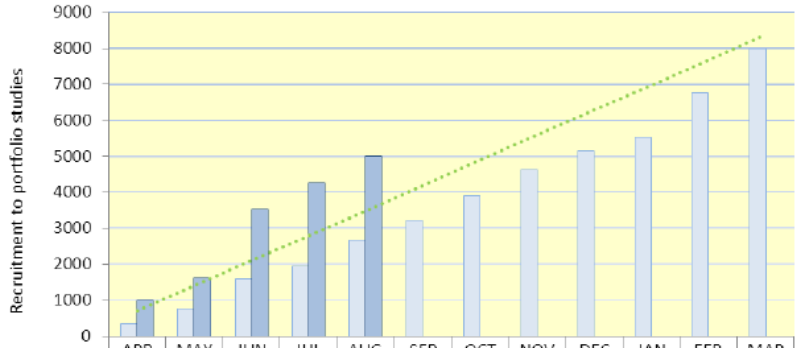
1.2. This is the second report since the R&D Committee became an executive committee and this report comprises a summary of the current situation and any present challenges.

2. Major Strengths

2.1. *Significant output of high-class clinical research activity.* NIHR Central Commissioning Facility ranks UHL in the first division (out of four) for the numbers of new clinical trials (111) reported in Q1 2013/14. Currently UHL has 791 active trials with a target of 961 for the year (82%), of which 515 are NIHR Portfolio studies. In relation to portfolio trials UHL is exceeding its target recruitment rate, having currently recruited 5505 patients against a year-end target of 8381 (see graphic below taken from latest CLRN activity report – full report circulated for information)

2.1 2013/14 UHL recruitment against target (NPM 1a.2)

Figure 2.1 provides a cumulative monthly breakdown of reported participant recruitment in portfolio studies by financial year for 2012/13 and 2013/14 year to date (YTD). The chart also shows how well UHL is recruiting towards the 2013/14 recruitment target.



	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	JAN	FEB	MAR
2012-13 Recruitment	336	769	1596	1937	2662	3222	3912	4618	5158	5530	6756	7982
2013-14 Recruitment	985	1614	3514	4246	4996							
2013-14 Target	698	1397	2095	2794	3492	4191	4889	5587	6286	6984	7683	8381

Figure 2.1: UHL recruitment by month and financial year (2012/13 and 2013/14)

2.2. *Excellent R&D approvals systems.* Study approval times continue to be amongst the best in the UK, in Q1 2013/14 the median number of calendar days for Trusts approval was 1 day (national target 30 days). Our research management team are frequently asked to share best practice with other Trusts. The most recent data (Q1 2013/14) show that we are one of the best Trusts for recruiting patients to time and target.

2.3. *Most of our leading research is innovative and of direct relevance to patient care, outcomes and service delivery.* It addresses detection, prevention and management of common long-term conditions: (i) cardiovascular disease e.g. genetics, hypertension , novel interventions, arrhythmias, stroke, vascular surgery; (ii) respiratory disease e.g. asthma, chronic obstructive

pulmonary disease, pulmonary rehabilitation; (iii) diabetes, e.g. prevention, early detection, management; (iv) cancer e.g. early phase trials, biomarkers, prevention, novel treatments; (v) influence of nutrition, exercise and lifestyle on long-term conditions. UHL won the Most Innovative Trust Award at the Health Enterprise East Awards Evening, October 2013.

2.4. *Other services participate in clinical research (including multicentre NIHR portfolio studies).* These include: neonatal medicine and outcomes; renal disease, infectious disease; child heath; care of the elderly; intensive care medicine; medical genetics, gastroenterology; dermatology; ophthalmology; medical genetics; emergency medicine; health services research; endocrinology, orthopaedics, musculoskeletal medicine; pain medicine.

2.5. *The Trust hosts several NIHR institutions:*

2.5.1. Three Biomedical Research Units (BRU): (i) Cardiovascular BRU (with University of Leicester): (ii) Respiratory Disease (with University of Leicester); (iii) Nutrition, Diet and Lifestyle (with Loughborough University & University of Leicester). Consequently, UHL hosts more BRUs than any other Trust outside of London, Oxford and Cambridge. All three BRUs recently submitted annual reports to NIHR. Subsequent feedback on these reports from NIHR was very positive eg. *'BRU to be commended…'*, *'..good examples of top achievements…'* , '*BRU is to be congratulated on an impressive and interesting range…*'.

2.5.2. *NIHR Collaboration for Leadership in Applied Health Research and Care for* Leicestershire, Northamptonshire & Rutland *(CLAHRC-LNR).* In 2008, UHL and partners were successful in bidding to lead CLAHRC-LNR. Implemented CLAHRC-LNR projects have shaped NHS services locally, nationally and internationally. Considered by external reviewers and the NIHR to be highly successful, CLAHRC-LNR substantially contributed to the recent successful new award of CLAHRC-East Midlands.

2.5.3. *Experimental Cancer Medicine Centre.* This centre which develops novel therapeutic strategies to treat cancer, including haematological malignancies.

2.5.4. *NIHR Research Networks.* These provide financial and managerial support for the delivery of NIHR funded or approved clinical trials ("portfolio trials"). UHL has been chosen in October 2013 to host the newly established East Midlands Clinical Research Network. The new network Clinical Director will be appointed in November 2013.

2.5.5. *NIHR Clinical Trials Unit* – hosted by University of Leicester but very significant for UHL R&D, received full NIHR accreditation in October 2013.

2.5.6. *Recent establishment of new Clinical Research Facilities (CRF)*. These include: Cardiovascular BRU CRF (Glenfield); oncology CRF (Hope Unit, LRI); CRF and diabetes centre (LGH); respiratory CRF (Glenfield).

2.6. *Effective patient and public involvement (PPI) in research.* We receive frequent positive feedback from external sources on our PPI policy and achievements. However, we are constantly seeking to extend and improve this further.

3. Current challenges

3.1. We need to support the BRUs in achieving their stated objectives. Also, we must ensure that they develop in a way that enables a credible application for NIHR Biomedical Research Centre status in the next round.

3.2. We have been major partners in the East Midlands Academic Health Sciences Cluster group which has led directly to the successful East Midlands Academic Health Sciences Network (AHSN) application and licence to operate (June 2013). It is important that we continue to play a major role in the development of the AHSN.

3.3. Historically, we have had an over-reliance on a small number of academic and industry partners. This has improved significantly e.g. collaborations with Loughborough University and the National Centre for Sports and Exercise Medicine. These must be maintained and develop further. Our relationship with the University of Leicester is excellent but is constantly evolving for mutual benefit. It is important that this relationship is maintained.

3.4. The numbers of patients recruited to NIHR portfolio clinical trials is a high profile target. Since its inception, UHL has always met or over performed on this target. Early data for this financial year are encouraging but we have more work to do to give UHL the best chance of achieving the target this year (see CLRN report). Constant vigilance is required to ensure these targets are met.

3.5. Challenging timelines and quality standards for R&D are being set by national and commercial bodies. Historically, we have scored well on the metrics e.g. study approval times. However, the new metrics (e.g. time from application to first patient recruited) are more challenging. Much of our time is now dedicated to delivering on these.

3.6. We must concentrate on our major research programmes described above. However we need to work with the new Clinical Management Group structure in UHL to foster and embed R&D culture throughout the organisation.

3.7. Presently, there are some support services within UHL which may limit our ability to delivery UHL's R&D potential. We are working constructively with colleagues and new working groups have been established to support this.

4. Report from the Leicestershire, Northamptonshire and Rutland CLRN

4.1. The CLRN provides quarterly reports to partner trusts on NIHR portfolio clinical trials performance. The latest report is included with this paper. This report is been considered by the R&D Executive Committee and will be presented with our quarterly reports to the Board (a requirement in order to qualify for NIHR funding).

5. Conclusion

5.1. This report is a high level summary of the present situation. We welcome suggestions from the Board on the content and format of future R&D reports.

Leicestershire, Northamptonshire and Rutland
Comprehensive Local Research Network

NHS
National Institute for Health Research

University Hospitals of Leicester NHS Trust

Monthly Activity Report

Report Date: **11 October 2013**
Data Sourced: 30 September 2013

Welcome to the monthly NIHR portfolio activity report for your trust. This report contains information on 2013/14 recruitment and performance measures.

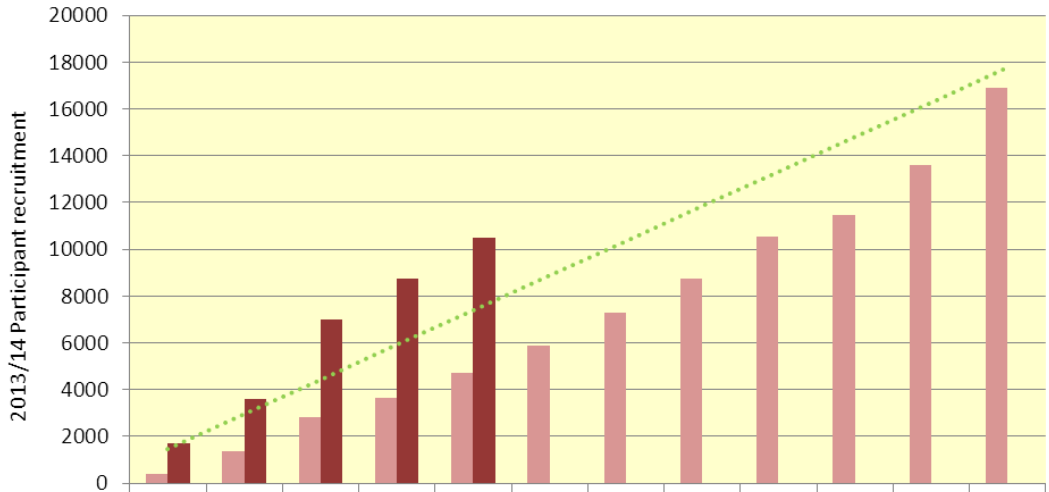
The table below is a snapshot of LNR CLRN member trusts and stakeholder organisations, progress measured against National and Local Performance Measures (N/LPMs). The table also states the corresponding chart within the report. This contains network-wide information, as well as individual information for your organisation.

Recruitment Criteria						
13/14 YTD RAG %	**Trust**	**YTD Recruitment**	**Annual Target**	**NPM/LPM**	**Description**	**Chart**
134.77%	**UHL**	**4,996**	**8,381**	**NPM 1a.1**	**Progress towards 13/14 recruitment target**	**1.2 2.1**
76.18%	KGH	371	1,101	NPM 1a.2	Progress towards 13/14 recruitment target	1.2
149.73%	LPT	351	530	NPM 1a.4	Progress towards 13/14 recruitment target	1.2
108.59%	NGH	609	1,268	NPM 1a.3	Progress towards 13/14 recruitment target	1.2
106.34%	NHfT	254	540	NPM 1a.5	Progress towards 13/14 recruitment target	1.2
190.74%	LRPC	3,222	3,819	NPM 1a.6a	Progress towards 13/14 recruitment target	1.2
73.30%	NPC	688	2,122	NPM 1a.6b	Progress towards 13/14 recruitment target	1.2
133.54%	LNR CLRN	10,491	17,761	NPM 1a	5% increase in recruitment (2012/13 to 2013/14)	1.1
Time and Target Criteria - Network-wide						
60%	LNR	N/A	80%	NPM 2b	% of Non-Commercial Studies (Closed) recruiting to Time and Target in LNR	1.3
73%	LNR	N/A	80%	NPM 2a.1	% of Commercial Studies (CCRN-Closed) recruiting to Time and Target in LNR	1.3
39%	LNR	N/A	80%	NPM 2a.2	% of Commercial Studies (CCRN-Open) recruiting to Time and Target in LNR	1.3
60%	LNR	N/A	80%	LPM 8.3	% of Non-Commercial Studies (Open) recruiting to Time and Target in LNR	1.3
First Patient First Visit (FPFV) - Network-wide						
13/14 YTD RAG %	**Area**	**2013/14 National Target**	**NPM/LPM**	**Description**		**Table**
22%	LNR	80%	NPM 4c	NHS Permission to first patient recruited in a trial (<=30 days) in median calendar days for >=80% for all studies		1.4
32%				NHS Permission to first patient recruited in a trial (<=30 days) in median calendar days for >=80% for CCRN-led studies		
Research Management and Governance Criteria - Network-wide						
Percent	**Area**	**2013/14 National Target**	**NPM**	**Description**		**Chart**
93%	LNR	80%	NPM 4a	Study-wide checks completed within 30 calendar days		1.5
100%	LNR	80%	NPM 4b	Local checks completed within 30 calendar days		1.5

Section 1—Research Network Overview

1.1 LNR CLRN recruitment against recruitment target (NPM 1a)

Figure 1.1 provides a monthly breakdown of reported participant recruitment in portfolio studies by financial year. This includes data from 2012/13 and 2013/14 year to date (YTD). The chart also shows how well LNR CLRN is recruiting towards the overall 2013/14 recruitment target of 17,761 participants.



	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	JAN	FEB	MAR
2012/13 Recruitment	408	1382	2809	3670	4699	5891	7306	8740	10563	11453	13577	16915
2013/14 Recruitment	1710	3589	7010	8768	10491							
2013/14 Target	1480	2960	4440	5920	7400	8881	10361	11841	13321	14801	16281	17761

Figure 1.1: LNR CLRN recruitment by month and financial year (2012/13 and 2013/14)

1.2 LNR CLRN progress towards recruitment target by member organisation (NPM 1a.1-6b and 5a)

Figure 1.2 illustrates how well LNR CLRN and member organisations are recruiting towards their 2013/14 YTD recruitment targets.

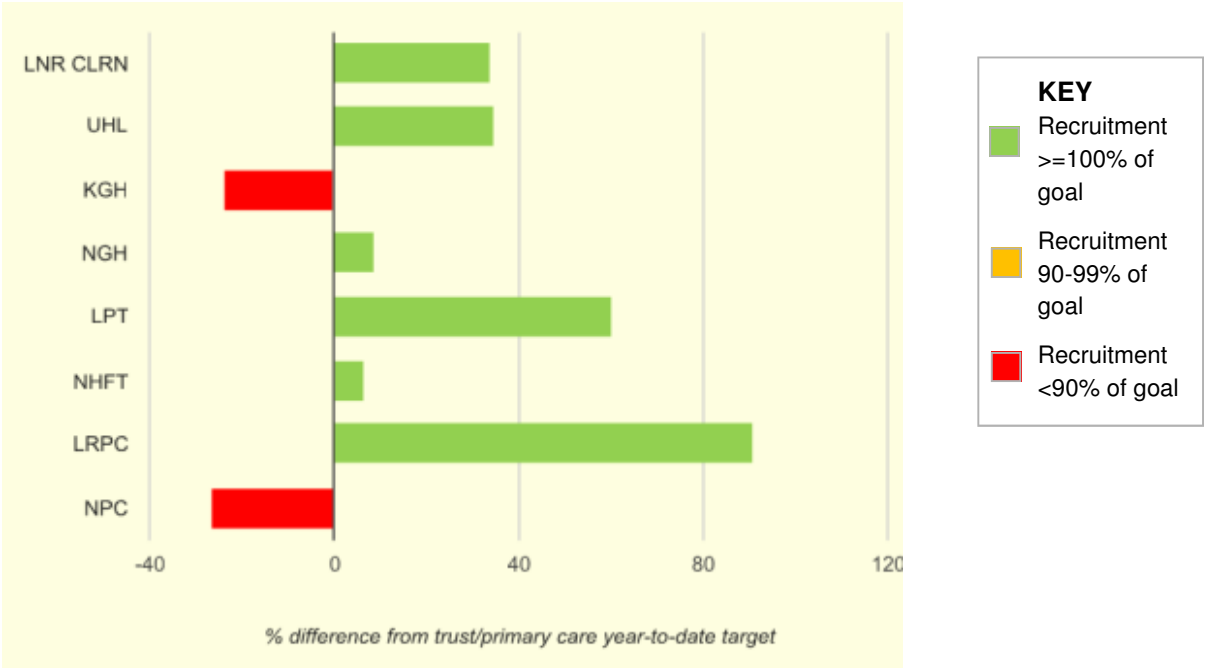
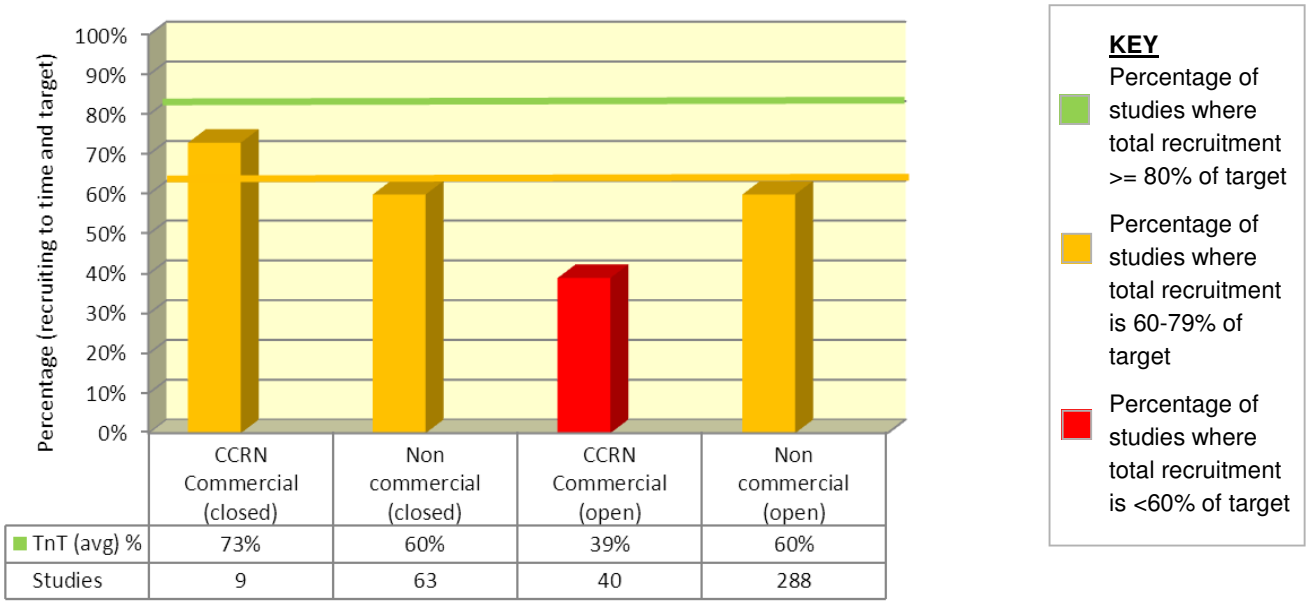


Figure 1.2: Percentage difference between 2013/14 YTD recruitment and YTD recruitment target by Member Organisation

1.3 LNR CLRN recruiting to time and target (NPM 2a.1, 2a.2, 2b and LPM 8.3)

LNR CLRN are performance managed on delivering all portfolio studies to time and target. We have three national performance measures (NPM) and one local performance measure (LPM) to monitor our progress. There are NPMs for open and closed studies for 80% of CCRN commercial portfolio studies to achieve their recruitment targets. The third NPM is for non-commercial studies and is measured at study closure. Open non-commercial studies are monitored locally and have an LPM also set at 80%, to ensure that they are recruiting to time and target throughout the study. Figure 1.3 shows data for all open study sites and those that have closed since 1 April 2013.



	CCRN Commercial (closed)	Non commercial (closed)	CCRN Commercial (open)	Non commercial (open)
TnT (avg) %	73%	60%	39%	60%
Studies	9	63	40	288

Figure 1.3: Percentage of LNR CLRN studies recruiting to time and target 2013/14 YTD

1.4 First Patient First Visit (FPFV) (NPM 4c)

LNR CLRN collects data on the number of days a study site takes to recruit a participant once NHS permission has been granted or site initiation is complete. In 2013/14, CLRNs are performance managed (NPM 4c) on ensuring that study sites recruit their first patients within 30 days of NHS permission or site initiation.

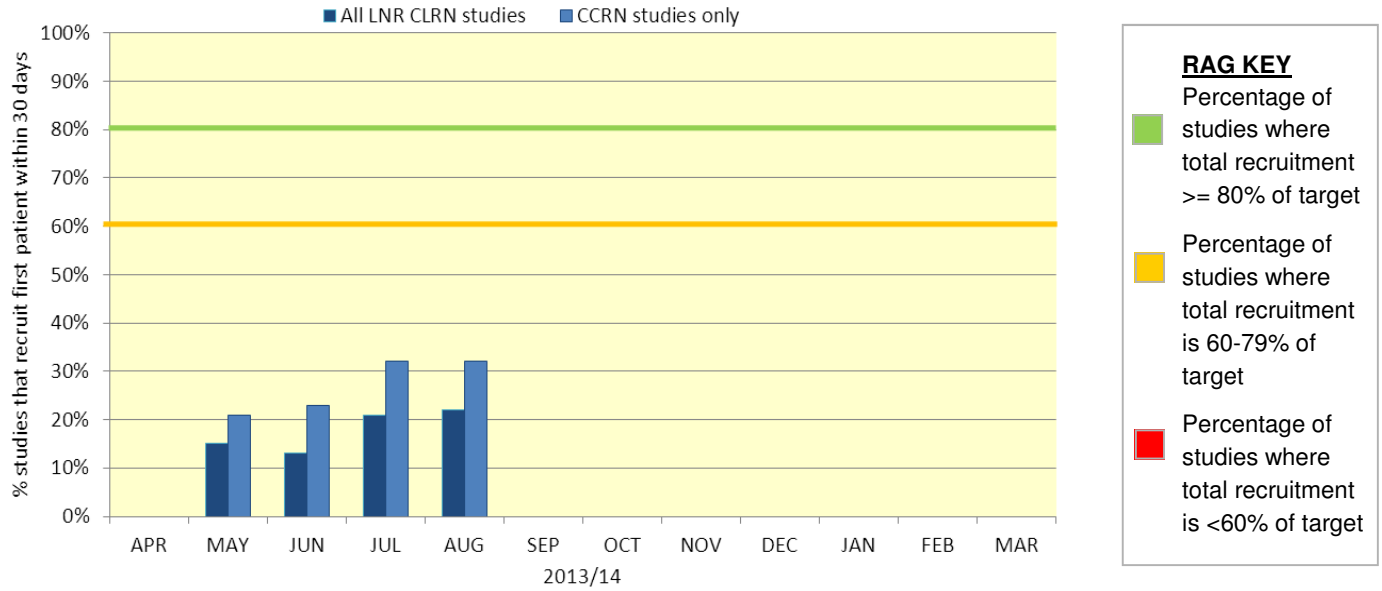


Figure 1.4: LNR CLRN performance against First Patient First Visit metrics 2013/14

1.5 Research Management and Governance (RM&G) (NPM 4a and 4b)

All CLRNs are performance measured on the time taken to complete study-wide and local site checks. This is to ensure that studies receive NHS permission as quickly as possible. The measure is for 80% of studies to have all checks completed within 30 calendar days. Figure 1.5 shows the percentage of studies approved each month that have had their study checks completed within 30 calendar days.

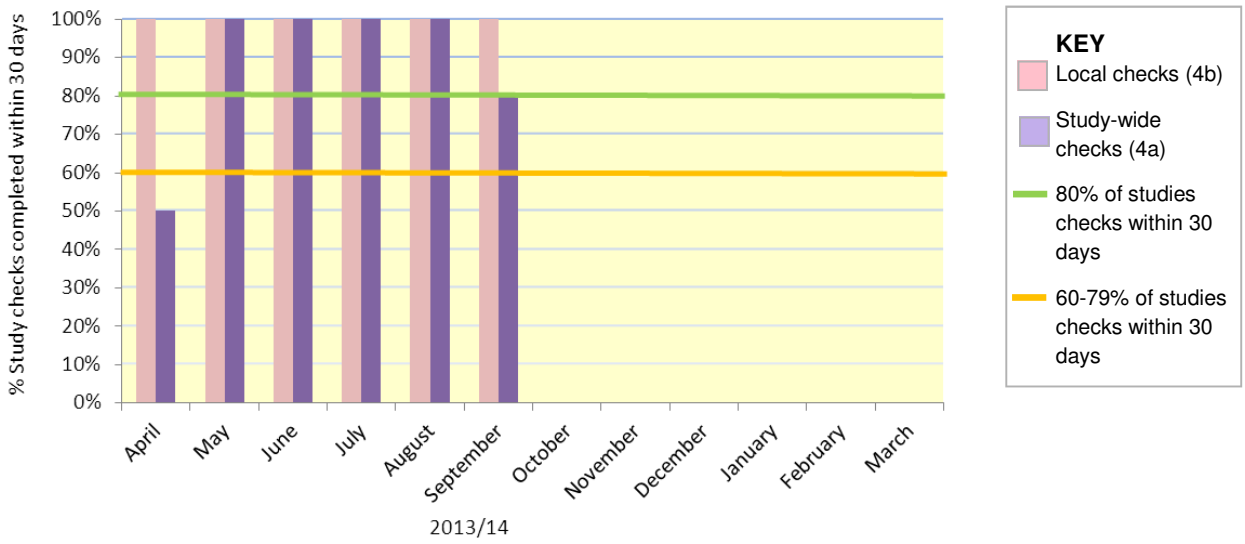


Figure 1.5: LNR CLRN RM&G performance against national metrics 2013/14

1.6 LNR CLRN funding

Figure 1.6a shows the percentage of funding allocated to member trusts and primary care (PC) in 2013/14. Figure 1.6b shows 2013/14 trust/primary care recruitment as a percentage of total LNR CLRN recruitment.

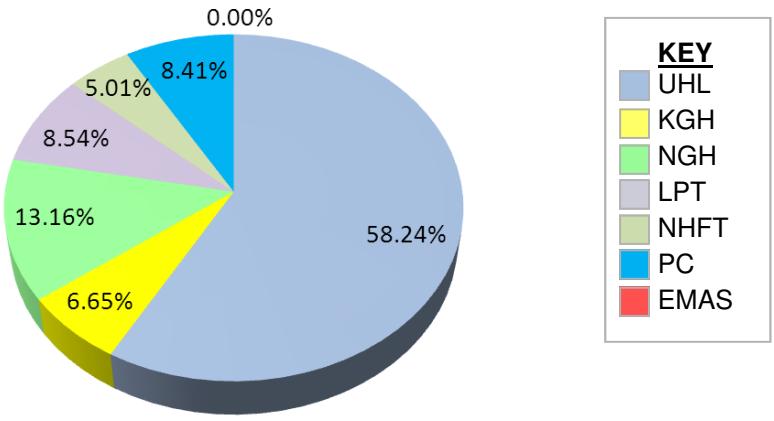


Figure 1.6a: LNR CLRN 2013/14 funding by trust

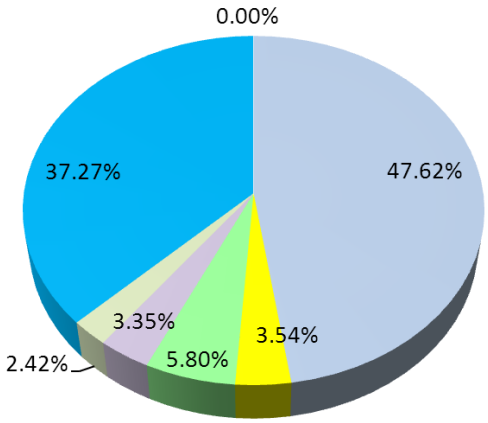


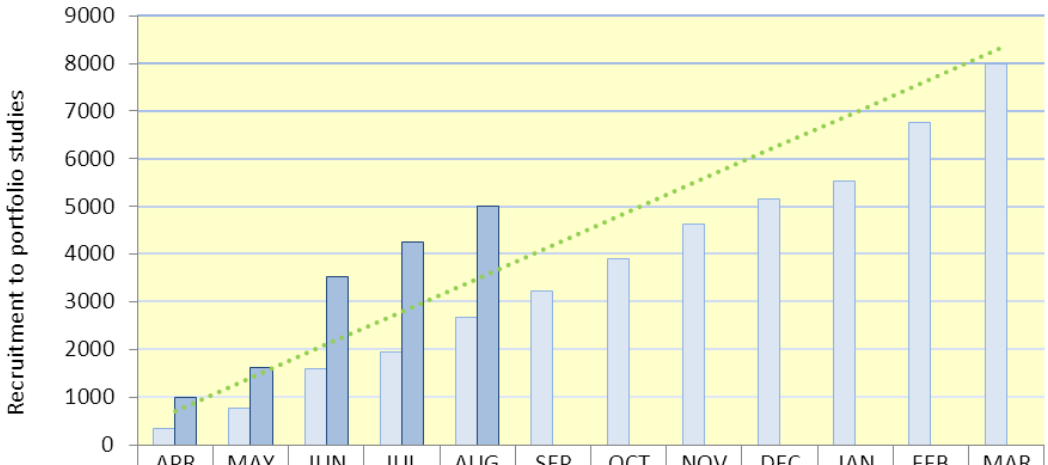
Figure 1.6b: LNR CLRN 2013/14 recruitment by trust

Note: The funding percentage for UHL is skewed as they host three research networks which provide support across a range of other NHS trusts in the region. Some of the funding shown for UHL is utilised in cross network coordinating functions of the South East Midlands Diabetes Research Network, LNR Cancer Research Network and Trent Stroke Network. At present, funding for primary care is considered as a total allocation, rather than by county, in line with the way recruitment is currently reported to us by the NIHR. Primary care funding also includes funding provided to the East Midlands and South Yorkshire Primary Care Research Network (EMSY PCRN). Please note that these figures do not take account of referrals from participant identification centres (PICs) to other sites where the recruitment actually takes place.

Section 2—Trust level information

2.1 2013/14 UHL recruitment against target (NPM 1a.2)

Figure 2.1 provides a cumulative monthly breakdown of reported participant recruitment in portfolio studies by financial year for 2012/13 and 2013/14 year to date (YTD). The chart also shows how well UHL is recruiting towards the 2013/14 recruitment target.



	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	JAN	FEB	MAR
2012-13 Recruitment	336	769	1596	1937	2662	3222	3912	4618	5158	5530	6756	7982
2013-14 Recruitment	985	1614	3514	4246	4996							
2013-14 Target	698	1397	2095	2794	3492	4191	4889	5587	6286	6984	7683	8381

Figure 2.1: UHL recruitment by month and financial year (2012/13 and 2013/14)

2.2 UHL 2013/14 recruitment by Topic Network and CCRN Specialty Group

Figure 2.2 looks at UHL recruitment by topic network and specialty group. For studies that have been formally co-adopted, recruitment has been counted for all relevant topic networks and specialty groups. Therefore, recruitment may have been counted more than once.

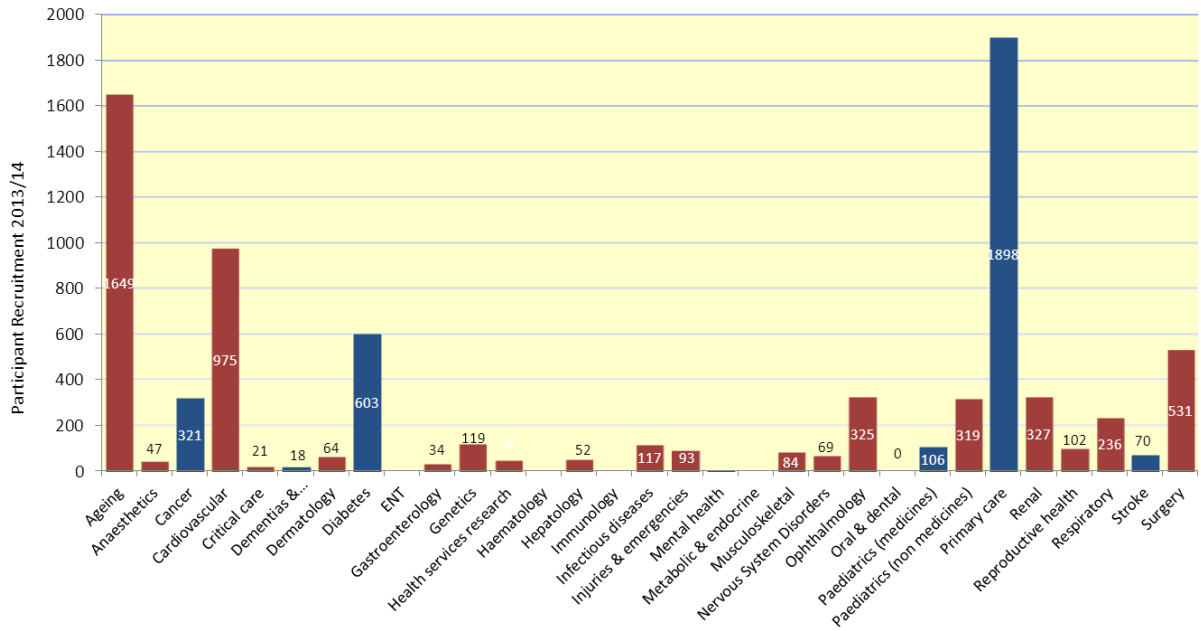
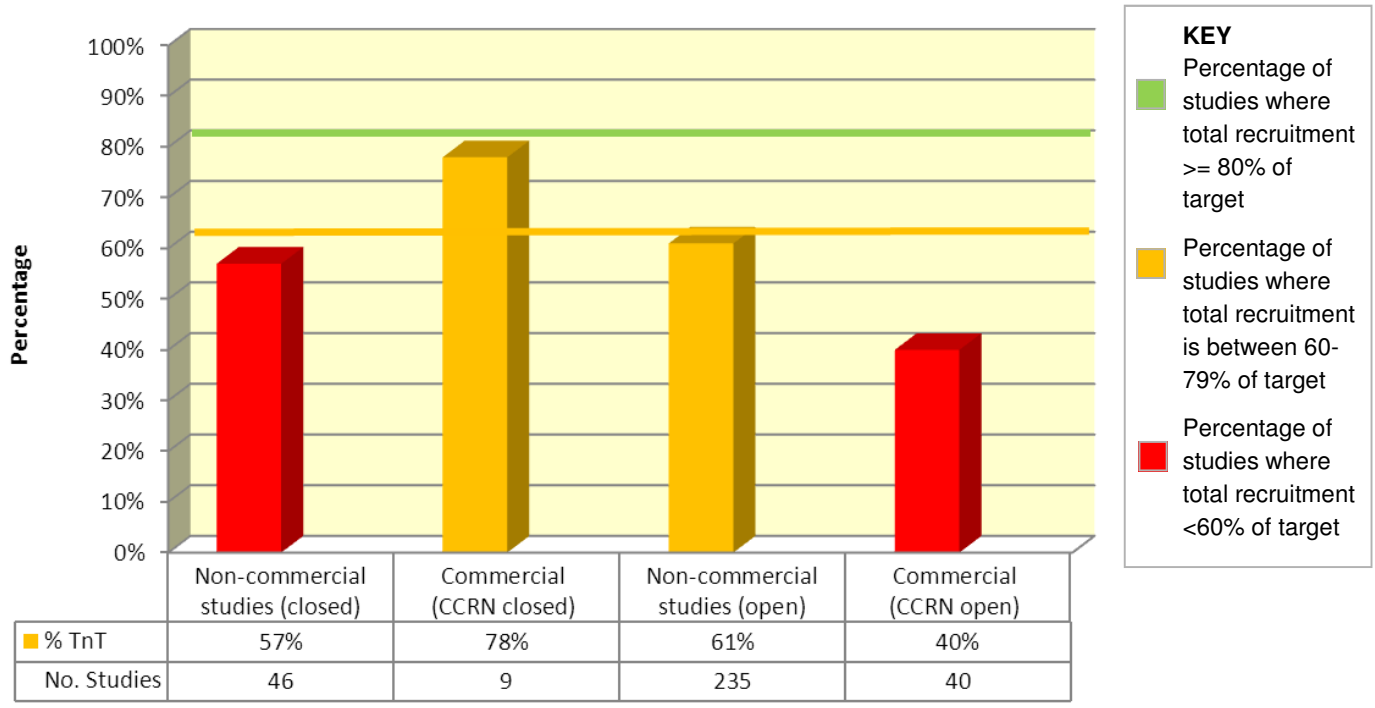


Figure 2.2: UHL 2013/14 recruitment in by Topic Network and CCRN Specialty Group

2.3 Percentage of UHL studies recruiting to time and target

Figure 2.3 shows recruitment to time and target data for open studies at UHL, and those that have closed since 1 April 2013. The data is displayed as an average across all studies that match the criteria, and shows commercial (CCRN only) and non-commercial (all studies) separately.

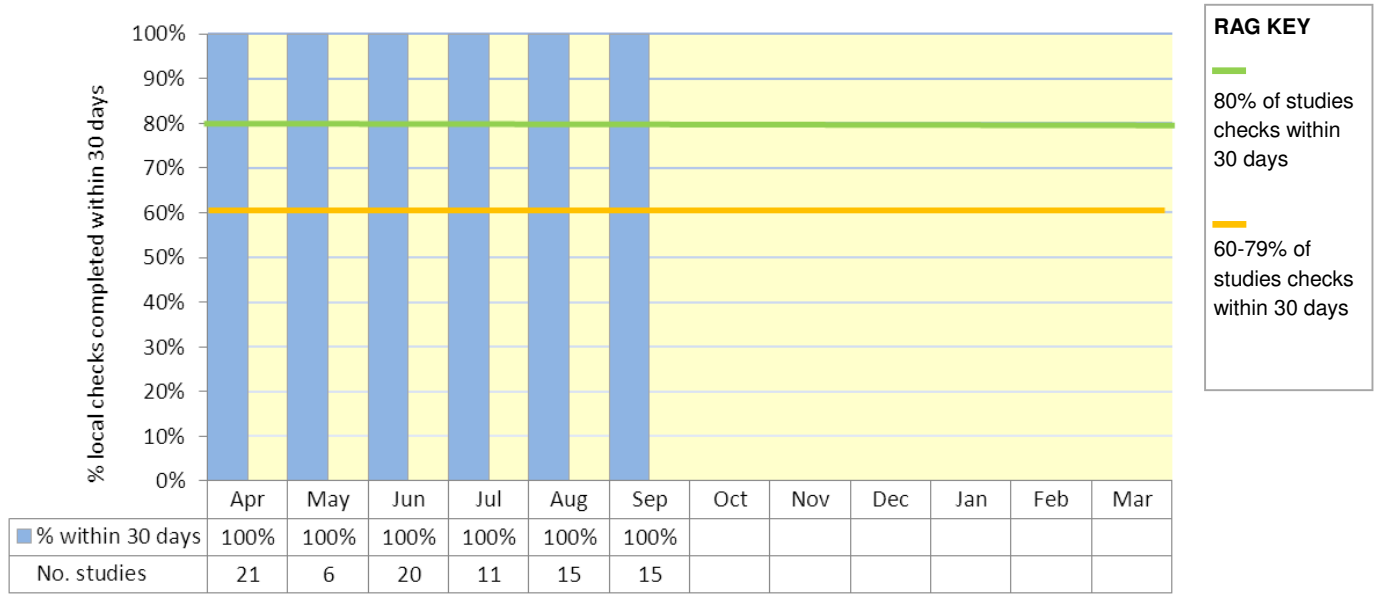


	Non-commercial studies (closed)	Commercial (CCRN closed)	Non-commercial studies (open)	Commercial (CCRN open)
% TnT	57%	78%	61%	40%
No. Studies	46	9	235	40

Figure 2.3: Percentage of UHL studies recruiting to time and target 2013/14 YTD

2.4 LNR CLRN Research Management and Governance (RM&G) for UHL in 2013/14

Figure 2.4 shows the percentage of studies approved each month that had their local study checks completed within 30 calendar days. The CLRN has a national performance measure to ensure 80% of studies obtain NHS permission within 30 calendar days.



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
% within 30 days	100%	100%	100%	100%	100%	100%						
No. studies	21	6	20	11	15	15						

Figure 2.4: LNR CLRN RM&G performance for UHL in 2013/14

Section 3—Appendices

The first two appendices to this report have been generated using the Time and Target (TnT) database. These reports compare study site recruitment with study site recruitment targets.

Time and Target (TnT) reports

3.1 TnT report—UHL all open studies

The first report captures all portfolio studies open at UHL. This report includes studies that have recruited participants as well as those that are yet to report recruitment.

3.2 TnT report— UHL closed studies

This report includes all studies that have closed for recruitment within UHL during the current financial year (2013/14).

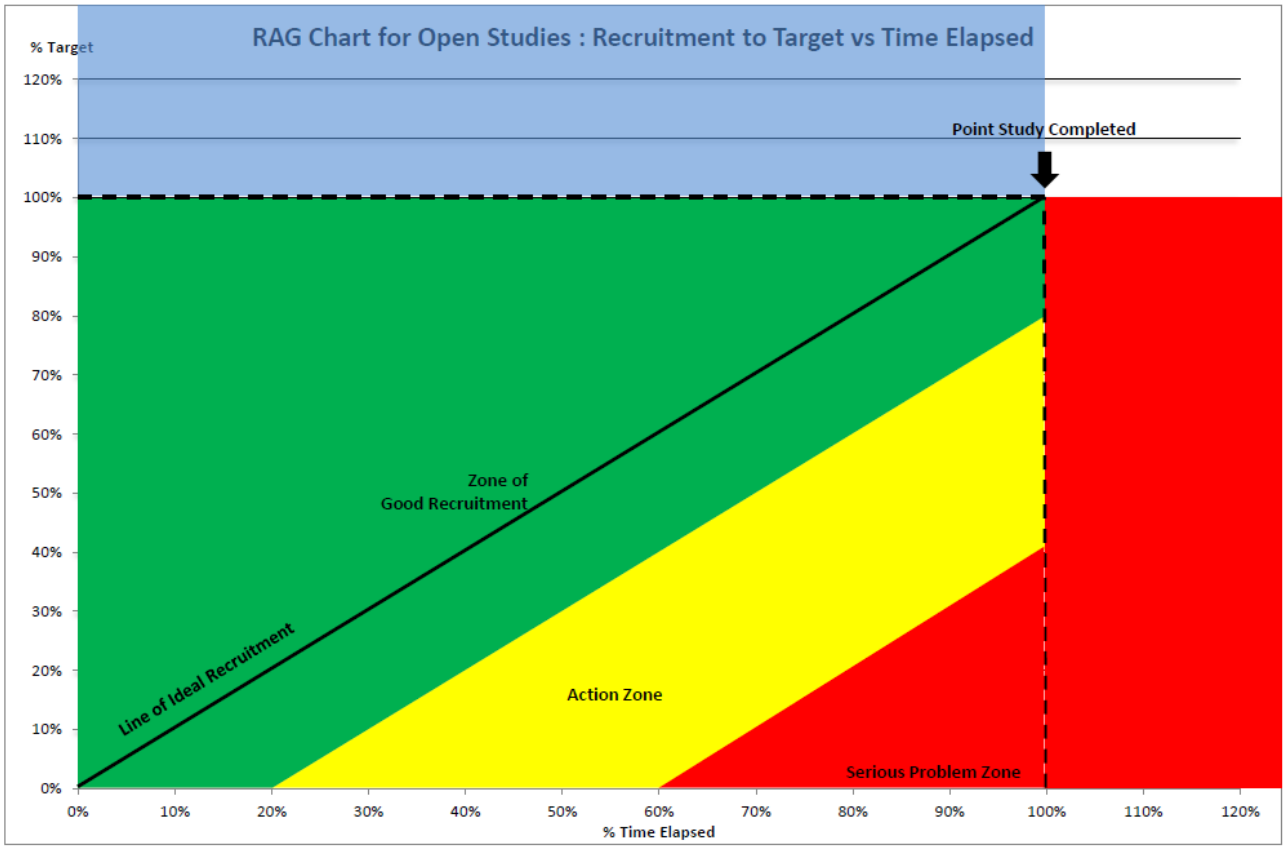
Glossary

Activity Based Funding (ABF)	Funding that is allocated to Comprehensive Research Networks which is based on recruitment and study complexity.
Awaiting response status (CSP report)	RM&G team are awaiting response from a member of the study team before the governance review can commence.
Closed study	A portfolio study that has closed to recruitment (across all study sites).
Commercial study	A commercial study is defined as one that is both industry-funded and industry-sponsored.
Commercial time and target data	There may be discrepancy between the time and target data presented in item 2.3 and the time and target reports. This is due to the delay in reporting commercial recruitment data nationally. We maintain local recruitment records for commercial studies which are accurate and these are used to calculate the data presented in item 2.3, while the national data is presented in the time and target reports.
CSP	The NIHR Coordinated System for gaining NHS Permission. CSP must be used for all new portfolio studies to gain NHS Trust permission and R&D approval.
Data sourced date	The date the national portfolio performance data is published by the NIHR CRN CC. This data is incorporated into our local TnT database and used to create this report. At present there is a four week lag from when a participant is recruited into a study and when this data will be reported by the NIHR CRN CC.
First Patient First Visit (FPFV)	This National Performance Measure looks at the time taken from NHS permission date (since 1 April 2013) **or** Site Initiation (which ever is later) to first patient recruited in a trial (<=30 days) for 80% of LNR CLRN studies.
Governance checks assigned (CSP report)	A LNR CLRN RM&G Facilitator has been assigned to the study for governance review.
Interventional study	A study where the participants' exposure to a particular intervention (e.g. treatment or lifestyle) is influenced by participating in the study (e.g. whether or not a participant receives a particular treatment will be determined by the research protocol). Clinical trials are the most common type of interventional study.
Lead CLRN—Trust R&D permission granted (CSP report)	The Chief Investigator is based at a trust within LNR. Trust R&D permission is granted at a research site once all governance checks have been undertaken by the CLRN.
LNR CLRN	The Leicestershire, Northamptonshire and Rutland Comprehensive Local Research Network (LNR CLRN) is one of 25 CLRNs across England. It coordinates and facilitates the conduct of clinical research and provides a wide range of support to the local research community. There are nine NHS Trusts and four Higher Education Institutions within the LNR CLRN constituency.
Local Performance Measure (LPM)	An objective decided by the LNR CLRN as a priority area for the financial year. Our progress towards achieving this measure is monitored locally and fed back to our local stakeholders and the NIHR CRN CC.

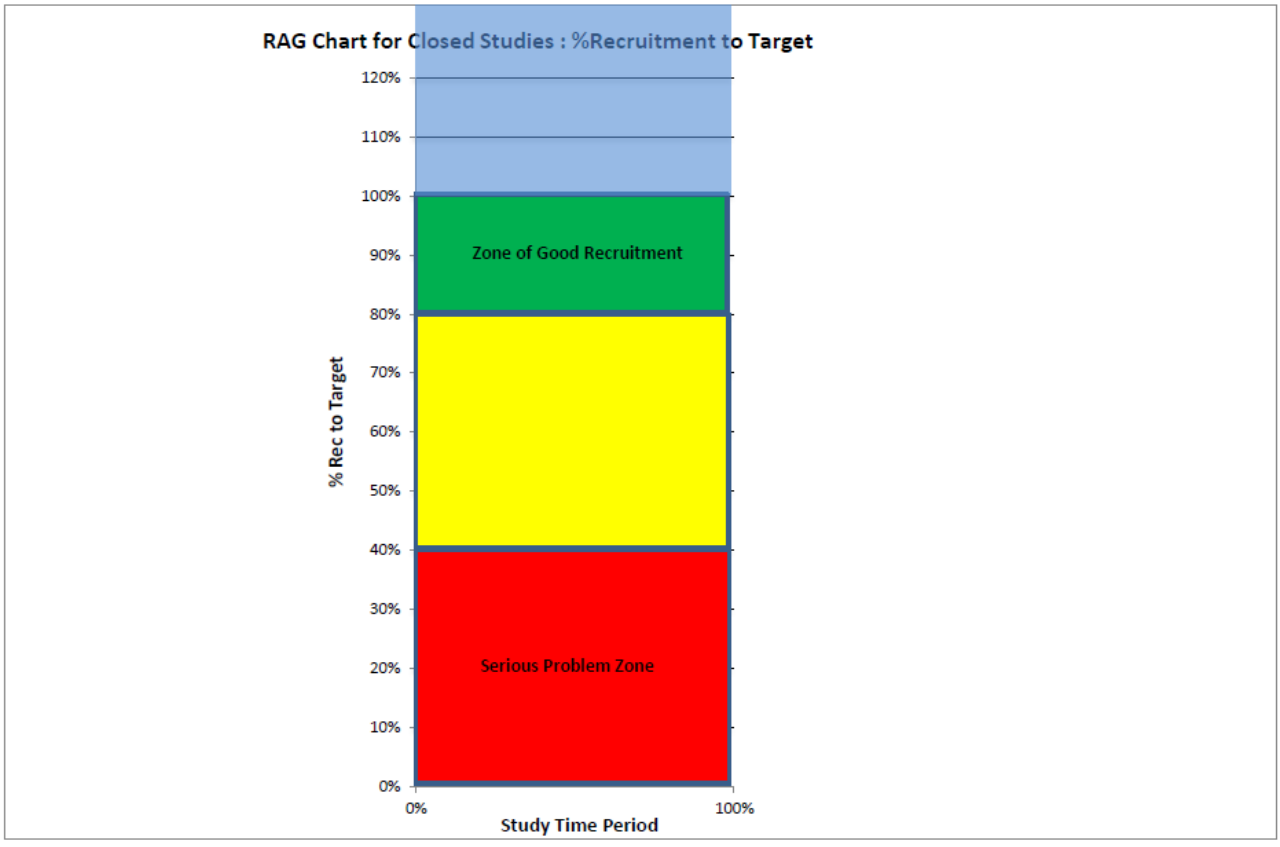
NHS Permission	Research cannot commence within the NHS without first gaining permission. This is granted as part of a study's research governance process, also referred to as R&D approval.
National Performance Measure (NPM)	An objective decided by the NIHR CRN CC as a priority area for all CLRNs. Our progress towards achieving this measure is monitored locally and fed back to our local stakeholders and the NIHR CRN CC.
NIHR CRN	National Institute of Health Research Clinical Research Network
NIHR CRN CC	National Institute of Health Research Clinical Research Network Coordinating Centre
Non-commercial study	A non-commercial study is one that has some of their research funded by the NIHR, other areas of central Government or NIHR non-commercial partners. However non-commercial studies can also be investigator initiated trials (i.e. commercial collaborative research) or funded by an overseas Government or overseas charity.
Observational study	A study in which the participants' lifestyle or care pathway is not affected by being part of the study i.e. the investigator does not determine whether or not the participants receive or do not receive a particular treatment. The investigator observes the outcome of participants following their exposure (or non-exposure) to a particular interventional or lifestyle.
Open Study	A portfolio study that has received NHS permission and is open to recruit patients. Open dates can vary across multi-centre studies as NHS permission has to be obtained at each study site.
Participant	A patient or individual who is recruited to a study.
Portfolio	A national database of research studies that meet specific eligibility criteria. Portfolio studies have access to infrastructure support via the NIHR Comprehensive Clinical Research Networks and swift R&D permissions through CSP.
QA (CSP report)	Once the governance review is complete, the study undergoes a final quality assurance process by a RM&G manager.
RAG criteria charts	RAG (red, amber, green) provides a key that help measures how well studies are recruiting to time and target. There are different charts for open and closed studies, and are included with this report.
Recruitment	The number of participants consented to a study.

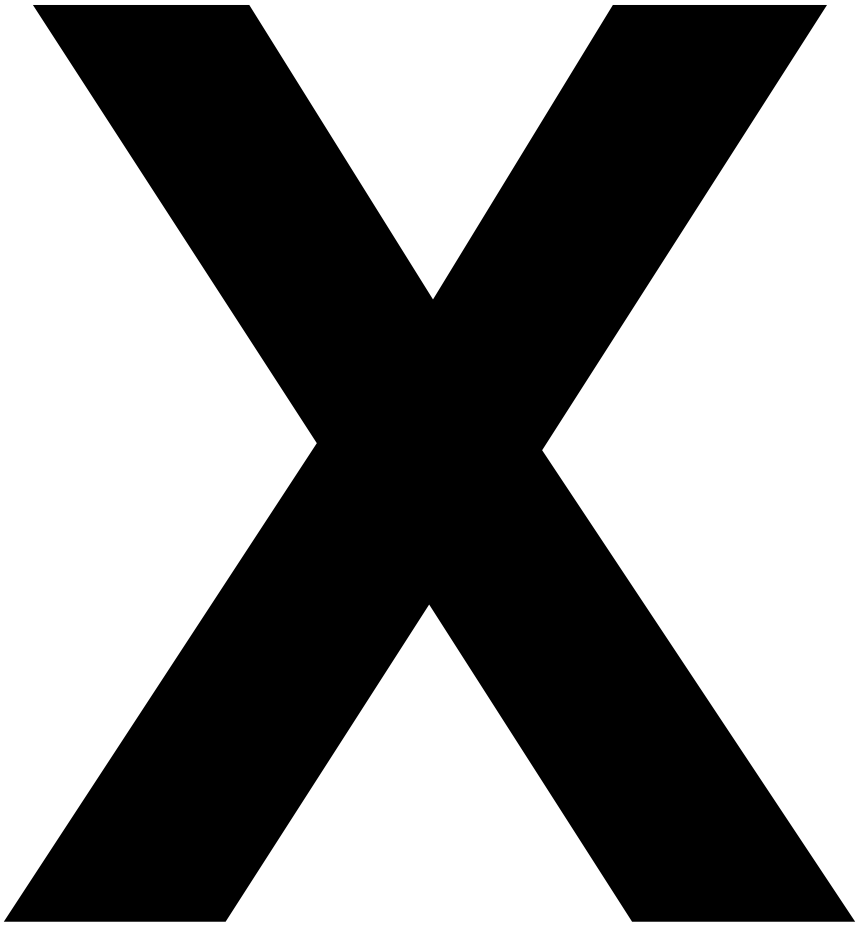
Recruitment target	An agreed target in participant recruitment into portfolio studies in 2013/14.
Report date	The date the report is issued.
Reported recruitment	The sum total of participants consented to a study that is uploaded to the NIHR CRN CC database by a study's recruitment data contact (RDC).
Research Governance	The regulations, principles and standards of good practice that exist to achieve, and continuously improve, research quality across all aspects of healthcare.
Specialty Group	Within the Comprehensive Clinical Research Network (CCRN), there are 23 national Specialty Groups that provide research expertise in their field. They are designed to increase opportunities for researchers to contribute to national and international NIHR portfolio studies.
Study Complexity	Study complexity (also referred to as study design) is considered along with recruitment when allocating activity based funding. Studies are either categorised as simple, observational or interventional.
Time and Target (TnT)	TnT is a project which monitors how well a study progresses towards their recruitment target before the study recruitment close date. TnT can be applied to an entire study (across several sites) or used for local site analysis.
Study review abandoned (CSP report)	A study review may be abandoned for a number of reasons including problems with the funding, non adoption onto the portfolio or site unsuitability.
Topic Network	There are six topic research networks (Cancer, Diabetes, Dementias and Neurodegenerative Diseases, Medicines for Children, Mental Health and Stroke) and a Primary Care research network within the NIHR CRN. Each research network coordinates and facilitates the conduct of clinical research for their local research community.
Trust R&D permission granted (CSP report)	Trust R&D authorise the study to be undertaken within their trust based on the CLRN RM&G governance review.
Unable to commence local research governance checks (CSP report)	The governance review process is unable to start as not all the relevant documents, authorisations or information has been received by the CLRN RM&G reviewer.
Undergoing research governance review using CSP (CSP report)	The governance review process for a study has commenced using CSP.
YTD	Year to date.

RAG criteria for open studies



RAG criteria for closed studies





Trust Board Paper X

	TRUST BOARD
From:	Rachel Overfield, Kevin Harris, Richard Mitchell Kate Bradley Andrew Seddon
Date:	**31st October 2013**
CQC regulation	All

Title:	**Quality & Performance Report**

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

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

The Report is provided to the Board for:

Decision		Discussion	√
Assurance	√	Endorsement	

Summary / Key Points:

Successes

- Theatres – 100% WHO compliant
- 62 day cancer – confirmed performance in August was 88.2%, against a national target of 85%. September is on track to deliver above trajectory.
- VTE - The 95% threshold for VTE risk assessment within 24 hours of admission has been achieved for Qtr2.
- Following the commissioner sign off of the Remedial Action Plan, the percentage of stoke patients spending 90% of their stay on a stroke ward has been achieved for 2 consecutive months.

Areas to watch:-

- Friends and Family Test - Performance on the FFT for September is 67.8.
- C Difficile – ahead of trajectory to date with 35 reported against cumulative target of 37. Monthly target for the rest of the year is 5 a month with a full year trajectory of 67.
- Imaging – delivered for September. Action plan is being monitored to ensure sustainable delivery.
- C&B – performance similar to this time last year and target is still not delivered.

Exceptions/Contractual Queries:-

- Pressure Ulcers - The UHL Pressure Ulcer Remedial Action Plan (RAP) has been updated and progress has been made against all actions.
- ED 4hr target - Performance for emergency care 4hr wait in September was 89.5%. Actions relating to the emergency care performance are included in the ED exception report.
- Cancelled Operations – contract query has been raised by the commissioners due to consistent failure of the threshold.
- RTT admitted and non-admitted -. The Intensive Support Team has been requested to support the Trust in the development of a robust and sustainable recovery action plan in respect of RTT. This has been triggered by an ongoing failure to agree a remedial action plan with commissioners.
- Ambulance Handovers - Remedial Action Plan and recovery trajectory have been formally accepted by the commissioners.

Finance:-

- The Trust is reporting a deficit at the end of September 2013 of £16.6m, which is approximately £16.0m adverse to the planned deficit of £0.6m.
- Patient care income £1.8m (0.6%) favourable against Plan, mainly due to outpatients.
- Pay costs are £9.8m over budget, £12.5m more than the same period in 2012/13 (5.7%). When viewed by staff group, the most significant increases year on year are seen across agency and medical locums, nursing spend and consultants' costs.
- CIP - Reported performance against the 2013/14 Plan is showing an adverse position of £1.0m against the Plan of £15.7m – 94% delivery.

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

University Hospitals of Leicester NHS
NHS Trust

Caring at its best

Quality and Performance – September 2013

Trust Board

Thursday 31st October 2013

One team shared values

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST

REPORT TO: **TRUST BOARD**

DATE: **31st OCTOBER 2013**

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

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

1.0 INTRODUCTION

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

2.0 2013/14 NTDA Oversight and Escalation Level

2.1 NTDA 2013/14 Indicators

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

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

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

Outcome Measures	Target	2012/13	Apr-13	May-13	Jun-13	Qtr1	Jul-13	Aug-13	Sep-13	Qtr2	YTD
30 day emergency readmissions	7.0%	7.8%	7.5%	7.8%	7.7%	7.7%	7.5%	7.6%			7.6%
Avoidable Incidence of MRSA	0	2	0	0	0	0	0	0	1	1	1
Incidence of C. Difficile	67	94	6	7	2	15	6	5	9	20	35
Incidence of MSSA		46	5	2	5	12	1	4	3	8	20
Safety Thermometer Harm free care		94.1%*	92.1%	93.7%	93.6%		93.8%	93.5%	93.1%		
Never events	0	6	1	0	0	1	0	0	1	1	2
C-sections rates	23%	23.9%	23.8%	26.1%	26.1%	25.3%	25.0%	25.2%	24.6%	24.9%	25.1%
Maternal deaths	0	0	0	0	0	0	0	0	0	0	1
Avoidable Pressure Ulcers (Grade 3 and 4)	0	98	11	4	8	23	8	8	5	21	44
SHMI	100	104.5	104.5	104.5	104.5		104.9	104.9	106.4		
VTE risk assessment	95%	94.5%	94.1%	94.5%	93.1%	93.9%	95.9%	95.2%	95.4%	95.3%	94.7%
Open Central Alert System (CAS) Alerts		13	14	9	15		36	10	10		
WHO surgical checklist compliance	100%	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes

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

2.2 UHL NTDA Escalation Level

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

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

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

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

3.0 QUALITY AND PATIENT SAFETY – KEVIN HARRIS/RACHEL OVERFIELD

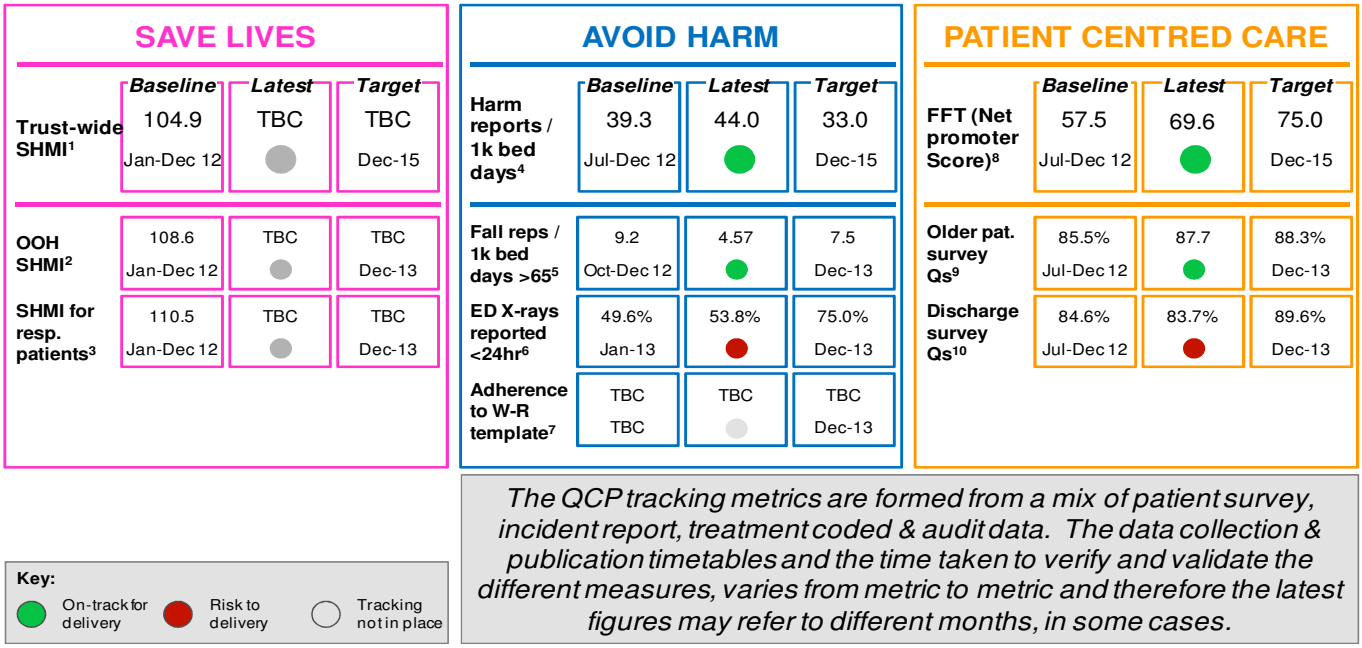
3.1 Quality Commitment

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

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

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

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



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

Save 1000 Lives

Respiratory pathway

Pneumonia Nurses now in place and are successfully managing the respiratory pathway at GH and LRI. There has been good adherence to the care bundle in CDU at Glenfield Hospital, however it is not being followed 100%. Areas for concern identified include the lack of completion of the severity scoring and therefore a knock on effect for the prescribing of antibiotics. Audit results show poor adherence to CAP care bundle triggered a need for a focus on education. Drop in training sessions have been organised with poor attendance in the first instance. Ward Sisters and Matrons have been made aware and have been asked to allow their Staff Nurses to attend when possible. The Pneumonia Nurses are also liaising with junior doctors as well as senior physicians. The respiratory pathway is a work in progress and it is hoped that formal teaching programmes will be implemented by December 2013.

Out-of-hours

Hand over from Outreach Lead to Project Manager has now taken place. There have been very few operational issues to report and the system is proving sufficiently adaptable to accommodate the needs of the different units. Feedback from juniors continues to be very positive. We still continue to develop plans to incorporate handover and phlebotomy cover into the QCP.

Avoid 5000 harms

Falls

Significant progress continues to be seen in the falls reduction programme data with impressive results reported in the reduced number of falls incidents and patient safety thermometer audit. There are over 25 wards currently in the Trust on the programme with high levels of engagement from ward sisters. A recent addition to the programme is

therapy contribution to the monthly confirm and challenge meetings. The red non slip slipper socks, laminated large leaves above patient's beds indicating high risk of falls, and call bell response time audits are examples of the initiatives that have been developed as part of this programme. The most impressive results have been seen in the speciality medicine CBU, where the most vulnerable patients at risk of falling are cared for. This clearly is a programme of work that has demonstrated that where focus is applied it is possible to reduce patient harm and consequently improve the patient experience.

Ward-round

Documentation/ implementation plan now in place and workstream leads are meeting fortnightly to discuss actions and deadlines. Communications launch planned for early 2014.

Ward round safety checklist template and notation paper now agreed with Medical Director and quotes obtained from printing room in order to implement on wards. Education and training sessions with nurses, consultants and trainees is to be launched in November (supported by FY2). Audit of ward round standards and documentation running until 31st October, 5 Critical Safety Actions Programme Lead has met with clinical audit team to discuss progress so far and to identify any hotspot areas. Monitoring and escalation to CMG leads in place for areas of concern.

Acting on results

A Lead Clinician is Radiology is working on a process for communicating significant high risk reports. This is to be discussed at a speciality leads steering group and recommendations to be made. This includes; developing a manageable list of "always diagnoses" to communicate, auditing CRIS to monitor performance and to continue the well established MDT codes for malignant disease.

Discussions are underway regarding integrating this workstream into the radiology capacity and demand improvement project.

An FY2 doctor is to start work on the acting upon results workstream as a leadership and management fellow under the leadership of the Associate Medical Director.

<u>Provide Patient Centred Care</u>

Older patients & dementia

Meaningful Activities Coordinators started in September and have completed induction. Quality Mark Steering Group has been established with Project Manager leading. The steering group aims to improve environments using LiA methodology (with 2 showcase wards). Re-audit of patient profile shows it is not being used, work to improve the implementation of this is to be discussed.

Discharge experience

The discharge workstream is approximately 4 months behind schedule due to handover and competing demands. There has been some concern over the past 12 months in the decline of discharge experience survey question scores. There is also apprehension over the change in focus towards 11am discharge, rather than patient experience with further concerns being raised regarding the ward review tool not including discharge experience. Discussions to clarify the focus on discharge experience are taking place this month. New discharge lounge opened at LRI and re-launch of discharge lounge at GH.

3.2 Mortality Rates

Mth | Qtr 1 | Qtr2 | YTD

UHL's HSMR for 12/13 is 101 and the latest SHMI covering the same time period is 106. Both of these are within expected but are above the England average of 100.

The LLR Patient Care Review, commissioned following UHL's continued >100 SHMI, has been completed and the findings are due to be published in November.

The Dr Foster Hospital Guide for 2013 will publish both Trust and Site specific mortality rates for 2012/13 and this will show the LRI site as having a 'higher than expected HSMR' at 114.

Whilst there are a number of explanations why the LRI has a higher HSMR and SHMI, 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. The HSMR for the LRI in 13/14 to date is 106 and is 'within expected'.

UHL's overall mortality is 'within expected' at 93 for 13/14 (April to July) but is not where we want it to be and this is one of the key drivers behind the 'Saving Lives' work-stream of the Quality Commitment with good progress being made with the implementation of the Respiratory Pathway.

3.3 Patient Safety

Mth | Qtr 1 | Qtr2 | YTD

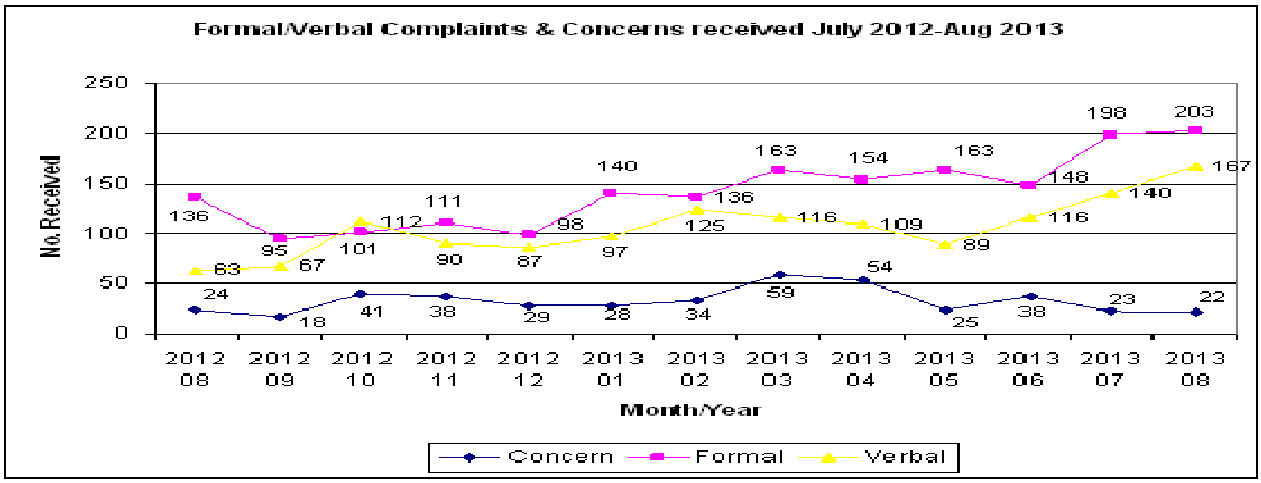
September showed some improvements on patient safety performance with further improved CAS compliance to a record level of 99% and further progress in embedding the 5 Critical Safety Actions.

One Never Event "Wrong implant / prosthesis" was reported for September 2013 in Ophthalmology. The patient was informed of the error as soon as it was identified by the surgeon and the patient returned to theatre for a replacement lens. The incident is being investigated and has been escalated internally and to external organisations.

In September, 14 new Serious Untoward Incidents (SUIs) were opened within the Trust, 5 of which were patient safety incidents (one being a Never Event), 7 were Hospital Acquired Pressure Ulcers and 2 were Healthcare Acquired Infections. Four patient safety root causes analysis (RCA) investigation reports were completed and signed off last month, the actions and learning of which have been shared internally.

Two clusters of incidents are medication errors and staffing incidents. The Chief Nurse has outlined the current position relating to staffing levels, vacancies, temporary staffing and recruitment plans which will seek to address the current gap in nurse staffing. With respect to work on reducing ten times medication errors, a thematic review has been undertaken which has identified common areas of error and recommendations for improvement

Complaints activity remains high but with reductions in re-opened complaints and exceptionally low levels of complaints upheld by the Ombudsman. Complaints and concerns raised relating to waiting times and cancelled operations / procedures continue to feature strongly. The trend of complaints is detailed below:-



3.4 5 Critical Safety Actions

Mth | Qtr 1 | Qtr2 | YTD

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

For Quarter 2 it has now been confirmed that the Trust will be receiving the commissioner visit to assess compliance for the CSA CQUIN on 31st October. Final details of areas to be visited will be confirmed after 16th October.

1. **Improving Clinical Handover**.

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

Actions:-

- Pilot work with alternative handover system from Nerve Centre complete. ACCA report was endorsed by the Trust for publication at 4th September QPMG meeting.
- Business plan to procure and purchase system submitted to commercial exec meeting at the end of September for discussion and approval.
- A template was sent out to all CBU leads to complete to identify and re-scope current handover practice for doctors in each speciality. There has been poor feedback from many specialities despite several chase emails. This evidence is required for CQUIN compliance. A further email will be sent to those speciality leads who have not yet responded to this request.

2. Relentless attention to Early Warning Score triggers and actions

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

Actions:-

- EWS non escalation incidents still being monitored this year. Trustwide currently on trajectory for 25% reduction in year.
- August report from Nerve Centre with response time data for red calls including EWS>4 shows that at out of hours at the GH and LGH sites 100% of escalation calls have been responded to within 30 minutes as per pathway. LRI data will be available when 24/7 fully implemented in site.

3. Acting upon Results

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

Actions:-

- Have now had confirmation for the acute division that 3 specialities have agreed signed off processes for managing diagnostic tests: Respiratory, Neurology and Emergency care. Others still in draft form that require sign off. Planned care almost complete. Women's and children's have deadline for mid November for completion.

4. Senior Clinical Review, Ward Rounds and Notation

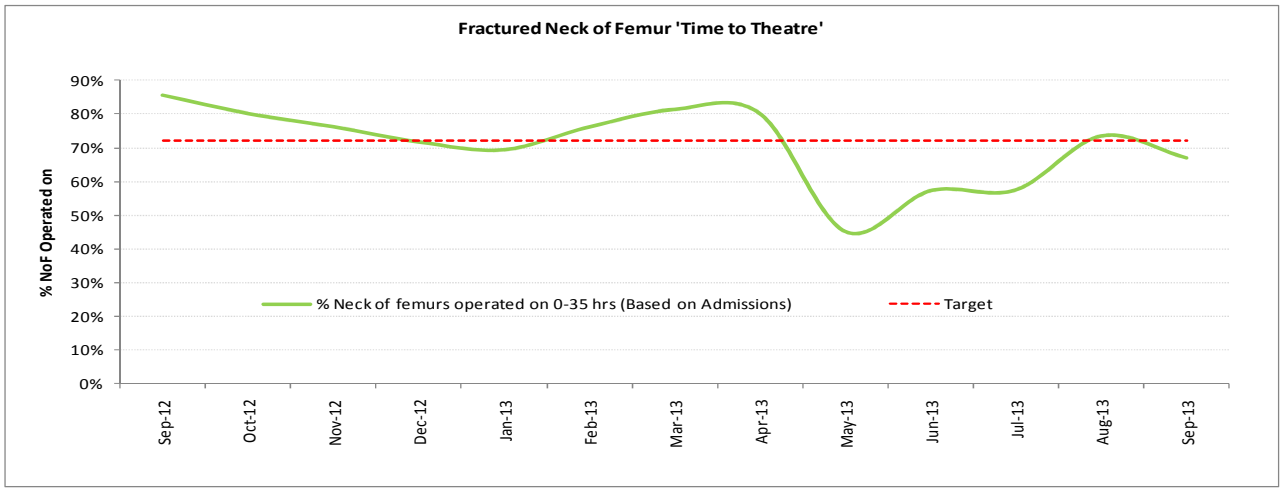
Aim -To meet national standards for clinical documentation. To provide strong medical leadership and safe and timely senior clinical reviews and ensure strong clinical governance.

Actions:-

- Ward round standards and documentation to be audited across the acute division throughout the month of October.
- The UHL ward round safety checklist and change to continuation paper has now been approved by the Medical Director.
- Work has now commenced to plan implementation of these to include education sessions.

3.5 Fractured Neck of Femur 'Time to Theatre'

Mth | Qtr 1 | Qtr2 | YTD



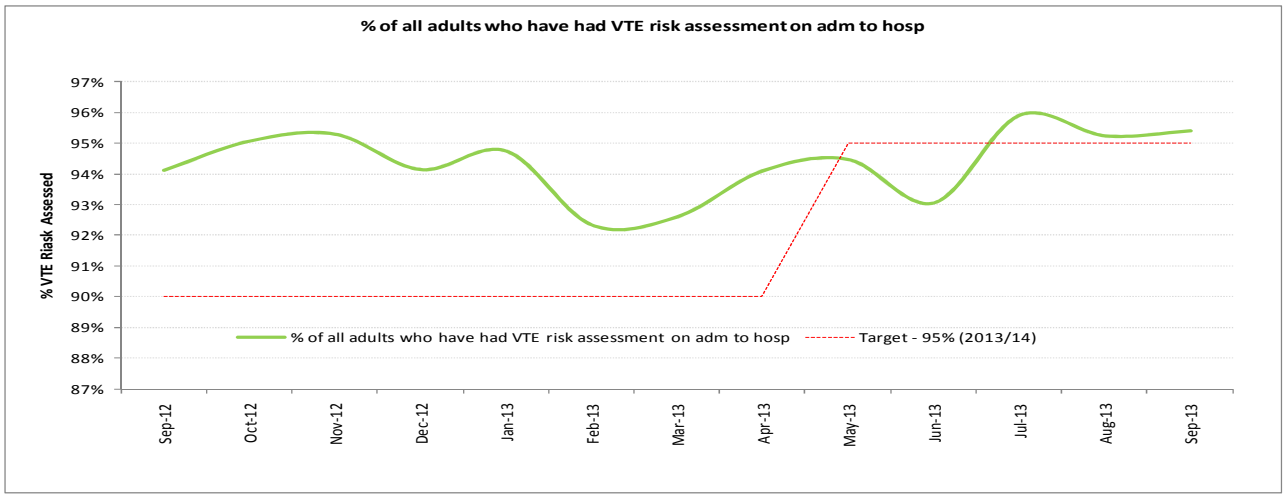
As per the #NOF action plan regular weekly meetings have been instigated with musculo – skeletal management team and Ward 32 relating specifically to the Best Practice Tariff (BPT) indicators. At the meetings specific issues around time to theatre are discussed. Performance has shown an improvement in September to 68% compared to Qtr 1. This is now believed to be a sustainable improvement which has been maintained in the first two weeks in October.

Performance against the other BPT indicators is also holding steady at the improved positions with the AMTS being the "worst" at 85%. In other words, all of our indicators, individually, are above the CCG set targets excepting time to theatre which is now

showing sustained improvement towards achieving 72%. Additionally, the patient's eligible for BPT is now at 57% which is another 6% improvement from last month.

3.6 Venous Thrombo-embolism (VTE) Risk Assessment

Mth | Qtr 1 | Qtr2 | YTD



The 95% threshold for VTE risk assessment within 24 hours of admission has been achieved for September at 95.4%. This is primarily due to an increase in the number of patients whose VTE risk assessment details have been entered onto Patient Centre.

3.7 CQUIN Schemes – Quarter 2

All CQUIN schemes are currently on track for meeting Q2's requirements.

Schedule	Ref	Indicator Title and Detail	Q2 Predicted RAG	Q2 Performance Comments
Nat CQUIN	Nat 1	Implementation of Friends and Family Test: 1.1 Phased Expansion 1.2 Increased Response Rate 1.3 Improved Performance on Staff Test	G	Good progress made with implementing F&F in Maternity
Nat CQUIN	Nat 2	2.1. To collect data on the following three elements of the NHS Safety Thermometer: pressure ulcers, falls UTI in patients with a catheter 2.2a Reduction in CAUTIs 2.2b Reduction in Falls	G	Data now being submitted to Safety Thermometer for Hospital Acquired Thrombosis so UHL's Harm Free % should now be included in the National reports produced by the HSCIC.
Nat CQUIN	Nat 3	3.1 .Patients aged 75 and over admitted as an emergency are screened for dementia, where screening is positive they are appropriately assessed and where appropriate referred on to specialist services/GP. 3.2. Ensuring sufficient clinical leadership of dementia within providers and appropriate training of staff. 3.3. Ensuring carers of people with dementia feel adequately supported	G	90% achieved for 3 consecutive months in all 3 parameters Training numbers increased. Carers Survey undertaken and actions being taken to increase support.

Schedule	Ref	Indicator Title and Detail	Q2 Predicted RAG	Q2 Performance Comments
Nat CQUIN	Nat 4	Reduce avoidable death, disability and chronic ill health from Venous thromboembolism (VTE) 1. VTE risk assessment 2. VTE RCAs	G	95% achieved for Risk Assessment for all 3 months of Q2
LLR CQUIN	Loc 1	Making Every Contact Count Increased advice and referral to STOP and ALW	G	Good progress being made with Smoking Cessation, Alcohol Reduction aspects of MECC. Reduction in number of referrals to STOP which should improve post STOPOBER. Some delays with progressing the Health Eating and Exercise MECC within MSK Pre-Op Assessment
LLR CQUIN	Loc 2	Implementation of the AMBER care bundle to ensure patients and carers will receive the highest possible standards of end of life care	G	Good progress made with Phase 2 Wards implementation and slightly ahead of plan. AMBER bundle maintained on all but one of the Phase 1 wards. New consultant starting on this ward and AMBER lead will be meeting with them early October to discuss re-introduction of the bundle.
LLR CQUIN	Loc 3	Improve care pathway and discharge for patients with Pneumonia a) Admission directly to respiratory ward (Glenfield site) and piloting of 'pneumonia virtual clinic for patients admitted to LRI') b) Improving care pathway and discharge for patients with Pneumonia - Implementation of Pneumonia Care Bundle	G	Pneumonia nurses in post from beginning of Sept and daily visits to LRI medical wards being undertaken to support implementation of care bundle and 'Virtual Respiratory Clinic'
LLR CQUIN	Loc 4	Improving care pathway and discharge for patients with Heart Failure - Implementation of Care Bundle and discharge Check List and piloting of 'virtual ward'	G	Good progress being made and on track to achieve thresholds. 32 patients completed on care bundle to date.
LLR CQUIN	Loc 5	Critical Safety Actions – Clinical Handover Acting on Results Senior Review/Ward Round Standards Early Warning Score	G	For Quarter 2 it has now been confirmed that the Trust will be receiving the commissioner visit to assess compliance for the CSA CQUIN on 31st October. Final details of areas to be visited will be confirmed after 16th October.
LLR CQUIN	Loc 7	Implementation of DoH Quality Mark with specific focus on Dignity Aspects	G	Co-ordinator in post and working closely with the Ward Sisters.
EMSCG CQUIN	SS1	Implementation of Specialised Service Quality Dashboards	G	Submission date is 28th October and all specialities on track to achieve deadline.
EMSCG CQUIN	SS2	Bone Marrow Transplant (BMT) – Donor acquisition measures	G	Indicator threshold is to submit data and although data was not routinely collected previously, changes have been made to do so since Q1.
EMSCG CQUIN	SS3	Fetal Medicine – Rapidity of obtaining a tertiary level fetal medicine opinion	G	Actions on track to achieve the end of year 90% threshold.

Schedule	Ref	Indicator Title and Detail	Q2 Predicted RAG	Q2 Performance Comments
EMSCG CQUIN	SS4	Increase use of Haemtrack for monitoring clotting factor requirements	G	CQUIN scope changed during Q2 following discussion between UHL and Specialised Services. On track to achieve end of year threshold of 50%.
EMSCG CQUIN	SS5	Discharge planning is important in improving the efficiency of units and engaging parents in the care of their infants thereby improving carer satisfaction of NICU services.	G	Threshold increased following receipt of Q1 data and discussion with the Network. UHL already above the 70% threshold.
EMSCG CQUIN	SS6	Radiotherapy – Improving the proportion of radical Intensity modulated radiotherapy (excluding breast and brain) with level 2 imaging – image guided radiotherapy (IGRT)	G	Actions being taken and on track to achieve end of year threshold (30%)
EMSCG CQUIN	SS7	Acute Kidney Injury	G	Due to commence Alerting process end of November
EMSCG CQUIN	SS8	PICU - . To prevent and reduce unplanned readmissions to PICU within 48 hours	G	Performance is on track to achieve quarterly threshold.

3.8 Theatres – 100% WHO compliance

Mth | Qtr 1 | Qtr2 | YTD

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

3.9 C-sections rates

Mth | Qtr 1 | Qtr2 | YTD

The C Section thresholds were locally agreed following the Regional 'Normalising Birth' CQUIN in 10/11.

For the past few months, the overall C Section rate has been higher than expected. A case note review has been completed which did not identify any decision making issues relating to Caesarean sections. Therefore a formal audit looking at timing of decision making, who made the decision, consultant involvement and other factors is about to commence.

Following discussion with the Women's and Children Commissioning Lead regarding the Maternity Dashboard threshold' for C Section rates, it was agreed during September that a threshold of 23% is unrealistic - given the national C Section rates in 2011 were 24.8% (RCM, 2012). Therefore the dashboard thresholds will be altered from Quarter 3 with a threshold of 25%.

3.10 Safety Thermometer

The Trust recommenced the recording of VTE harms as part of the safety Thermometer in September. It can be seen in the table below that re-introducing VTE prevalence has slightly reduced the percentage of harm free care to 92.84%.

- The prevalence of newly acquired pressure ulcers from August to September reduced from 25 to 16 ulcers (avoidable and unavoidable). It should be noted that the prevalence of pressure ulcers in patients admitted to UHL has increased from 67 in August to 87 in September. These ulcers may have been avoidable or unavoidable and have occurred in patients who were admitted from their own home who have no current contact with any health or social care professional. Nevertheless, this information has been shared with the lead nurse for pressure ulcers within the Leicestershire Partnership Trust to see if there are any correlations with their safety thermometer data
- The Prevalence of harmful falls remained the same in September at 3. Two of these falls occurred within UHL where both patients sustained a level 2 harm. The injuries sustained were a laceration to the arm and a laceration to the head. The 3rd fall that was reported occurred prior to admission to UHL and has been recorded as a new fall in line with CQUIN / ST guidance. The patient fell whilst in their nursing home and sustained a laceration to the arm**.**
- The prevalence of CAUTIs decreased from 24 in August to 21 in September.
- The number of newly acquired VTEs was 6. This is a figure comparable to the number of VTEs recorded on the Safety Thermometer in 2013.

		May-13	Jun-13	Jul-13	Aug-13	Sep-13
	Number of patients	1686	1650	1514	1496	1579
3 Harms (PU, Falls & UTIs with Catheter)	Total No of patients with any 3 Harms	110	108	96	101	117
	No of patients with no Harms	1580	1545	1420	1399	1470
	% Harm Free for 3 of the harms	93.71%	93.64%	93.79%	93.52%	93.10%
All Harms	Total No of patients with Harms	-	-	-	-	122
	No of patients with no Harms	-	-	-	-	1465
	% Harm Free for All Harms	-	-	-	-	92.84%
Newly Acquired Harms	Total No of Newly Acquired (UHL) Harms	51	51	45	52	47
	No of Patients with no Newly Acquired Harms	1636	1601	1469	1445	1534
	% of UHL Patients with No Newly Acquired Harms	97.034%	97.030%	97.02%	96.59%	97.15%
Harm One	All Pressure Ulcers (Grades 2, 3 or 4)	75	73	66	67	87
	No of Newly Acquired Grade 2, 3 or 4 Pus	27	26	19	25	16
Harm Two	No of Patients having fallen in hospital in previous 72 hrs	8	8	5	3	3
Harm Three	No of Patients with Urinary Catheter and Urine Infection (prior to or post admission)	27	27	25	31	25
	Newly Acquired UTIs with Catheter	16	17	21	24	21
Harm Four	Newly Acquired VTE (either DVT, PE or Other)	-	-	-	-	6

Pressure Ulcer Incidence

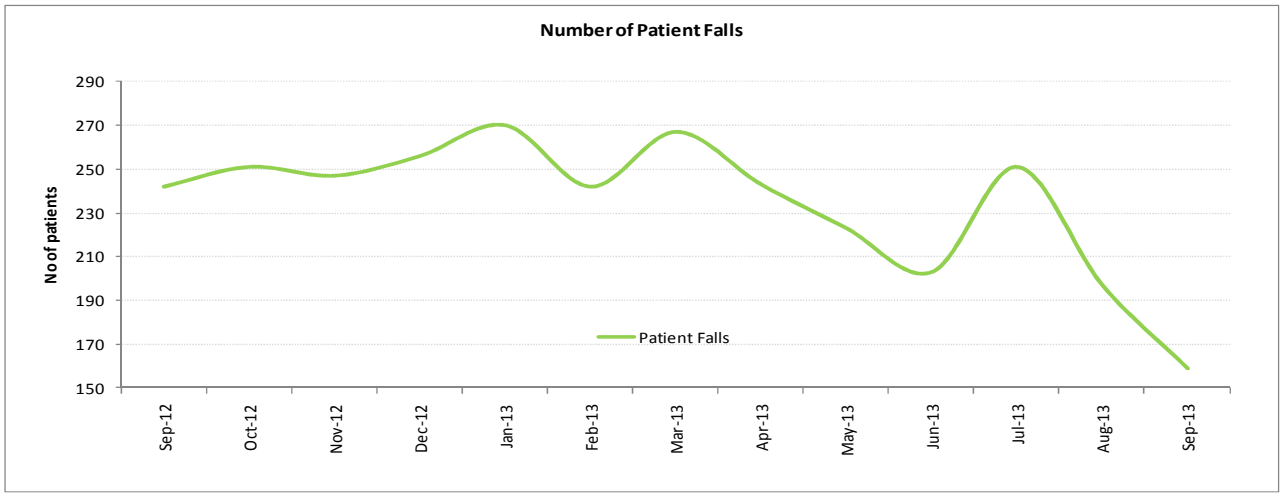
Mth | Qtr 1 | Qtr2 | YTD

Although the revised trajectories for avoidable pressure ulcers have not been achieved for September, there has been a reduction in avoidable grade 2 and 3 pressure ulcers (zero grade 4 ulcers reported 2013/14). The UHL Pressure Ulcer Remedial Action Plan (RAP) has been updated and progress has been made against all actions.

Trajectory for Grade 2 Avoidable Pressure Ulcers 2013/14													
Month	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Total YTD
Trajectory	0	0	0	11	8	4	0	0	0	0	0	0	23
Incidence Data	12	10	20	21	10	5							78
+ / -	-12	-10	-20	-10	-2	-1							-55

Trajectory for Grade 3 Avoidable Pressure Ulcers 2013/14													
Month	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Total YTD
Trajectory	0	0	0	5	4	3	0	0	0	0	0	0	12
Incidence Data	11	4	8	8	8	5							44
+ / -	-11	-4	-8	-3	-4	-2							-32

Patient Falls



Significant progress continues to be seen in the falls reduction programme data with impressive results reported in the reduced number of falls incidents and patient safety thermometer audit. There are over 25 wards currently in the Trust on the programme with high levels of engagement from ward sisters. A recent addition to the programme is therapy contribution to the monthly confirm and challenge meetings. The red non slip slipper socks, laminated large leaves above patient's beds indicating high risk of falls, and call bell response time audits are examples of the initiatives that have been developed as part of this programme. The most impressive results have been seen in the speciality medicine CBU, where the most vulnerable patients at risk of falling are cared for. This clearly is a programme of work that has demonstrated that where focus is applied it is possible to reduce patient harm and consequently improve the patient experience.

4.0 PATIENT EXPERIENCE – RACHEL OVERFIELD

4.1 Infection Prevention

a) MRSA

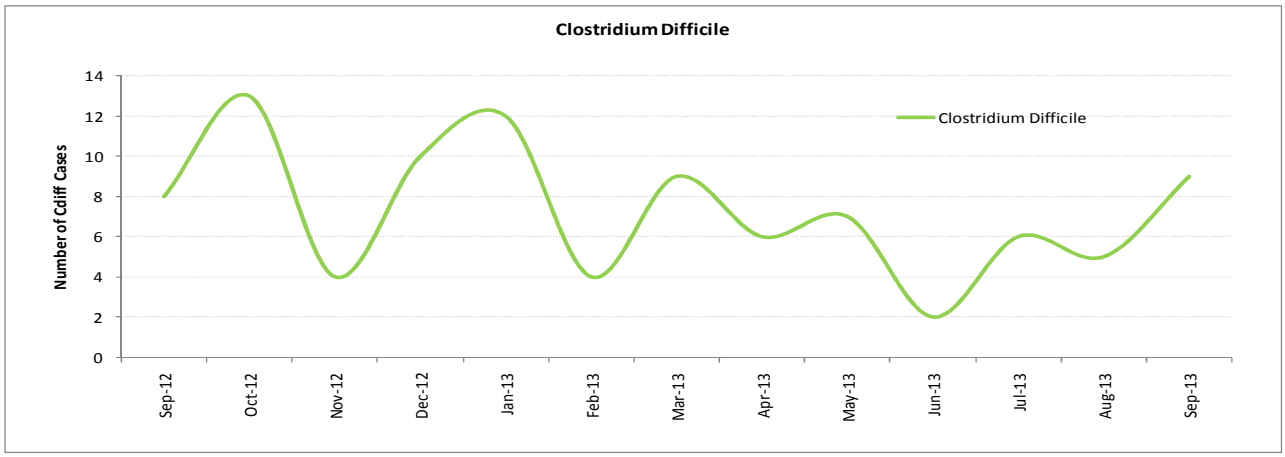
Mth | Qtr 1 | Qtr2 | YTD

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

b) CDT

Mth | Qtr 1 | Qtr2 | YTD

Ahead of trajectory to date with 35 reported against cumulative target of 37. All 9 cases of CDT reported in September have been fully investigated and there are no links between any of the cases.



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

4.2 Patient Experience

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

In September 2013, 3,696 Patient Experience Surveys were returned this is broken down to:

- 2,191 paper inpatient/day case surveys
- 969 electronic surveys
- 387 ED paper surveys
- 149 maternity paper surveys

Share Your Experience – Electronic Feedback Platform

In September 2013, a total of 969 electronic surveys were completed via email, touch screen, our Leicester's Hospitals web site or handheld devices.

A total of 449 emails were sent to patients inviting them to complete a survey. The table below shows how this breaks down across the trust:

Share Your Experience Survey	Email	Touch Screen	Hand held	Web	Total Surveys	Emails sent
Carers Survey				4	4	
Children's Urgent & ED Care		53			53	
A&E Department	1	69	19	5	93	2
Eye Casualty		220			220	
Glenfield CDU		16	1		17	
Glenfield Radiology	20				20	86
IP and Childrens IP				10	10	
Maternity Survey			442	7	449	
Neonatal Unit Survey				14	14	
Outpatient Survey	53	4		3	60	361
Windsor Eye Clinic		27		2	29	
Total	**74**	**388**	**462**	**45**	**969**	**449**

In September 2013 Labour Wards, Birthing Centres and Postnatal Wards have been successful in surveying enough patients to meet the national requirements. This success has showcased the suitability of the new handheld (Ipad) survey devices, 9 of which are distributed across maternity services.

The willingness and engagement of staff with the new technology, from housekeepers to midwives, has ensured the trust is in a strong position for the October 2013 launch of Maternity Friends and Family national reporting.

Treated with Respect and Dignity

Mth	Qtr 1	Qtr2	YTD

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

Friends and Family Test

Inpatient

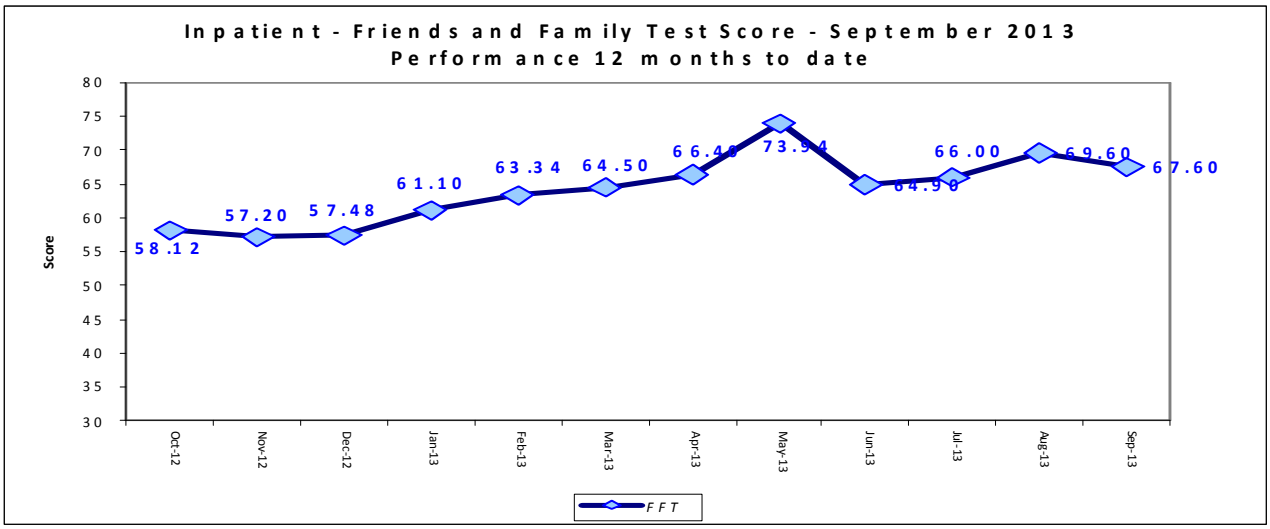
The inpatient surveys include the Friends and Family Test question; **How likely are you to recommend this ward to friends and family if they needed similar care or treatment?'** Of all the surveys received in September, 1,658 surveys included a response to this question and were considered inpatient activity (excluding day case / outpatients) and therefore were included in the Friends and Family Test score for NHS England.

Overall there were 6,430 patients in the relevant areas within the month of September 2013. The Trust easily met the 15% target achieving coverage of **25.8%.**

The Friends & Family Test responses broken down to:

Extremely likely:	1,187
Likely:	380
Neither likely nor unlikely:	53
Unlikely	13
Extremely unlikely	10
Don't know:	15

Overall Friends & Family Test Score **67.6**



August 2013 Data Published Nationally

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

With private, single speciality and Trusts that achieved less than a 20% footfall excluded the UHL Friends and Family Test score of 70 for August, ranks the Trust 62nd out of the remaining 118 Trusts.

Division Performance Changes

Acute Care, and Women's and Children's, both showed small increases in their FFT scores in September when compared to August. Acute Care achieved a score of 74, their highest score to date this year. In Women's and Children's, whilst the number of promoters fell this month, the number of passives increased and the number of detractors fell, balancing out the effect of the reduction in promoters.

For Planned Care there was a decline in their score between September and August by over 5 points. In September Planned Care surveyed a much larger number of patients than in August however and coverage rose from 17% to 25%. The larger survey base may explain some of the variance in the score for Planned Care this month.

Compared to August, most specialties showed a decline, or only marginal increase, on their FFT score in September, with the exception of Emergency Medicine and Specialist Surgery who achieved an increase of 18 and 12 points respectively on the previous month's score.

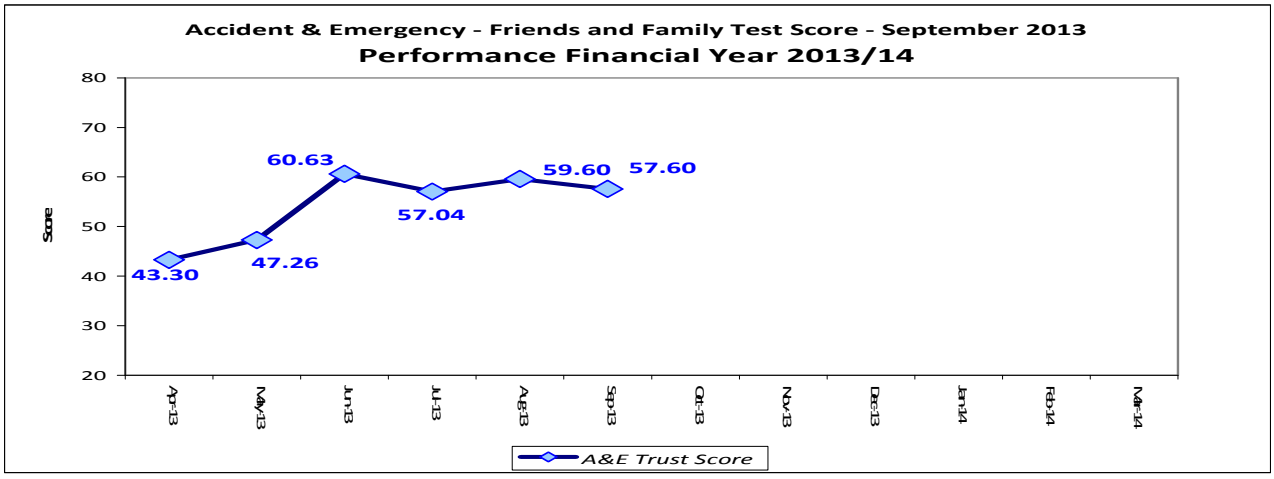
	Apr-13	May-13	Jun-13	Jul-13	Aug-13	Sep-13	Point Change in FFT Score (Aug - Sep 13)
UHL Trust Level Totals	**66.4**	**73.9**	**64.9**	**66.0**	**69.6**	**67.6**	*-1.95*
Acute Care	***67***	***74***	***67***	***72***	***72***	***74***	*+1.97*
Planned Care	***65***	***72***	***62***	***58***	***64***	***59***	*-5.27*
Women's & Children's	***78***	***80***	***74***	***68***	***76***	***77***	*+0.79*
Emergency Department	***43***	***47***	***61***	***57***	***60***	***58***	*-2.03*

Emergency Department & Eye Casualty

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

Overall there were 5,850 patients who were seen in A&E and then discharged home within the month of September 2013. The Trust surveyed 649 eligible patients meeting **11.1%** of the footfall. The Friends & Family test responses break down to:

Extremely likely:	406
Likely:	206
Neither likely nor unlikely:	15
Unlikely	12
Extremely unlikely	7
Don't know:	3
Overall Friends & Family Test Score	**57.6**



Breakdown by department	No. of responses	FFT Score	Total no. of patients eligible to respond
Emergency Dept Majors	13	23.1	1,376
Emergency Dept Minors	13	30.8	2,389
Emergency Dept – not stated	382	64.6	
Emergency Decisions Unit	36	80.6	793
Eye Casualty	205	44.3	1,292

August 2013 Data Published Nationally

NHS England also published all trust's A&E Friends & Family Test scores. August data was published at the end of September and the average Friends and Family Test score for A&E in England was **56** including data from 144 Trusts.

If we filter out the Trusts that achieved less than 15% footfall, the UHL score of **60 for August** ranks 21st out of **44** Trusts.

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

4.3 Nurse to Bed Ratios

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

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

For the month of September 2013, actual nurse to bed ratio when reviewing the staffing levels for wards are all above the agreed minimum ratio and therefore no action plans have been attached to this report.

4.4 Same Sex Accommodation

Mth	Qtr 1	Qtr2	YTD

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

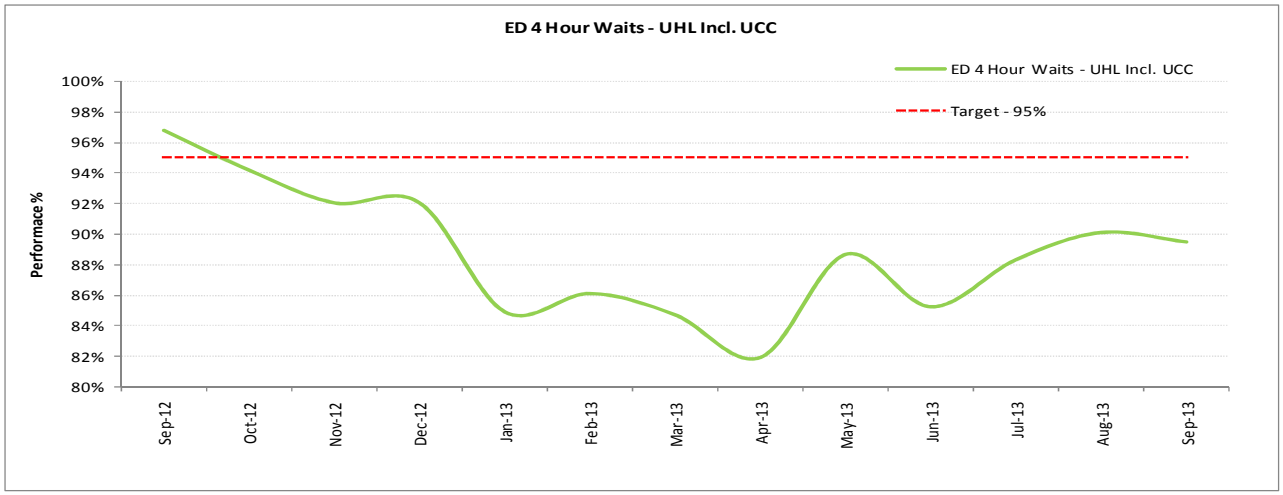
5.0 OPERATIONAL PERFORMANCE – RICHARD MITCHELL

Outcome Measures

Performance Indicator	Target	2012/13	Sep-12	Q2	Oct-12	Nov-12	Dec-12	Q3	Jan-13	Feb-13	Mar-13	Q4	Apr-13	May-13	Jun-13	Q1 2013	Jul-13	Aug-13	Sep-13	Q2 2013	YTD
A&E - Total Time in A&E (UHL+UCC)	95%	91.9%	96.8%	97.0%	94.2%	92.0%	92.0%	92.7%	84.9%	86.1%	84.7%	85.2%	82.0%	88.7%	85.3%	85.3%	88.3%	90.1%	89.5%	89.3%	87.3%
RTT waiting times – admitted	90%	91.3%	91.2%		91.2%	91.7%	91.9%		92.2%	91.9%	91.3%		88.2%	91.3%	85.6%	88.4%	89.1%	85.7%	81.8%	85.6%	
RTT waiting times – non-admitted	95%	97.0%	97.7%		97.1%	96.7%	97.3%		97.3%	97.0%	97.0%		97.0%	95.9%	96.0%	96.3%	96.4%	95.5%	92.0%	94.6%	
RTT - incomplete 92% in 18 weeks	92%	92.6%	94.0%		94.6%	93.9%	93.3%		93.4%	93.5%	92.6%		92.9%	93.4%	93.8%	93.8%	93.1%	92.9%	93.8%	93.8%	
RTT - 52+ week waits	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Diagnostic Test Waiting Times	<1%	0.5%	0.5%		0.4%	0.6%	1.1%		0.7%	1.0%	0.5%		1.6%	0.7%	0.5%		0.6%	0.8%	0.7%		
Cancelled operations re-booked within 28 days	95.0%	92.9%	100.0%	92.6%	91.0%	97.3%	89.0%	93.1%	97.1%	92.3%	94.2%	94.6%	90.4%	91.0%	86.4%	89.4%	99.1%	96.0%	98.5%	98.0%	94.4%
Cancelled operations on the day (%)	0.8%	1.2%	0.9%	0.8%	1.1%	1.6%	1.2%	1.3%	1.6%	1.6%	1.6%	1.6%	1.5%	1.5%	1.0%	1.3%	1.2%	1.4%	2.2%	1.6%	1.5%
Cancelled operations on the day (vol)		1247	74	202	100	149	91	340	137	130	137	404	125	134	81	340	114	124	203	441	781
Urgent operation being cancelled for the second time	0	1	0	0	0	0	1	1	0	0	0	0	0	0	0	0	0	0	0	0	0
2 week wait - all cancers	93%	93.4%	93.9%	94.1%	93.0%	90.6%	95.1%	92.8%	89.8%	95.9%	95.2%	93.7%	93.0%	95.2%	94.8%	94.4%	94.2%	94.6%			94.4%
2 week wait - for symptomatic breast patients	93%	94.5%	96.3%	95.3%	93.4%	93.9%	94.6%	93.9%	93.6%	93.1%	95.4%	94.0%	94.0%	94.8%	93.2%	94.1%	93.6%	92.0%			93.6%
31-day for first treatment	96%	97.4%	96.9%	98.3%	98.3%	97.5%	97.4%	97.8%	96.6%	97.6%	98.8%	97.6%	97.5%	97.0%	99.0%	97.8%	98.3%	99.7%			98.3%
31-day for subsequent treatment - drugs	98%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%			100.0%
31-day wait for subsequent treatment - surgery	94%	95.8%	100.0%	96.6%	98.1%	97.4%	94.6%	97.1%	94.6%	94.1%	92.7%	94.0%	97.2%	94.4%	97.5%	96.4%	100.0%	98.4%			97.6%
31-day wait subsequent treatment - radiotherapy	94%	98.5%	100.0%	98.8%	99.3%	98.9%	100.0%	99.4%	99.1%	98.9%	99.1%	99.0%	100.0%	97.8%	99.1%	98.8%	100.0%	100.0%			99.3%
62-day wait for treatment	85%	83.5%	86.5%	86.5%	85.6%	85.8%	84.6%	85.3%	79.5%	75.4%	81.5%	78.8%	80.9%	80.3%	85.9%	82.3%	85.8%	88.2%			84.1%
62-day wait for screening	90%	94.5%	92.2%	94.6%	96.8%	98.7%	92.3%	96.3%	91.7%	95.7%	95.8%	94.4%	98.6%	94.3%	95.0%	95.9%	90.6%	97.2%			95.0%
Stroke - 90% of Stay on a Stroke Unit	80%	79.8%	86.3%	82.2%	83.7%	79.5%	71.3%	77.9%	77.8%	81.4%	82.3%	80.6%	77.4%	80.0%	78.0%	78.5%	87.1%	88.6%			81.7%
Stroke - TIA Clinic within 24 Hours (Suspected TIA)	60%	68.4%	73.4%	63.9%	68.7%	72.5%	68.7%	70.0%	60.8%	85.1%	77.0%	73.1%	51.1%	69.2%	72.0%	63.9%	60.5%	73.6%	64.6%	66.0%	64.9%
Choose and Book Slot Unavailability	4%		11%		10%	13%	8%		5%	10%	9%		7%	9%	13%		15%	14%	11%		
Delayed transfers of care	3.5%	3.1%	3.2%	3.4%	3.4%	3.6%	2.7%	3.3%	2.8%	2.7%	3.7%	3.0%	3.7%	3.9%	3.1%	3.6%	3.6%	3.1%	3.9%	3.5%	3.5%

5.1 Emergency Care 4hr Wait Performance

Mth | Qtr 1 | Qtr2 | YTD



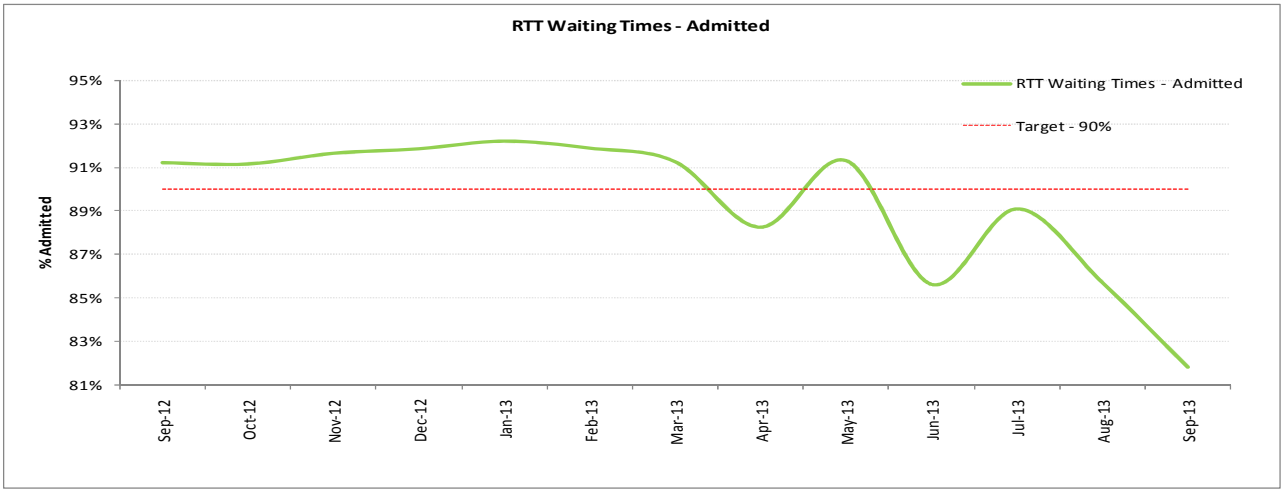
Performance for emergency care 4hr wait in September was 89.5%. Actions relating to the emergency care performance are included in the ED exception report.

UHL was ranked 137 out of 145 Trusts with Type 1 Emergency Departments in England for four weeks up to 13th October 2013. Over the same period 70 out of 145 Acute Trusts delivered the 95% target.

5.2 RTT – 18 week performance

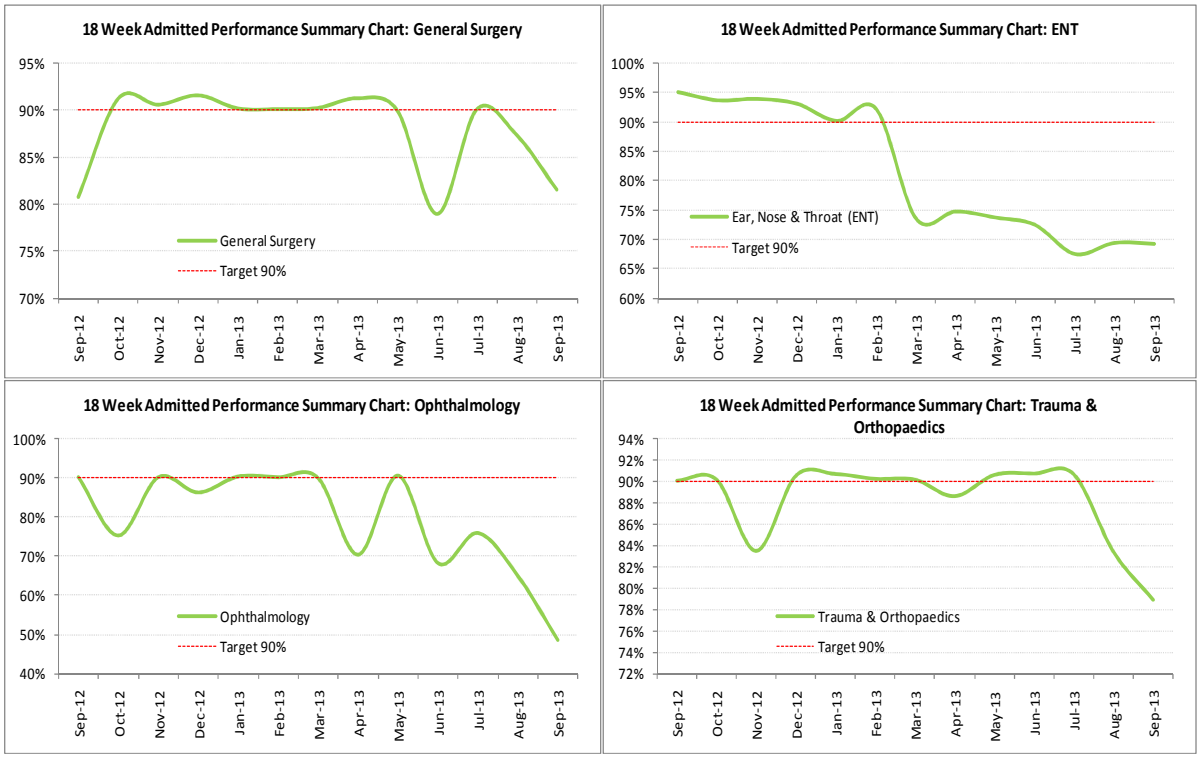
a) RTT Admitted performance

Mth | Qtr 1 | Qtr2 | YTD



RTT admitted performance for September was 81.8% with significant speciality level failures in General Surgery, Orthopaedics, Ophthalmology and ENT.

The national admitted performance in August (latest published figures) was 92.2%. 115 out of the 176 Trusts missed the target at specialty level and 74 Trusts had between 2 and 10 specialty failures.



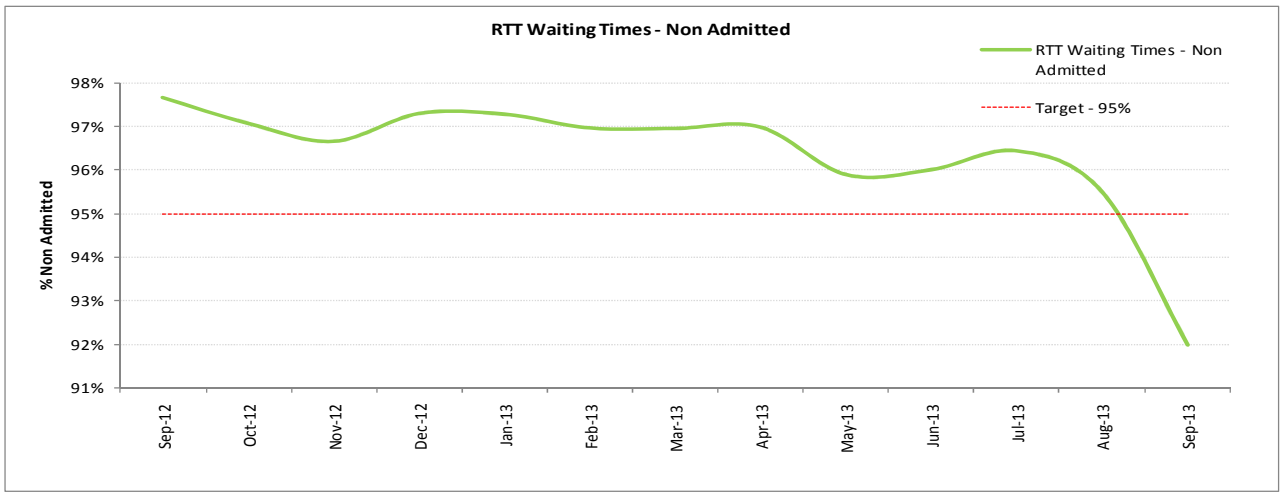
The Intensive Support Team has been requested to support the Trust in the development of a robust and sustainable recovery action plan in respect of RTT. This has been triggered by an ongoing failure to agree a remedial action plan with commissioners.

The development of a plan will entail detailed analysis of current capacity and demand for key services, the provision of ring fenced elective capacity above current levels and an understanding between the Trust and Commissioners that RTT performance will not be on track for an agreed level period of time. It is expected that the IST capacity and demand analysis will be complete by the end of October.

Planning around outsourcing elective activity to the Independent Sector and Community Hospitals is well advanced. Following review and sign off of governance and contractual arrangements patients will be offered treatment in IS hospitals from November.

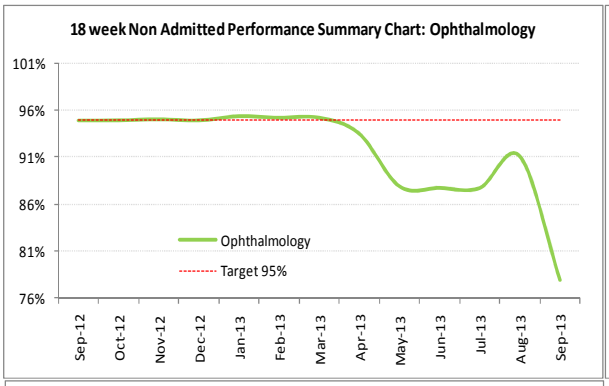
b) RTT Non Admitted performance

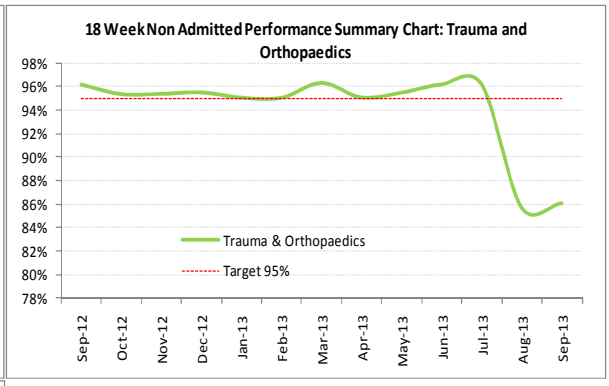
Mth | Qtr 1 | Qtr2 | YTD

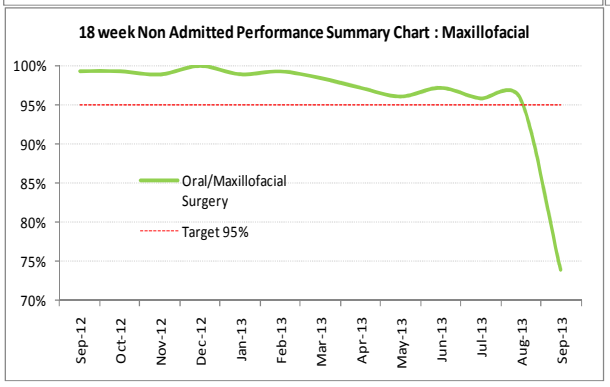


Non-admitted performance during September was 92.0%, with the significant specialty level failures in Maxillo Facial Surgery, Orthopaedics and Ophthalmology. The deterioration in performance during September was as a result of the plan to reduce the number of non-admitted patients waiting 18+ weeks.

The national non-admitted performance in August (latest published figures) was 97.2%. 97 out of the 203 Trusts missed the target at specialty level and 72 Trusts had between 2 and 10 specialty failures.

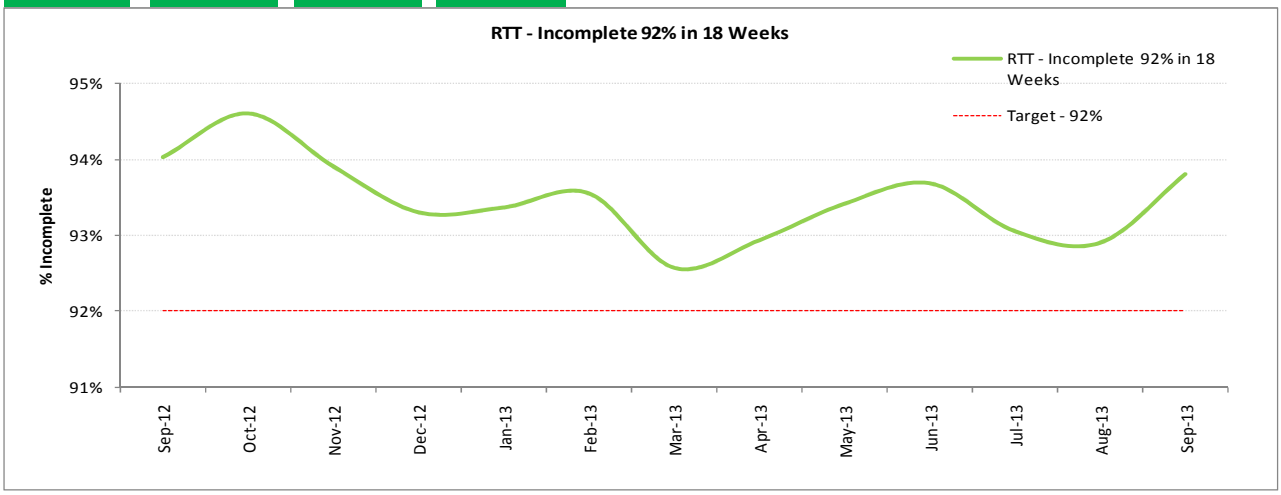






c) RTT Incomplete Pathways

Mth | Qtr 1 | Qtr2 | YTD

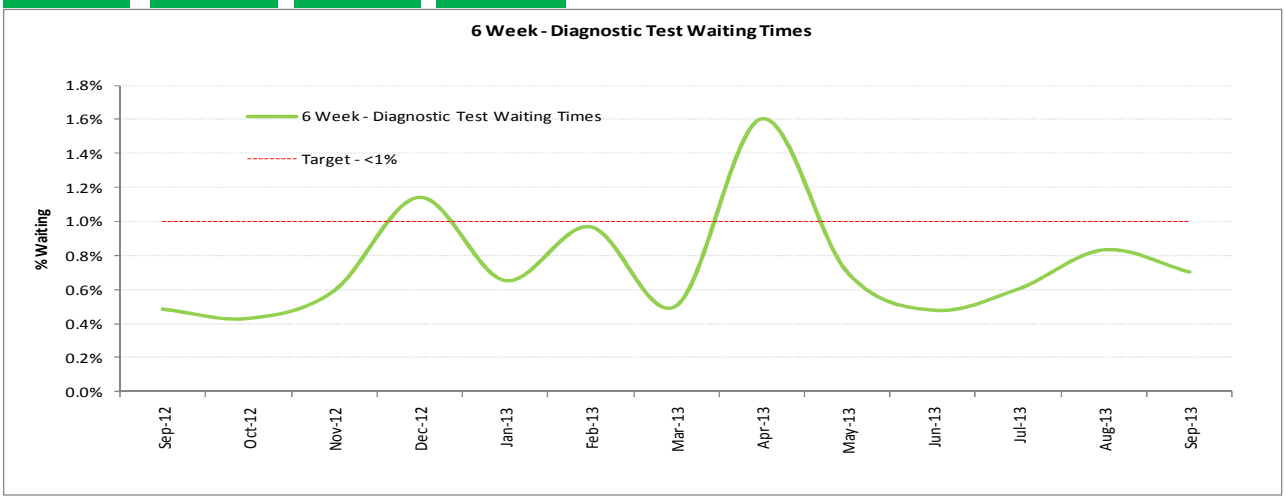


RTT incomplete (i.e. 18+ week backlog) performance was 93.8%.In numerical terms the total number of patients waiting 18+ weeks for treatment (admitted and non-admitted) at the end of September was 2,511.

The national incomplete pathways performance in August (latest published figures) was 94.2%. 107 out of the 203 Trusts missed the target at specialty level and 64 Trusts had between 2 and 10 specialty failures.

5.3 Diagnostic Waiting Times

Mth | Qtr 1 | Qtr2 | YTD



At the end of September 0.7% of patients were waiting for diagnostic tests longer than 6 weeks. National performance for August shows that 1.1% of patients were waiting for diagnostic tests longer than 6 weeks.

5.4 Cancer Targets

a) Two Week Wait

Mth | Qtr 1 | Qtr2 | YTD

August performance for the 2 week to be seen for an urgent GP referral for suspected cancer was achieved at 94.6% (national performance 94.9%). Performance for the 2 week symptomatic breast patients (cancer not initially suspected) was not achieved at 92.0% (national performance 93.7%), predominantly due to patient choice. Performance for September has improved and both these indicators will be delivered.

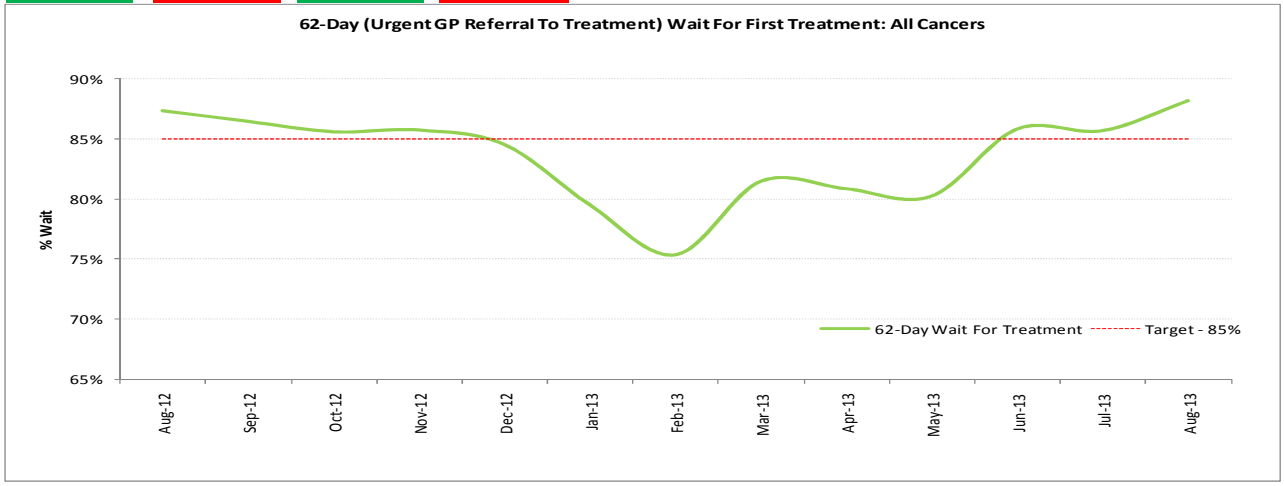
b) 31 Day Target

Mth | Qtr 1 | Qtr2 | YTD

All the 31 day cancer targets have been achieved in August (latest reported month). The UHL is above the national average for all four of the 31 day cancer indicators.

c) 62 Day Target

Mth | Qtr 1 | Qtr2 | YTD



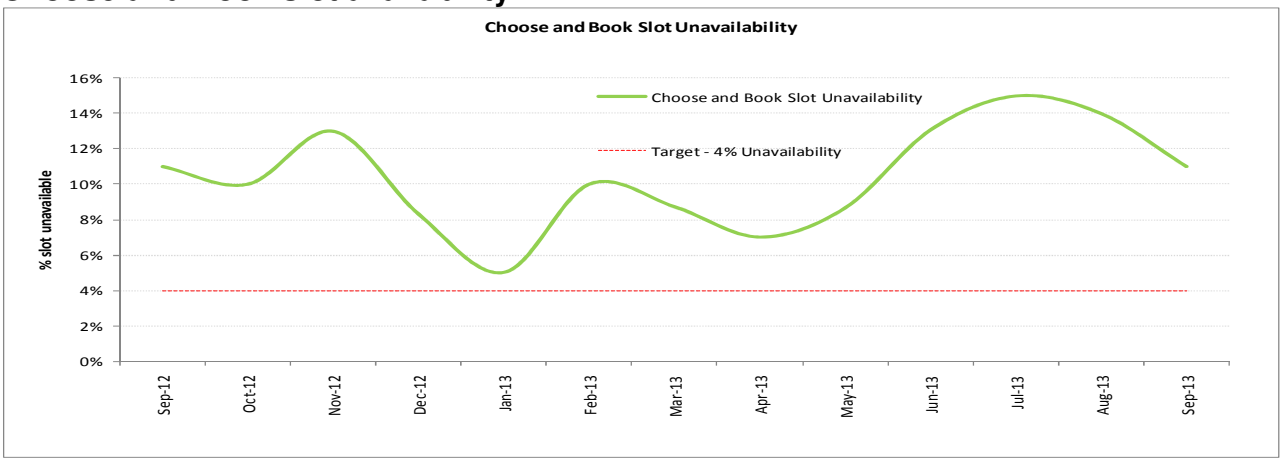
The 62 day urgent referral to treatment cancer performance in August was 88.2% and the year to date position is 84.1%, against a national target of 85%. National performance for the 62 day target was 87.4% in August.

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

The key points to note this month are:-

- Performance for September is on track to deliver trajectory
- 62 day backlog is 19 as at the 11th October (threshold is 30)
- 4 of the 5 patients waiting 100+ days have treatment dates in October. All have been reviewed in the MDT meetings.
- Senior manager for the Cancer Centre commenced beginning of October
- A weekly and monthly cancer scorecard has been developed.

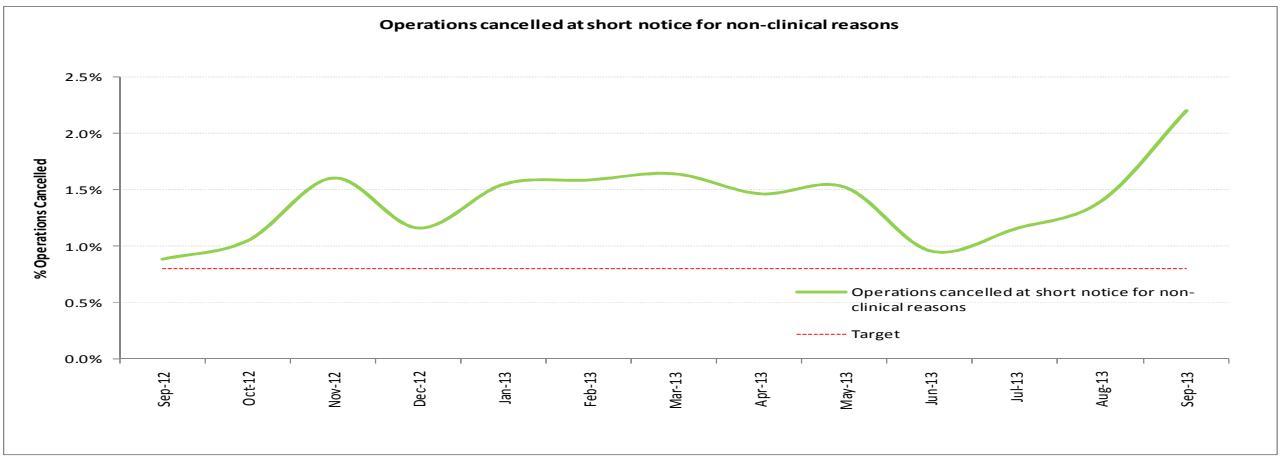
5.5 Choose and Book slot availability



Choose and book slot availability performance for September is 11% (an improvement on last month's position), with the national average at 10%.Resolution of slot unavailability requires a reduction in waiting times for 1st outpatient appointments in key specialties and prospectively, ensuring that there is sufficient capacity available at all times. Actions required to reduce waiting times will be addressed in the RTT Remedial Action Plan

5.6 Short Notice Cancelled Operations

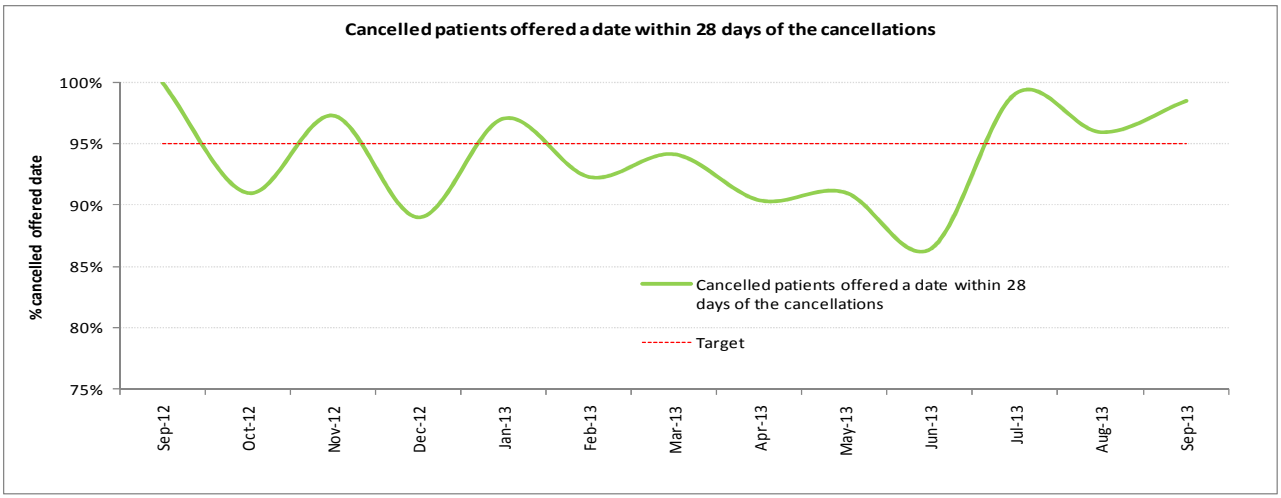
Mth | Qtr 1 | Qtr2 | YTD



September performance shows that the percentage of operations cancelled on/after the day of admissions of all elective activity for non-clinical reasons was 2.2% against a target of 0.8%. Further details are included in the Cancelled Operation exception report, see Appendix 3.

Cancelled patients offered a date within 28 days

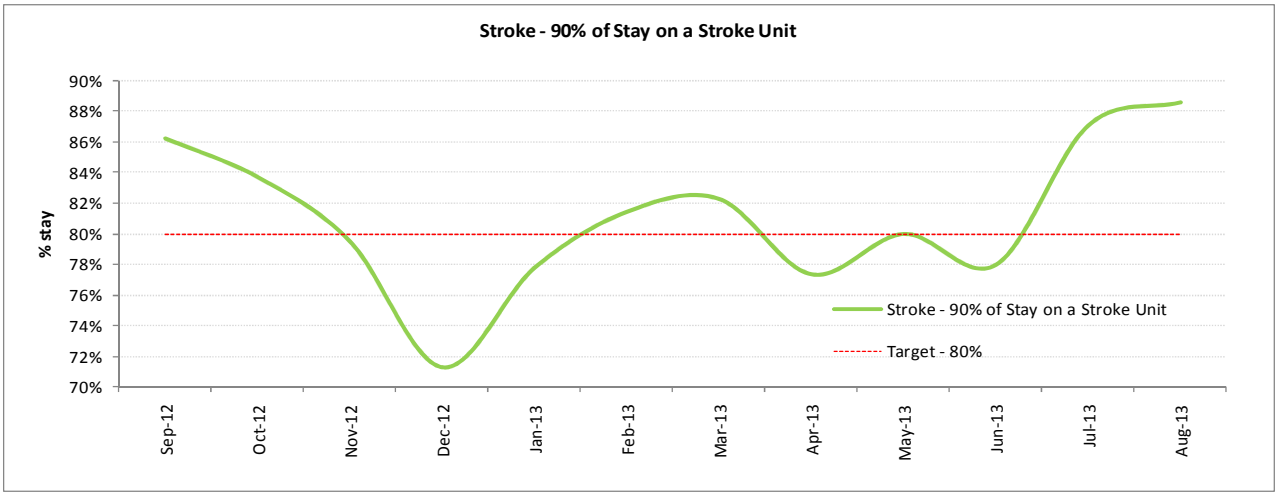
Mth | Qtr 1 | Qtr2 | YTD



The percentage offered a date within 28 days of the cancellation was 98.5% against a threshold of 95%.

5.7 Stroke % stay on stroke ward

Mth | Qtr 1 | Qtr2 | YTD



The percentage of stoke patients spending 90% of their stay on a stroke ward in August (reported one month in arrears) is 88.6% against a target of 80%.

The Stroke Remedial Action Plan has been received and accepted during August with monthly updates provided to the Contract Performance Meeting with commissioners.

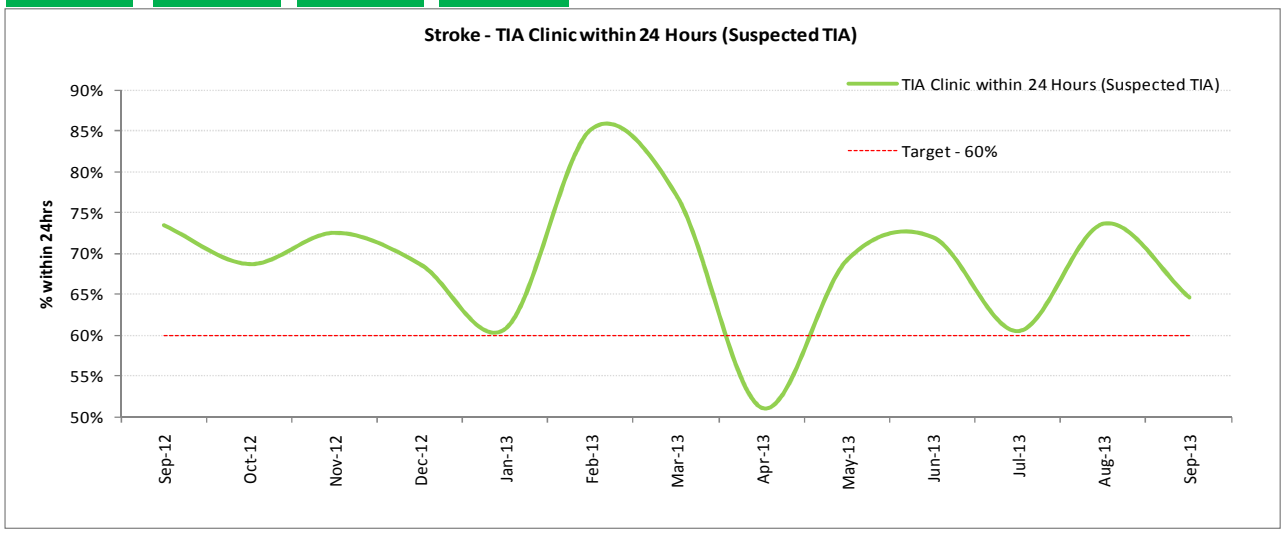
The key points to note this month are:-

- Band 6 specialist nurse recruited on secondment
- Incidents are being reported as per escalation policy. Report to be presented to Steering Group.

- Actions including on-going training at induction and junior doctor change over, every 4 months

5.8 Stroke TIA

Mth | Qtr 1 | Qtr2 | YTD



The percentage of high risk suspected TIAs receiving relevant investigations and treatment within 24 hours of referral receipt is 64.6% against a national target of 60.0%. The contractual target for this indicator remains under review.

5.9 Delayed Transfers of Care

Mth | Qtr 1 | Qtr2 | YTD

During September 2013 UHL has seen an improvement in the performance for city patients and a deterioration for county patients. There were 262 episodes recorded as a 'Delayed Transfer of Care' on the weekly sitreps recorded at midnight each Thursday during September 2013, making the combined average of 7.3 delays per 100,000 population.

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

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

**indicates 5 week month*

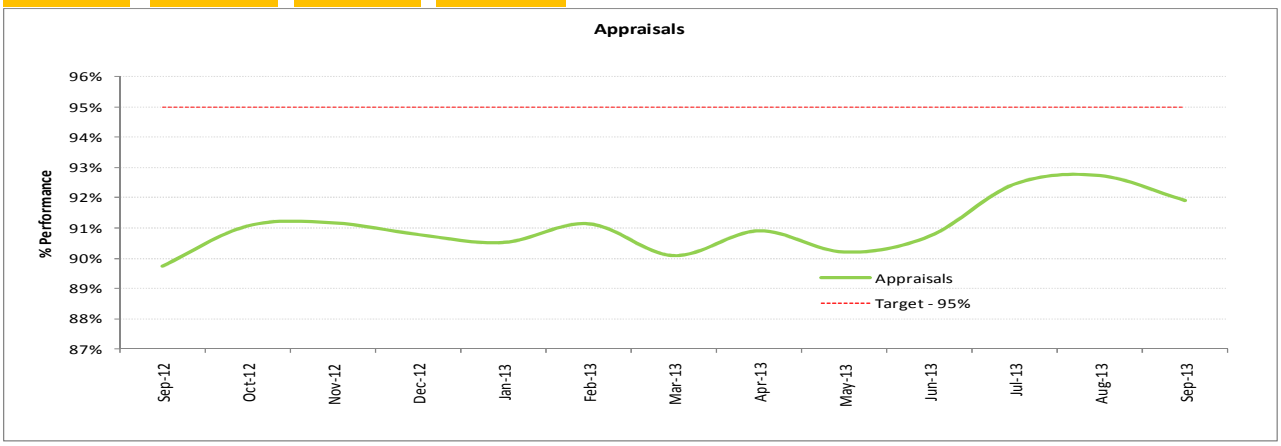
Delays continue to be escalated internally at bed meetings and externally at daily teleconferences. This issue has been picked up by the Urgent Care Board who have allocated additional resources to open Intensive Community Support capacity as well starting to open an additional 24 community hospital beds in October 2013. This should improve the position regarding patients waiting for non-acute NHS care.

The contractual target for DTOC's has been amended to report the "Total number of patients delayed (as at the census date) divided by the total number of occupied beds", with a threshold of 3.5%.

6.0 HUMAN RESOURCES – KATE BRADLEY

6.1 Appraisal

Mth | Qtr 1 | Qtr2 | YTD



Division	Mar-13	Apr-13	May-13	Jun-13	Jul-13	Aug-13	Sep-13
Acute Care Total	88.8%	90.5%	91.1%	91.8%	94.1%	94.0%	91.9%
Planned Care Total	92.9%	91.6%	91.0%	90.8%	92.3%	93.3%	94.9%
UHL Corporate Division Total	87.2%	88.2%	84.2%	86.7%	86.9%	88.4%	86.5%
Women's & Children's Total	90.7%	92.8%	91.4%	90.9%	92.8%	92.0%	91.0%
Grand Total	90.1%	90.9%	90.2%	90.7%	92.4%	92.7%	91.9%

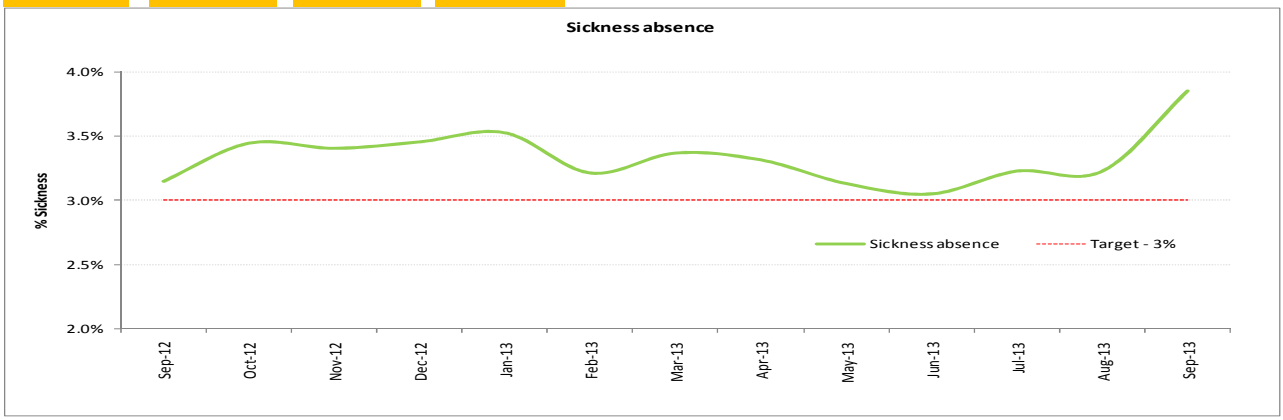
Whilst there has been a great deal of appraisal activity over the last month, there has been a reduction in overall appraisal performance at the end of September, potentially impacted on by the re-alignment of responsibilities in the new CMG Structure. We are pleased that there are four clinical areas who have met the 95% target, these being Professional Services, Cancer Services & Haematology, GI Medicine & Surgery and Musculo-Skeletal Services. In addition three management groups and three corporate areas have also met the 95% target.

We understand that in some areas the non-achievement of target is due to underreporting; systems and processes for reporting appraisal are being reviewed including the ESR self-service reporting. Checking mechanisms will also be revisited, appraisal data leads for all service areas and CMGs must be identified in the new structure to ensure accuracy.

A new procedure for appraisal delivery and reporting has been drafted and will be circulated Trust wide on approval.

6.2 Sickness

Mth | Qtr 1 | Qtr2 | YTD



The sickness rate for September is 3.85% and the August figure has now adjusted to 3.22% to reflect closure of absences. The overall cumulative sickness figure is now 3.35%. This is below the previous SHA's target of 3.4% but slightly above the Trust stretch target of 3%.

Amica Staff Counselling and Support Services, which is hosted by UHL, have recently produced their annual report for 2012-13 which highlights the work being undertaken to maintain healthy well being in the workplace. The report highlights that almost 1000 UHL employees accessed face to face counselling in the reporting period and Amica received positive feedback from clients stating that the service had prevented a period of sickness or supported an earlier return to work. Emotional Resilience training provided by Amica evaluates well and attendees report increased levels of confidence in managing stress at work.

This month the 'At Work for Patients' and 'Well Being' Groups have been combined

6.3 Mandated Training

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

Division	Fire Training %age	Moving & Handling %age	Hand Hygiene %age	Equality & Diversity %age	Info. Gover'ce %age	Safeguard Adults & Children %age	Personal Safety Aware'ss %age	Bullying & Harassm't %age	Resus - BLS Equivalent %age	Average %age Compliance
Refresher period in Months	12	24	12	36	12	36	36	n/a	12	
Currently Delivered by: (E = eLearning, F = Face to Face)	E&F	E&F	E	E	E	E	F	E	F	
Acute Care Total	66%	71%	65%	53%	46%	72%	38%	66%	59%	60%
Planned Care Total	67%	73%	59%	41%	47%	72%	29%	65%	83%	58%
Women's & Children's Total	66%	76%	60%	35%	37%	86%	22%	62%	76%	56%
UHL Corporate Directorates Total	45%	53%	41%	35%	42%	47%	18%	42%	57%	47%
Trustwide Compliance	62%	69%	58%	43%	44%	69%	29%	60%	69%	
UHL staff are this compliant with their mandatory & statutory training from the key 9 subjects										55%

At the end of September 2013 UHL staff compliance against Statutory and Mandatory Training has increased from 49% to 55% across the nine core areas. Some areas are making excellent progress in achieving the Trust's initial 75% compliance target (specific to 2013/14 only) and work is being undertaken in sharing areas of best practice.

Actions taken to improve performance include:-

- Revision of the Statutory and Mandatory Training policy to reflect the national programme and this is currently out for consultation
- OCB media commissioned to produce the e-learning modules to support the revision of Statutory and Mandatory Training, with the first three modules rolled out on 16th October 2013.
- Extra resuscitation places have been made available and all staff sent email reminders and guidance for priority subject compliance via e-UHL.
- A comprehensive communications plan is being constructed and will feature highlights to all new training products available, details of the implementation of the newly proposed Content/learning management system and system support details.
- An option appraisal has been taken to investigate the most suitable system to use (e-UHL, Dynamic OLM and OCB solutions) and
- System changes are currently being worked on to ensure accurate and real-time reporting of Statutory and Mandatory training completion.

7.0 2013/14 CONTRACTUAL QUERY STATUS

Commissioner Notices	Subject	Action/Update	Associated Penalty	Status
Contract Query	Cancer 62 Day	Remedial Action Plan (RAP) has been signed off Monthly progress reports against the agreed RAP	-	Completed Monthly Progress Report
Contract Query	ED Performance	Remedial Action Plan & Trajectory Agreed Performance against trajectory is failing.	2% Overall Contract penalty commencing August Automatic Contract Penalty	Failing to meet RAP
Contract Query	18 Wk RTT	Revised Remedial Action Plan rejected September 2013. Intensive Support Team commenced work with Trust in October. Revised trajectory being worked up alongside the RAP	2% overall contract value commencing September. Automatic Individual specialty penalties	RAP Rejected This will result in a 2% overall contract penalty in M6
Contract Query	Ambulance Turnaround	Remedial Action Plan has been signed off. Agreement to re-invest incurred penalties upon trajectory achievement for the requested £90-£100k	Automatic Contract Penalty	On-going
Contract Query	Pressure Ulcers	Remedial Action Plan (RAP) has been signed off The action plan is reported as RED against the trajectory. CCG's to work with UHL to see a significant sustained improvement	Three month review of performance before 2% overall contract penalty levied (Sept 13). Automatic penalties applied.	On-going
Contract Query	Stroke	Remedial Action Plan (RAP) has been signed off Monthly progress reports against the agreed RAP	-	Completed Monthly Progress Report
Contract Query	Short notice cancelled operations and rebooking in 28 days	Remedial Action Plan has been requested.	Automatic Contract Penalty	
Activity Query Notice	Emergency over performance	Emergency analysis provide by commissioners and initial meeting held. Discussed at October CPM. UHL to respond to a number of questions by 1st November.	Withholding over performance	On-going
Activity Query Notice	Outpatients over performance	Analysis awaited from commissioners.	Withholding over performance	On-going

8.0 UHL - FACILITIES MANAGEMENT– RACHEL OVERFIELD

8.1 Introduction

This report provides a summary of the performance of Facilities Management (FM) services as provided through the contract with Interserve for September which was month 7 of their operation.

8.2 Key Performance Indicators

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

Table 1 - UHL KPI Status Summary - September 2013

KPI Status (Change since last month)	Number of KPIs July to August	Number of KPIs August - September
Green	**49**	**48**
Deteriorated	7	2
Improved	10	10
No change	32	36
Amber	**6**	**5**
Deteriorated	2	3
Improved	4	2
Red	**26**	**28**
Deteriorated	18	15
Improved	8	13
Not Measured/In abeyance	**2**	**2**
	83	83
Net number improved minus number deteriorated	-5	+5

The above table when viewed overall shows a levelling in performance for September with improvements in some areas.

Table 2 on page 31 is an extract of 10 KPI's covering key services which are currently being closely monitored by the Trust to identify indicative service delivery across the 3 acute hospital sites. A similar picture is demonstrated from this information in respect in the "levelling off" of performance. Encouragingly this analysis shows an overall improvement in performance scores for September whilst some of the RAG rated KPI's remain unchanged.

Table 2 - KEY PERFORMACE INDICATORS FOR SEPTEMBER

Ref	Service	KPI	Red	Green	Sept	Change
2	Contract Management	Average score (%) of Customer Surveys returned in the Contract Month	≤ 80%	≥ 90%	100.00%	↑
7	Estates	Percentage of statutory inspection and testing completed in the Contract Month measured against the PPM schedule	≤ 98%	100.0%	74.61%	↑
12	Estates	Percentage of Urgent requests achieving response time	≤ 96%	≥ 98%	36.36%	↑
13	Estates	Percentage of Urgent requests achieving rectification time	≤ 96%	≥ 98%	90.91%	↑
26	Portering	Percentage of scheduled Portering tasks completed in the Contract Month	≤ 98%	99%	100.00%	←→
27	Portering	Percentage of Emergency Portering requests achieving response time	≤ 98%	100.0%	64.29%	↓
45	Cleaning	Monthly percentage of Joint Audits undertaken against agreed schedules	≤ 98%	100.0%	87.43%	↓
46	Cleaning	Percentage of audits in clinical areas achieving NCS audit scores for cleaning above 90%	≤ 98%	100.0%	85.71%	↑
57	Patient Catering	Percentage of meals delivered to wards in time for the designated meal service as per agreed schedule.	≤ 95%	97.0%	97.11%	↑
81	Helpdesk	Percentage of telephone calls to the helpdesk answered within 5 rings using a non-automated solution.	≤ 95%	≥ 97%	96.10%	↑

8.3 Service Update

Interserve have submitted a Remedial Action Plan to the Trust having identified key root causes of weak performance. In summary these relate to the transformation of services particularly management of change, workforce issues and technological challenges. Interserve are implementing changes and have identified that improvements will be demonstrated through October and November.

To support this process the Trust staff and NHS Horizons are actively supporting Interserve in reviewing and implementing improvements with a specific focus on cleaning and patient catering services at ward level. Interserve are also actively engaging additional management and staff to ensure robust and reliable services are delivered consistently and in line with contractual requirements.

The refurbishment of the UHL restaurants was completed on 22 August for the LRI and GGH facilities, and early September for the LGH. Initial feedback has proved positive with regards the environment, but critical of the costs for many items. In response Interserve in conjunction with the Trust have reviewed the options, information and pricing structure of

their restaurant menu and a number of changes to broaden the budget range on offer have been introduced.

9.0 September IM&T Service Delivery Review

9.1 Highlights

Go live of Xcelera a replacement for the Heartlab system
Upgrade to the JAC Pharmacy system
Upgrade to the Clinical Form Electronic Handover system

9.2 IT Service Review

There were 7296 incidents were logged during September, out of which 7138 were resolved. 1990 or these incidents were closed on first contact

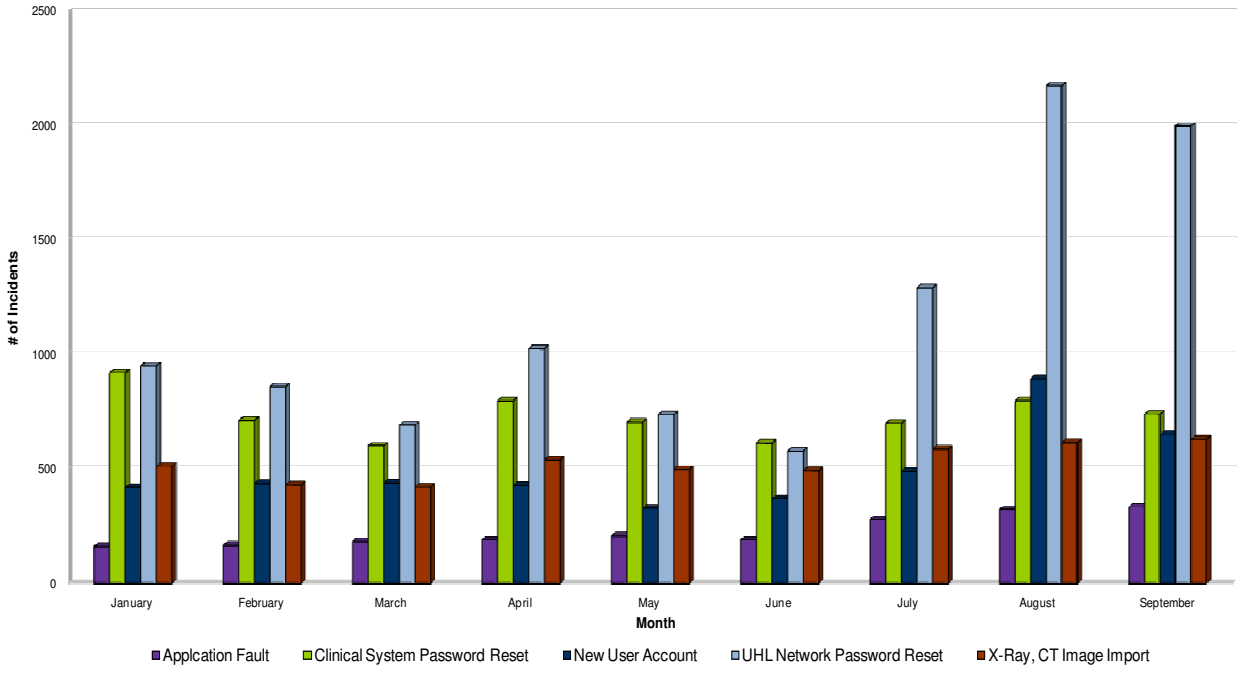
Performance against service level agreements is as expected and follows the flight path for service level agreements improvements following the transfer of staff to the Managed business Partner.

There were 1,005 incidents logged out of hours via the 24/7 service desk function

9.3 Telecommunication Team update

The telecommunication team reduced in WTE due to Telecoms Manager leaving employment. To backfill this post the Managed Business Partner have employed an experienced telecoms engineer.

9.4 IM&T Service Desk top 5 issues



9.5 IM&T September Heatmap

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

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

Service Level Agreements

Red : <90% of calls resolved within SLA

Amber : 90-94.99% of calls resolved within SLA

Green : >95% of calls resolved within SLA

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

10.0 FINANCE – ANDREW SEDDON

10.1.1 This paper summarises the Month 6 financial position. As well as the following commentary, this report contains a number of key financial statements included at the end of this finance section.

- Income and Expenditure
- Balance Sheet
- Cash Flow
- Capital Programme
- CIP Performance by CMG (and Division and CBU)
- Financial Performance by CMG (and Division and CBU)

10.2 FINANCIAL POSITION AS AT END OF SEPTEMBER 2013

10.2.1 The Trust is reporting a deficit at the end of September 2013 of £16.6m, which is approximately £16.0m adverse to the planned deficit of £0.6m. The position to date also reflects £5.0m of the contingency release recognised in the Month 6 result – consistent with the Annual Plan assumptions.

The in month position is a £3.2m deficit, £3.4m adverse to the Plan.

10.2.2 Table 1 outlines the current position and Table 2 outlines the Financial Risk Rating (FRR). The consequence of the current financial performance, predominately the £16.6m actual deficit, is that the FRR is 2.2. In addition, the Trust is risk rated at Level 4 by the NHS Trust Development Authority (NTDA), a rating reserved for Trusts either planning or at high risk of delivering a deficit for the year.

Table 1: Income & Expenditure Position

	Sept 2013			April -Sept 2013		
	Plan £m	Actual £m	Var £m	Plan £m	Actual £m	Var £m
Income						
Patient income	53.5	53.6	0.1	318.7	320.5	1.8
Contigency Release	0.0	0.0	0.0	5.0	5.0	0.0
Teaching, R&D	6.2	5.8	(0.4)	38.5	38.0	(0.6)
Other operating Income	3.6	3.2	(0.4)	19.8	19.1	(0.6)
Total Income	**63.2**	**62.5**	**(0.7)**	**382.0**	**382.6**	**0.6**
Operating expenditure						
Pay	37.0	38.6	(1.6)	223.3	233.1	(9.8)
Non-pay	22.3	23.7	(1.4)	137.3	144.7	(7.4)
Total Operating Expenditure	**59.3**	**62.3**	**(3.0)**	**360.6**	**377.7**	**(17.1)**
EBITDA	**3.9**	**0.2**	**(3.7)**	**21.4**	**4.9**	**(16.5)**
Net interest	0.0	(0.1)	0.0	0.0	(0.0)	(0.0)
Depreciation	(2.7)	(2.7)	0.0	(16.2)	(16.0)	0.2
PDC dividend payable	(1.0)	(0.6)	0.3	(5.8)	(5.5)	0.3
Net deficit	**0.3**	**(3.2)**	**(3.4)**	**(0.6)**	**(16.6)**	**(16.0)**
EBITDA %		**0.4%**			**1.3%**	

Table 2: Financial Risk Rating

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

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

- **Patient care income £1.8m (0.6%)** favourable against Plan, mainly due to outpatients
- **Pay costs, £9.8m (4.4%) adverse to Plan**
- **Non pay costs, £7.4m (5.4%)** adverse to Plan
- **CIP performance** of £1.0m adverse to Plan
- Adverse variances across all Divisions – we are also showing performance by the new Clinical Management Groups in the attached appendices.

There has been no recognition of any components of additional income assumed in the Trust's September recovery plan as these are in discussion with Commissioners.

The **Month 6 YTD position** may be analysed as follows.

10.3 INCOME

10.3.1 Within patient income, NHS income is £2.7m (0.9%) above Plan year to date. The key areas are shown in the following table:

- Elective IP activity is 3.8% down on Plan, but income is £83k (0.2%) favourable
- Emergency IP activity 3.2% up on Plan, but income is £232k (0.3%) adverse
- Over-performance in outpatients, £1.6m (4%) and ED, £0.2m (1.8%)

Table 3: Patient Care Activity

Case mix	Plan to Date (Activity)	Total YTD (Activity)	Variance YTD (Activity)	Variance YTD (Activity %)	Plan to Date (£000)	Total YTD (£000)	Variance YTD (£000)	Variance YTD (Activity %)
Day Case	40,407	41,770	1,363	3.37	24,653	25,173	520	2.11
Elective Inpatient	11,368	10,932	(436)	(3.84)	35,272	35,356	83	0.24
Emergency / Non-elective Inpatient	46,857	48,358	1,501	3.20	88,419	88,187	(232)	(0.26)
Marginal Rate Emergency Threshold (MRET)	0	0	0	0.00	(1,706)	(1,706)	(0)	0.00
Outpatient	365,725	376,776	11,051	3.02	41,594	43,237	1,642	3.95
Emergency Department	79,106	79,404	298	0.38	8,491	8,647	155	1.83
Other	3,865,464	3,928,706	63,242	1.64	118,386	118,912	526	0.44
Grand Total	**4,408,928**	**4,485,946**	**77,019**	**1.75**	**315,110**	**317,805**	**2,695**	**0.86**

10.3.2 Table 4 below highlights the impact of price and volume changes in activity across the major "points of delivery". Overall, this shows that the £2.7m Trust level over-performance is as a consequence of a volume (activity) related £4.1m favourable impact, lessened slightly by a £1.4m adverse shift in average tariff prices.

Table 4: Price and Volume Impact on Patient Care Activity

Average tariff	Price Variance YTD %	Volume Variance YTD %	Price / Mix Variance (£000)	Volume Variance (£000)	Variance YTD (£000)
Day Case	(1.2)	3.4	(311)	831	520
Elective Inpatient	4.2	(3.8)	1,437	(1,354)	83
Emergency / Non-elective Inpatient	(3.4)	3.2	(3,065)	2,833	(232)
Marginal Rate Emergency Threshold (MRET)			(0)	0	(0)
Outpatient	0.9	3.0	386	1,257	1,642
Emergency Department	1.4	0.4	124	32	155
Other			0	526	526
Grand Total	**(0.9)**	**1.7**	**(1,431)**	**4,125**	**2,695**

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

Some of the adverse mix in non-elective IP is attributable to a loss of tertiary cardiology work to Lincolnshire. The specialty is seeking to recover this activity. The majority of the non-elective/emergency favourable volume variances relate to under-delivery on Commissioner led deflection schemes. There has also been a change in treatment of elderly short stay patients which pushes up emergency attendances but depresses average tariff. This is under discussion with Commissioners.

10.3.3 Within the year to date income position, we have made provision for the following **penalties**. Year to date, this amounts to just over £4m, £1.1m if we exclude re-admissions.

Table 5: Penalties & Fines

	£'000s
EM Readmissions	2,878
RTT	470
Ambulance Turnaround	-
Diagnostic Imaging	17
Never Events	4
Pressure Ulcers	36
Cancelled Ops	44
ED Wait Times (automatic)	168
ED 12 Hour Trolley Breaches	3
Cancer 62 Day Target (Automatic)	50
Contract Penalties Provision	50
CQUIN Provision	300
Total	**4,020**

The key RTT penalties relate to General Surgery, ENT, Ophthalmology and Orthopaedics. Other includes pressure ulcers, cancelled operations and ED 12 hour trolley breaches.

As can be seen in table 5, at the moment, we are not assuming any penalties around Ambulance Turnaround times, and the ED and RTT rapid action plans.

10.4 EXPENDITURE

10.4.1 Operating expenditure is £17.1m above Plan as at the end of September (4.7%).

10.4.2 The Divisions/CBUs have identified that a total of £14.7m CIP savings have been delivered year to date, representing a £1.0m adverse variance to the £15.7m CIP Plan. The 2013/14 CIP paper provides further details on the CIP performance to date, year end forecasts, remedial action plans and RAG ratings for the remaining schemes.

10.4.3 **PAY –** as at Month 6, pay costs are £9.8m over budget, £12.5m more than the same period in 2012/13 (5.7%). When viewed by staff group, the most significant increases year on year are seen across agency and medical locums, nursing spend and consultants' costs (see below).

Table 6

Staff Type	2013/14 £'000s	2012/13 £'000s	Change £'000s	Change %
A&C / Managers	29,267	30,217	950	3.1
Agency / Medical Locums	11,184	7,865	(3,319)	(42.2)
Allied Health Prof's	9,341	9,413	72	0.8
Medical - Non Consultant	30,984	30,194	(790)	(2.6)
Consultant	44,304	40,131	(4,174)	(10.4)
Nursing & Midwifery	86,714	82,067	(4,647)	(5.7)
Other	21,283	20,655	(627)	(3.0)
TOTAL	**233,076**	**220,541**	**(12,535)**	**(5.7)**

10.4.4 Analysis of the year to date £9.8m variance to Plan highlights the following key factors:

- Estimated pay over-spend due to patient care activity over-performance **- £2.0m,** assuming that pay stepped/marginal cost is c50% of patient care income volume variance and staffed at non-premium rates
- Declared under-delivery on pay CIP schemes £**1.4m**
- Continued use of extra capacity wards (Fielding Johnson, Ward 1 LRI, Ward 2 LGH, Ward 19 LRI and Odames LRI) to meet the emergency activity levels. Premium spend has covered a significant amount of the staff costs in these areas. Nursing incentives are also being paid to bank and agency to increase the "fill rates", although these are now restricted to the Emergency Care CBU
- The "old" Acute Care Division has been rostering more doctors and nurses in Medicine and ED to ensure the flow of patients from ED to support the 4 hour target
- A continued reliance on premium payments as per Chart 1 below. Increases have continued into this financial year, climbing to almost £4m in May and June, falling to £3.5m in July, and remaining around this level for the last two months. Table 7 illustrates the relative percentages of total pay spend of each type. It can be seen that there has been a significant rise in the total percentage to almost 10% in quarter 1 of this financial year (falling to 9% in Month 6).

Chart 1: Non-Contracted/Premium Pay Spend

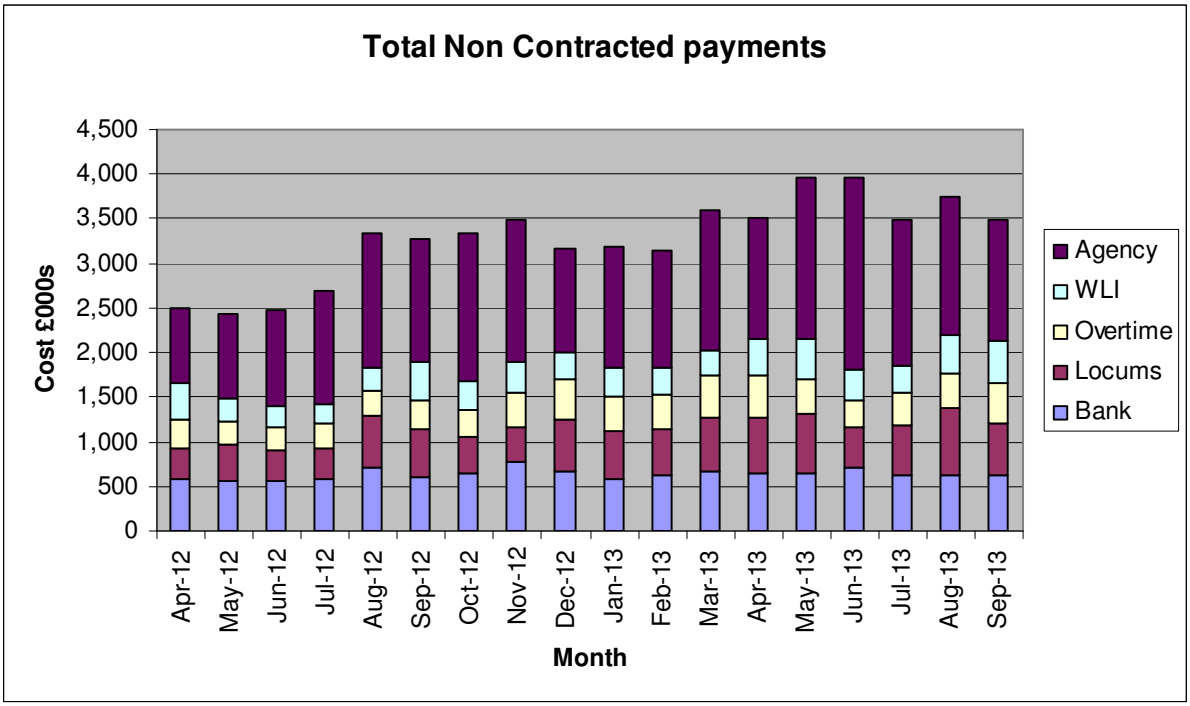


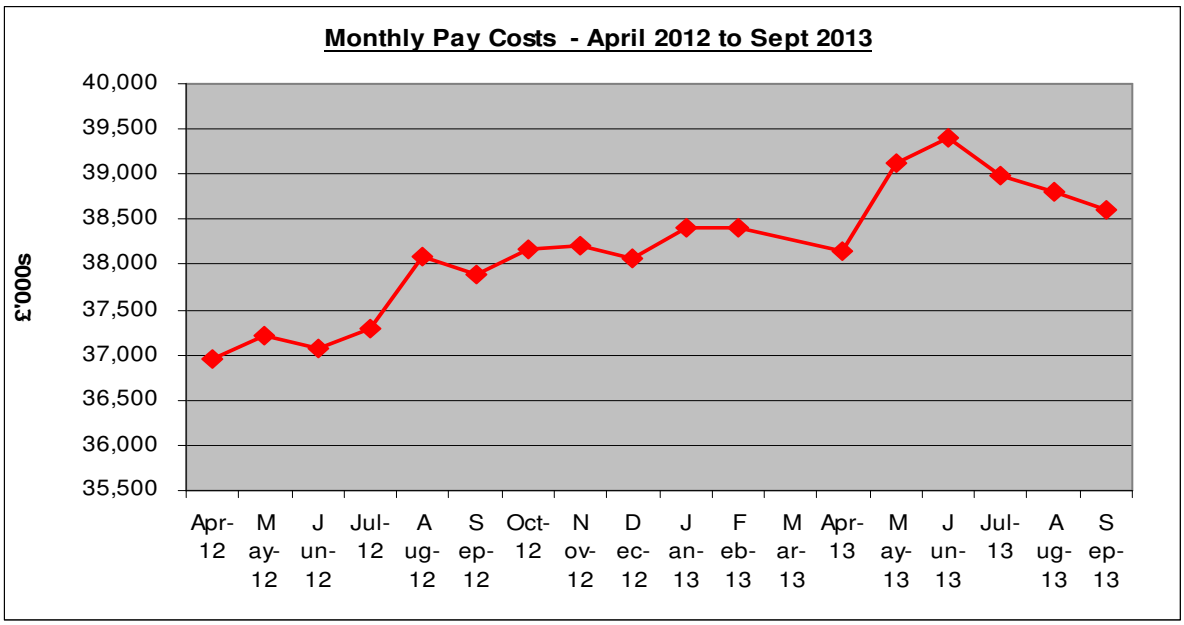
Table 7: Non-Contracted Pay Costs as %age of Total Pay Bill

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

10.4.5 Pay costs have continued to rise steadily from April 2012 to July 2013, hitting a peak of £39.4m in June; July saw a reduction to £39.0m with August (£38.8m) and September continuing this trend down at £38.6m. Whilst the downwards trend is encouraging, the level of monthly pay spend is not sustainable. Chart 2 shows the pay costs from April 2012 until September 2013.

Nursing and related agency costs make up the largest part of the adverse pay variance. Some of the overspend, as described above, is volume related (extra capacity opened) and the impact of agency rates is clear. Increase in nurse to bed ratios has also pushed up costs. The challenges associated with the nursing workforce are described in the separate paper to F&P Committee.

Chart 2: Monthly Pay Costs



10.4.6 The continued reliance on premium staff comes at the same time as our contracted staff numbers in medical and nursing professions have increased by 3.5%, equivalent to an increase of 217 WTE since March 2012 (Table 8).

Table 8: Contracted WTE

Staff Type	Movement Sept 13 March 12		Contracted Staff	
	WTE	(%)	Sept 13 WTE	March 12 WTE
ADMIN & CLERICAL	(25)	(1.4)	1,761	1,787
ALLIED HEALTH PROFESSIONALS	(10)	(2.2)	448	458
CAREER GRADES	7	10.6	77	70
CONSULTANT	46	8.7	579	533
HEALTHCARE ASSISTANTS	18	8.5	236	217
HEALTHCARE SCIENTISTS	(20)	(2.7)	721	741
MAINTENANCE & WORKS	1	10.6	7	6
NURSING QUALIFIED	11	0.3	3,360	3,348
NURSING UNQUALIFIED	106	8.8	1,300	1,195
OTHER MEDICAL & DENTAL STAFF	28	3.1	927	899
OTHER SCIEN, THERAP & TECH	37	13.6	312	274
SENIOR MANAGERS	(34)	(20.0)	137	171
TOTAL	**166**	**1.7**	**9,864**	**9,699**
MEDICAL & NURSING	217	3.5	6,479	6,262
OTHER STAFF GROUPS	(51)	(1.5)	3,386	3,437
TOTAL	**166**	**1.7**	**9,864**	**9,699**

10.4.7 **NON PAY** - spend is now showing a YTD adverse position to Plan of £7.4m (5.4%) which is spread across all four Divisions (Table 9 provides the breakdown by Division).

10.4.8 This is as a result of four main factors:

- Declared under-delivery of non pay CIP schemes - **£1.3m**

- Activity related marginal costs e.g. keeping Ward 19 open - **£1.1m** (assuming that non pay marginal cost is c25% of patient care income variance)
- Patient care income backed costs such as NICE/HCT costs - **£1.4m** e.g. haemophilia patients, high cost devices in Acute and Women's & Children's
- Other cost pressures/over-stated non-pay CIP delivery - **£3.6m.** This includes:

    - £0.6m Imaging consumables
    - £0.4m Use of independent sector
    - £0.4m Blood products
    - £0.5m Printing, stationery and postage
    - £0.2m Security
    - £0.5m Maintenance and MES costs
    - £0.6m Consultancy
    - £0.3m Furniture, office equipment and IT

CIP Performance

10.4.9 Reported performance against the 2013/14 Plan is showing an adverse position of £1.0m against the Plan of £15.7m – 94% delivery. The CBU, Divisional and CMG details are reflected in the appendices and further analysis is covered within the CIP paper.

Table 9: Divisional Financial Performance

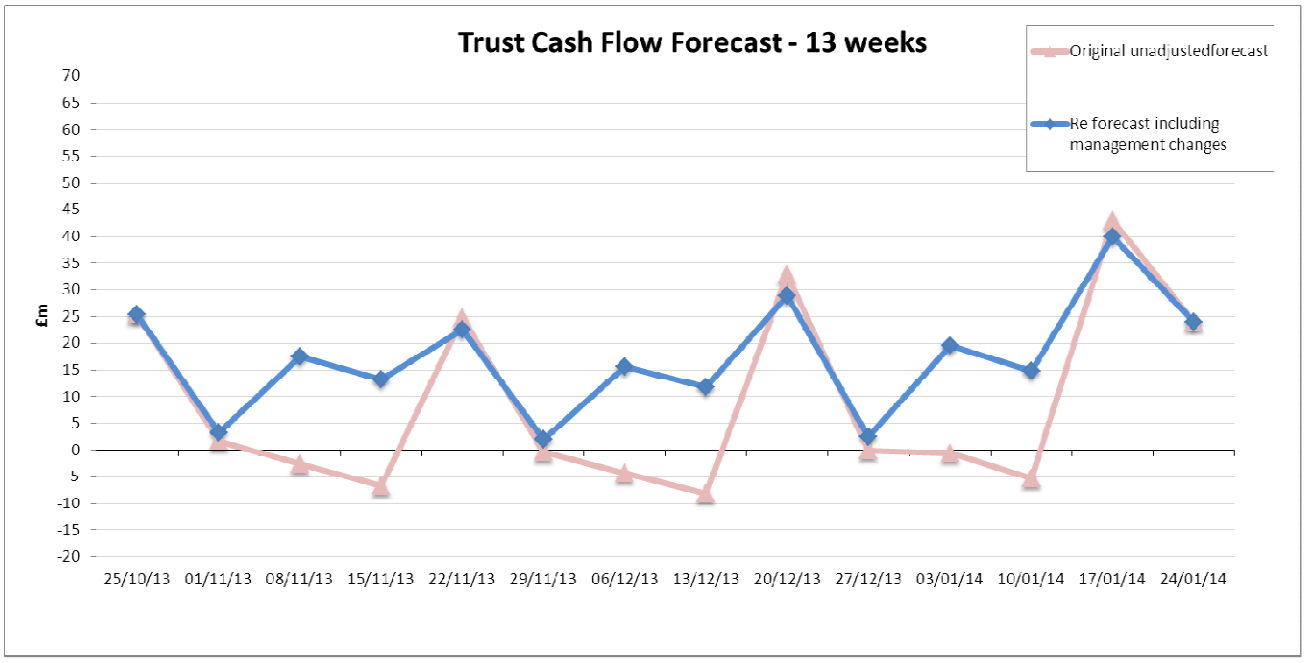
Division	Income			Pay Expenditure			Non Pay Expenditure			Total		
	Plan £'000	Actual £'000	Variance £'000	Plan £'000	Actual £'000	Variance £'000	Plan £'000	Actual £'000	Variance £'000	Plan £'000	Actual £'000	Variance £'000
Acute Care Division	125,643	127,729	2,085	85,011	90,854	(5,843)	42,615	45,365	(2,750)	**(1,983)**	**(8,490)**	**(6,507)**
Planned Care Division	122,014	121,644	(370)	71,290	73,259	(1,969)	37,016	39,497	(2,481)	**13,708**	**8,887**	**(4,821)**
Women's & Children's Division	69,967	70,061	94	37,082	36,955	127	14,742	15,232	(490)	**18,142**	**17,873**	**(269)**
Corporate Division	31,492	31,872	379	31,813	31,942	(128)	42,537	43,916	(1,379)	**(42,858)**	**(43,986)**	**(1,128)**

As reflected in the above table, all Divisions are showing an adverse position to the Plan. Note that this is the last month in which Divisions and Clinical Business Units (CBUs) will be the principal operating entities within UHL. Seven Clinical Management Groups, each of approximately £100m cost base, have been established and will report directly to the Chief Operating Officer. Financial plans and accountabilities have substantially been transferred and new clinical/management teams are in place.

10.5 CASH

10.5.1 The Trust's cash balance was £4.5m at the end of September 2013, following payment of the mid-year PDC dividend in September.

10.5.2 In mid-November, December and January, the cash balance is forecast to fall below the £2m minimum allowable level before any management actions are taken, as shown on the following graph:



10.5.3 The main management action that has been taken to cover these shortfalls is that we have agreed with CCGs to bring forward an element of the monthly SLA payments to the beginning of each month (instead of the usual 15th of the month). This will help us to maintain sufficient operating levels of cash. Cash management actions are the subject of a separate paper to the Finance and Performance Committee.

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

- Payroll, tax and national insurance (£36m per month)
- Large business critical suppliers
- Small local suppliers which are dependent on income from the Trust (£20k per month).

10.6 CAPITAL

10.6.1 The Trust has spent £10.4m of capital at the end of September 2013, which is approximately 75% of the YTD Plan.

10.6.2 Progress against the Capital Plan will be monitored via the Commercial Executive and actions taken as appropriate to manage the programme.

10.7 CONCLUSION

10.7.1 The Trust has reported to the TDA that we are £16.0m adverse to our planned £0.6m deficit. Plans and actions have reduced the run rate, but we are £0.5m adverse on the cost position to our September recovery plan. Energy and focus is being directed around the CMG units to improve the current run rate and get back to a sustainable financial position, whilst not impacting negatively on the quality of patient care. Urgent discussions continue with Commissioners and the TDA regarding additional income and support to allow the Trust to deliver a breakeven position for the year.

Income and Expenditure Account for the Period Ended 30 September 2013

	September 2013			April 2013 - September 2013		
	Plan	Actual	Variance (Adv) / Fav	Plan	Actual	Variance (Adv) / Fav
	£ 000	£ 000	£ 000	£ 000	£ 000	£ 000
Elective	5,519	**5,606**	88	35,272	**35,356**	83
Day Case	4,076	**4,293**	216	24,653	**25,173**	520
Emergency	14,365	**14,195**	(170)	86,713	**86,481**	(232)
Outpatient	7,073	**7,344**	271	41,594	**43,237**	1,642
Contingency Release	0	**0**	0	5,000	**5,000**	0
Non NHS Patient Care	605	**501**	(104)	3,623	**2,737**	(886)
Other	21,829	**21,635**	(194)	126,878	**127,559**	681
Patient Care Income	**53,467**	**53,575**	**108**	**323,733**	**325,542**	**1,809**
Teaching, R&D income	6,191	**5,795**	(396)	38,511	**37,950**	(561)
Other operating Income	3,566	**3,167**	(399)	19,758	**19,143**	(615)
Total Income	**63,224**	**62,537**	**(687)**	**382,002**	**382,635**	**633**
Pay Expenditure	**37,027**	**38,609**	**(1,582)**	**223,322**	**233,076**	**(9,754)**
Non Pay Expenditure	**22,254**	**23,699**	**(1,445)**	**137,270**	**144,651**	**(7,381)**
Total Operating Expenditure	**59,281**	**62,308**	**(3,027)**	**360,592**	**377,727**	**(17,135)**
EBITDA	**3,943**	**229**	**(3,714)**	**21,410**	**4,908**	**(16,502)**
Interest Receivable	7	**4**	(3)	41	**119**	78
Interest Payable	(5)	**(108)**	(103)	(30)	**(128)**	(98)
Depreciation & Amortisation	(2,707)	**(2,697)**	10	(16,241)	**(16,025)**	216
Surplus / (Deficit) Before Dividend and Disposal of Fixed Assets	**1,238**	**(2,572)**	**(3,810)**	**5,180**	**(11,126)**	**(16,306)**
Dividend Payable on PDC	(964)	**(634)**	330	(5,784)	**(5,454)**	330
Net Surplus / (Deficit)	**274**	**(3,206)**	**(3,480)**	**(604)**	**(16,580)**	**(15,976)**
EBITDA MARGIN		**0.37%**			**1.28%**	

Balance Sheet

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

Cash Flow Forecast

Cash Flow for the period ended 30th September				Rolling 12 month cashflow forecast - October 2013 to September 2014											
	2013/14 Apr - Sep Plan £ 000	2013/14 Apr - Sep Actual £ 000	2013/14 Apr - Sep Variance £ 000	2013/14 October Forecast £ 000	2013/14 November Forecast £ 000	2013/14 December Forecast £ 000	2013/14 January Forecast £ 000	2013/14 February Forecast £ 000	2013/14 March Forecast £ 000	2014-15 April Forecast £ 000	2014-15 May Forecast £ 000	2014-15 June Forecast £ 000	2014-15 July Forecast £ 000	2014/15 August Forecast £ 000	2014/15 September Forecast £ 000
CASH FLOWS FROM OPERATING ACTIVITIES															
Operating surplus before Depreciation and Amortisation	23,165	4,908	(18,257)	6,199	4,566	3,658	5,321	1,279	3,366	2,098	5,468	2,098	5,468	5,468	2,971
Donated assets received credited to revenue and non cash	(1,100)	(115)	985	(25)	(25)	(25)	(25)	(25)	(26)	(26)	(26)	(26)	(26)	(26)	(26)
Interest paid	(420)	(424)	(4)	(77)	(77)	(77)	(77)	(79)	(78)	(82)	(82)	(81)	(81)	(80)	(80)
Movements in Working Capital:															
- Inventories (Inc)/Dec	(207)	(1,435)	(1,228)												
- Trade and Other Receivables (Inc)/Dec	2,148	(1,019)	(3,167)	14	50	65	20	74	2,937	(2,869)	(10)	41	9	8	41
- Trade and Other Payables Inc/(Dec)	(278)	4,570	4,848	(65)	(65)	(65)	(65)	(65)	(64)	(83)	(83)	(83)	(83)	(83)	(83)
- Provisions Inc/(Dec)				(8)	(8)	(8)	(8)	(8)	(8)	(8)	(8)	(8)	(8)	(8)	(8)
PDC Dividends paid	(5,568)	(5,454)	114						(5,619)						(5,615)
Other non-cash movements		162	162										(21)		
Net Cash Inflow / (Outflow) from Operating Activities	**17,740**	**1,193**	**(16,547)**	**6,038**	**4,440**	**3,547**	**5,166**	**1,176**	**508**	**(970)**	**5,259**	**1,941**	**5,258**	**5,279**	**(2,800)**
CASH FLOWS FROM INVESTING ACTIVITIES															
Interest Received	32	35	3	6	7	8	8	8	8	6	6	6	6	7	7
Payments for Property, Plant and Equipment	(15,750)	(14,200)	1,550	(2,250)	(2,251)	(2,251)	(2,252)	(2,251)	(2,262)	(2,294)	(2,295)	(2,294)	(2,295)	(2,294)	(2,295)
Capital element of finance leases	(2,316)	(2,530)	(214)	(382)	(382)	(382)	(382)	(382)	(384)	(391)	(391)	(391)	(391)	(391)	(391)
Net Cash Inflow / (Outflow) from Investing Activities	**(18,034)**	**(16,695)**	**1,339**	**(2,626)**	**(2,626)**	**(2,625)**	**(2,626)**	**(2,625)**	**(2,638)**	**(2,679)**	**(2,680)**	**(2,679)**	**(2,680)**	**(2,678)**	**(2,679)**
CASH FLOWS FROM FINANCING ACTIVITIES															
New PDC															
Other Capital Receipts															
Net Cash Inflow / (Outflow) from Financing															
Opening cash	18,200	19,986	1,786	**4,484**	**7,896**	**9,711**	**10,632**	**13,172**	**11,723**	**9,593**	**5,944**	**8,523**	**7,785**	**10,363**	**12,964**
Increase / (Decrease) in Cash	(294)	(15,502)	**(15,208)**	3,412	1,814	922	2,540	(1,449)	(2,130)	(3,649)	2,579	(738)	2,578	2,601	(5,479)
Closing cash	**17,906**	**4,484**	**(13,422)**	**7,896**	**9,711**	**10,632**	**13,172**	**11,723**	**9,593**	**5,944**	**8,523**	**7,785**	**10,363**	**12,964**	**7,485**

Capital Programme

	Capital Plan 2013/14	YTD Spend 13/14	Expenditure Profile												Forecast Out Turn	Variance
			Actual						Forecast							
			Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar		
	£000's	£000's	£000's	£000's	£000's	£000's	£000's	£000's	£000's	£000's	£000's	£000's	£000's	£000's	£000's	£'000's
Sub Group Budgets																
IM&T	3,375	1,786	69	226	290	203	688	311	220	616	129	116	146	362	3,375	0
Medical Equipment	4,187	1,332	264	7	209	119	386	347	553	589	300	400	506	507	4,187	0
Facilities Sub Group	6,000	1,476	286	204	193	388	261	143	365	500	650	997	1,000	1,012	6,000	0
Total Sub Groups	**13,562**	**4,594**	**619**	**437**	**693**	**709**	**1,335**	**800**	**1,138**	**1,705**	**1,079**	**1,513**	**1,652**	**1,882**	**13,562**	**0**
Acute Care																
Divisional Discretionary Capital	200	24	8	1	3	11	2	(0)	13	21	17	23	29	73	200	0
Emergency Flow	4,000	310	2	7	14	79	79	130	100	100	100	1,600	1,600	190	4,000	0
Total Acute Care	**4,200**	**334**	**10**	**8**	**16**	**89**	**80**	**129**	**113**	**121**	**117**	**1,623**	**1,629**	**263**	**4,200**	**0**
Planned Care																
Divisional Discretionary Capital	200	193	126	42	0	0	15	11	28	0	0	0	0	0	221	(21)
Osborne Ventilation	566	12	0	0	0	0	13	(1)	54	100	100	100	100	100	566	0
Endoscopy Redesign	250	135	0	80	(1)	24	5	28	35	0	0	0	0	0	170	80
Total Planned Care	**1,016**	**340**	**126**	**121**	**(1)**	**24**	**32**	**37**	**117**	**100**	**100**	**100**	**100**	**100**	**957**	**59**
Women's & Children's																
Divisional Discretionary Capital	200	46	16	23	6	(0)	0	1	58	15	15	20	17	29	200	0
Maternity Interim Development	2,800	1,023	3	18	9	273	388	332	298	310	300	312	304	253	2,800	0
Total Women's & Children's	**3,000**	**1,069**	**19**	**41**	**16**	**273**	**388**	**333**	**356**	**325**	**315**	**332**	**321**	**282**	**3,000**	**0**
Reconfiguration Schemes																
Theatres Assessment Area (TAA)	1,549	735	4	10	27	30	491	172	180	180	180	180	94	0	1,549	0
Advanced Recovery LRI & LGH	625	123	63	(7)	55	11	7	(6)	0	12	15	0	200	200	550	75
GGH Vascular Surgery	1,156	0	0	0	0	0	0	0	0	0	100	100	450	506	1,156	0
Hybrid Theatre (Vascular)	500	0	0	0	0	0	0	0	0	0	0	100	200	200	500	0
Daycase / OPD Hub	350	0	0	0	0	0	0	0	0	0	0	0	150	200	350	0
GH Imaging	500	0	0	0	0	0	0	0	0	0	0	100	200	200	500	0
Ward 4 LGH / H Block Isolation	283	0	0	0	0	0	0	0	33	0	0	50	100	100	283	0
GH Modular Wards * 2	4,050	0	0	0	0	0	0	0	50	0	0	500	500	3,000	4,050	0
Brandon Unit Refurb: OPD 1-4	2,000	10	0	0	0	0	5	4	0	100	400	500	500	490	2,000	0
ITU Consolidation	140	0	0	0	0	0	0	0	0	0	0	0	0	140	140	0
Poppies Conversion	250	0	0	0	0	0	0	0	0	50	100	100	0	0	250	0
Feasibility Studies	100	0	0	0	0	0	0	0	8	8	10	17	27	30	100	0
Total Reconfiguration	**11,503**	**867**	**68**	**3**	**82**	**42**	**503**	**170**	**271**	**350**	**805**	**1,647**	**2,421**	**5,066**	**11,428**	**75**
Corporate / Other Schemes																
Aseptic Suite	650	11	7	0	1	0	0	2	100	100	100	100	100	139	650	0
Diabetes BRU	600	492	0	62	125	128	141	37	145	113	0	0	0	0	750	(150)
Respiratory BRU	500	720	3	809	(245)	190	9	(46)	0	0	0	0	0	0	720	(220)
MES Installation Costs	1,750	1,457	38	178	343	455	40	403	200	200	250	250	200	193	2,750	(1,000)
Stock Management System	3,000	0	0	0	0	0	0	0	151	20	20	809	1,000	1,000	3,000	0
Other Developments	0	474	163	123	91	36	69	(9)	100	100	0	0	0	(1,911)	(1,236)	1,236
	6,500	**3,155**	**212**	**1,173**	**315**	**808**	**260**	**388**	**696**	**533**	**370**	**1,159**	**1,300**	**(579)**	**6,634**	**(134)**
Total Capital Programme	**39,781**	**10,359**	**1,054**	**1,783**	**1,121**	**1,945**	**2,598**	**1,858**	**2,691**	**3,134**	**2,786**	**6,374**	**7,423**	**7,014**	**39,781**	**0**

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

	September			Year to date			Projected Year End Out-turn					Financial Risk			
	Plan £000	Actual £000	Surplus / (Deficit) £000	Plan £000	Actual £000	Surplus / (Deficit) £000	Plan £000	Actual £000	Surplus / (Deficit) £000	Number of Schemes	Average Scheme Value (Actual/forecast) £'000	Red - forecast under-delivery £'000	Red £'000	Amber £'000	Green £'000
Acute															
Acute Care Division	0	0	**0**	0	0	**0**	0	0	**0**	0		0	0	0	
Cardiac Renal & Respiratory Cbu	321	355	**34**	1,772	1,564	**-208**	4,150	4,128	**-22**	31	133	22	0	719	3,409
Emergency Medicine Cbu	122	173	**51**	832	632	**-200**	1,718	1,932	**214**	12	161	-214	0	242	1,691
Specialty Medicine Cbu	120	138	**18**	803	637	**-166**	1,905	2,276	**371**	17	134	-371	0	394	1,882
Imaging & Medical Physics Cbu	195	222	**28**	802	627	**-174**	2,241	1,731	**-510**	19	91	510	0	519	1,212
Professional Services Cbu	106	133	**27**	578	643	**66**	1,267	1,338	**71**	26	51	-71	0	18	1,319
Sub-total - Acute	**863**	**1,022**	**158**	**4,786**	**4,103**	**-683**	**11,281**	**11,405**	**124**	**105**	**109**	**-124**	**-**	**1,892**	**9,512**
		118.3%			***85.7%***			***101.1%***				***-1.1%***	***0.0%***	***16.8%***	***84.3%***
Planned															
Cancer Haem & Onc Cbu	94	144	**50**	239	547	**308**	1,244	1,932	**688**	20	97	-688	-	626	1,306
Gi Medicine Surgery Cbu	161	181	**19**	925	779	**-146**	2,136	2,093	**-43**	20	105	43	-	187	1,906
Musculo Skeletal Cbu	170	136	**-34**	800	701	**-99**	1,986	1,814	**-172**	22	82	172	-	14	1,800
Planned Care Division	1	1	**0**	6	7	**0**	12	13	**1**	1	13	-1	-	-	13
Specialist Surgery Cbu	124	117	**-8**	521	507	**-15**	1,617	1,462	**-156**	22	66	156	-	342	1,120
Itaps Cbu	356	388	**32**	1,814	1,782	**-32**	4,405	4,393	**-12**	27	163	12	-	-	4,393
Sub-total - Planned	**907**	**966**	**59**	**4,306**	**4,322**	**16**	**11,400**	**11,707**	**307**	**112**	**105**	**-307**	**-**	**1,169**	**10,538**
		106.5%			***100.4%***			***102.7%***				***-2.7%***	***0.0%***	***10.3%***	***92.4%***
Clinical Support															
CSD Divisional Management	3	0	**-3**	18	19	**1**	36	19	**-17**	1	19	17	-	-	19
Sub-total - Clinical Support	**3**	**0**	**-3**	**18**	**19**	**1**	**36**	**19**	**-17**	**1**	**19**	**17**	**-**	**-**	**19**
		0.0%			***107.0%***			***53.5%***					***0.0%***	***0.0%***	***100.0%***
Women's and Children's															
Childrens Cbu	129	305	**176**	744	846	**102**	1,682	2,178	**496**	17	128	-496	-	56	2,121
W & C Divisional Management	2	0	**-2**	11	0	**-11**	22	0	**-22**	0		22	-	-	-
Womens Cbu	274	251	**-23**	1,563	1,356	**-206**	3,553	3,110	**-443**	16	194	443	-	18	3,092
Sub-total - Womens & Childrens	**405**	**556**	**151**	**2,317**	**2,202**	**-115**	**5,258**	**5,288**	**31**	**33**	**160**	**-31**	**-**	**74**	**5,214**
		137.3%			***95.0%***			***100.6%***				***-0.6%***	***0.0%***	***1.4%***	***99.2%***
Corporate															
Communications & Ext Relations	15	2	**-13**	55	11	**-44**	148	44	**-105**	3	15	105	-	-	44
Corporate & Legal	26	26	**0**	158	159	**1**	315	317	**2**	2	159	-2	-	-	317
Corporate Medical	-0	27	**27**	64	149	**85**	558	481	**-77**	3	160	77	-	332	149
Facilities	178	240	**63**	1,085	1,312	**227**	2,500	2,524	**24**	3	841	-24	-	-	2,524
Finance & Procurement	52	98	**46**	440	517	**77**	754	841	**87**	7	120	-87	-	-	841
Human Resources	40	48	**8**	252	297	**45**	505	540	**34**	21	26	-34	-	-	540
IMT	181	10	**-171**	1,067	185	**-882**	2,500	463	**-2,037**	10	46	2,037	-	111	352
Corporate Nursing	46	40	**-6**	319	285	**-34**	628	556	**-72**	11	51	72	-	-	556
Operations	41	51	**10**	251	264	**13**	614	574	**-40**	8	72	40	-	-	574
Strategic Devt	21	21	**0**	124	125	**1**	247	249	**2**	2	125	-2	-	-	249
Pathology Cbu	78	50	**-29**	470	330	**-140**	940	802	**-138**	5	160	138	-	120	682
Central	0	316	**316**	0	474	**474**	0	1,906	**1,906**	4	477	-1,906	-	1,077	830
	679	**930**	**251**	**4,285**	**4,106**	**-178**	**9,710**	**9,296**	**-414**	**79**	**118**	**414**	**-**	**1,640**	**7,657**
		137.0%			***95.8%***			***95.7%***				***4.3%***	***0.0%***	***16.9%***	***78.9%***
TRUST TOTAL	**2,857**	**3,474**	**617**	**15,712**	**14,753**	**-959**	**37,684**	**37,715**	**31**	**330**	**114**	**-31**	**0**	**4,775**	**32,940**
		121.6%			***93.9%***			***100.1%***				***-0.1%***	***0.0%***	***12.7%***	***87.4%***

FINANCIAL POSITION APRIL TO SEPTEMBER 2013

CBU	Patient Care Income			Other Income			Pay Expenditure			Non Pay Expenditure			Total				CIP PERFORMANCE			
	Plan £'000	Actual £'000	Variance £'000	Plan £'000	Actual £'000	Variance £'000	Plan £'000	Actual £'000	Variance £'000	Plan £'000	Actual £'000	Variance £'000	Plan £'000	Actual £'000	Variance £'000	RAG Rating	Plan £'000	Actual £'000	Variance £'000	RAG Rating
Acute Care Division			0	297	1	(296)	1,381	1,344	37	408	74	334	(1,492)	(1,417)	75	G	0	0	0	G
Cardiac Renal & Respiratory Cbu	62,734	62,826	91	1,628	1,200	(428)	28,281	28,927	(646)	20,999	22,471	(1,472)	15,083	12,628	(2,455)	R	1,772	1,564	(208)	R
Emergency Medicine Cbu	10,576	10,796	220	1,137	840	(297)	13,215	15,748	(2,533)	2,585	2,550	35	(4,088)	(6,662)	(2,575)	R	832	632	(200)	R
Imaging & Medical Physics Cbu	5,386	5,674	288	952	813	(139)	12,519	12,749	(231)	5,172	6,068	(895)	(11,353)	(12,331)	(977)	R	802	627	(174)	R
Professional Services Cbu	1,279	1,224	(55)	959	664	(295)	11,276	11,311	(35)	893	980	(87)	(9,932)	(10,404)	(472)	R	578	643	66	G
Specialty Medicine Cbu	39,363	42,253	2,890	1,333	1,439	105	18,340	20,775	(2,434)	12,557	13,222	(664)	9,799	9,696	(103)	R	803	637	(166)	R
Acute Care Division	**119,338**	**122,773**	**3,435**	**6,306**	**4,956**	**(1,350)**	**85,011**	**90,854**	**(5,843)**	**42,615**	**45,365**	**(2,750)**	**(1,983)**	**(8,490)**	**(6,507)**	R	**4,786**	**4,103**	**(683)**	R
Cancer Haem & Onc Cbu	26,522	27,590	1,068	523	692	169	8,329	8,426	(98)	12,535	13,826	(1,290)	6,181	6,030	(151)	R	239	547	308	G
Gi Medicine Surgery Cbu	32,096	31,694	(403)	962	773	(190)	15,005	14,803	201	5,342	5,980	(637)	12,711	11,683	(1,028)	R	925	779	(146)	R
Itaps Cbu	13,730	13,317	(413)	367	348	(19)	25,244	27,164	(1,920)	9,798	10,452	(653)	(20,945)	(23,951)	(3,005)	R	1,814	1,782	(32)	R
Musculo Skeletal Cbu	21,945	21,544	(400)	411	291	(120)	9,127	9,229	(102)	4,441	4,393	48	8,788	8,214	(574)	R	800	701	(99)	R
Planned Care Division			0	16	1	(15)	597	556	41	5	18	(13)	(587)	(573)	13	G	6	7	0	G
Specialist Surgery Cbu	24,884	24,983	99	558	412	(146)	12,989	13,082	(93)	4,894	4,829	65	7,560	7,484	(76)	R	521	507	(15)	R
Planned Care Division	**119,177**	**119,128**	**(50)**	**2,837**	**2,516**	**(321)**	**71,290**	**73,259**	**(1,969)**	**37,016**	**39,497**	**(2,481)**	**13,708**	**8,887**	**(4,821)**	R	**4,306**	**4,322**	**16**	G
Childrens CBU	26,751	27,443	691	775	636	(139)	13,647	13,902	(255)	4,547	4,743	(196)	9,332	9,434	102	G	744	846	102	G
W & C Divisional Management			0	30	30	(0)	257	221	36	5	5	(0)	(231)	(196)	36	G	11	0	(11)	R
Womens CBU	41,201	40,823	(378)	1,210	1,129	(80)	23,178	22,832	346	10,191	10,485	(294)	9,041	8,635	(406)	R	1,563	1,356	(206)	R
Women's & Children's Division	**67,952**	**68,265**	**313**	**2,015**	**1,796**	**(219)**	**37,082**	**36,955**	**127**	**14,742**	**15,232**	**(490)**	**18,142**	**17,873**	**(269)**	R	**2,317**	**2,202**	**(115)**	R
Communications & Ext Relations			0	17	10	(6)	399	438	(39)	61	62	(1)	(443)	(490)	(46)	R	55	11	(44)	R
Corporate & Legal			0	0	72	72	486	485	0	584	698	(114)	(1,069)	(1,111)	(42)	R	158	159	1	G
Corporate Medical			0	728	755	27	1,897	1,894	4	458	363	95	(1,628)	(1,502)	126	G	64	149	85	G
Facilities			0	5,734	5,762	28	637	597	40	27,133	26,369	763	(22,036)	(21,204)	831	G	1,085	1,312	227	G
Finance & Procurement			0	25	24	(1)	2,099	2,073	26	1,348	1,277	71	(3,422)	(3,325)	97	G	440	517	77	G
Human Resources			0	1,429	1,592	163	2,720	2,683	37	908	1,010	(102)	(2,199)	(2,101)	98	G	252	297	45	G
Im&T			0	104	102	(3)	1,814	1,706	108	2,039	3,163	(1,124)	(3,749)	(4,768)	(1,019)	R	1,067	185	(882)	R
Nursing			0	138	153	16	2,797	2,540	257	6,634	6,671	(38)	(9,293)	(9,059)	235	G	319	285	(34)	R
Operations			0	0	35	35	2,040	2,060	(20)	148	189	(41)	(2,188)	(2,215)	(27)	R	251	264	13	G
Pathology Cbu	5,283	5,440	157	1,716	1,860	144	10,034	10,439	(405)	(5,014)	(4,430)	(584)	1,980	1,292	(688)	R	124	125	1	G
Strategic Devt			0	0	58	58	626	763	(136)	18	216	(198)	(644)	(921)	(276)	R	470	330	(140)	R
Research & Development			0	16,318	16,008	(311)	6,263	6,263	0	8,221	8,327	(106)	1,834	1,418	(417)	R			0	G
Corporate Division	**5,283**	**5,440**	**157**	**26,209**	**26,431**	**222**	**31,813**	**31,942**	**(128)**	**42,537**	**43,916**	**(1,379)**	**(42,858)**	**(43,986)**	**(1,128)**	R	**4,285**	**3,632**	**(653)**	R
Central Division	**8,131**	**7,078**	**(1,054)**	**24,755**	**24,252**	**(502)**	**(1,875)**	**66**	**(1,941)**	**22,374**	**22,128**	**246**	**12,387**	**9,135**	**(3,251)**		**18**	**493**	**475**	
GRAND TOTAL	**319,881**	**322,684**	**2,803**	**62,121**	**59,951**	**(2,170)**	**223,322**	**233,076**	**(9,754)**	**159,284**	**166,139**	**(6,854)**	**(604)**	**(16,580)**	**(15,976)**	R	**15,712**	**14,753**	**(959)**	R

FINANCIAL POSITION APRIL TO SEPTEMBER 2013

	Patient Care Income			Other Income			Pay Expenditure			Non Pay Expenditure			Total				CIP PERFORMANCE			
CMG/Corporate	Plan £'000	Actual £'000	Variance £'000	Plan £'000	Actual £'000	Variance £'000	Plan £'000	Actual £'000	Variance £'000	Plan £'000	Actual £'000	Variance £'000	Plan £'000	Actual £'000	Variance £'000	RAG Rating	Plan £'000	Actual £'000	Variance £'000	RAG Rating
Cancer, Haematology, GI Medicine and Surgery	58,618	59,284	665	1,485	1,464	(21)	23,333	23,230	104	17,878	19,805	(1,927)	18,892	17,713	(1,179)	R	1,164	1,326	161	G
Cardiac, Renal and Respiratory	62,734	62,826	91	1,628	1,200	(428)	28,281	28,927	(646)	20,999	22,471	(1,472)	15,083	12,628	(2,455)	R	1,772	1,564	(208)	R
Emergency and Specialist Medicine	49,938	53,049	3,110	2,470	2,278	(192)	31,555	36,522	(4,967)	15,143	15,772	(629)	5,711	3,033	(2,678)	R	1,635	1,269	(366)	R
Musculoskeletal and Specialist Surgery	46,829	46,527	(301)	969	703	(266)	22,116	22,310	(195)	9,335	9,222	113	16,348	15,698	(650)	R	1,321	1,208	(114)	R
Professional Services, Imaging, Medical Physics and Empath	11,948	12,339	391	3,627	3,337	(290)	33,829	34,500	(671)	1,051	2,618	(1,567)	(19,305)	(21,443)	(2,137)	R	1,849	1,601	(248)	R
Theatres, Anaesthesia, Pain and Sleep, (ITAPS)	13,730	13,317	(413)	367	348	(19)	25,244	27,164	(1,920)	9,798	10,452	(653)	(20,945)	(23,951)	(3,005)	R	1,814	1,782	(32)	R
Women's and Children's	67,952	68,265	313	1,985	1,766	(219)	36,826	36,734	91	14,738	15,228	(490)	18,373	18,069	(304)	R	2,317	2,202	(115)	R
Sub-total - CMGs	**311,750**	**315,606**	**3,856**	**12,531**	**11,096**	**(1,434)**	**201,184**	**209,387**	**(8,204)**	**88,941**	**95,567**	**(6,626)**	**34,156**	**21,748**	**(12,408)**	R	**11,873**	**10,951**	**(922)**	R
Communications & Ext Relations			0	17	10	(6)	399	438	(39)	61	62	(1)	(443)	(490)	(46)	R	55	11	(44)	R
Corporate & Legal			0	0	72	72	486	485	0	584	698	(114)	(1,069)	(1,111)	(42)	R	158	159	1	G
Corporate Medical			0	728	755	27	1,897	1,894	4	458	363	95	(1,628)	(1,502)	126	G	64	149	85	G
Facilities			0	5,734	5,762	28	637	597	40	27,133	26,369	763	(22,036)	(21,204)	831	G	1,085	1,312	227	G
Finance & Procurement			0	25	24	(1)	2,099	2,073	26	1,348	1,277	71	(3,422)	(3,325)	97	G	440	517	77	G
Human Resources			0	1,429	1,592	163	2,720	2,683	37	908	1,010	(102)	(2,199)	(2,101)	98	G	252	297	45	G
Im&T			0	104	102	(3)	1,814	1,706	108	2,039	3,163	(1,124)	(3,749)	(4,768)	(1,019)	R	1,067	185	(882)	R
Nursing			0	138	153	16	2,797	2,540	257	6,634	6,671	(38)	(9,293)	(9,059)	235	G	319	285	(34)	R
Operations			0	0	35	35	2,040	2,060	(20)	148	189	(41)	(2,188)	(2,215)	(27)	R	251	264	13	G
Research & Development	-	-	0	16,318	16,008	(311)	6,263	6,263	0	8,221	8,327	(106)	1,834	1,418	(417)	G			0	R
Strategic Devt			0	0	58	58	626	763	(136)	18	216	(198)	(644)	(921)	(276)	R	124	125	1	G
Former Divisional Management			0	343	31	(312)	2,234	2,121	114	418	100	318	(2,310)	(2,190)	120	G	24	26	2	G
Sub-total - Corporate	**0**	**0**	**0**	**24,836**	**24,603**	**(233)**	**24,014**	**23,623**	**391**	**47,969**	**48,446**	**(477)**	**(47,147)**	**(47,467)**	**(319)**	G	**3,839**	**3,328**	**(511)**	R
Central Division	**8,131**	**7,078**	**(1,054)**	**24,755**	**24,252**	**(502)**	**(1,875)**	**66**	**(1,941)**	**22,374**	**22,128**	**246**	**12,387**	**9,138**	**(3,251)**		**0**	**474**	**474**	
GRAND TOTAL	**319,881**	**322,684**	**2,803**	**62,121**	**59,951**	**(2,170)**	**223,322**	**233,076**	**(9,754)**	**159,284**	**166,142**	**(6,857)**	**(604)**	**(16,580)**	**(15,979)**	R	**15,712**	**14,753**	**(959)**	R

University Hospitals of Leicester NHS
NHS Trust
Caring at its best

Friends & Families Test

What is the Friends & Family test?

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

Patients can choose from one of the following answers:

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

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

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

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

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

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

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

University Hospitals of Leicester NHS
NHS Trust

Caring at its best

FRIENDS AND FAMILY TEST - April - September '13

								SEPTEMBER SCORE BREAKDOWN				
		Apr-13	May-13	Jun-13	Jul-13	Aug-13	Sep-13	Total Responses	Promoters	Passives	Detractors	Score
GLENFIELD HOSPITAL	GH WD 15	55	0	100	91	100	82	11	9	2	0	82
	GH WD 16 Respiratory Unit	88	69	74	80	68	80	20	16	4	0	80
	GH WD 17	0	0	65	-	-	77	45	36	6	2	77
	GH WD 23A	65	80	100	83	-	80	30	24	6	0	80
	GH WD 24	75	87	94	100	-	95	40	38	2	0	95
	GH WD 26	92	87	-	0	94	93	27	25	2	0	93
	GH WD 27	0	0	66	45	90	67	21	14	7	0	67
	GH WD 28	79	85	88	90	96	76	21	17	3	1	76
	GH WD 29	-10	42	21	96	75	68	25	17	8	0	68
	GH WD 30	0	83	-	91	94	0	0	0	0	0	0
	GH WD 31	0	79	79	87	94	88	25	22	3	0	88
	GH WD 32	74	85	83	81	87	81	31	27	2	2	81
	GH WD 33	85	84	79	81	73	76	45	34	11	0	76
	GH WD 33A	68	94	86	80	84	67	27	20	5	2	67
	GH WD 34	-	-	-	-	-	0	0	0	0	0	0
	GH WD Clinical Decisions Unit	48	72	46	49	58	50	20	13	4	3	50
	GH WD Coronary Care Unit	84	86	90	98	90	91	54	50	3	1	91

University Hospitals of Leicester NHS
NHS Trust

Caring at its best

FRIENDS AND FAMILY TEST - April - September '13

								SEPTEMBER SCORE BREAKDOWN				
		Apr-13	May-13	Jun-13	Jul-13	Aug-13	Sep-13	Total Responses	Promoters	Passives	Detractors	Score
LEICESTER GENERAL HOSPITAL	LGH WD 10	100	48	60	80	70	50	10	5	5	0	50
	LGH WD 14	77	71	83	70	85	61	36	25	8	3	61
	LGH WD 15A HDU Neph	-	-	50	-	-	88	8	7	1	0	88
	LGH WD 15N Nephrology	0	0	75	-	-	38	18	8	6	2	38
	LGH WD 16	67	88	95	75	71	50	12	7	4	1	50
	LGH WD 17 Transplant	75	92	84	81	84	88	25	23	1	1	88
	LGH WD 18	88	100	91	75	93	71	21	15	6	0	71
	LGH WD 18	88	100	91	75	93	71	21	15	6	0	71
	LGH WD 19	79	63	59	66	84	0	1	0	1	0	0
	LGH WD 2	0	0	-	25	-	87	15	13	2	0	87
	LGH WD 20	0	0	-	-	-	0	0	0	0	0	0
	LGH WD 22	42	95	45	42	50	79	14	12	1	1	79
	LGH WD 23	29	0	53	41	50	100	1	1	0	0	100
	LGH WD 26 SAU	0	46	52	65	48	46	36	17	17	1	46
	LGH WD 27	83	89	57	0	64	55	22	14	6	2	55
	LGH WD 28 Urology	45	24	55	31	100	24	55	20	27	7	24
	LGH WD 29 EMU Urology	-30	54	50	35	31	24	89	36	35	15	24
	LGH WD 3	0	0	33	67	70	43	7	4	2	1	43
	LGH WD 31	-	90	79	84	73	83	50	40	8	0	83
	LGH WD Brain Injury Unit	0	0	-	100	-	100	4	4	0	0	100
	LGH WD Young Disabled	100	0	100	-	100	100	3	3	0	0	100

University Hospitals of Leicester NHS
NHS Trust

Caring at its best

FRIENDS AND FAMILY TEST - April - September '13

								SEPTEMBER SCORE BREAKDOWN				
		Apr-13	May-13	Jun-13	Jul-13	Aug-13	Sep-13	Total Responses	Promoters	Passives	Detractors	Score
LEICESTER ROYAL INFIRMARY	LRI WD 14 Bal L4	100	100	91	100	95	0	0	0	0	0	0
	LRI WD 14 Bal L4	100	100	91	100	95	0	0	0	0	0	0
	LRI WD 15 AMU Bal L5	40	33	31	43	65	56	43	27	13	3	56
	LRI WD 16 AMU Bal L5	52	88	58	42	11	93	43	41	1	1	93
	LRI WD 17 Bal L5	0	57	-9	0	48	74	66	50	15	1	74
	LRI WD 18 Bal L5	64	65	-	47	-100	57	50	30	17	2	57
	LRI WD 19 Bal L6	44	-	5	43	35	59	27	18	7	2	59
	LRI WD 21 Bal L6	88	90	91	-	89	100	20	20	0	0	100
	LRI WD 22 Bal 6	38	55	48	64	44	38	24	13	7	4	38
	LRI WD 23 Win L3	85	95	83	65	75	80	20	16	4	0	80
	LRI WD 24 Win L3	58	67	47	29	52	38	21	10	9	2	38
	LRI WD 25 Win L3	95	100	60	75	69	88	40	36	3	1	88
	LRI WD 26 Win L3	92	80	58	80	65	0	2	1	0	1	0
	LRI WD 27 Win L4	60	100	33	75	100	75	4	3	1	0	75
	LRI WD 27 Win L4	60	100	33	75	100	75	4	3	1	0	75
	LRI WD 28 Windsor Level 4	75	-	87	50	-	0	0	0	0	0	0
	LRI WD 28 Windsor Level 4	75	-	87	50	-	0	0	0	0	0	0
	LRI WD 29 Win L4	61	100	65	55	70	65	20	13	7	0	65
	LRI WD 30 Win L4	82	88	-	88	92	96	24	23	1	0	96
	LRI WD 31 Win L5	0	73	48	64	48	23	26	9	14	3	23
	LRI WD 32 Win L5	86	80	43	23	48	58	12	7	5	0	58
	LRI WD 33 Win L5	71	67	58	77	75	58	26	17	7	2	58
	LRI WD 34 Windsor Level 5	80	70	-	80	58	55	20	12	7	1	55
	LRI WD 36 Win L6	20	61	0	50	50	60	20	12	8	0	60
	LRI WD 37 Win L6	68	86	91	86	71	81	21	17	4	0	81
	LRI WD 38 Win L6	94	100	100	87	85	100	25	24	0	0	100
	LRI WD 39 Osb L1	70	89	89	87	72	88	25	22	3	0	88
	LRI WD 40 Osb L1	88	89	82	77	-	71	21	16	4	1	71
	LRI WD 41 Osb L2	42	50	47	55	73	50	20	11	8	1	50
	LRI WD 7 Bal L3	65	76	70	71	64	61	25	16	5	2	61
	LRI WD 8 SAU Bal L3	35	52	70	49	52	56	18	11	6	1	56
	LRI WD Bone Marrow	100	88	0	100	67	33	3	2	0	1	33
	LRI WD Chemo Suite Osb L1	-	-	86	86	86	88	24	21	3	0	88
	LRI WD Endoscopy Win L2	-	-	85	100	64	100	1	1	0	0	100
	LRI WD Fielding John Vic L1	-	-	60	71	67	86	22	19	3	0	86
	LRI WD GAU Ken L1	-	65	70	46	82	65	26	17	9	0	65
	LRI WD Hambleton Suite	-	-	100	95	94	100	14	14	0	0	100
	LRI WD IDU Infectious Diseases	65	67	69	80	68	48	23	13	8	2	48
	LRI WD ITU Bal L2	-	-	80	90	95	87	31	26	4	0	87
	LRI WD Kinmonth Unit Bal L3	65	68	80	70	57	89	26	23	3	0	89
	LRI WD Ophthalmic Suite Bal L6	85	83	86	76	79	0	0	0	0	0	0
	LRI WD Ophthalmic Suite Bal L6	85	83	86	76	79	0	0	0	0	0	0
	LRI WD Osborne Assess Unit	68	88	88	68	84	88	26	22	3	0	88

University Hospitals of Leicester NHS
NHS Trust

Caring at its best

FRIENDS AND FAMILY TEST - April - September '13

								SEPTEMBER SCORE BREAKDOWN				
		Apr-13	May-13	Jun-13	Jul-13	Aug-13	Sep-13	Total Responses	Promoters	Passives	Detractors	Score
EMERGENCY DEPARTMENT	ED - Majors	35	45	42	50	47	23	13	6	4	3	23
	ED - Minors	38	37	64	60	65	31	13	7	3	3	31
	ED - (not stated)	64	60	60	63	72	65	382	267	93	21	65
	Eye Casualty	65	75	70	55	54	44	205	97	99	7	44
	Emergency Decisions Unit	-	-	-	-	69	81	36	29	7	0	81

University Hospitals of Leicester NHS
NHS Trust

Caring at its best

FRIENDS AND FAMILY TEST - April - September '13

Wards Excluded due to fewer than 5 survey responses

GH WD 30
GH WD 34
GH WD GICU Gen Intensive
LGH WD 19
LGH WD 20
LGH WD Brain Injury Unit
LGH WD Young Disabled
LRI WD 14 Bal L4
LRI WD 14 Bal L4
LRI WD 26 Win L3
LRI WD 27 Win L4
LRI WD 27 Win L4
LRI WD 28 Windsor Level 4
LRI WD 28 Windsor Level 4
LRI WD Bone Marrow
LRI WD Endoscopy Win L2
LRI WD Ophthalmic Suite Bal L6
LRI WD Ophthalmic Suite Bal L6
LRI WD Paed ITU

	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%	15
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%	

APPENDIX 3 - OPERATIONAL PERFORMANCE EXCEPTION REPORT

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

Present state

The Trust target for cancelled operations is 0.8% for non-clinical reasons, for some time we have struggled to meet this target for a number of reasons. There is a long history surrounding this particular performance target having received a contract query in 2011 following which a remedial action plan was submitted to our commissioners, a revised action plan was required in May 2012 due to continued non-performance. Since May our performance has been varied resulting in a formal contract query being submitted in October 2013.

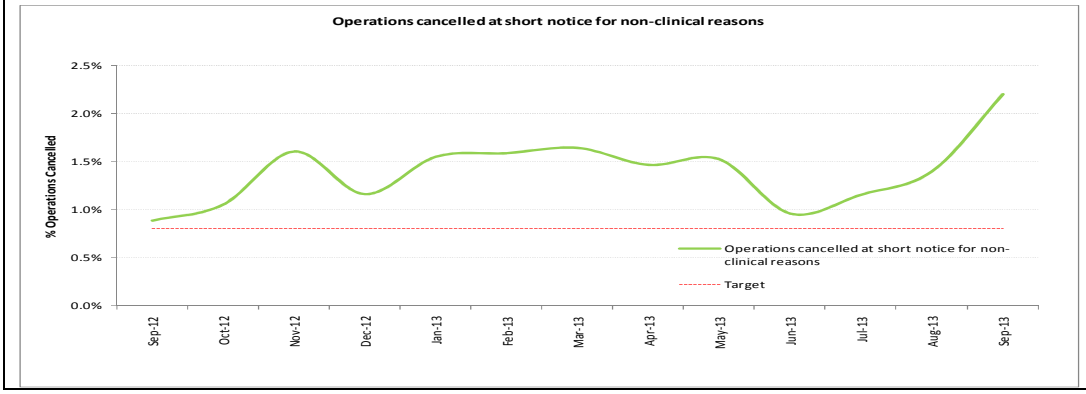
There are three indicators which commissioners use to measure performance nationally:

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

Our performance on measure three is good, with no urgent patients being cancelled for a second time, but the first two indicators present major challenges to UHL and form the basis of our contract query

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

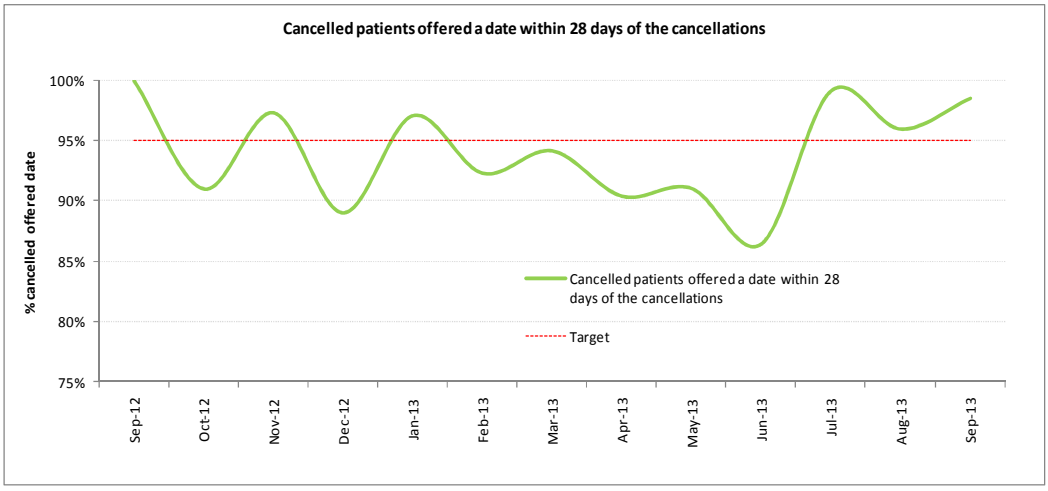
Performance in September shows that the percentage of operations cancelled on/after the day of admission of all elective activity for non-clinical reasons was 2.2% against a target of 0.8%. Performance in September has significantly deteriorated when compared to previous months and is indeed our worst performance over the last year.



There are two main reasons for the cancellations, which are a lack of beds (60%) and theatre time/list over runs (13%). Bed cancellations have seen an increase of 145%, the highest number observed in the last year. Theatre cancellations have remained constant over the last six months at an average rate of 30.

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

The percentage offered a date within 28 days of the cancellation was 98.5% against a threshold of 95%. The % of cancelled patients offered a date within 28 days has continued to see improvement compared to previous months and the standard was met for three months in a row.



The summary of reasons for the cancellations is below:

		Apr-13	May-13	Jun-13	Jul-13	Aug-13	Sep-13	Oct-13
Capacity Pressures	HOSPITAL CANCEL - HDU BED UNAVAILABLE	4	6	12	4	2	5	2
	HOSPITAL CANCEL - ITU BED UNAVAILABLE	3	4	5	3		2	
	HOSPITAL CANCEL -PT DELAYED TO ADM HIGH PRIORITY PATIENT	12	14	12	17	10	17	9
	HOSPITAL CANCEL - WARD BED UNAVAILABLE	61	55	22	31	55	135	16
	TOTAL	**80**	**79**	**51**	**55**	**67**	**159**	**27**
Other	HOSPITAL CANCEL - CASENOTES MISSING	2	4	2	6	6	3	5
	HOSPITAL CANCEL - LACK ANAESTHETIC STAFF		3	4	5	3	4	2
	HOSPITAL CANCEL - LACK SURGEON	9	4	2	11	15	6	1
	HOSPITAL CANCEL - LACK THEATRE EQUIPMENT	1	4	2	2	1	4	4
	HOSPITAL CANCEL - LACK THEATRE STAFF		5	2	1		1	1
	HOSPITAL CANCEL - LACK THEATRE TIME / LIST OVERRUN	31	34	22	35	31	30	17
	UNREASONABLE OFFER TO PATIENT	1	1			1	1	
	TOTAL	**44**	**55**	**34**	**60**	**57**	**49**	**30**
TOTAL	**TOTAL**	**124**	**134**	**85**	**115**	**124**	**208**	**57**

Work is currently being undertaken to review and update the current action plan in response to the contract query that has been submitted from our CCGs. This will be available by the end of October 2013.

University Hospitals of Leicester NHS
NHS Trust

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST

REPORT BY TRUST BOARD COMMITTEE TO TRUST BOARD

DATE OF TRUST BOARD MEETING: 31 October 2013

COMMITTEE: Quality Assurance Committee

CHAIRMAN: Ms J Wilson, Non-Executive Director

DATE OF COMMITTEE MEETING: 25 September 2013

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

None.

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

- **PLACE assessments (Minute 87/13/5)**
- **Hospital Acquired Pressure Ulcers Update (Minute 88/13/2 refers);**
- **Nursing workforce (Minute 88/13/4);**
- **#NOF performance (discussion under Quality and Performance report - Minute 89/13/1), and**
- **Infection Prevention matters (discussion under Quality and Performance report Minute 89/13/1).**

DATE OF NEXT COMMITTEE MEETING: 29 October 2013

Ms J Wilson
25 October 2013

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST

MINUTES OF A MEETING OF THE QUALITY ASSURANCE COMMITTEE HELD ON WEDNESDAY 25 SEPTEMBER 2013 AT 12:00 NOON IN THE LARGE COMMITTEE ROOM, MAIN BUILDING, LEICESTER GENERAL HOSPITAL

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

In Attendance:
Mr P Burns – Head of Trust CIP (for Minute 87/13/7)
Miss M Durbridge – Director of Safety and Risk
Mrs S Hotson – Director of Clinical Quality
Ms D Mitchell – Head of Improvement and Innovation (for Minute 87/13/7)
Mr A Powell – Head of Performance and Quality Assurance, NHS Horizons (for Minute 87/13/5)
Ms C Ribbins – Director of Nursing
Ms C Rudkin – CSA Programme Lead (for Minute 87/13/6)
Mr I Scudamore – Divisional Director, Women's and Children's (for Minutes 87/13/1 – 87/13/4)

RESOLVED ITEMS **ACTION**

85/13 APOLOGIES

Apologies for absence were received from Dr B Collett, Associate Medical Director and Mr P Panchal, Non-Executive Director.

86/13 MINUTES

Resolved – that the Minutes of the meeting held on 28 August 2013 (papers A & A1 refer) be confirmed as a correct record.

87/13 MATTERS ARISING REPORT

In respect of Minute 76/13(i), the Committee Chair advised that 'Ophthalmology performance' would now be discussed at Finance and Performance Committee meetings and therefore this action could be removed from the QAC progress log. **TA**

Minute 77/13/4 – the Director of Nursing undertook to circulate a briefing note in respect of safeguarding processes to QAC members (it was noted that a note had already been circulated to Trust Board members). **DN**

Minute 67/13/2 – the Committee Chair stated that the 'Imaging Performance and Plans for Improvement' discussion would now be taken forward through the Finance and Performance Committee. Therefore, this action could now be removed from the log. **TA**

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

87/13/1 Update on Perinatal Mortality

Mr I Scudamore attended the meeting to present paper C, a report providing assurance that the Women's CBU were appropriately addressing action plans to reduce perinatal mortality rates. It was noted that appropriate benchmarking data was not available. He

highlighted that previous internal reviews had indicated that there might be issues with data analysis which exaggerated the incidence. Discussion had taken place with Dr Fosters and it had been agreed that there was a need to undertake a joint piece of work with them to understand how their data was analysed. The Medical Director suggested that there might be some risk adjustment models available. A Perinatal Mortality Overview Committee had been established and would meet quarterly to review progress in addressing all aspects aimed at reducing perinatal mortality rates in Leicester. A Perinatal Death Overview Working Group met on a weekly basis to review every perinatal death. Individual Consultants had been tasked to review medical research/literature to assess clinical interventions that might have greatest impact in helping to reduce perinatal mortality rates across the health community and were expected to provide reports to a Divisional meeting on 19 November 2013. The Divisional Director, Women's and Children's agreed to circulate an updated action plan to QAC members. The Committee Chair requested that a further update be provided in six months' time (i.e. March 2014).

DD, W&C

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

(B) the Divisional Director, Women's and Children's to:-

- **circulate an updated perinatal mortality action plan, and**
- **provide an update on perinatal mortality to the QAC in March 2014.**

DD, W&C

87/13/2 Maternity Outlier Alert for Puerperal Sepsis and Other Puerperal Infections at UHL – actions to date

The Divisional Director, Women's and Children's advised members that the CQC had initially notified UHL in 2011 that they had identified significantly high rates of puerperal sepsis and other puerperal infections within 42 days of delivery at the Trust. Following this alert, a Task and Finish Group had been convened and it was identified that the reason for the alert was due to the method by which the diagnosis was coded rather than significant patient illnesses. A checklist was implemented for clinical staff to use on discharge to record the principal clinical diagnosis for coding. A series of actions were developed (in the context of the recommendations of Saving Mothers Lives) to ensure that the high rates of puerperal sepsis reported by the Trust's coded data did not reflect a significant incidence of serious septic illness at UHL. The alert was closed in April 2012. However, the CQC had written in August 2013 to notify the Trust of the same alert. Paper D detailed the Trust's response provided to the CQC in September 2013 in respect of this alert.

Mr I Scudamore highlighted that the checklist referred to above was poorly utilised by medical staff and had been withdrawn, leaving the Trust with a coding process which was little changed from the time of the previous alert. Following the 2013 alert, a comprehensive case-note review, audit of caesarean section rates and prospective analysis of the incidence of serious septic illness related to delivery at UHL had been undertaken. The evidence from these workstreams had been included in the summary section of the Trust's response to the CQC.

Notwithstanding that this review provided assurance that there was no issue with maternity related sepsis at UHL, the Trust would continue to have the identification and management of sepsis as a matter of high importance to the Women's CBU in order to maintain and improve where possible the high standards of care for its patients. The Divisional Director, Women's and Children's noted the need to provide more accurate data from the coding process for the diagnoses that were the focus of the alert. He highlighted that the CBU would work with the clinical coders to improve the clinical relevance of the coding process and this would require regular clinical engagement and a form of monitoring to ensure that the coding better reflected the actual levels of septic illness experienced by patients.

Resolved – that the contents of paper D and the verbal update be received and

noted.

87/13/3 UHL Quality Schedule 2013-14 – Maternity Dashboard – Blood Loss Indicator

Further to Minute 76/13/1 of 28 August 2013, the Divisional Director, Women's and Children's present paper E which provided an update on:-

- plan to monitor the rates of women having a blood loss of >1500mls (all births), and
- actions in progress to monitor Caesarean section rates and promote normal birth.

The Divisional Director, Women's and Children's highlighted that the monitoring blood loss of >1500mls (all births) was a subjective measure and noted the need for an objective measure to be in place. A case note review had been undertaken by the Trust in conjunction with the CCGs. As part of this review, outcomes and percentage of women having vaginal deliveries experiencing >1500mls would also be specifically audited.

In respect of the maternity dashboard threshold for C section rates, given that the national C section rates in 2011 were 24.8%, an agreement had been reached with Commissioners to alter the dashboard thresholds (Red – above 26%; Amber – 25-26% and Green – below 25%) from quarter 3 (2013-14) from the current threshold of 23%.

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

87/13/4 10 X Medication Errors – Children's CBU – Overview

Paper F provided the root cause analysis reports of two 10 X medication errors in Children's CBU. In both these cases, the level of independent checking at each stage of the process did not comply with guidelines. A thematic review was being undertaken to focus on specific actions for improvement. The Committee Chair requested that an update be provided to the QAC in December 2013. **Children's CBU**

The Chief Nurse noted the need for a wider piece of work in relation to assessing the numeracy skills of nursing staff to be undertaken. **CN**

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

(B) the Children's CBU be requested to attend the QAC meeting in December 2013 to provide an update on the action plan following the two 10X medication errors, and **Children's CBU**

(C) wider work in relation to assessing the numeracy skills of nursing staff be undertaken. **CN**

87/13/5 Patient-Led Assessment of the Care Environment (PLACE) Results

Mr A Powell, Head of Performance and Quality Assurance attended to present paper F1, the results of the 2013 PLACE undertaken in June 2013 across a sample of wards and outpatient departments in UHL's three hospital sites. The category headings were – cleanliness, food services, privacy, dignity & wellbeing and estates. Mr Powell provided a brief analysis of the results and advised that detailed improvement and actions plans would be coordinated and led by the Chief Nurse and supported by NHS Horizons. An update would be provided to the QAC in October 2013. In discussion, he agreed to circulate the graph which showed UHL's position in comparison to other Trusts. Responding to queries, it was noted that action plans needed to be site-specific given that the scores and the environment varied at all three sites. **HPQA** **HPQA**

The Patient Adviser made members aware that he had been part of the review panel of

the previous Patient Environment Action Team (PEAT) assessments (the PLACE assessment programme replaced the PEAT assessment) and highlighted that UHL had faired well in those assessments. He commented whether the Patient Advisers who had undertaken the PLACE assessments had taken into account many factors (i.e. the age of the building) and therefore had been critical. In response, it was noted that the PLACE assessments were more intense and extensive.

Resolved – that (A) the contents of paper F1 be received and noted, and

(B) the Head of Performance and Quality Assurance to:- **HPQA**

- **circulate the graph which showed UHL's position in comparison to other Trusts in respect of the PLACE assessment results, and**
- **attend the QAC meeting in October 2013 to provide an update on the actions put in place following the results of the PLACE assessments.**

87/13/6 Critical Safety Actions (CSA) Update re. Ward Round/Senior Clinical Review/ Notation

Ms C Rudkin, CSA Programme Lead attended the meeting to present Paper G. Ward round processes across the Acute Care Division had been standardised through a standard operating procedure implemented in May 2013. An audit of this would be undertaken in October 2013 to ensure that the standards were being adhered to. A standardised ward round safety tick box would be implemented across the Trust to ensure that the key safety components were considered for every patient interaction. In addition to this, members were advised that a ward round safety checklist would also be in place.

In response to a query from the Committee Chair, the CSA Programme Lead advised that further to the first audit, an audit programme would be put in place to ensure that the processes were monitored appropriately. In respect of training and education – e-learning and ward round training would be put in place. Any under-performing areas would be required to provide an update to the Quality and Performance Management Group. In response to a suggestion by Professor D Wynford-Thomas, Non-Executive Director and Dean of the Leicester Medical School, the Director of Safety and Risk advised that a discussion in respect of education and training for medical staff had already taken place with Professor N London, Honorary Consultant.

The Chief Executive noted the need for the processes to be linked with patient flows. The Chief Nurse and Quality Officer East Leicestershire and Rutland CCG requested that the audits included a question on 'time from decision to discharge' , in response the CSA programme Lead advised that this provision would be considered in subsequent audits as the current audit proformas were ready for roll-out.

The Committee supported the recommendations and the Committee Chair commended the work that had been undertaken.

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

87/13/7 CIP/ Improvement and Innovation Framework – Governance Arrangements

The Head of Trust CIP and the Head of Improvement and Innovation attended to present paper H, UHL's governance system and processes for managing its CIP. Members noted that quality impact assessments were sought automatically for any CIP scheme with a value greater than £100k or with a risk rating at 15 or above. The CIP Project Management Tracking Tool would automatically flag these schemes periodically for review by the CIP to monitor and ensure delivery as per plan.

The Committee noted that there were gaps in respect of ongoing monitoring of quality assessments and suggested that key performance monitoring indicators be put in place and requested the Head of Improvement and Innovation to liaise with the Chief Nurse **HII**

and Medical Director in respect of this matter. In addition, a programme of on-going monitoring of existing 2013-14 schemes also needed to be put in place. The Chief Nurse highlighted the need for equality impact assessment for CIP schemes to also be put in place and members suggested that standard equality assessments tools be used – however, the Head of Trust CIP undertook to seek guidance from the Chief Nurse. The Committee Chair requested that a further update be provided to the QAC in October 2013. **HTCIP**

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

(B) the Head of Improvement and Innovation to liaise with the Chief Nurse and Medical Director in respect of ongoing monitoring of quality assessments for new CIP schemes and retrospectively for existing 2013-14 schemes; **HII**

(C) Head of Trust CIP undertook to seek guidance from the Chief Nurse in respect of equality impact assessments for CIP schemes, and **HTCIIP**

(D) the Head of Improvement and Innovation and the Head of Trust CIP to provide a further update on CIP governance arrangements at the QAC in October 2013. **HII/ HTCIP**

88/13 SAFETY

88/13/1 <u>Update on data reported in the NHS Safety Thermometer (ST) regarding 'harms'</u>

The Chief Nurse presented paper I, an update on the NHS Safety Thermometer prevalence results for August 2013. The Chief Nurse highlighted that the main reason for the increase in the prevalence of newly acquired pressure ulcers was due to incomplete documentation to evidence that the work had been undertaken. Daily Matron rounds had been put in place on targeted wards to audit the documentation using a standardised template. The Committee Chair requested that the pressure ulcer remedial plan appended to this report when presented to QAC on a monthly basis. **CN**

<u>Resolved</u> – that (A) the contents of paper I be received and noted, and

(B) the pressure ulcer remedial action plan be appended to the NHS ST report when presented to QAC on a monthly basis. **CN**

88/13/2 <u>Update on Hospital Acquired Pressure Ulcers</u>

Paper J provided a quarterly update on the Trust's current position with the elimination of avoidable hospital acquired pressure ulcers. In response to a query from the Committee Chair in respect of the recommendations from Medstorm following a review into mattress provision and equipment delays – the Director of Nursing highlighted that the recommendations were for the Trust (a) to recruit a Registered Nurse to support Medstorm and (b) increase the value of the contract. These had been carefully considered by the Trust.

In discussion on the above recommendations, the Director of Nursing stated that there were significant cost implications and insufficient evidence that the delays would be completely resolved by increasing the value of the existing contract. The Divisional Heads of Nursing and Lead Nurses had suggested that before further investment was made, additional training and awareness into the ordering and return of equipment was required for all ward staff. Therefore, three Trust wide training days on all three hospital sites had been organised by Medstorm at the end of September 2013. Following these sessions, regular audits would be undertaken prior to making a decision on whether increasing the value of the contract by increasing the number of bed days for mattress hire was a viable option. The Committee Chair requested that a decision on the way forward be provided to the QAC in October 2013. **CN**

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

(B) the Chief Nurse to provide an update on the way forward in respect of recommendations from Medstorm in relation to pressure relieving mattresses and equipment be provided to the QAC in October 2013. **CN**

88/13/3 Falls Monitoring Update

Paper K provided an update on progress regarding implementation of actions in relation to prevention, management and reporting of inpatient falls. Quarter 1 (2013-14) had seen a 14% reduction in the number of falls reported compared to quarter 4 of 2012-13. Some innovative approaches had led to reduction in inpatient falls and members noted that significant positive progress had been made. The Director of Safety and Risk reported that Loughborough University had recently published the results of the falls review undertaken at UHL which had identified some fairly simple changes and requested that those be incorporated within the Trust's work.

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

88/13/4 Nursing Workforce Report

Paper L provided an overview of the nursing workforce position for UHL. The Director of Nursing advised that the ward staffing budgets had been approved by the Executive Team. Therefore, the budgeted nurse to bed ratios for the nursing workforce report to QAC would be amended from October 2013. The Chief Executive reiterated that in the revised nursing workforce report, the Committee should expect a few more wards to be 'red' rated for a period of time but there would not be a significant increase because some wards had already been staffed over budget.

It was noted that the Emergency Department nurse vacancy position for August 2013 was in a better position than July 2013. Currently, there were 33 registered nurse vacancies (with 14 nurses waiting to start) and no HCA vacancies. The Chief Nurse advised that vacancy gaps would be monitored on a shift by shift basis and the vacancy position for the whole Trust would be provided to the October 2013 Clinical Quality Review Group and QAC. Members were advised that Acute Care Division had prepared a trajectory of when vacancies would be recruited to and this information would be circulated to QAC members. **CN** **CN**

The Patient Adviser noted that the vacancy information was provided in detail within internal forums of the Trust and queried if any information was available to be provided to the public. In response, the Chief Nurse advised that from October 2013, a white board on the entrance of each ward would provide details re. the number of nurses required on the current shift and the actual number of nurses that were on the shift. If there were less than the required numbers then the actions put in place to resolve the difference would also be included as bullet points on the white board in order to reassure patients/visitors/public. Ward nurses would also be provided with clear details on ward staffing establishments so that they would be able to provide correct information to the public. However, consideration would need to be given regarding the release of nursing workforce details for public consumption. It was suggested that the Patient Adviser and the Director of Nursing liaise regarding this. **DN/PA**

A brief discussion also took place regarding the Local Education and Training Board and Local Education and Training Council interactions in respect of commissioning nursing plans. The need for appropriate interaction with Human Resources and workforce planning was suggested.

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

(B) the vacancy position for the whole Trust be provided to the October 2013 **CN**

Clinical Quality Review Group and QAC;

(C) the Director of Nursing and the QAC Patient Adviser liaise regarding the information that should be available in the public domain in respect of nursing workforce details. **CN/PA**

88/13/5 Report by the Acting Chief Nurse

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

88/13/6 Patient Safety Report

The Director of Safety and Risk presented paper N, the patient safety report. The following points were highlighted in particular:- **DSR**

(i) an update of complaints would be presented to the QAC in November 2013. The Committee Chair suggested that discussion with other Trusts in respect of complaints handling would be useful and requested that complaint rates by Specialty be included within the report to the QAC in November 2013; **DSR**

(ii) SUIs reported and closed in August 2013. Most of the SUIs were in relation to the emergency care pathway in ED. The Director of Safety and Risk had been liaising with colleagues in respect of capturing themes arising from these SUIs and a verbal update on any immediate actions that had been put in place would be provided at the QAC in October 2013. A new process which focussed on quality and safety had been agreed in respect of 12 hour trolley breaches. These breaches would now feature in the patient safety report alongside the SUIs, and

(iii) responding to a query from the Patient Adviser, the Director of Safety and Risk highlighted that consideration was being given to a number of initiatives for engagement with patients and public. Consideration was also being given to inviting Patient Advisers to be a part of the SUI investigative process, and

(iv) responding to a further query, members were advised that a recovery plan was in place re. ophthalmology outpatient letter issues and the Chief Operating Officer would be leading this workstream. The Committee Chair requested that the Ophthalmology recovery plan which was due to be presented to the Finance and Performance Committee in October 2013 be circulated to QAC members for information. Ms C O'Brien reported that at the CQRG, the Chief Operating Officer had agreed to circulate the clinical risk assessment in respect of backlog of clinic letters in Ophthalmology. **TA**

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

(B) the Director of Safety and Risk to provide an update on complaints (and include complaint rates by Specialty) at the QAC in November 2013; **DSR**

(C) the Director of Safety and Risk to provide a verbal update on any immediate actions put in place following a discussion on themes arising from SUIs in relation to the emergency care pathway in ED, and **DSR**

(D) the Ophthalmology recovery plan scheduled to be presented to the October 2013 Finance and Performance Committee be circulated to QAC members for information. **TA**

88/13/7 Update on the reasons for the increase in open CAS alerts

The Director of Safety and Risk verbally advised that the number of CAS alerts received by the Trust had increased but the Trust's completion and closure performance had significantly improved.

Resolved – that the verbal update be noted.

88/13/8 Legal Requirement to report RIDDOR incidents to the Health and Safety Executive

The Director of Safety and Risk orally reported that some RIDDOR cases were made aware to the managers only after 7 days or more after the incident (i.e. after the employees returned back to work after being off-sick). It was noted that the Health and Safety team was working with Divisions to put an appropriate system in place to ensure that RIDDORs were immediately reported.

Resolved – that the verbal update be noted.

89/13 QUALITY

89/13/1 Month 5 – Quality and Performance Update

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

The following issues were highlighted in particular:-

(a) although the performance for time to surgery within 36 hours for fractured neck of femur patients had improved from July 2013, the Committee Chair noted the need for an update on the action plan and an analysis on capacity to be included within the Q&P report in October 2013. The #NOF team be invited to attend the QAC meeting in November 2013 to provide an update on performance. **MD**
(b) 95% threshold for VTE risk assessment within 24 hours of admission had been achieved for July and August 2013;
(c) overall friends and family test score 69.6, and
(d) 2 cases of MRSA bacteraemia had been reported. The results of the review of these cases be presented to QAC in October 2013. The Infection Prevention Committee was being re-established to ensure that an appropriate focus was kept on infection prevention matters. It was noted that the C Difficile trajectory had been challenging. Provision for decant facility had been discussed by the Executive Team and consideration for a modular ward was being considered. The Chief Executive requested that the C Diff action plan be reviewed by the QAC in October 2013, and **DN** **DN**
(e) it was agreed that MSSA figures would also be included in the Q&P report. **DN**

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

(B) an update on the #NOF action plan and analysis on capacity be included within the Q&P report in October 2013; **MD**

(B) #NOF Lead/Team be invited to attend the November 2013 QAC meeting to provide an update on #NOF performance, and

(C) the Director of Nursing to:- **DN**

- **present the results of the review of the two MRSA bacteraemias in September 2013 at the QAC in October 2013;**
- **present the C Diff action plan to QAC in October 2013, and**
- **include the MSSA figures in the Q&P report from October 2013.**

89/13/2 Briefing from FTN/CQC event on future surveillance and ratings

The Director of Clinical Quality presented paper P which provided a summary of the briefing from FTN/CQC event on future surveillance and ratings. The Director of Clincial Quality had met with the Assistant Director of Information who would map the Trust's existing Quality and Performance report with the CQC's surveillance model. The CQC planned to publish their surveillance information at Trust level for all indicators with risk

scoring/ranking. Further to a query from the Committee Chair, the Director of Clinical Quality undertook to seek clarity from the CQC whether the surveillance information would first be available to the Trust for an initial review prior to publication. The Medical Director also suggested that learning could be sought from other Trusts which had piloted this model. **DCQ**

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

(B) the Director of Clinical Quality to seek clarity from the CQC whether the surveillance information would first be available to the Trust for an initial review prior to publication. **DCQ**

89/13/3 New Interventional Procedures and Advisory Group (NIPAG) Annual Report

The Medical Director presented paper Q, the 2012-13 NIPAG annual report highlighting that the terms of reference of UHL's NIPAG were considered as an exemplar. Consideration was being given to replicate this rigour in the Trust's Therapeutics Advisory Group. The Chief Executive queried whether audits were undertaken to ensure that unauthorised procedures were not being undertaken, in response it was noted that discussions were held at mortality and morbidity meetings and Consultants were also appropriately briefed as part of their induction programme.

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

90/13 ITEMS FOR INFORMATION

90/13/1 UHL's Response to the AUKUH in respect of CQC' Consultation

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

90/13/2 Accreditation Visits Update

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

90/13/3 Data Quality Report

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

91/13 MINUTES FOR INFORMATION

91/13/1 Finance and Performance Committee

Resolved – that the public Minutes of the Finance and Performance Committee meeting held on 28 August 2013 (paper U refers) be received and noted.

91/13/2 Executive Performance Board

Resolved – that the action notes of the Executive Performance Board meeting held on 27 August 2013 (paper V refers) be received and noted.

92/13 ANY OTHER BUSINESS

92/13/1 Governance Arrangements for Outsourcing to the Independent Sector

Ms C O'Brien reported that commissioning teams would be populating a dashboard for all Independent Sector providers so that Trusts were able to get a sense-check of whether the providers were fit for purpose for the services that they were being appointed for. She noted the need for appropriate scrutiny. The Chief Executive requested the Director of Clinical Quality to liaise with the Chief Nurse regarding this. **DCQ**

Resolved – that the Director of Clinical Quality to undertake the above action. **DCQ**

93/13 IDENTIFICATION OF ANY KEY ISSUES FOR THE ATTENTION OF THE TRUST BOARD

Resolved – that the following items be brought to the attention of the Trust Board on 26 September 2013:-

- **PLACE assessments (Minute 87/13/5)**
- **Hospital Acquired Pressure Ulcers Update (Minute 88/13/2 refers);**
- **Nursing workforce (Minute 88/13/4);**
- **#NOF performance (discussion under Quality and Performance report - Minute 89/13/1), and**
- **Infection Prevention matters (discussion under Quality and Performance report Minute 89/13/1).**

94/13 DATE OF NEXT MEETING

Resolved – that the next meeting be held on Tuesday, 29 October 2013 at 9:30am in the Board Room, Victoria Building, Leicester Royal Infirmary.

The meeting closed at 2.44pm.

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

Name	*Possible*	*Actual*	*% attendance*	*Name*	*Possible*	*Actual*	*% attendance*
J Adler	*6*	*4*	*66*	*R Overfield*	*1*	*1*	*100*
*M Caple**	*6*	*5*	*83*	*R Palin**	*4*	*3*	*75*
S Dauncey	*1*	*1*	*100*	*P Panchal*	*6*	*4*	*66*
K Harris	*6*	*4*	*66*	*C Ribbins*	*5*	*4*	*80*
S Hinchliffe	*1*	*1*	*100*	*J Wilson*	*6*	*6*	*100*
*C O'Brien – East Leicestershire/Rutland CCG**	*6*	*4*	*66*	*D Wynford-Thomas*	*6*	*4*	*66*

** non-voting members*

Hina Majeed, **Trust Administrator**

University Hospitals of Leicester NHS
NHS Trust

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST

REPORT BY TRUST BOARD COMMITTEE TO TRUST BOARD

DATE OF TRUST BOARD MEETING: 31 October 2013

COMMITTEE: Finance and Performance Committee

CHAIRMAN: Mr R Kilner, Non-Executive Director

DATE OF COMMITTEE MEETING: 25 September 2013

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

None

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

- **Minute 101/13/2 – nursing workforce and vacancy rates;**
- **Minute 101/13/7 – 2013-14 winter bed capacity planning;**
- **Minute 102/13/1 – month 5 financial performance, and**
- **Minutes 103/13/1.1 and 103/13/1.3 – progress with the Outpatients and Theatres Improvement and Innovation projects.**

DATE OF NEXT COMMITTEE MEETING: 30 October 2013

Mr R Kilner
25 October 2013

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST

MINUTES OF A MEETING OF THE FINANCE AND PERFORMANCE COMMITTEE, HELD ON WEDNESDAY 25 SEPTEMBER 2013 AT 8.30AM IN SEMINAR ROOMS A & B, CLINICAL EDUCATION CENTRE, LEICESTER GENERAL HOSPITAL

Present:
Mr R Kilner – Non-Executive Director (Committee Chair)
Mr J Adler – Chief Executive
Colonel (Retired) I Crowe – Non-Executive Director
Mr A Seddon – Director of Finance and Business Services
Mr G Smith – Patient Adviser (non-voting member)
Ms J Wilson – Non-Executive Director

In Attendance:
Mr P Burns – Head of Trust Cost Improvement Programme (for Minutes 101/13/1 to 103/13/2 inclusive)
Mr J Clarke – Chief Information Officer (for Minute 101/13/1 only)
Mrs S Khalid – Head of Improvement and Innovation (for Minute 103/13/1 only)
Ms E Meldrum – Assistant Director of Nursing (for Minute 103/13/1 only)
Mrs K Rayns – Trust Administrator
Mr S Sheppard – Deputy Director of Finance
Ms E Stevens – Deputy Director of Human Resources (for Minutes 101/13/2 and 101/13/3)
Mr O Sudar – Project Manager, Outpatient Improvement and Innovation Programme (for Minute 103/13/1 only)

ACTION

RESOLVED ITEMS

98/13 APOLOGIES

Apologies for absence were received from Mr R Mitchell, Chief Operating Officer and Mr P Panchal, Non-Executive Director.

99/13 MINUTES

Resolved – that the Minutes of the 28 August 2013 Finance and Performance Committee meeting (papers A and A1) be confirmed as a correct record.

100/13 MATTERS ARISING PROGRESS REPORT

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

(a) Minute 77/13/6 of 24 July 2013 – the Director of Finance and Business Services reported verbally on his discussions with Ms H Seth, Deputy Director of Strategy regarding the Trust's relationship with Asteral, the Trust's Managed Equipment Service (MES) provider. He provided assurance that the financial implications of delays in the MES installation works were not of a significant nature and he highlighted opportunities for the Trust to become a smarter customer in terms of improving machinery specifications, procurement processes, VAT recovery mechanisms and maintenance cycle alignment.

The Committee requested a detailed report on the Imaging Department's financial and operational performance and arrangements for improving the Trust's control mechanisms relating to the MES contract. It was agreed that this would be presented to the Finance and Performance Committee on 27 November 2013 to allow for the new Clinical Management Group structure to become embedded. The Director of Finance and Business Services agreed to convey this request to the appropriate individuals and provided assurance that a range of improvement

DFBS

actions were being progressed in the meantime;

(b) Minute 79/13 of 24 July 2013 – the Deputy Director of Finance confirmed that the financial "road map" briefing note had been finalised and circulated to the UHL clinicians who had attended the financial workshops. He agreed to share this with members of the Committee. The Director of Finance and Business Services highlighted the success of this workshop format (as presented by Dr S Agrawal and Mr S Sheppard) which was now being presented nationally; **DDF**

(c) Minute 83/13 of 24 July 2013 – the Chief Executive noted the intention for the Finance and Performance Committee to schedule regular presentations by each of the Clinical Management Groups (CMGs) with effect from November 2013 and requested an opportunity to meet with the Committee Chairman to consider the performance management interface between this Committee and the CMGs, and **CE/ Chair**

(d) Minute 67/13(D) of 26 June 2013 – the Deputy Director of Finance confirmed the availability of benchmarking data in respect of Consultant numbers by patient care activity and Consultant PAs per WTE. A pilot scheme had been implemented in Trauma and Orthopaedics to measure Consultant costs in the context of patient activity and case mix. A further report on the development of this workstream would be presented to the Executive Team and Finance and Performance Committee in October 2013. **DDF**

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

101/13 STRATEGIC MATTERS

101/13/1 <u>IM&T Quarterly Update</u>

The Chief Information Officer attended the meeting to introduce paper C, providing the quarterly progress report on activities for the IM&T Directorate and an update on the Managed Business Partnership (MBP) with IBM. He particularly drew members' attention to the following issues:-

(a) the transfer of services to IBM and NTT was progressing according to plan, although NTT had been providing support to the Telephony service earlier than expected due to UHL staff sickness. The next transfers would be the Desktop and Network services. Assurance was provided that gateway meetings were being held to ensure that safe and sustainable service delivery was maintained;
(b) a 3 month period of steady state was being maintained for the wave 1 services which had transferred in August 2013 prior to implementation of any service improvements;
(c) the service desk was now available 24 hours per day 7 days per week and overnight reports had increased accordingly. Any complaints arising from service desk calls were being monitored appropriately and calls were recorded for staff training purposes;
(d) business cases for transformational projects were progressing well, with Managed Print Services scheduled for Trust Board consideration on 26 September 2013 and Electronic Document Records Management (EDRM) due to be submitted to the November 2013 Trust Board meeting, and
(e) that the new Chief Medical Information Officer (CMIO) was expected to be in post by 1 October 2013 – he confirmed that other senior clinicians had been providing support to this role since August 2013 when the previous CMIO had left.

In response to a question raised by Ms J Wilson, Non-Executive Director regarding the biggest risks to the service, the Chief Information Officer reported on the need to plan effectively for any increases in IM&T support within the Trust's reconfiguration programme. In addition he noted the importance of maintaining robust communications

links through posters, newsletters and face to face briefings – tapping into a range of existing meeting forums for this purpose. The Chief Executive requested the Chief Information Officer to provide a slide and some narrative for inclusion in the next Chief Executive's briefing session. **CIO**

Ms J Wilson, Non-Executive Director noted from the covering proforma that patient and public involvement was not planned at the current stage. The Chief Information Officer confirmed that patient and public consultation was planned for key projects, such as the Electronic Patient Record project. Consideration was currently being undertaken regarding the optimum timing for engagement with a wide range of stakeholders, including Universities and patient groups (eg carers of patients suffering from dementia).

Resolved – that (A) the quarterly update on IM&T activities be received and noted, and

(B) the Chief Information Officer be requested to provide a briefing slide and narrative on IM&T activities to inform the next Chief Executive's briefing session. **CIO**

101/13/2 Workforce Plan Update

Paper D provided a summary of the Trust's month 5 workforce and pay position as at August 2013 and the actions planned to control and reduce any non-essential pay expenditure. Ms E Stevens, Deputy Director of Human Resources attended the meeting to present this item, particularly highlighting section 3.4 of the report relating to an increase in premium rate medical agency expenditure to cover August 2013 junior doctor rotation gaps and to provide appropriate cover arrangements for new starter induction training.

Ms J Wilson, Non-Executive Director noted a difference in total staffing numbers between chart 2 and table 2 and requested that these numbers be aligned for future reports taking into account the staff transfers that had been undertaken as part of the facilities management and IM&T procurement processes.

Discussion took place regarding the impact of increased nursing establishment levels upon the Trust's nursing vacancy rate. It was agreed that a report on nursing recruitment and a trajectory for reducing the nursing vacancies would be presented to the 31 October 2013 Trust Board meeting. The Chief Executive voiced his view that the Trust should aim towards a 10% bank nurse fill rate with minimal use of agency nurses. Ms J Wilson, Non-Executive Director requested that a status report on ward clerk vacancy levels and recruitment plans also be provided as it was crucial to reduce the amount of nursing time spent on administrative tasks. **CN/ DHR**

Resolved – that (A) the update on UHL's Workforce Plan as at August 2013 be received and noted;

(B) clarity be provided relating to the total staffing numbers (net of any staff transfers) in future iterations of this report, and **DHR**

(C) a report on nursing vacancy rates and recruitment and retention proposals be presented to the 31 October 2013 Trust Board meeting (including a status report on ward clerk roles). **CN/ DHR**

101/13/3 Residential Accommodation Proposals

Paper E provided an interim progress report on the development of the Strategic Outline Case for developing a right-sized model for UHL's residential accommodation requirements. The Deputy Director of Human Resources attended the meeting for this item, but attendance by Mr A Chatten, Managing Director of LLRFMC had been stood

down by the Director of Finance and Business Services.

The Director of Finance and Business Services summarised the site differentials in respect of residential accommodation arrangements and the scope to develop more sustainable solutions. The timetable for this work was set out at the end of paper E and members noted that the completed Outline Business Case would be presented to the Finance and Performance Committee in November 2013 prior to seeking Trust Board approval of the Strategic Outline Case by April 2014. **DFBS/ DHR**

The Committee Chairman expressed his view that UHL should be given an opportunity to evaluate the long list of options being developed by Interserve for assurance purposes.

<u>Resolved</u> – that (A) the interim report on developing proposals for right-sizing UHL's residential accommodation (paper E) be received and noted;

(B) a further progress report be presented to the Executive Team at the end of October 2013, and **DFBS/ DHR**

(C) the Outline Business Case be presented to the Finance and Performance Committee in November 2013. **DFBS/ DHR**

101/13/4 <u>Improvement and Innovation Framework Update</u>

Paper F provided a progress report on the implementation and roll out of UHL's Improvement and Innovation Framework (IIF). The Chief Executive highlighted the approach to multi-year CIP development (as supported by the Improvement and Innovation Framework Board on 11 September 2013) and further work to strengthen the interface between IIF and Listening into Action (LiA).

The Committee Chairman sought and received assurance that the financial benefits arising from transformational projects – such as the Electronic Patient Record – would be translated into multi-year CIP savings and accounted for in the same way as other CIP schemes. The Committee noted that a more detailed report would be presented to the 30 October 2013 Finance and Performance Committee meeting with an increased focus on the Framework outputs and opportunities. **CE/HII**

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

(B) a further update be provided to the 30 October 2013 Finance and Performance Committee meeting with an increased focus on the IIF outputs and opportunities. **CE/HII**

101/13/5 <u>Imaging Review of Services Capacity and Demand</u>

The Committee Chairman commented that several of the reports for this meeting had been circulated late and that consequently the Committee was likely to have a less effective discussion on these items. The report on Imaging Investment Proposals (paper G) had been circulated electronically on the afternoon of 24 September 2013 and printed copies were provided at the meeting.

The Director of Finance and Business Services introduced this report recognising that some members had not yet had an opportunity to review it in detail. He briefed members on the Imaging Services Managed Equipment Service (MES) model and VAT recovery benefits. In November 2011 a "deep dive" review had been undertaken by Deloitte and Finnamore but the outputs had been subjected to challenge. Early in 2013, the Imaging CBU had presented 2 unsuccessful capital equipment business cases to the Commercial Executive. Since then, Ms M Harris, Divisional Manager, Acute Care had commissioned this demand and capacity review of Imaging Services and the associated Radiology

Consultant job plans. A comparison had also been undertaken with the Swansea Model for reporting times – this was the model generally accepted by the Royal College of Radiologists (appendix 3 refers).

Members discussed the action plan appended to paper G and forthcoming changes in leadership within the CBU. As agreed under Minute 100/13 item (a) above, the Committee would be seeking a detailed report on the Imaging Department's financial and operational performance and capital equipment requirements in November 2013, once the new management structure was embedded. The Chief Executive commented that under the new structure, the Imaging Department would become a large component of a small business unit and he suggested that a refined action plan be presented to the Committee in December 2013. **COO**

The Committee Chairman voiced his view that the investment proposals did not appear to acknowledge the need for a 24 hour 7 day service and he queried whether there was any scope for outsourcing the day-to-day scheduling of imaging appointments to increase utilisation rates. Colonel (Retired) I Crowe, Non-Executive Director highlighted opportunities to synchronise the provision of 2 dedicated CT scanners for the Emergency Department with the proposals currently being developed to reconfigure the Emergency Floor at the LRI.

Resolved – that (A) the demand and capacity review of Imaging Services and the associated action plan be received and noted;

(B) a refined action plan be presented to the Finance and Performance Committee in December 2013 with an increased focus on booking system efficiency and 24 hour 7 day working. **COO**

101/13/6 Planning Process 2014-15

Paper H provided a high level overview of the planning process for 2014-15. The Director of Finance and Business Services advised that the Trust Development Authority (TDA) planning guidance had not yet been received, but this was expected to include a focus on 5 year strategic planning (2 years detailed and 3 years outline) in line with existing Monitor guidance. The 2014-15 tariff was expected to be received within the next 2 weeks and this was likely to reflect efficiency savings in the region of 4% – a further update report would be provided to the Committee on 30 October 2013. **DFBS**

The Patient Adviser referred to section 9 of the report (relating to wider involvement and coordination) and highlighted additional requirements for engagement with Healthwatch and the Overview and Scrutiny Committees. The Director of Finance and Business Services also noted the need for increased visibility in respect of healthcare funding which had been transferred into social services (eg reablement funding).

The Committee Chairman noted that the Board level review of the first cut Annual Operational Plan was scheduled for 19 December 2013 and he queried the vehicle for this. In response it was noted that a Trust Board development session was scheduled for that date. The Chief Executive also noted that the Trust Board meeting was currently scheduled for Monday 30 December 2013 and he requested the Trust Administrator to explore opportunities to reschedule the December Board meeting to be held before Christmas. **TA**

Resolved – that (A) the proposed arrangements for the 2014-15 planning process be supported (as presented in paper H);

(B) an update on the 2014-15 tariff and planning guidance be presented to the 30 October 2013 Finance and Performance Committee meeting, and **DFBS**

(C) the Trust Administrator be requested to explore opportunities to reschedule the 30 December 2013 Trust Board meeting. **TA**

101/13/7 2013-14 Winter Bed Capacity Planning

In the absence of the Chief Operating Officer, the Director of Finance and Business Services introduced paper I, providing an update on UHL's bed capacity planning process for winter 2013-14. Following consideration by the Executive Performance Board on 24 September 2013, the report had been updated and circulated by the Chief Operating Officer later that evening. Printed copies were provided at the meeting, but some members of the Committee had not had an opportunity to read the report prior to the meeting.

The Committee Chairman noted the requirement to identify an additional 74 beds on the LRI site and the actions proposed to relocate existing activity to the Glenfield and LGH sites. He queried the extent to which UHL's Commissioners were sighted to the number of patients whose period of acute hospital care was complete and they were awaiting transfer into community beds (delayed transfers of care). The Chief Executive confirmed that the criteria for timely access to community beds was one of the priority actions being taken forward by the Urgent Care Board.

The Chief Executive suggested that appropriate discussion on winter bed capacity planning be held at the next day's Trust Board meeting as part of the discussion on Emergency Care performance. At which point he intended to brief the Board on revised ways of working with the CCGs to strengthen the delivery of priority emergency care actions across the whole health care community. He noted the intention to table a supporting paper on this theme at the Trust Board meeting.

Resolved – that (A) the update on winter bed capacity planning be received and noted, and

(B) further discussion on bed capacity issues be held at the 26 September 2013 Trust Board meeting. **CE/ COO**

102/13 PERFORMANCE

102/13/1 Month 5 Quality, Performance and Finance Report

Paper J provided an overview of UHL's quality, patient experience, operational targets, HR and financial performance against national, regional and local indicators for the month ending 31 August 2013. Paper J1 provided a high level overview of the Divisional Heatmap report.

On behalf of the Chief Operating Officer, the Director of Finance and Business Services highlighted the following aspects of UHL's operational performance (reporting by exception):-

(a) 1 confirmed MRSA bacteraemia and a potential further case which was being investigated;
(b) Clostridium Difficile performance remained challenging but within the established trajectory;
(c) the 62 day cancer performance target had been met in July 2013 and was on track to deliver in August 2013 (reported 1 month in arrears);
(d) RTT admitted performance stood at 85.7% against the 90% target – an exception report was appended to paper J. Members noted the particular challenges within the specialty of Ophthalmology and the potential for significant fines to be levied against the Trust for non-compliant performance;
(e) the percentage of cancelled operations on or after the day of admission for non-

clinical reasons had deteriorated to 1.4% (against a target of 0.8%);
(f) the target for the percentage of stroke patients spending 90% of their time on a stoke ward had been met for July 2013 (reported 1 month in arrears), and
(g) ED 4 hour wait performance stood at 90.1% and a detailed report on emergency care recovery plans was scheduled to take place at the next day's Trust Board meeting.

Finance and Performance Committee members raised the following comments and queries in relation to the Trust's operational performance:-

1) Ms J Wilson, Non-Executive Director voiced her concerns regarding operational performance within Ophthalmology Services and the number of complaints relating to this specialty. The Committee requested that a detailed report on the actions required to recover performance in Ophthalmology be presented to the 30 October 2013 Finance and Performance Committee meeting; **COO**
2) the Chief Executive briefed members on the Executive Performance Board's decision to reinforce the existing policy relating to the ring-fencing of 2 beds on the stroke unit, recognising the difference that such beds made to clinical quality;
3) the Committee Chairman sought and received assurance that the actions in place to reduce avoidable pressure ulcers had been reviewed by the recently appointed Chief Nurse and were considered appropriate. In addition, members noted that the Quality Assurance Committee had also reviewed the action plan in place to reduce pressure ulcers. Colonel (Retired) I Crowe, Non-Executive Director noted that issues surrounding the availability of pressure relieving mattresses had been highlighted in a recent CCG-led ward inspection;
4) Colonel (Retired) I Crowe, Non-Executive Director sought and received additional information regarding the process for checking ward level resuscitation equipment and the importance of robust documentation of these checks.

Section 8 of paper J updated Finance and Performance Committee members on performance in respect of Facilities Management services for June 2013 and members queried the reasons for not providing more up-to-date performance data, noting that the August 2013 data was due to be considered that afternoon at the NHS Horizons Board meeting. Discussion took place regarding the Patient Led Assessments of the Care Environment (PLACE) results, which were due to be reviewed at the Quality Assurance Committee meeting later that afternoon, alongside the immediate actions to address issues raised by the audits. The Committee Chairman provided some contextual information regarding the timing of these assessments which were undertaken in June 2013, before any service transformation work had commenced but whilst the management of change process was underway.

The Deputy Director of Finance briefed members on the Trust's month 5 financial performance, noting an in-month income and expenditure deficit of £3.5m (£3.9m adverse to plan) and a cumulative year to date deficit of £13.4m (approximately £12.5m adverse to the planned deficit of £0.9m). Key drivers behind the deficit included a favourable income position against plan, but significant challenges to the Trust's cost base, both in the areas of pay and non-pay. Table 5 detailed the breakdown of penalties and fines provided for within the income position (totalling nearly £2.8m) and members noted that at the current time no provision had been allowed for potential penalties surrounding ambulance turnaround times.

The Committee Chairman noted a slight improvement in the average monthly pay expenditure variance which would appear to imply that the Trust's control in this area was beginning to take effect. In the area of non-pay, he noted a continued deterioration in the average monthly variance and he sought assurance regarding the Trust's ability to deliver an improved position. In response, the Director of Finance and Business Services made reference to the Trust's financial recovery plans, acknowledging that a report on this item (which featured later in this agenda as paper M) had not yet been circulated. He proceeded to report verbally on the detailed analysis of UHL's non-pay variance and the

immediate actions agreed by the Executive Performance Board on 24 September 2013 in order to deliver an improved position for month 6.

The Chief Executive noted that August was sometimes a disappointing month in respect of financial run-rate calculations due to the holiday season. He requested that the updated Divisional recovery plans for Acute Care and Planned Care be circulated to members for information and he emphasised the need for a seamless switch into the new Clinical Management Group (CMH) structure. The Chief Executive noted his direct involvement in the weekly vacancy controls process and that he had written formally to the CCGs seeking visibility on their use of funding raised through penalty systems (eg EMRET and readmissions). In addition, the Chief Executive advised that the Trust was not likely to deliver a year end surplus or break-even position without the additional strategic transitional support and transformation funding. **DFBS**

Putting aside the issues surrounding additional financial support, the Committee Chairman reflected upon UHL's ability to manage the pay and non-pay elements of the 2013-14 financial position according to plan. In response, the Deputy Director of Finance advised that some of the additional costs were directly related to additional activity and that this was appropriately reflected in the income line. However, he noted a potential false variance relating to Theatre supplies, advising that a manual stock check was being undertaken that weekend and that this would be repeated on a quarterly basis until the new stock control system was put in place.

Finally, the Director of Finance and Business Services noted the need to challenge clinical variation at Consultant level through the Patient Level Information Costing System (PLICS). He also paid tribute to the Women's and Children's Divisional team, who had managed to maintain a positive position against the year to date plan, despite variations in the areas of sexual health services and maternity activity.

<u>Resolved</u> – that (A) the month 5 Quality, Performance and Finance report (paper J) be received and noted;

(B) detailed discussion on ED performance and emergency care issues be deferred to the public Trust Board meeting on 26 September 2013; **COO**

(C) a detailed report on the actions required to recover RTT performance in Ophthalmology be presented to the 30 October 2013 Finance and Performance Committee meeting, and **COO**

(D) finalised Divisional recovery plans for Acute and Planned Care to be shared with Finance and Performance Committee members outside the meeting. **DFBS**

103/13 FINANCE

103/13/1 <u>Delivery of Cost Improvement Programme (CIP)</u>

The Head of Trust Cost Improvement Programme introduced paper K, providing the August 2013 update on the status of 323 CIP schemes with an in-year value of £36.1m against the revised target of £37.7m. He briefed the Committee on a number of additional CIP schemes being developed to bridge the shortfall of £1.6m, noting that these schemes would be worked up and included in the next iteration of this report.

Members noted that proposals for a centrally managed medical equipment library might deliver in the region of £0.5m in savings, but confirmation was awaited from the Facilities Department regarding a suitable location for this function.

The Committee Chairman invited the Head of Trust CIP to highlight any key risks to the programme and noted in response that these related mainly to Empath and Theatre

related schemes and a potential forthcoming change in HMRC guidance relating to the VAT element of medical locum expenditure. The Chief Executive particularly noted the need to mitigate the CIP gap resulting from a reduced target for IM&T.

Discussion took place regarding recent slippage in the Empath business case and the Deputy Director of Finance provided assurance that the Empath management team was fully engaged in the CIP process and that no savings had been assumed in the 2013-14 financial year.

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

(B) the Head of Trust CIP be requested to ensure that the next iteration of this report contained the additional schemes being developed to address the shortfall for 2013-14. **HTCIP**

103/13/1.1 Outpatients Improvement and Innovation Programme

Mr O Sudar, Outpatients Project Manager presented paper K1, providing a progress update on the Outpatients Improvement and Innovation Programme, noting that in the first 5 months of 2013-14 a reduction of 2,600 clinic DNAs (Did Not Attend) had been achieved and outpatient activity data stood at 13,351 appointments above plan which equated to approximately £1.8m of additional income for the Trust. An overview of the 3 key projects was provided in section 3 of paper K1:-

(a) reducing DNAs by increasing the percentage of patients receiving an SMS text reminder of their appointment;
(b) rolling out 'Patient Call Optimiser' a targeted intervention for those clinic appointments evaluated to be at greatest risk of DNA, and
(c) clinic reviews, analysis and observation to improve capacity and patient flows.

Members particularly noted 2 areas where some additional project resources would help to support the current level of progress – replacing the Band 5 Project Facilitator who had commenced in August 2013 but had since moved to support the Ophthalmology Service and some additional junior resources to assist with the capture of patients' mobile telephone numbers in order to expand coverage of the automated text reminder service for clinic appointments. It was suggested that the Booking Centre team based at Glenfield Hospital might be able to assist with the process of capturing patients' mobile numbers. **COO**

Ms J Wilson, Non-Executive Director commended the progress to date and queried the expected impact of the forthcoming service reconfiguration work to move Outpatients Clinics 1 to 5 to an alternative location. In response, the Outpatients Project Manager suggested that changes in the clinic location might complement other planned improvements for the service, but he voiced a slight concern that staffing resources might be re-directed away from the Improvement and Innovation workstreams during the relocation process.

Resolved – that (A) the update on the Outpatients Improvement and Innovation Programme (paper K1) be received and noted, and

(B) the Chief Operating Officer be requested to explore the availability of additional supporting resources (as per the requirements identified above). **COO**

103/13/1.2 Clinical Nurse Specialist Review

The Assistant Director of Nursing attended to provide an overview of the Clinical Nurse Specialist Review, as detailed in paper K2. A breakdown of the income and savings assumptions arising from this scheme for 2013-14 was provided in appendix 1 to paper

K2. Members noted that the terms of reference for this project had been reviewed since the original £1m savings target had been set and the full year effect of savings was now expected to be £510,696.

A status report had been presented to the Improvement and Innovation Board on 11 September 2013 and a focused approach towards workforce planning and productivity had been agreed. Discrepancies had been noted in respect of the ESR data relating to Nurse Specialists and a data validation exercise was underway alongside a process to standardise job titles. In addition, work was taking place to ensure that Nurse Specialist telephone clinics met the required criteria and were appropriately documented to capture the income relating to this activity – the Deputy Director of Finance confirmed that this activity would be reflected within the 2014-15 contract. Recommendations had been made for the future governance of replacement posts and the arrangements for visibility of any income streams prior to recruitment had been strengthened.

The Committee requested that the Nurse Specialist workforce plan (including the trajectory for the next 5 years) be presented to the Finance and Performance Committee meeting in December 2013 or January 2014.

Resolved – that (A) the update on the Clinical Nurse Specialist Review (paper K2) be received and noted, and

(B) the workforce plan for Clinical Nurse Specialists be presented to the Finance and Performance Committee in December 2013 or January 2014. **DHR/ CN**

103/13/1.3 Theatre Transformation Programme

Further to Minute 92/13/1.2 of 28 August 2013, Mrs S Khalid, Head of Improvement and Innovation attended the meeting to present an update on the recent review and analysis of theatre performance data (as detailed in paper K3). The league tables highlighting all elective sessions below 70% utilisation had been used to identify the specialties for further focus and to date 8 sessions has been identified as potential areas for decommissioning subject to the scheduled check and challenge sessions set out in paper K3. Strong links were noted with the Outpatients and Job Planning Projects due to the impact of clinic overruns upon the Trust's ability to commence theatre lists on time.

Ms J Wilson, Non-Executive Director sought further information regarding the softer analysis of theatre utilisation and noted in response that a high proportion of Urology sessions at Glenfield Hospital had been cancelled due to the breakdown of equipment. A capital scheme had now been developed to replace this equipment. A review was also underway to review procedures and delays caused by heavy blood loss during theatre sessions.

The Head of Improvement and Innovation reported on a validation process for ORMIS data and opportunities to standardise theatre scheduling by type of procedure based upon UHL's own performance data.

Resolved – that (A) the update on the Theatre Transformation Programme (paper K3) be received and noted.

103/13/2 Update on 5 Year CIP and 2014-15 Planning Process

Further to Minute 77/13/5 of 24 July 2013, the Head of Trust CIP introduced paper L which described the process to support the generation of ideas, initiation and implementation of new CIP schemes, alongside the outputs from the Trust's partnership with IBM, existing multi-year CIP schemes, reconfiguration opportunities, market assessment and service analysis. Members noted that the potential target for 2014-15 might be in the region of £45m and to date schemes had been identified which might

deliver a full year effect of £10m. These schemes were broadly grouped as Improvement and Innovation related (63%) and business as usual (37%).

The Deputy Director of Finance noted the need to engage the new Clinical Management Groups in developing their 2014-15 CIP schemes in a timely manner to avoid any slippage. Ms J Wilson, Non-Executive Director noted that it would be helpful to see the overall CIP position in terms of headcount changes by staff group and the mechanism for achieving any workforce changes.

Discussion took place regarding the approach to bed related CIP savings, in view of the current bed modelling and winter capacity planning work that was underway. It was agreed that schemes involving improved bed utilisation and reduced length of stay would be progressed accordingly, but concerns were raised about the deliverability of any schemes which involved any reduction in overall bed capacity.

Resolved – that the update upon the Trust's 5 year CIP and 2014-15 Planning Process (paper L) be received and noted.

103/13/3 Trust Financial Recovery Plans

Finance and Performance Committee members received tabled copies of paper M, providing a summary of the month 5 financial re-forecast, any associated risks and opportunities and the initial action plans to address the Trust's financial recovery. Members were requested to review the report following the meeting and raise any issues through discussion at the Trust Board meeting on 26 September 2013. **ALL**

Resolved – that (A) the tabled report on UHL's financial recovery plans (paper M) be received, and

(B) any issues arising from the report be raised through discussion at the next Trust Board meeting on 26 September 2013. **ALL**

104/13 SCRUTINY AND INFORMATION

104/13/1 Divisional Confirm and Challenge

Resolved – that the notes of the 21 August 2013 Divisional Confirm and Challenge meeting (paper N) be received and noted.

104/13/2 Executive Performance Board

Resolved – that the notes of the 27 August 2013 Executive Performance Board meeting (paper O) be received and noted.

104/13/3 Improvement and Innovation Framework Board

Resolved – that the notes of the 11 September 2013 Improvement and Innovation Framework Board meeting (paper P) be received and noted.

104/13/4 Quality Assurance Committee (QAC)

Resolved – that the Minutes of the 28 August 2013 QAC meeting (paper Q) be received and noted.

104/13/5 Quality and Performance Management Group (QPMG)

Resolved – that the notes of the 7 August 2013 QPMG meeting (paper R) be received and noted.

105/13 ITEMS FOR DISCUSSION AT THE NEXT FINANCE AND PERFORMANCE COMMITTEE

Paper S provided a draft agenda for the 30 October 2013 meeting. It was agreed that the Trust Administrator would update this draft agenda to include a number of additional items arising from this meeting and recirculate the draft agenda outside the meeting. **TA**

Resolved – that (A) the items for consideration at the Finance and Performance Committee meeting on 30 October 2013 (paper S) be noted, and

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

106/13 ITEMS TO BE HIGHLIGHTED TO THE TRUST BOARD

Resolved – that the following issues be highlighted verbally to the Trust Board meeting on 29 August 2013:- **FPC CHAIR**

- **Minute 101/13/2 – nursing workforce and vacancy rates;**
- **Minute 101/13/7 – 2013-14 winter bed capacity planning;**
- **Minute 102/13/1 – month 5 financial performance, and**
- **Minutes 103/13/1.1 and 103/13/1.3 – progress with the Outpatients and Theatres Improvement and Innovation projects.**

107/13 ANY OTHER BUSINESS

107/13/1 Report 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 personal information and that public consideration at this stage could be prejudicial to the effective conduct of public affairs.

108/13 DATE OF NEXT MEETING

Resolved – that the next Finance and Performance Committee be held on Wednesday 30 October 2013 from 8.30am – 11.30am in the C J Bond Room, Clinical Education Centre, Leicester Royal Infirmary

The meeting closed at 11.35am

Kate Rayns,
Trust Administrator

Attendance Record

Name	Possible	Actual	% attendance	Name	Possible	Actual	% attendance
R Kilner (Chair from 1.7.13)	6	6	100%	I Reid (Chair until 30.6.13)	3	3	100%
J Adler	6	6	100%	A Seddon	6	6	100%
I Crowe	3	3	100%	G Smith *	6	5	83%
R Mitchell	3	2	66%	J Tozer *	2	2	100%
P Panchal	3	1	33%	J Wilson	6	5	83%

* non-voting members

To:	**Trust Board**
From:	**Rachel Overfield, Chief Nurse**
Date:	**31 October 13**
CQC regulation:	Outcomes: 5, 8, 10 and 16

Title:	**Patient-led Assessment of the Care Environment (PLACE)**
Author / Responsible Director:	Andy Powell Head of Performance & Quality Assurance NHS Horizons

Purpose of the Report:

SUPPLEMENTARY PLACE UPDATE

This report gives further details and analysis of the UHL PLACE results as requested by the QAC meeting of 25 Sept 13.

The Report is provided to the Board for:

Decision		Discussion X	
Assurance X		Endorsement	

Summary / Key Points:

1. Under the new outsourced arrangements for the provision of Estates and FM Services, NHS Horizons, as intelligent client, have responsibility for the management of the PLACE assessment process, which replaced the PEAT inspections with effect from 1st April 13.
2. The PLACE results received by the UHL in September following the inspections of June are now represented in a thermometer format and are referenced against the national average. The category headings are:-

    a. Cleanliness
    b. Food services
    c. Privacy, Dignity & Wellbeing
    d. Condition, Appearance and Maintenance

    The results across the UHL were mixed and the 4 categories can be compared against the National average as below:-

	Categories Above NA	Categories Below NA
GLENFIELD GENERAL HOSPITAL	3	1
LEICESTER GENERAL HOSPITAL	1	3
LEICESTER ROYAL INFIRMARY	0	4

A full analysis of the results by hospital and category is at attached to this summary at Appendix 1.

The distribution of site cleanliness scores nationally for the 4 categories for comparison purposes are attached to this report under Appendix 2.

Detailed action plans are currently being developed and implemented and are focussed on the following key aspects:-

a. Improved FM and nursing delivery of operational requirements.
b. Review and Investment in upgrading of equipment and furnishings.
c. Review and investment in the Estate and the Environment and the opportunity to release operational areas for upgrade and refurbishment.

Recommendations:
The Quality Assurance Committee are asked:

- Note the feedback and results of the assessments for UHL and the future actions proposed.

Previously considered at another corporate UHL Committee?

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

Resource Implications (e.g. Financial, HR)

Assurance Implications

Patient and Public Involvement (PPI) Implications
Patient Representatives will play a key role in the assessment process with 50% of the assessment team comprising patient representatives.

Equality Impact
Due regard to the positive general duties of the Equality Act 2010 has been taken in the development of this paper.

Information exempt from Disclosure

Requirement for further review?

Appendix 1

UNIVERSITY HOSPITALS OF LEICESTER

PATIENT LED ASSESSMENT OF THE CARE ENVIRONMENT RESULTS 2013

Revised PLACE Scores of September 2013

	Cleanliness Fig 1	National Average (NA) 95.74%	Condition Appearance & Maintenance Fig 2	National Average (NA) 88.75%	Privacy, Dignity & Wellbeing Fig 3	National Average (NA) 88.87%	Food Fig 4	National Average (NA) 84.98%
TRUST AVERAGE SCORE	90.6%	Below NA	78%	Below NA	78.19%	Below NA	84.51%	Below NA
GLENFIELD GENERAL HOSPITAL	95.89%	Above NA	89.67%	Above NA	84.73%	Below NA	85.94%	Above NA
LEICESTER GENERAL HOSPITAL	89.29%	Below NA	74.91%	Below NA	71.95%	Below NA	85.57%	Above NA
LEICESTER ROYAL INFIRMARY	86.63%	Below NA	75%	Below NA	78.25%	Below NA	83.58%	Below NA

See Annexes 1-4 to compare UHL results against National Profile

Summary of UHL PLACE Results against national Averages (NA)

	Categories Above NA	Categories Below NA
GLENFIELD GENERAL HOSPITAL	3	1
LEICESTER GENERAL HOSPITAL	1	3
LEICESTER ROYAL INFIRMARY	0	4

Fig 1

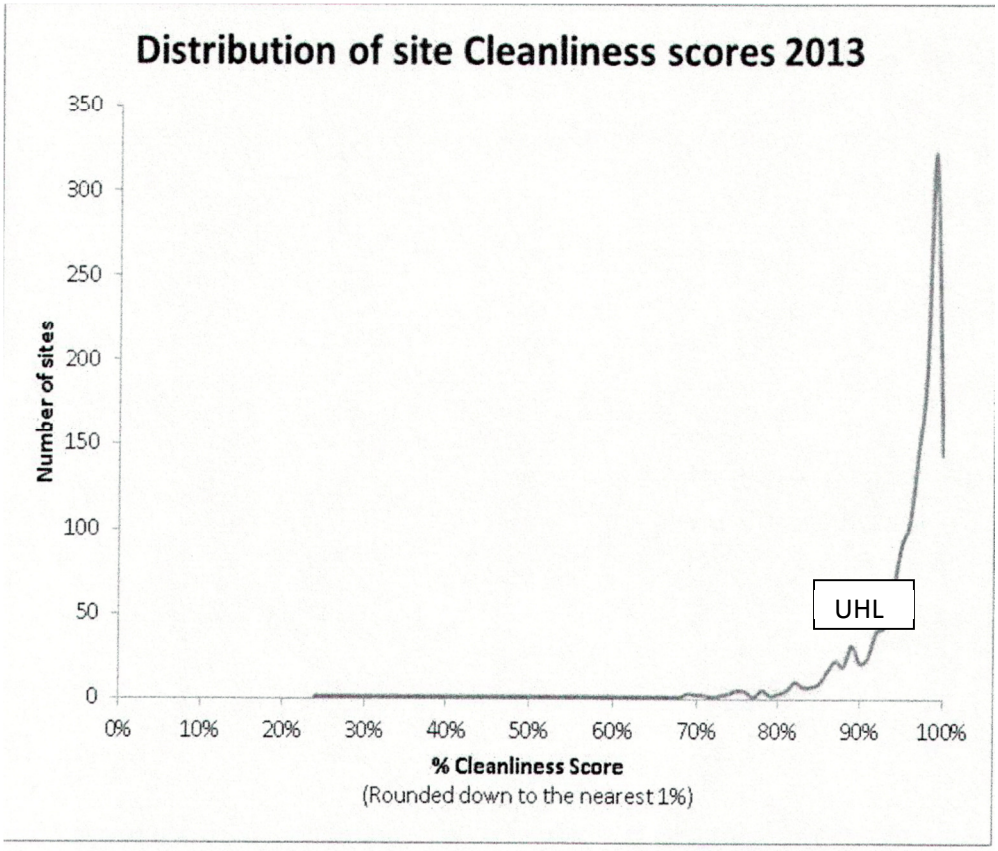

Distribution of site Cleanliness scores 2013
Number of sites
350
300
250
200
150
100
50
0
0%
10%
20%
30%
40%
50%
60%
70%
80%
90%
100%
% Cleanliness Score
(Rounded down to the nearest 1%)
UHL

Fig 2

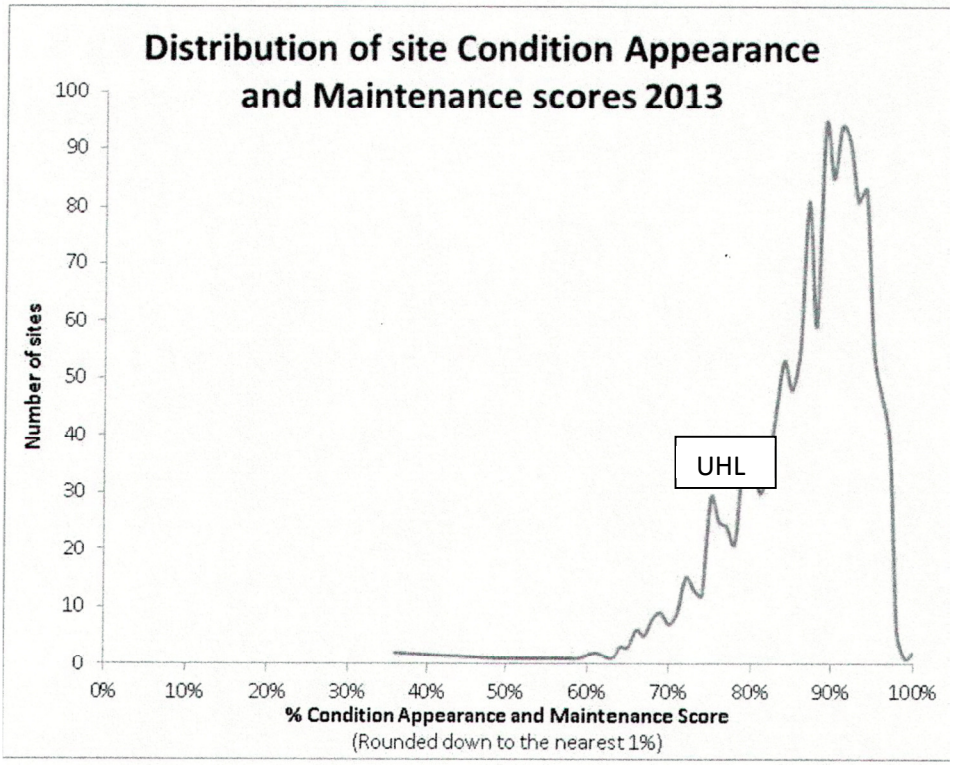

Distribution of site Condition Appearance and Maintenance scores 2013
Number of sites
100
90
80
70
60
50
40
30
20
10
0
0%
10%
20%
30%
40%
50%
60%
70%
80%
90%
100%
% Condition Appearance and Maintenance Score
(Rounded down to the nearest 1%)
UHL

Fig 3

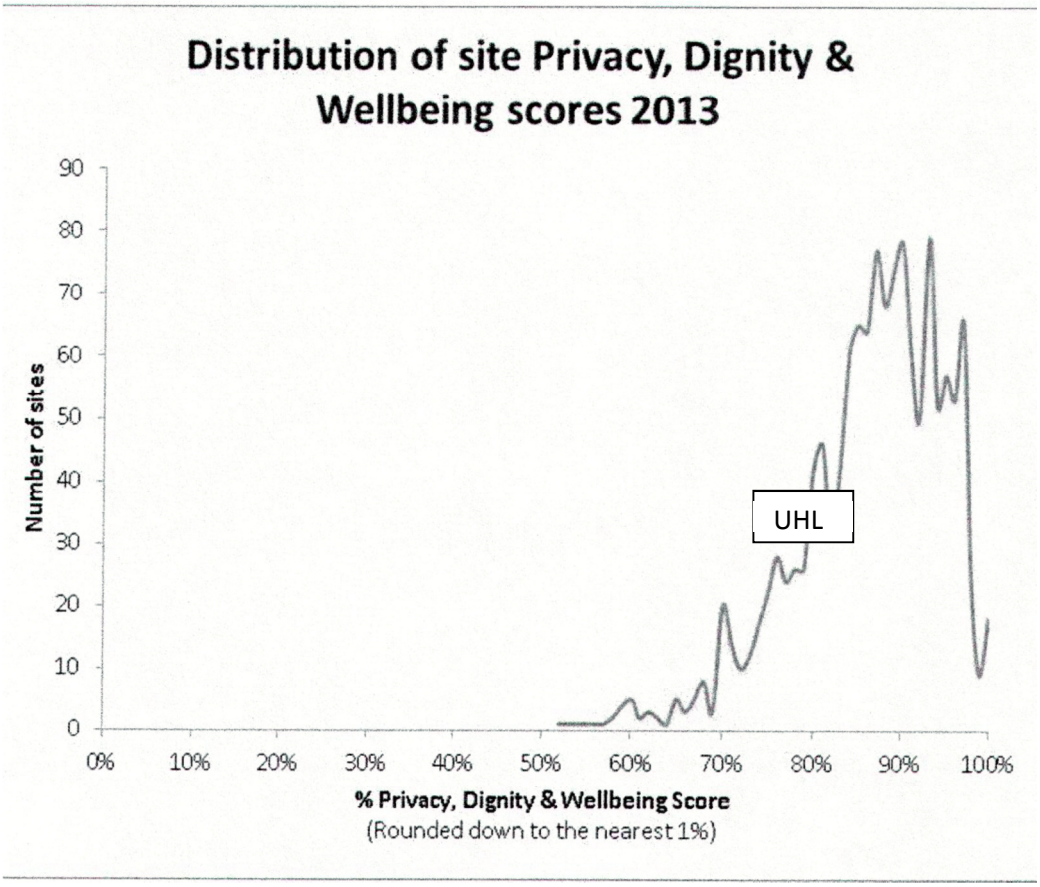
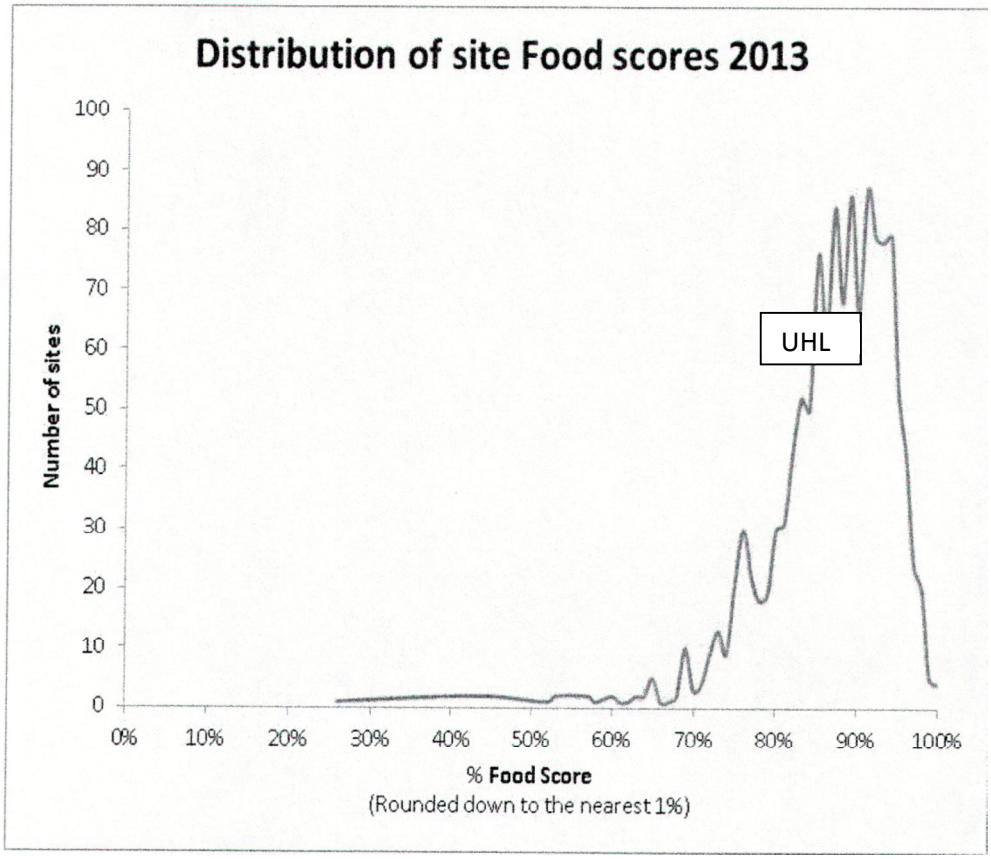
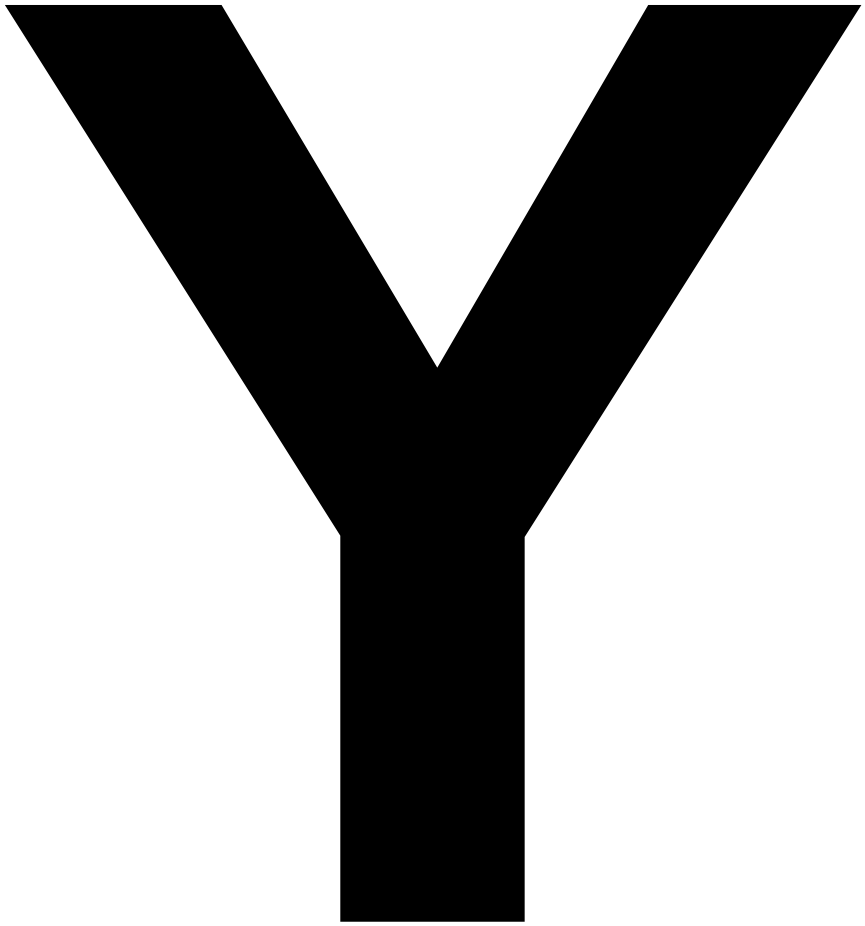

Distribution of site Privacy, Dignity & Wellbeing scores 2013
Number of sites
0
10
20
30
40
50
60
70
80
90
0%
10%
20%
30%
40%
50%
60%
70%
80%
90%
100%
UHL
% Privacy, Dignity & Wellbeing Score
(Rounded down to the nearest 1%)

Fig 4


Distribution of site Food scores 2013
Number of sites
0
10
20
30
40
50
60
70
80
90
100
0%
10%
20%
30%
40%
50%
60%
70%
80%
90%
100%
UHL
% Food Score
(Rounded down to the nearest 1%)



Trust Board Paper Y

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

Title:	Emergency Department Performance Report

Author: Richard Mitchell, Chief Operating Officer

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

The Report is provided to the Board for:

Decision		Discussion	
Assurance	√	Endorsement	

Summary / Key Points:

- Performance in September was 89.50%
- Performance year to date is 87.84%.
- Performance in the first half of October improved linked to a reduction in admissions and improved ways of working with one week over 95% (first in 52 weeks)
- Emergency admissions have increased by 8% recently creating significant bed pressures
- Sixteen additional admissions beds open at the LRI on 4 November 2013
- CCG and UHL colleagues have recently agreed a step change to working by resourcing a joint team to focus on four key actions
- The two key actions remain providing timely access to medicine and emergency beds and recruiting to vacant posts
- Performance continues to come under considerable external scrutiny.

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

Previously considered at another UHL corporate Committee N/A

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

Resource Implications (eg Financial, HR)
Yes

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

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

Equality Impact
N/A

Information exempt from Disclosure
N/A

Requirement for further review
Monthly

REPORT TO:	**Trust Board**
REPORT FROM:	**Richard Mitchell, Chief Operating Officer**
REPORT SUBJECT:	**Emergency Care Performance Report**
REPORT DATE:	**31 OCTOBER 2013**

Introduction

UHL's performance continues to vary against the four hour emergency care measure. Plans for performance improvement including the ECAT action Plan and the wider NHS England (NHSE) action plan are in place. An improved integrated way of working with CCGs has been in place for four weeks and is led by West Leicester CCG.

This report provides an overview of performance for September and October 2013 and details the factors contributing to poor performance and the internal and external actions taken to remedy them.

Performance overview

In September 2013, 89.50% of patients were treated, admitted or discharged within four hours. This is a slight deterioration from the performance in August (90.16%). October 2013 month to date (up to and including 22 October 2013) performance is 92.82% and year to date performance is 87.84%.

UHL performance for the week ending 13 October 2013 was 95.45% (table one). This was the first week of compliant performance in 52 weeks and placed UHL 81st out of 144 NHS Trusts with an A&E.

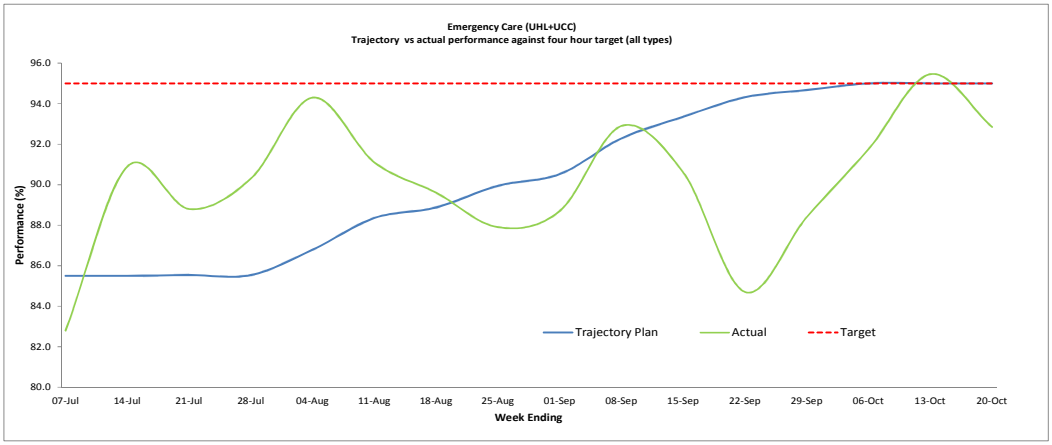


Table one

Day to day performance remains variable, with more recently, longer periods of improved performance followed by deterioration in performance (table two).

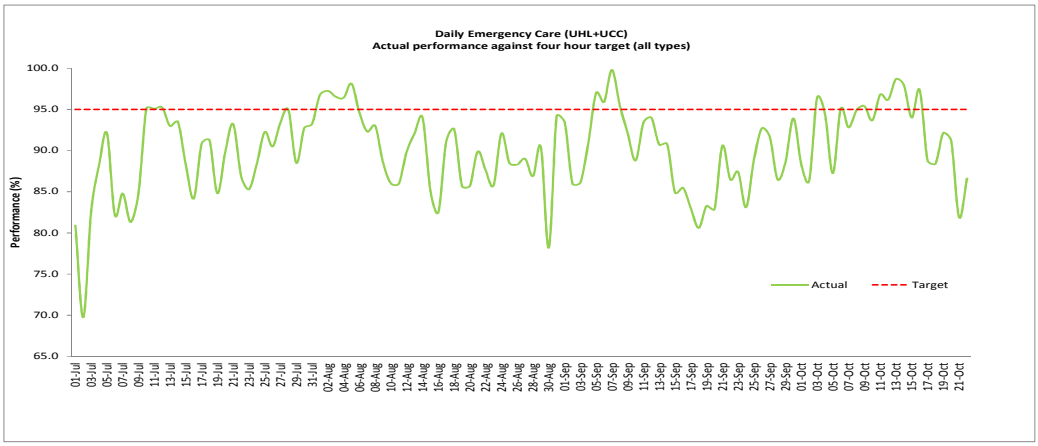


Table two

Root cause of poor performance

As detailed previously, an in-depth diagnosis of causative factors for poor performance was conducted in July and early August and actions were put in place to negate the factors. Success has occurred with the range of factors at play reducing but the two remaining key factors are:

1. Timely access to beds
2. Staffing

The primary reason for performance deterioration in September compared to August was the increase in admissions, without a corresponding increase in discharges (table three). As detailed above, performance for the week ending 13 October 2013 was 95.45% and performance for the following week was 92.6%. Admissions increased by 8% in the second week, and were the third highest week of admissions since April 2011, but discharges did not increase. Discharges will naturally increase after high admissions, but there is a lag time linked to length of stay. To fully rectify this, discharges across the week needs to improve and emergency patients need to access a larger bed stock.

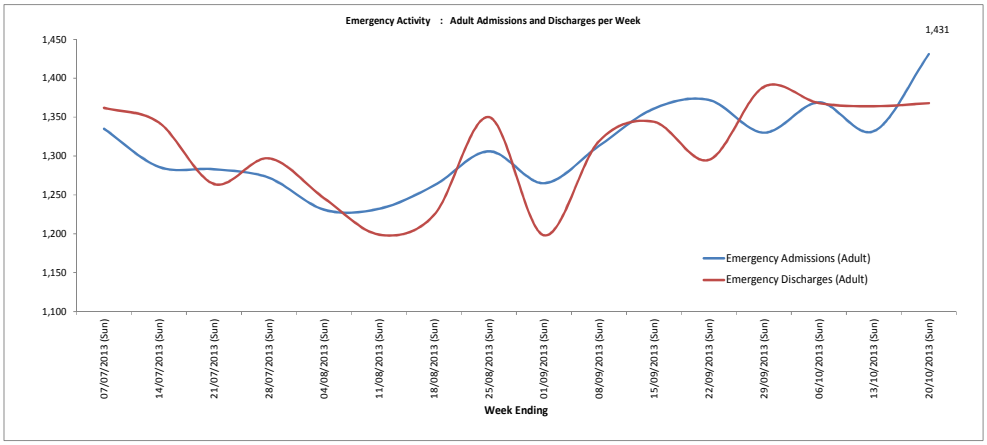


Table three- the graph below shows a weekly macro position for admissions compared to discharges. This hides daily variation, in particular the net position in the morning.

UHL currently does not have sufficient empty medical or admissions beds nor the ability to rapidly increase the number of discharges to accommodate increases in admissions in a timely manner. This means the number of patients breaching will increase when admissions increase. Discharges continue to vary on a day to day basis, with 15 of the 16 lowest discharges occurring on a Sunday (table four).

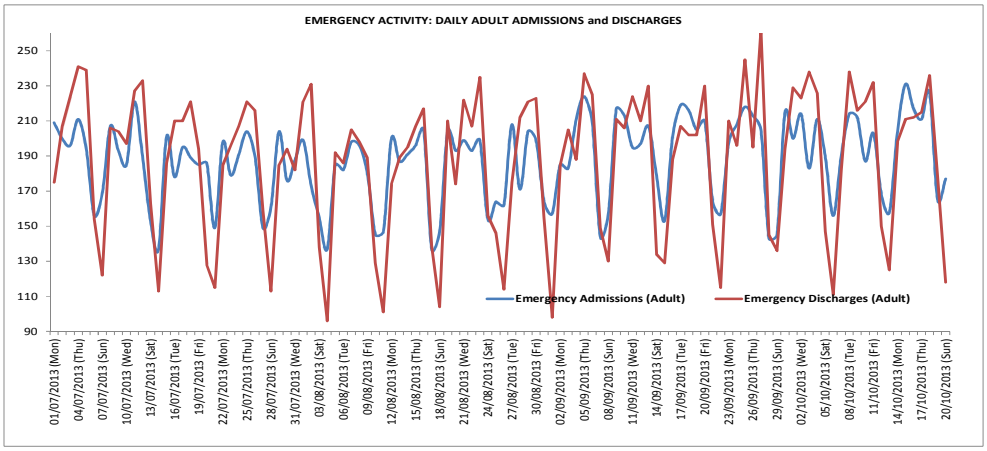


Table four

Staffing continues to be problematic both within the A&E department and the admissions and base wards. The vacancy factor for nurses is well known and UHL is highly reliant on bank, agency and locum staff to run the emergency and medicine service. Recruitment campaigns for all vacant posts

are underway with regular checks on progress conducted in the confirm and challenges meetings and other forums.

Key actions since last month

- Integrated way of working with CCG partners focussed on four whole system solutions
    - Ward practice led by Chief Nurse
    - ED/ Speciality working led by Medical Director
    - Operational working led by Chief Operating Officer
    - Multi-agency working led by Managing Director for West Leicester CCG
- NTDA signed off bed modelling confirming UHL has 74 too few beds at the LRI for winter, with the majority of the additional beds required in medicine
- NTDA signed off assessment bed modelling confirming UHL has 26 too few assessment beds at the LRI
- Outsourcing of selective elective work to IS has begun
- Estates enabling work to convert day case facilities to inpatient facilities begins next week
- Opening of increased community beds has begun
- Confirmation that additional beds cannot open at UHL because of vacancy factor and no modular wards available
- Tightening of operational grip especially in site meetings and command and control centre fully functioning
- Changes to senior manager and exec on call function
- Chief Nurse is focussing on improving quality on the wards which will strengthen this work
- Confirmation of winter monies planning
    - £7.8m of £10m is being spent on improving discharge, operational grip and staffing at UHL
    - Actions within the winter monies allocation were developed through careful analysis of the data and listening to clinicians

Future focus

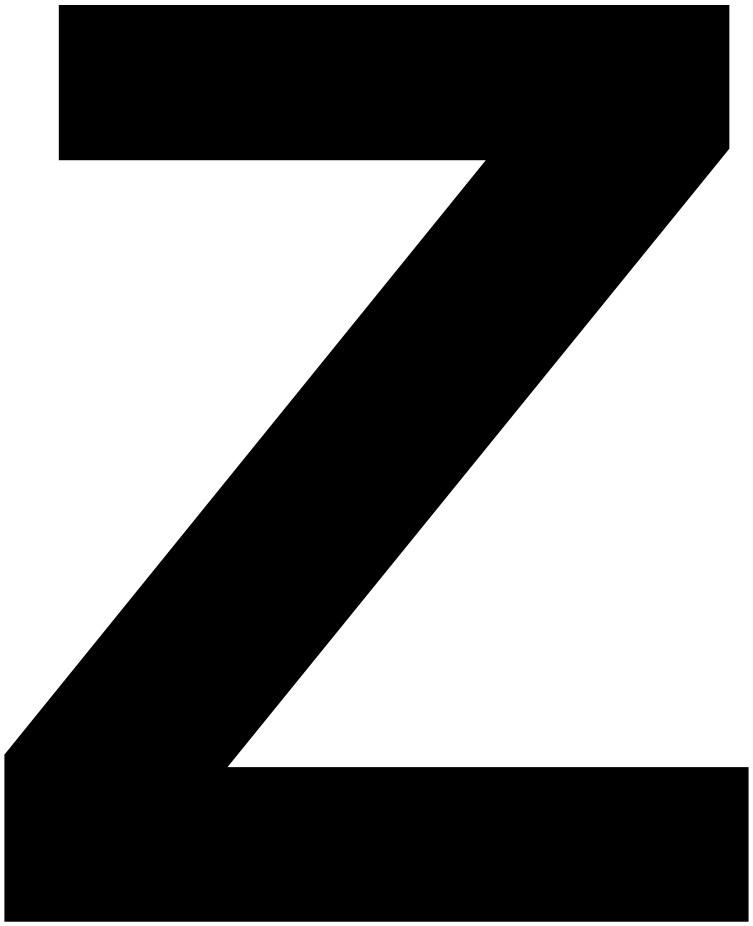
The key actions for winter 2013 are:

- Improving timely access to beds by:
    - Timely decision in ED
    - Improving the rate of discharge
    - Increasing the number of medicine beds at LRI including 16 additional assessment beds opening on 4 November 2013
    - Increasing community provision
- Continuing the recruitment process for nurses and doctors and reducing the reliance on bank, agency and locum staff

Recommendations

The Board is asked to:

- Note the contents of the report
- Acknowledge the continuing focus on further and continued sustained performance improvement
- Note the on-going support from the CCGs and healthcare partners to deliver the required step changes across the Health Economy



Trust Board Paper Z

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

Title:	Winter bed and capacity planning

Author: Richard Mitchell, Chief Operating Officer

Purpose of the Report:
To provide an overview of plans for additional beds and other capacity changes in winter 2013/14

The Report is provided to the Board for:

Decision		Discussion	
Assurance	√	Endorsement	

Summary / Key Points:

- Bed modelling has been completed indicating that UHL has 74 too few ward beds and 26 too few admission beds this winter
- All possible UHL, community and Independent Sector options for increasing the winter bed base have been explored
- Emergency admissions are increasing and timely access to beds will be critical this winter
- UHL and LLR have submitted their winter plans and the UHL winter plan is presented to the October Trust Board for approval
- The Flu plan will be presented to the October Emergency Planning and Business Continuity Committee
- Accountability for managing winter performance will be through the weekly Emergency Care Action Team meetings, chaired by the CEO
- Winter performance will be reported to the Trust board via the Chief Operating Officer's monthly report on the 4 hour performance
- There is a weekly meeting with UHL and the Urgent Care Board where UHL is held to account for its performance

Recommendations:
The Trust Board is invited to receive and note this report and the winter plan is submitted for approval.

Previously considered at another UHL corporate Committee N/A

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

Resource Implications (eg Financial, HR)
Yes

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

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

Equality Impact
N/A

Information exempt from Disclosure
N/A

Requirement for further review
Monthly

REPORT TO:	**Trust Board**
REPORT FROM:	**Richard Mitchell, Chief Operating Officer**
REPORT SUBJECT:	**Winter beds and capacity planning 2013/14**
REPORT DATE:	**31 October 2013**

Purpose

This paper provides the Trust Board with a brief update on 2013/14 winter bed capacity and winter planning.

Update

Bed modelling is complete and has been signed off by the Head of Delivery and Development at the NTDA. Based on current length of stay, occupancy rates and activity forecasts, it is estimated that UHL requires a further 74 medical beds and 26 assessment spaces this winter to support timely transfer of patients from ED without affecting RTT throughput.

Actions taken

All possible UHL, community and Independent Sector options for increasing the winter bed base have been explored. Key actions taken to increase the bed numbers are:

Action	Likelihood of delivery
Additional community beds opening (24)	
Additional Respiratory beds at the Glenfield to open (15)	
Estates work begins this week to convert the day case facility at LRI into an overnight ward (16). Nb, keeping this facility open overnight will not be possible at the moment because of staffing constraints	
Elective work outsourced to the Independent Sector from November although at the moment this is primarily to improve RTT performance	
A range of options have been investigated to hire modular wards and Vanguard theatres but UHL has been unable to find a suitable provider	
Additional assessment beds from medical bed base opening 4 November 2013 (16). Nb, these are not an additional 16 beds to the UHL bed base	
Options to reopen the Brandon Unit are being investigated	

This will provide a further 39 medicine ward beds (24 of them in the community) and a further 16 assessment beds. In addition to the above actions, recruitment to existing vacancies is on-going and collaborative work with the CCG focusses on improving the discharge rate. Admissions last week were 8% higher than the previous week and higher than at any time since at least the beginning of April 2013.

Recommendation

The Trust Board is asked to note the paper and the on-going work to improve access to beds. Access to beds will be the critical factor this winter.

University Hospitals of Leicester

Winter Plan 2013/14

1st December 2013 to 31st March 2014

Signatories to agreement of Trust Winter Plan 2013/14

Name: Richard Kilner Trust Chair	Signature Date:
Name: John Adler Trust Chief Executive	Signature Date:
Name: Simon Freeman Lead Commissioner	Signature Date:

Winter plan guidance

- The winter plan specifically relates to the period between 1st December 2013 and March 31st 2014
- The plan should be focused on the modelling of winter demand and therefore what additional measures will be required to sustain safe and effective care during this period.
- A separate focus is required for the Christmas and new year period 21st December – 5th January due to the way the banks holidays fall
- UHL's winter plan will continue to be revised in light of the impact of the LLR winter plan. The plan will be reviewed on a weekly basis and an update provided to ECAT for action as necessary.

Winter Planning 2013/14

Demand & Capacity	Trust demonstrates it has undertaken a demand and capacity review for : •ED with regard to staffing numbers and skill mix to manage predicted demand modelled at the 85th centile. •Assessment Areas for numbers of assessment / short stay spaces in addition to staffing to manage the 85th centile of admissions. The Trust must set out the additional capacity (beds, support services and staff) it intends to deploy during the winter period.
Delivery	The Trust demonstrates it has effective models of care , this would include: •Senior review on attendance / admission to ED / AMU as early as possible following presentation. •Ambulatory Emergency Care •Daily senior review of all patients every day •Same day access to diagnostics for inpatients •EDD and Clinical Criteria for discharge set at the point of admission and reviewed every day via board / ward rounds
Governance	The Trust needs to demonstrate the following •An approach to daily / weekly performance management / service improvement •A clear structure of accountability with an executive lead •Board reporting in place with the plan signed off by the board. •That the Trust is clear on Risks and associated mitigating actions
Partnership	• The Trust demonstrates it is working with all parts of the system to reduce urgent care demand and improve internal flow. And are fully engaged with any decision regarding investment.
Investment Priorities	• The Trust needs to identify its investment priorities and be in a position to bid for investment from winter pressures funding. The focus will be on investments which have previously delivered benefits and capacity to match anticipated demand.
Sign off	• A successful plan will require all parties to be closely aligned and fully signed up to there agreed responsibilities.

Demand & Capacity (1)

Bed Modelling

Could the Trust provide details to the following question:

•Could the Trust provide the model for bed requirements for assessment units, inpatient beds, Critical Care and any re-ablement capacity for the 2013/14 winter period?, Best practice would suggest the following assumptions should be considered:

- Predicted admissions modelled at the 85th centile levels
- Length of stay increase during winter for non elective admissions.
- Bed Occupancy modelled at 92% across the inpatient hospital bed base

The trust has modelled the bed requirements (appendix 1) for winter, which has also been reviewed and supported by ECIST. Assumptions in the model include;

Elective

- No change in average length of stay
- Occupancy set at 95% for a 5 days of the week (which equates to 68% for the week)
- Activity levels as per contracted levels
- Day cases excluded

Emergency/ Non-Elective

- No change in average length of stay
- Occupancy set at current occupancy with a ceiling set at 92% for specialties that are 93% and above
- Activity levels as per 2012/13 outturn
- Maternity beds excluded

Demand & Capacity (2)

Additional Capacity

Based on the modelling exercise what additional capacity are you planning to put in place?

•This should include additional beds of any type, staffing both clinical and non clinical and any other support services already commissioned by the Trust.

Additional Capacity

•Additional capacity

The completed modelling work has shown that

•There is a shortage of acute medical beds of around 74, with 26 too few assessment beds.

•Following the modelling work, UHL are increasing assessment beds at LRI – to be done by using 16 beds on ward 33,

•Expand respiratory beds at GH for winter period, probably on ward 23, GGH – leading to a respiratory bed increase of 15. This will be affected by day case move back to LGH and the safe and sustainable agenda

- ITU demand has been reviewed for the last 24 months. There is little variation in demand due to seasonal pressures. There are all year round pressures on ITU which are being discussed via contracting. Flex capacity in theatres is part of the flu plan.
- Additional Community Support is being put in place on October 1st. This should increase capacity to manage up to 40 additional patients at home as well as an additional 24 patients in community hospital beds
- Additional leadership from the CCG has been put in place to strengthen the site management service

Demand & Capacity (2)

Additional Capacity

Based on the modelling exercise what additional capacity are you planning to put in place?

•This should include additional beds of any type, staffing both clinical and non clinical and any other support services already commissioned by the Trust.

Additional Capacity Actions

•UHL currently has all general capacity areas open.

•Work is being done in a variety of areas to increase the capacity throughout winter.

•The key areas are detailed below;

Additional Bed Capacity	Impact
Community Beds – Add beds	24
Use Glenfield beds for adult respiratory - Add beds	15
TOTAL	39

Demand & Capacity (2)

Additional Capacity

Based on the modelling exercise what additional capacity are you planning to put in place?

•This should include additional beds of any type, staffing both clinical and non clinical and any other support services already commissioned by the Trust.

Staffing and support services (Appendix 2)

Service	Service Description
Increased ED Processing capacity decision	This will lead to reduced times for patients to see a senior clinical maker leading to reduced waits for a decision on the intended outcome
Increased porters	An additional 2 porters to enable patients to be transported minimizing delays in getting to the wards/imaging thereby reducing 4 hour breaches.
Ward clerk support for assessment units	1 additional person 24/7 to ensure patients are put on to systems immediately allowing for better tracking of all ED patients
ED Assessment equipment	To ensure that all assessment areas are fully functional to support faster assessment at the front door
Bed co-ordinators	4 additional bed coordinators to undertake to increase discharges before 11:00.
Hospital at night	Funding to allow service to operate until 31 March 2014. This will mean that all patient care continues through the night leading to earlier discharges

Demand & Capacity (2)

Additional Capacity

Based on the modelling exercise what additional capacity are you planning to put in place?

•This should include additional beds of any type, staffing both clinical and non clinical and any other support services already commissioned by the Trust.

Staffing and support services cont.

Service	Service Description
Additional Site Management Staff	To ensure tighter operational grip and stronger capacity plans earlier in the day
Equipment for the control room	To monitor patient flow and to avoid any delays
Care Home Brokerage	To help reduce Discharge to Assess and fastrack discharge times by 50%
Discharge specialists	Additional 4 staff to reduce DTOCs by 4 per day
Expanded assessment unit reduced	To have faster access to senior medical decision maker, leading to admissions
Weekend Imaging Support	To expand service to operate longer hours through weekend leading to better patient care as well as reduced length of stay
Weekend consultant shifts in medicine	This links with expanding services throughout the weekend to improve patient care and reduce LoS
Increased weekend Pharmacy and phlebotomy	This links with expanding services throughout the weekend to improve patient care and reduce LoS

Demand & Capacity (3)

Workforce

Could the Trust provide us with your winter staffing plan and how this aligns to predicted demand for services?

- Currently there are significant numbers of vacancies in qualified nursing staff across the Trust (circa 500). This particularly affects nursing in acute medicine. Fortnightly recruitment meetings are taking place in areas of specific shortage e.g. ITAPS, ED to track progress against specific workforce/ recruitment plans.
- A paper is going to the Board on the workforce plans for nursing which outlines key actions to be taken to improve recruitment for nursing at UHL. This paper will include contingency plans for non-ward based nurses who may need to be placed on wards due to pressure.
- A workforce plan for ED has been presented to the Board and progress is reported to the Emergency Care Action Team (ECAT) weekly (Appendix 3). The staffing shortages have reduced over the last 3 months due to focussed recruitment/retention processes
- Recruitment and retention premia have now been applied to Band 5 Nursing and substantive Consultant posts in ED to attract and retain these staff
- There are areas of particular deficit in medical staffing including middle grades and consultants in specific hotspot areas in ED, acute medicine, neonatal transport and renal. A workforce plan is being drawn up for these areas and work is being done with HR to improve recruitment including international recruitment
- The expansion of the assessment facility will require additional acute medical staff, which is being addressed. There are current adverts for additional junior medical staff
- The pilot of a consultant discussing all medical patients referred to the bed bureau by a GP, has been successful and will need additional medical staffing to maintain it through the winter.
- UHL is undertaking international recruitment to support recruitment to nursing and medical posts in particular shortage areas. This will have a specific resource dedicated to this area.

Demand & Capacity (4)

Patient Safety – managing peaks in demand safely

Could the Trust provide details of what actions have been undertaken during the development of the winter plans to ensure quality & patient safety is not compromised during times of surge and or when the ED(s) are full?

- There are three performance monitoring processes in place to ensure that ED quality of care is monitored weekly :-
  - A weekly report to Director of Nursing, City CCG, where performance is less that 80% in ED (Appendix 4)
  - A weekly monitoring of the Quality metrics as part of ECAT dashboard (Appendix 5)
  - A UCB paper (Appendix 6) indicates how the CCG will ensure the quality of service in the ED using current metrics and unannounced visits. The focus will be on the overall care and the care for patients experiencing long delays

- There is a hospital escalation plan with alerts at each stage to ensure actions are taken to maintain patient safety and quality.

- The Chief Nurse has required ED to identify additional staff to undertake hourly rounding and caremakers for all patients throughout winter

- Safety in the ED, on the wards in medicine and in any outlying areas is monitored especially closely at times of excessive activity by additional safety walkabout visits by matrons and senior managers

Delivery

Delivery (1)

Effective models of Care.

Could The Trust describe its models of care / access standards in the following areas:
ED
Acute Medicine
Inpatient bed base
Confirmation of provision of Ambulatory Emergency Care
Access to diagnostics / pathology

•Attached are the Standard Operating Procedures for the ED, ED Assessment Bay, ED Minor Injuries, AMU and CDU. (Appendices 7-10). These are monitored by the manager on for the acute division. All SOPs are being reviewed in the next fortnight to ensure that they are fit for purpose.

•The Draft Internal Professional SLA for the imaging department is attached (App 11) Additional winter funding will support the delivery of these response times. Response times for imaging are reported every day. There is an escalation plan for any imaging delay which is monitored by the site managers.

•There will be an Internal Professional Standard for Health Care Professionals by mid November. There is an escalation plan for any therapy delay which is monitored by the site managers.

•Attached is a list of ambulatory care services currently provided UHL (App 12). These have been advertised to the LLR GPs in a variety of formats to encourage use.

Delivery (2)

Seasonal Flu/ Pandemic Flu and Norovirus

Could The Trust send copies of updated Flu, Norovirus and infection outbreak management plans, including when the plans were updated or are proposed to be updated?
Could the Trust set out its plans for staff flu vaccination including a trajectory?

•The trusts target for flu vaccination is 100% of all staff.

•Appendices 13-16 include the Flu Plan, Norovirus Toolkit and Infection Outbreak Plan as well as a paper presented to the executive team on the plan for achieving 100% uptake for flu immunisation

•A large number of roving clinics have proven to be very successful. Currently we have given 3,321 injections out of an available stock of 5,000. Another 500 have been ordered and many staff are getting vaccinated by external services

•The service will continue to vaccinate staff until the end of the flu season so expects to use up all available injections

Delivery (3)

2013/14 Christmas/ New Year arrangements

- **Given the way Christmas and New Year Bank holidays will fall in 2013/14 could the Trust in the space below provide assurances that arrangements are in place to cover the Christmas/ New Year period, including specifically a workforce plan for this period covering 21st December 2013 through to 5th January 2014.**
- Agreement with all clinical areas is being addressed on staffing levels needed for the Xmas/New Year period.
- UHL will have a detailed winter staffing plan in a draft format by the end of October. The plan will indicate the staffing for each area and will be assessed against the admission and discharge profile for the last three years.
- The trust is working with external partners to develop a pan-health economy plan for Xmas and New Year.
- All services (those delivering direct patient and those that support patient care) will be expected to be up to normal staffing as a minimum. In many of the support areas the levels of staff post New Year will be higher than usual to help with the expected discharge delays.

Governance

Governance (1)

Governance Structure

Could the Trust provide details to the following questions within the space provided:

•How the board will review and formally approve the winter resilience and influenza plans?

•Can the Trust describe the accountability framework in place to manage winter performance and how the Board will hold the Executive team to account.

•The winter plan will be presented to the October Trust Board for approval

•The Flu plan will be presented to the October Emergency Planning and Business Continuity Committee. A Non-Executive Director sits on this group and will report to the board.

•Accountability for managing the winter performance will be through the weekly Emergency Care Action Team meetings, chaired by the CEO

•The winter performance will be reported to the Trust board via the Chief Operating Officer's monthly report on the 4 hour performance.

•There is a weekly meeting with UHL and the Urgent Care Board where UHL is held to account for its performance

Governance (2)

Daily management and escalation

- Can you set out the process of daily / weekly performance and capacity management and your escalation process? this should also include the metrics you use to support this.
- Can you describe the process for engaging external partners in the escalation process

- There are 4 site meeting daily where ED, capacity and any other issues affecting patient flow are addressed.
- Any breach of 4 hours must be reported to the CEO or the COO as per the escalation policy (See appendix 18)
- There are daily ED meetings at 08:00 and 12:00 where any issues that may affect performance are addressed.
- There are daily meeting to discuss all medical discharges at the LRI.
- There is a daily complex discharge conference call including staff from the Local Authorities, LPT and UHL
- The Emergency Care Action Team (ECAT) meets weekly to review the performance from the last week (see appendix 5 for metrics)
- There is a monthly Executive Team performance meeting which discusses all performance issues including the 4hr ED performance
- A weekly update goes from the Chief Operating Officer to all staff to ensure that UHL staff are aware of the ED performance.
- There is an escalation plan which includes actions for external partners dependant on the level and cause of the escalation.

Governance (3)

Quality & Patient Safety

Ensuring patient outcomes and experience do not deteriorate during winter pressures is a key challenge:

- What governance arrangements are in place to ensure Quality & Patient Safety is not compromised during winter period? Could the Trust outline these arrangements?
- Could the Trust describe what plans are in place to ensure operational standards are maintained consistently throughout the year e.g. A&E and Acute Medicine Clinical Quality Indicators, referral to treatment times, cancer operational standards, HCAIs.

- A weekly dashboard is reviewed by ECAT that looks at a variety of quality indicators (Appendix 5)
- The Acute Division Board monitors all accidents, incidents and complaints on a monthly basis and produces an action plan to address any issues
- Additional staff are being put in place to manage any patient awaiting for long periods in ED. They will ensure that patients comfort and safety issues such as observations &, pressure area care are monitored
- There is an agreed process with the CCG for reporting and learning from any 12 hour breaches, as well as actions reported to the CCG to maintain quality of patient care when performance drops below 80%
- There are on-going plans to ensure the delivery of the RTT and Cancer standards are delivered and exception reports on these areas are presented to the board every month, where necessary.
- The UHL Quality Performance Management Group reviews all SUIs, and complaint profile for ED on a monthly basis. This group reports to the board.
- The UHL committee structure monitor patient experience through the Quality Performance Management Group and the Clinical Quality Review Group, both groups reporting to the board.
- The CCG are undertaking an audit of long waits in ED (Over 8 hours) to assess the quality of care given to patients whilst in the ED.

Governance (4)

Additional Investment

Could the Trust provide details to the following questions within the space provided:

- If winter monies were made available in 2013/14 could the Trust give a clear outline of the areas where these monies would be targeted, this should be in addition to any planned investments / services already commissioned. The investments need to evidence the contribution to the Trusts capacity to deliver and sustain quality care.

	Workstream	Service	Managing Inflow	Managing UHL Internal Flow	Managing Outflow	Totals
	Focus on ED process	Additional ED support for supported discharge		£ 400,000.00		
	Focus on ED process	Increase portering service		£ 131,040.00		
	Focus on ED process	Ward clerk support for assessment units		£ 126,000.00		
	Focus on ED process	Assessment Unit equipment		£ 78,166.00		
	Focus on ED process	UHL improved emergency effectiveness		£ 1,475,000.00		
	Focus on ED process	Imaging support at weekends for faster turnaround		£ 75,500.00		
	Focus on ED process	ED ambulance penalties investment / supporting ambulance turnaround		£ 63,329.00		
	Clinical Leadership and Organisational Engagement	Increase medical capacity		£ 866,120.00		
	Clinical Leadership and Organisational Engagement	Hospital at night		£ 500,000.00		
	Clinical Leadership and Organisational Engagement	ED consultant 6-midnight		£ 127,323.00		
	Clinical Leadership and Organisational Engagement	Weekend consultant shifts in Medicine		£ 126,800.00		
	Clinical Leadership and Organisational Engagement	Improve Site Management Team		£ 153,000.00		

Governance (4)

Additional Investment

Could the Trust provide details to the following questions within the space provided:

	Workstream	Service	Managing Inflow	Managing UHL Internal Flow	Managing Outflow	Totals
	Clinical Leadership and Organisational Engagement	Command and control centre on ground floor		£ 23,000.00		
	Reducing Bed Breaches due to lack of bed availability	Bed co-ordinators		£ 92,000.00		
	Reducing Bed Breaches due to lack of bed availability	Care home brokerage		£ 90,000.00		
	Reducing Bed Breaches due to lack of bed availability	Discharge specialists & targeted support to poorly performing wards		£ 160,000.00		
	Reducing Bed Breaches due to lack of bed availability	Additional Bed Capacity for winter activity surge		£ 2,156,302.00		
	Reducing Bed Breaches due to lack of bed availability	Investment in Assessment Unit model		£ 655,000.00		

Governance (4)

Additional Investment

Could the Trust provide details to the following questions within the space provided:

	Workstream	Service	Managing Inflow	Managing UHL Internal Flow	Managing Outflow	Totals
	Reducing Bed Breaches due to lack of bed availability	Therapy support		£ 225,000.00		
	Reducing Bed Breaches due to lack of bed availability	Pharmacy weekend service plus targeted discharges		£ 39,000.00		
	Reducing Bed Breaches due to lack of bed availability	Phlebotomy at weekends		£ 79,127.00		
	Reducing Bed Breaches due to lack of bed availability	15 additional LRI assessment beds one locum consultant from 16/9		£ 73,500.00		
	Timely information to support decision making	Band 7 information analyst		£ 24,943.00		
	Timely information to support decision making	Make key live data available remotely incl IPhones and IPads		£ 50,000.00		
	Arriva discharge support	Arriva discharge support			£ 441,960.00	
	Increase in community beds	Intermediate care beds in community settings			£ 400,000.00	
	Increased community equipment	Mobile community equipment service			£ 200,000.00	

A weekly meeting takes place to ensure that the funding is tracked and having the expected impact. All allocated funds have KPIs against which the spend will be monitored. The on going spend is reported to the UCB.

Governance (5)

Stress testing the plans

Could the Trust explain the process to stress test the plans and how will lessons from this testing be including in the winter plan?

•Currently there is a surge/winter plan meeting which meets fortnightly, co-ordinated by the Director for Emergency Care, LLR. All LLR escalation plans were put through a stress test in Sept and the plan was subsequently revised. A stress test of the revised plan is set for the 29th October.

•Scenario testing of the current UHL escalation plan was undertaken with the Divisions. This has led to monthly feedback as an iterative process to strengthen the escalation plan (appendix 17)

•The ED escalation plan has recently been re-written and now includes direct escalation to the COO/CEO for 4 hour breaches (Appendix 18)

Governance (6)

Risk management

- **What are the key risks / challenges currently regarding winter planning? Have they been placed on the corporate risk register?**

- The Board Assurance Framework (Appendix 19) indicates 3 key issues related to winter planning and emergency flow. These are;
    - Failure to transform the emergency care system (risk 2)
    - Failure to achieve and sustain high standards of operational performance (risk 9)
    - Loss of business continuity (risk 11)
- Each risk has an action plan which is reviewed monthly at Trust Board.
- Other risks which could be associated with winter pressure currently identified on the Risk Register (scoring 15 or above) have been included (Appendix 20).

Partnership

Partnership

Partnership Working

What arrangements are in place with the Urgent Care Board and key health economy partners?

- There are weekly meetings with the UCB to address any issues that will improve performance
- LLR wide escalation plans are being re-written to identify escalation status across LLR and will be stress tested at the end of October
- There is joint working with LPT and the local authorities to ensure in-reach discharge posts and social work staff
- There is a single front door shared by UHL and Urgent Care Centre
- In early October there will be additional community rehabilitation capacity (Increased ICS support, 1st October, equivalent to 40 beds)
- At the weekend there are now daily conference calls from on call directors for CCG, UHL and LPT are now taking place to ensure that co-ordination and action occur throughout 7 days
- There are now 5 rapid improvement groups involving all agencies, led by West CCG to rapidly improve 5 key areas. These are reduced admissions, faster ED processes, faster Ward processes, faster access to community facilities and bed capacity

Appendix – Good Practice

- Acute Frailty Unit – Implemented and fully functioning
- ECAT Dashboard – Implemented and use to focus action
- Listening into Action – ED is an early adopter.
- Acute Medical Clinic – In operation.
- Review of all GP referrals by consultant – In operation
- Rapid Assessment Team in ED – Functioning at the front door to get fast intial assessment
- Board rounds in all medical areas – In all medical areas. Now being rolled out to surgical wards
- Daily discharge meeting – Implemented in medicine at LRI. Being rolled out over next 3 months

List of Appendices

1. Bed Model
2. UHL Rapid Improvement Plan
3. ED Workforce Plan
4. ED Monitoring form to CCG
5. ECAT Dashboard
6. UCB Paper on quality assurance in ED
7. ED SOP index
8. ED Assessment Bay SOP
9. ED Minor Injuries SOP
10. UHL Assessment UNIT SOP v0.1 revised model 2013.05.14
11. LRI Imaging assessment unit SLA v0 6 12 March 2013 CL FINAL
12. Ambulatory Care Pathways at UHL
13. UHL Pandemic Influenza Plan May 2013
14. NOROVIRUS toolkit 2012
15. Managing Increased Incidence and Outbreaks of Infection in Hospitals Policy
16. Flu Immunisation Plan 201314
17. UHL Wide Escalation v 5.1 July 31st 2013
18. 4 Hour Escalation
19. Board Assurance Framework
20. Extreme & High report - Winter Pressures - 2 Oct 13

Healthwatch Leicester, Leicestershire and Rutland
9 Newarke Street
Leicester
LE1 5SN
Tel 0116 2574 999
Fax 0116 257 5039
info@healthwatchleics.co.uk
www.healthwatchleicester.co.uk

September 30, 2013

Dear All,

On 25th September there was a very well attended monthly meeting of all Healthwatches in Leicester, Leicestershire & Rutland (LLR). There was a very thorough and detailed discussion about Urgent Care informed by Dr Mike Pepperman our representative on the Urgent Care Board.

Not withstanding the strenuous efforts of all concerned over the past few weeks and examples of some successes, notably the new triage arrangements at UHL, we would be failing our responsibility to local people if we did not express our grave concerns at the Emergency Department situation. With winter approaching the current position is deeply worrying; the experience of some patients attending A&E over the weekend of 14-15th September was extremely distressing and quite unacceptable.

Our meeting was also made aware of the information provided to the UHL Board on the numbers of patients eligible and ready for discharge for whom there were no community places where they could be transferred. We are not unaware of the complexity of the issues that arise when discharge is considered or the financial constraints under which you have to operate but unless urgent solutions are found across health and social care our grave concerns will become a crisis.

We find it difficult to equate the above with the closure of the Charnwood Ward at Loughborough and the decision of the City Council to close some of its residential homes.

We have similar anxieties about the pressures facing LPT and the unavailability of beds resulting in LLR patients having to be placed out of the county. Once again we recognise that this is not an LLR position alone but taken together with the above it is difficult to remain positive.

As local Healthwatch we keen to do everything we can to support you all in the resolution of these issues but nothing short of a collaborative approach across health and social care can save patients from a very challenging winter.

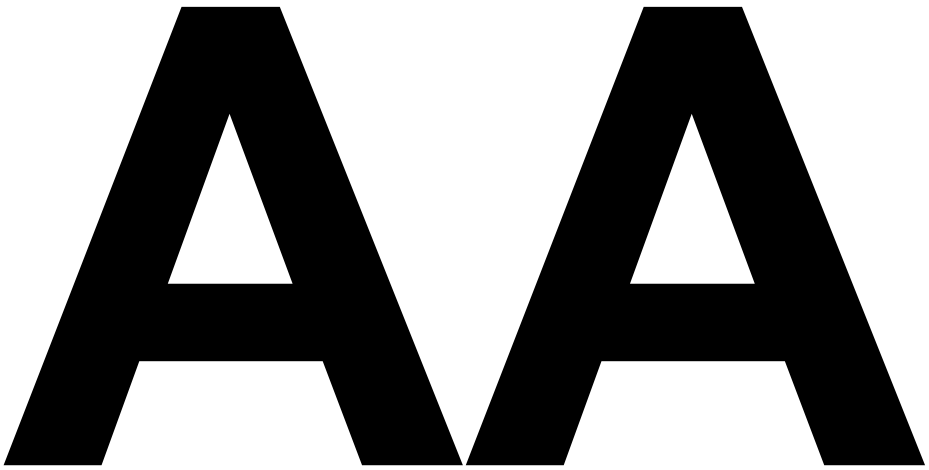
We would ask that you and your social care colleagues produce an action plan and publish before the winter which tackles these complex problems in the round. The people of Leicester, Leicestershire and Rutland deserve no less.

Yours sincerely,

Philip Parkinson
Interim Chair of
Healthwatch Leicester

Vijay Sharma
Interim Chair of
Healthwatch
Leicestershire

J A Fenelon
Interim Chair of
Healthwatch
Rutland


AA

Trust Board Paper AA

To:	Trust Board
From:	Stephen Ward, Director of Corporate & Legal Affairs
Date:	31st October 2013
CQC regulation:	N/A

Title:	NHS trust oversight self certification

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

Purpose of the Report:

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

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

At the time of the launch of the Accountability Framework, the NTDA requested that on an interim basis, the Trust continue to complete and submit the Governance Risk Rating, Financial Risk Rating, quality and contractual data elements of part two of the Single Operating Model (SOM) published by the Department of Health in August 2012.

The NTDA have subsequently clarified that the submission of these returns is no longer a mandatory requirement. Having taken advice from the Chief Executive and the Acting Chairman, the Trust, in line with other peer trusts, will from this month onwards, no longer be submitting these to the returns to the NTDA.

The Report is provided to the Board for:

Decision	X	Discussion	
Assurance		Endorsement	

Summary / Key Points:

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

- An initial RTT action plan was submitted to commissioners on 14th August 2013. A revised plan was subsequently submitted on 11th September 2013. Formal acceptance of this plan is still awaited

Recommendations:

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

Previously considered at another corporate UHL Committee? No

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

Resource Implications (eg Financial, HR): No

Assurance Implications: Yes

Patient and Public Involvement (PPI) Implications: No
Stakeholder Engagement Implications: No
Equality Impact: None
Information exempt from Disclosure: None
Requirement for further review? All future trust oversight self certifications will be presented to the Trust Board for approval

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST

REPORT TO: Trust Board

DATE: 31st October 2013

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

SUBJECT: NHS trust oversight self certification

---

1) Introduction

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

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

At the time of the launch of the Accountability Framework, the NTDA requested that on an interim basis, the Trust continue to complete and submit the Governance Risk Rating, Financial Risk Rating, quality and contractual data elements of part two of the Single Operating Model (SOM) published by the Department of Health in August 2012.

The NTDA have subsequently clarified that the submission of these returns is no longer a mandatory requirement. Having taken advice from the Chief Executive and the Acting Chairman, the Trust, in line with other peer trusts, will from this month onwards, no longer be submitting these to the returns to the NTDA.

2) Key points to note

Appendix B:-

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

- An initial RTT action plan was submitted to commissioners on 14th August 2013. A revised plan was subsequently submitted on 11th September 2013. Formal acceptance of this plan is still awaited

3) Recommendations

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

NHS TRUST DEVELOPMENT AUTHORITY

OVERSIGHT: Monthly self-certification requirements - Compliance Monitor

Monthly Data.

CONTACT INFORMATION:

Enter Your Name: John Adler

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

Full Telephone Number: 01162588940 Tel Extension: 8940

SELF-CERTIFICATION DETAILS:

Select Your Trust: University Hospitals Of Leicester NHS Trust

Submission Date: 31/10/2013 Reporting Year: 2013/14

Select the Month

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

COMPLIANCE WITH MONITOR LICENCE REQUIREMENTS FOR NHS TRUSTS:

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

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

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

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

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

COMPLIANCE WITH MONITOR LICENCE REQUIREMENTS FOR NHS TRUSTS:

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

		Comment where non-compliant or at risk of non-compliance
4. Condition G8 Patient eligibility and selection criteria.	Yes	
		Timescale for compliance:

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

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

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

NHS TRUST DEVELOPMENT AUTHORITY

OVERSIGHT: Monthly self-certification requirements - Board Statements

Monthly Data.

CONTACT INFORMATION:

Enter Your Name: John Adler

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

Full Telephone Number: 01162588940 Tel Extension: 8940

SELF-CERTIFICATION DETAILS:

Select Your Trust: University Hospitals Of Leicester NHS Trust

Submission Date: 31/10/2013 Reporting Year: 2013/14

Select the Month

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

BOARD STATEMENTS:

CLINICAL QUALITY
FINANCE
GOVERNANCE

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

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

BOARD STATEMENTS:

For CLINICAL QUALITY, that

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

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

BOARD STATEMENTS:

For CLINICAL QUALITY, that

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

2. CLINICAL QUALITY
Indicate compliance.

Yes

Timescale for compliance:

RESPONSE:

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

BOARD STATEMENTS:

For CLINICAL QUALITY, that

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

3. CLINICAL QUALITY
Indicate compliance.

Yes

Timescale for compliance:

RESPONSE:

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

BOARD STATEMENTS:

For FINANCE, that

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

4. FINANCE
Indicate compliance.

Yes

Timescale for compliance:

RESPONSE:

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

BOARD STATEMENTS:

For GOVERNANCE, that

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

5. GOVERNANCE
Indicate compliance.

Yes

Timescale for compliance:

RESPONSE:

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

BOARD STATEMENTS:

For GOVERNANCE, that

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

6. GOVERNANCE
Indicate compliance.

Yes

Timescale for compliance:

RESPONSE:

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

BOARD STATEMENTS:

For GOVERNANCE, that

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

7. GOVERNANCE
Indicate compliance.

Yes

Timescale for compliance:

RESPONSE:

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

BOARD STATEMENTS:

For GOVERNANCE, that

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

8. GOVERNANCE
Indicate compliance.

Yes

Timescale for compliance:

RESPONSE:

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

BOARD STATEMENTS:

For GOVERNANCE, that

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

9. GOVERNANCE
Indicate compliance.

Yes

Timescale for compliance:

RESPONSE:

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

BOARD STATEMENTS:

For GOVERNANCE, that

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

10. GOVERNANCE
Indicate compliance.

No

Timescale for compliance:

RESPONSE:

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

UHL is currently non compliant with the ED 4 hour wait target and the Referral to Treatment (RTT) - admitted target.

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

An initial RTT action plan was submitted to commissioners on 14th August 2013. A revised plan was subsequently submitted on 11th September 2013. Formal acceptance of this plan is awaited.

BOARD STATEMENTS:

For GOVERNANCE, that

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

11. GOVERNANCE
Indicate compliance.

Yes

Timescale for compliance:

RESPONSE:

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

BOARD STATEMENTS:

For GOVERNANCE, that

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

12. GOVERNANCE
Indicate compliance.

Yes

Timescale for compliance:

RESPONSE:

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

BOARD STATEMENTS:

For GOVERNANCE, that

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

13. GOVERNANCE
Indicate compliance.

Yes

Timescale for compliance:

RESPONSE:

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

BOARD STATEMENTS:

For GOVERNANCE, that

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

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

BB

Trust Board Paper BB

To:	**Trust Board**
From:	**Andrew Seddon – Director of Finance and Business Services**
Date:	**31 October 2013**
CQC regulation:	**All**

Title:	**QUARTER 2 REVIEW 2013/14 ANNUAL OPERATING PLAN (AOP)**

Author/Responsible Director: Andrew Seddon/Helen Seth

Purpose of the Report:
To present to Trust Board a high level overview of performance against the actions identified in our 2013/14 AOP between July and September 2013/14 (quarter two – Q2) and in the context of individual monthly and quarterly reviews already received by the Board, provide assurance on the activity being undertaken to address any area of adverse variance.

The Report is provided to the Board for:

Decision		Discussion	X
Assurance	X	Endorsement	X

Summary / Key Points:
The 2013/14 Annual Operating Plan represents the Trust's first steps on our challenging pathway towards financial and clinical sustainability. 2013/14 is the first year that the development and delivery of provider (i.e. trust) plans has been overseen by the NHS Trust Development Authority (TDA).

Our Q2 report captures a high level overview of what is working well and what needs to be improved. Illustrative examples include:

What is working well?

Delivering our Quality Commitment – Progress against the specific actions outlined in our AOP has generally progressed well. There is evidence in discrete areas of how creating a culture of engagement can drive performance improvement. Illustrative examples include:

i. The work of the Older People's Team with targeted wards to reduce falls which has led to an impressive drop in the number of fall observed in Datix reports and in the Safety Thermometer audit.
ii. The joint work of the Trust and Alzheimer's Society in implementing two 'Carers Support Programmes' for new carers of people with dementia.

Organisational Development - There are many examples of how targeted engagement is creating a sense of empowerment to change things for the better. The first 12 LiA Pioneering Teams and 10 'Enabling our People' schemes are progressing well.

Clinical Leadership - The appointment of a Lead Cancer Clinician, the establishment of a weekly Cancer Action Board and a clear accountability framework has made a

material contribution to the improvement and achievement of the cancer 62 day target in July (above trajectory at 85.7%). Early indications for August and September are positive, with performance anticipated to be above the agreed trajectory. This represents a significant achievement.

What needs to be better?

Financial performance – Our financial position remains a significant challenge with a deficit at the end of September 2013 of £16.6m, which is approximately £16.0m adverse to the planned deficit of £0.6m. A re-forecasting process has been undertaken which is outside the scope of this paper.

Emergency process – The Trust failed to deliver the A&E standard in Q2 2013/14. Whilst the introduction of a single front door to the Emergency Department has started to deflect attendances to more appropriate settings, it has not resulted in sustained improvement against the ED target.

Referral to Treatment Time (Admitted) – Activity being undertaken to eliminate the backlog of patients waiting longer than eighteen weeks has continued to have a detrimental (but predictable) effect on the achievement of the RTT target. The failure to achieve the target at an aggregate level triggered a Contract Query Notice from Commissioners. A Remedial Action Plan (RAP) was submitted to Commissioners in August. In September a Failure to Agree Notice was received by the Trust. In seeking to achieve the standard required the Trust has invited the National 18 Week Intensive Support Team (IST) to assist in the development of a sustainable recovery plan.

Summary - Despite the hard work of our staff our overall results delivered to date are disappointing. The progress we are making on our Quality Commitment is yet to make a material impact on outcomes. Whilst nursing ratios have been reviewed and enhanced in the light of the Francis report and local acuity reviews the backdrop of continued overheating of emergency demand and the inability of the Trust to manage this effectively, has meant that this has yet to result in a positive impact on our operational and financial performance.

Delivery of key access targets has been compromised, despite investment of non-recurrent financial resources, external support, changes in clinical management and solid Commissioner support. How we achieve the necessary scale and pace required to make a stepped improvement in quality, clinical outcomes and financial terms remains a significant challenge.

The Accountability Framework for NHS Trust Boards sets out five different categories by which Trusts are defined, depending on their performance against key quality, delivery and finance standards. The five categories are:

1 - No identified concerns
2 - Emerging concerns
3 - Concerns requiring investigation
4 - Material issue
5 - Formal action required

As a consequence of our poor financial and emergency performance year-to-date, the Trust has been graded at Level 4 (material issues) by the NTDA, which we understand is reserved for those trusts that have submitted a deficit AOP or are reporting material adverse deficits year-to-date.

In parallel the Care Quality Commission have released the first of their new look 'Intelligent Monitoring' reports. This report is being used to assess which Trusts will be visited first in the next wave of CQC inspections.

The intelligent monitoring approach is based on 150 indicators that look at a range of information including patient experience, staff experience and statistical measures of performance for example whether a Trust is hitting the A&E 4 hour wait target. The indicators are weighted and therefore some have a greater impact on the overall score than others. The NTDAs assessment of our operational and financial performance is also taken into account.

Trusts are banded between 1 and 6, dependent on the number / severity of the risks the Trust is perceived to be dealing with. Band 1 represents a higher risk than Band 6.

The Trust been assessed as band 1, which means that the CQC currently assess us as being relatively higher risk. Of the 10 indicators which were seen as risks, the Trust already has plans in place for majority of them through things like the work on our Quality Commitment however there is no room for complacency. In the context of the Trust's banding we expect a CQC inspection sometime early in Q4.

Recommendations: The Trust Board is asked to:

RECEIVE this report

NOTE the progress against Q2 delivery of our Annual Operational Plan and the overall, high level RAG rating of key aspects

NOTE the key areas of variance and the outline action proposed to rectify the position

Previously considered at another corporate UHL Committee?
Finance and Performance
Trust Board

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

Resource Implications (eg Financial, HR): Set out in the AOP 2013/14**.**

Assurance Implications: N/A

Patient and Public Involvement (PPI) Implications: See below "Stakeholder engagement implications".

Stakeholder Engagement Implications:
Prospective Board of Governors and our Patient Advisors have received an overview presentation of our AOP for 2013/14

Equality Impact: The AOP is subject to the Trust's equality impact processes.

Information exempt from Disclosure: None

Requirement for further review? Q3 report on the AOP 2013/14 will be submitted to the Board in January 2014.

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST

REPORT TO: Trust Board

REPORT FROM: Andrew Seddon, Director of Finance and Business Services

AUTHOR: Helen Seth

RE: Executive Summary – Q2 Review Annual Operational Plan 2013/14

DATE: 31 October 2013

1. PURPOSE

The purpose of this paper is to:

i. Provide an executive summary of the Q2 review of the 2013/2014 Annual Operational Plan (AOP). It should be considered alongside the detailed quarterly and monthly reports presented to Trust Board in September and October.

ii. Summarise Q2 performance against the key improvement and development priorities for 2013/14 (Appendix 1).

iii. Highlight key areas of variance and the action being taken to bring performance in line with plan.

2. ACCOUNTABILITY FRAMEWORK FOR 2013/2014

2013/14 is the first year that the development and delivery of provider (i.e. trust) plans has been overseen by the NHS Trust Development Authority (NTDA).

Following an iterative development process the Trust submitted our final 2013/14 AOP to the NTDA on 30 April 2013. Having undertaken due diligence the TDA wrote to the Trust on the 29 May confirming the recommendation that the Trust's 2013/14 AOP be approved, subject to a small number of conditions.

In early April the NTDA published the *Delivering High Quality Care for Patients: The Accountability Framework for NHS Trust Boards.*

The Accountability Framework sets out five different categories by which Trusts are defined, depending on their performance against key quality, delivery and finance standards. The five categories are:

i. No identified concerns
ii. Emerging concerns
iii. Concerns requiring investigation
iv. Material issue
v. Formal action required

As part of the Trust's own review processes we undertake a thematic review of performance against plan. Our observations are compared and contrasted to those of the NTDA and other external parties. This helps identify what action is within our own control and which requires wider facilitation and support.

3. HIGH LEVEL OVERVIEW

Our AOP for 2013/14 was developed against a backdrop of performance, economic and service challenges. These broadly align to four common themes that we know must be addressed through our short, medium and longer term plans if our services are to remain safe and sustainable. The themes are the emergency process, clinical and financial sustainability, delivering quality and securing clinical reconfiguration.

With these in mind a high level overview of performance in Q2 against our Annual Operational Plan may be summarised as follows:

i. **Financial performance** - remains a significant challenge with a deficit at the end of September 2013 of £16.6m, which is approximately £16.0m adverse to the planned deficit of £0.6m.

ii. **Emergency process** – The Trust failed to deliver the A&E standard in Q2 2013/14. Whilst the introduction of a single front door to the Emergency Department has started to deflect attendances to more appropriate settings it has not resulted in a sustained impact on performance improvement.

iii. **62 day cancer target** – Robust clinical and managerial leadership complemented by clearer lines of accountability has contributed to the anticipated achievement of the 62 day cancer in Q2 (forecast position).

iv. **Referral to Treatment Time (Admitted)** – Activity being undertaken to eliminate the backlog of patients waiting longer than eighteen weeks has continued to have a detrimental effect on the achievement of the RTT target. The failure to achieve the target at an aggregate level triggered a Contract Query Notice from Commissioners. A Remedial Action Plan (RAP) was submitted to Commissioners in August. In September a Failure to Agree Notice was received by the Trust. In seeking to achieve the standard required the Trust has invited the National 18 Week Intensive Support Team (IST) to assist in the development of a sustainable recovery plan.

v. **Delivering our Quality Commitment** – Progress against the specific actions for 2013/14 outlined in our AOP have generally progressed well; there is evidence in discrete areas that creating a culture of engagement and involvement can drive performance improvement, although in contrast, the adoption and compliance with standards and best practice is still not where we would like it to be. The progress made to date is yet to make a material impact on outcomes and how we achieve the necessary scale and pace required to make a stepped improvement in quality and clinical outcomes, remains a significant challenge.

vi. **Clinical configuration –** The development of our critical estate reconfiguration projects is progressing through the steps of business case development. The requirement of the NTDA for an Outline Business Case prior to Full Business Case is being addressed and every effort made to minimise any impact on anticipated timescales.

vii. **Management of change –** The Trust has taken forward a management of change process to support the introduction of a new Clinical Management Group (CMG) structure. The two main drivers for the proposed change are the reduction

of the multi-tiered layers of management and the size and complexity of the Divisions. The anticipated benefits of the new structure include improved operational grip, clearer management accountability, improved clinical engagement and enhanced ability to deliver Trust and health community objectives.

In summary, despite the hard work of our staff our overall results delivered to date are disappointing. Whilst nursing ratios have been reviewed and enhanced in the light of the Francis report and local acuity reviews the backdrop of continued overheating of emergency demand and the inability of the Trust to manage this effectively, has meant that this has yet to result in a positive impact on our operational and financial performance. Delivery of key access targets has been compromised, despite investment of non-recurrent financial resources, external support, changes in clinical management and solid Commissioner support.

The Accountability Framework for NHS Trust Boards sets out five different categories by which Trusts are defined, depending on their performance against key quality, delivery and finance standards. The five categories are:

1 - No identified concerns
2 - Emerging concerns
3 - Concerns requiring investigation
4 - Material issue
5 - Formal action required

As a consequence of our poor financial and emergency performance year-to-date, the Trust has been graded at Level 4 (material issues) by the NTDA, which we understand is reserved for those trusts that have submitted a deficit AOP or are reporting material adverse deficits year-to-date.

Whilst this is disappointing it is a realistic reflection of our current position.

As we seek to establish how best to turn this position around it is important that we:

i. Take time to reflect of those things that are working well so that we can consider how we might create greater scale and pace in improvement
ii. Recap on our original planning assumptions and carefully consider how we turn around the fundamental performance challenges we face and how we can work with health community partners and other stakeholders to deliver our remedial plans for improvement.

4. CONTRACTUAL PERFORMANCE 2013/14

The Trust agreed the Heads of Terms for the 2013/14 contract with our local CCGs (core clinical contract) and the National Commissioning Board (NCB Specialised Commissioning Group) on 28 March 2013. This represented an income envelope of £573.6m (£195.1 SCG and £378.5 CCG). Contracts with all commissioners were subsequently signed and reflect the income figures reflected in our AOP.

4. FINANCIAL PERFORMANCE 2013/14

Detailed reports on the Trust's year to date position are considered by Trust Board and the Finance and Performance Committee on a monthly basis and will not therefore be repeated in any detail here. It is however appropriate to consider the key headlines.

Regrettably, the Trust is materially off our plan for 2013/14 and there is significant risk in the assumptions underpinning the recovery plan, submitted to the NTDA in mid-September 2013 – particularly in respect of income assumptions.

Standing back from the detail it is important we consider this position in context by reviewing the development of the 2013/14 plan, the underlying assumptions, how those have been reflected in actual performance and finally what implications these have for our forecast outturn position.

Historical Overview

UHL's 2013/14 AOP was signed off by the Trust Board in March 2013. Whilst the Trust had just delivered the 2012/13 surplus and cash targets this was due in significant part to a favourable non-recurrent year end settlement with our local Commissioners with £7.5m from the newly-formed Local Area Team and £7.0m from what was the PCT cluster (Chart 1).

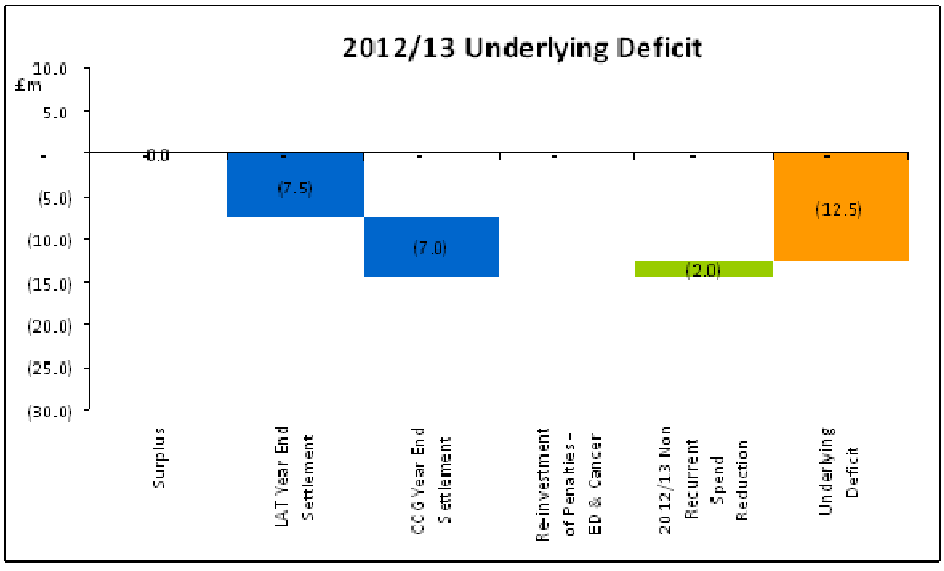
Within the reported surplus of £90k for 2012/13, £44k favourable to 2012/13 Plan, there were significant I&E variances:

Income was £35.8m (5%) over Plan, stated net of a £5.1m MRET 70% deduction.

Operating costs were cumulatively £36.1m over Plan, reflecting the impact of the unsatisfactory performance in year, premium cost staff to deliver the additional activity, the fiscal drag of the sub-optimal configuration of hospital services and the residual impact of non-PbR tariff arrangements.

With this in mind it was made explicit that the 2013/14 AOP was based on an underlying deficit of approximately £12.5m (1.6% of turnover).

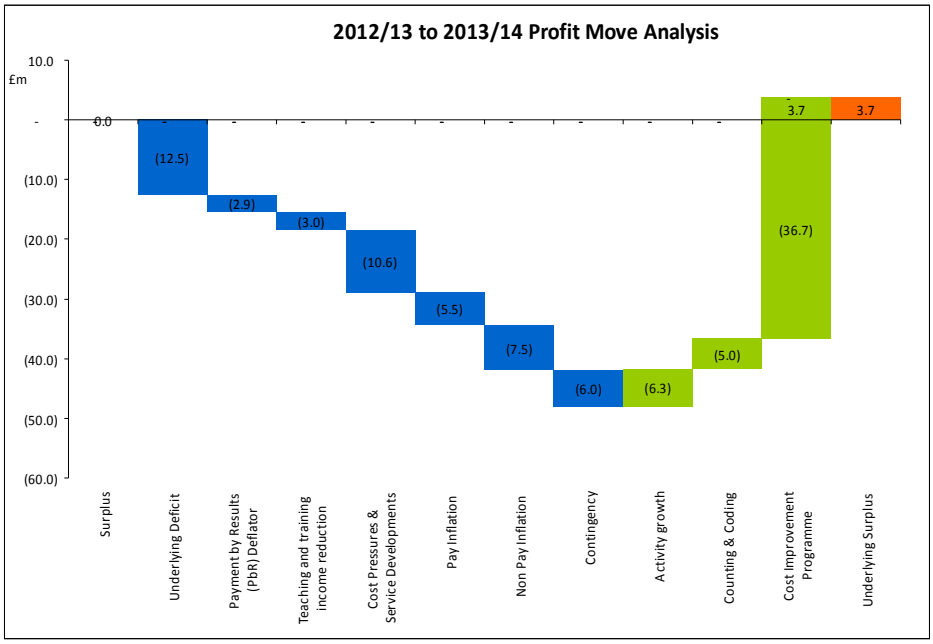
Chart 1 – 2012/13 Underlying Deficit (as per AOP Executive Summary)



Movement from 2012/13 outturn to 2013/14 Plan

The following "waterfall chart" shows at a high level the key drivers for the movement from the 2012/13 outturn (£90k surplus) to the 2013/14 Plan (£3.7m surplus).

Chart 2 - High level the movement from the 2012/13 outturn (£90k surplus) to the 2013/14 Plan (£3.7m surplus)



Key points to highlight in addition to the underlying deficit and the key drivers for change are:

i. Whilst our AOP income assumptions included c£8m of embedded marginal rate emergency threshold (MRET) deduction and readmission penalties no reinvestment of those monies was assumed within our AOP. There were also no further assumptions regarding fines and penalties within the AOP.

ii. £10.6m of investment was reflected in the AOP to address unavoidable cost pressures and/or services. This includes the investment made in nurse staffing (acuity, supervisory and emergency flow) following the detailed nursing workforce review undertaken during Q2. Whilst elements of these cost pressures were linked to Transformation schemes, no additional income was assumed within the Plan (T**ransformation funding**, as for any other NHS provider, should be received out of the non-recurrent "2% fund" and to facilitate delivery of 2013/14 transformation/CIP schemes (equates to circa £12 million).

iii. The requirement to deliver a CIP of £40.4m

In summary, whilst our financial plan was challenging, our assumptions were prudent.

4.1 FINANCIAL POSITION AS AT THE END OF SEPTEMBER 2013

The Trust is reporting a deficit at the end of September 2013 of £16.6m, which is approximately £16.0m adverse to the planned deficit of £0.6m. This compares to the position reported at the end of Q1 which reflected a deficit of £6.9m, approximately £5.8m adverse to the planned deficit of £1.1m (position reflected £5.0m of the contingency release).

The consequence of the current financial performance, predominately the £6.9m actual deficit, is that our Financial Risk Rating (FRR) has fallen to 2 (2.2 in Q1). Recovery plans and actions are in place to improve the current run rate and get back to a sustainable financial position and FRR, whilst not impacting negatively of the quality of patient care. There are however significant risks which will need to be managed, the key headlines of which will be covered below.

Key points to highlight in the year to date (YTD) position are:

i. **Patient care income** £1.8m (0.6%) favourable against Plan, mainly due to outpatients (0.6 % comparable to Q1)
ii. **Pay costs** £9.8m (4.4%) adverse to Plan (4.2% adverse variance in Q1)
iii. **Non pay costs** £7.4m (5.4%) adverse to Plan (4.2% adverse variance Q1)
iv. CIP performance of £1.0m adverse to Plan (£1.3m in Q1)

The principal YTD variances are summarised as follows:

Month 6 variance analysis

	Income £m	Pay £m	Non-pay £m	EBITDA £m
Plan result	**382.0**	**-223.3**	**-137.3**	**21.4**
Additional activity	2.7	-1.3	-1.1	0.3
Cost pressures - operations			-1.5	-1.5
Cost pressures - other			-2.9	-2.9
Winter beds		-1.2	-0.6	-1.8
Premium pay - Emergency Care		-2.6		-2.6
Premium pay - other variances		-3.3		-3.3
Acuity investment		-1.4		-1.4
Other income shortfall	-1.2			-1.2
Performance fines	-1.1			-1.1
CIP under-delivery	0.3	0.0	-1.3	-1.0
Actual result	**382.7**	**-233.1**	**-144.7**	**4.9**

4.1.1 INCOME YTD

NHS patient care income (excludes non NHS income) is £2.7m (0.9%) above Plan year to date. This reflects provision for £4m penalties associated with ED waiting times, RTT delivery and Cancer 62 Day target:

Key areas of variance are as follows:

Elective In Patient (IP) activity - 3.8% down on Plan, resulting in a £83k favourable variance in value i.e. case mix has got richer. This compares to a Q1 position of activity 6% down against the activity Plan, £122k adverse in value.

Emergency IP activity - 3.2% up on Plan, resulting in a £232k adverse variance in value. This compares to a Q1 position of 1.4% over performance on activity, resulting in 569k adverse variance in value.

Outpatients - over performance in of £1.6m (4%). This compares to a Q1 over-performance of £1.7m (8.3%).

Emergency Department - over performance of £0.2m (1.8%). This compares to a Q1 over-performance of £0.4m (8.7%).

Important points to note:

i. Type 1 and 2 ED attendances year to date are now down by 5.1% compared to the same period in 2012/13. This is in contrast with Q1 which saw 0.8% increase in activity when compared with the same period in 2012/13. This is due to the redirection of all adult walk-in patients to a new 'Single Front Door' located in the Urgent Care Centre (UCC) and reflects the anticipated benefits of improved deflection from ED. The impact on demand (along with other QIPP schemes) was reflected in part in the income Plan agreed with our commissioners however there is a risk that the allowance made will be exceeded in 2013/14.

ii. Whilst we are seeing increases in outpatients and ED attendances, elective inpatients are below our activity Plan. This is predominantly due to capacity constraints resulting from the continued overheating of the emergency process. The year to date position does reflect the financial benefit of a change in case mix however the activity volume risk remains – as reflected in our RTT performance.

iii. Our AOP income assumptions included c£8m of embedded marginal rate emergency threshold (MRET) adjustments and readmission penalties. On grounds of prudence, no reinvestment of those monies was assumed within our AOP. Given the expenditure pressures facing the Trust, it is now essential that we seek reinvestment of a material proportion of those funds by commissioners into UHL (as national guidance allows), as was the case (non-recurrently) in 2012/13.

4.1.2 EXPENDITURE YTD

Operating expenditure is £17.1m above Plan as at the end of September (4.7%).

PAY

The pay position as at Month 6 is £9.8m adverse to budgeted Plan, £12.5m more than the same period in 2012/13 (5.7%). When viewed by staff group, the most significant increases year-on-year are seen across agency, medical locums, nursing spend and consultant costs. This compares to a Q1 position of £4.8m adverse to budgeted Plan.

This is a result of a number of key factors including:

i. Estimated pay over-spend due to patient care activity over-performance **- £2.0m,** assuming that pay stepped/marginal cost is c50% of patient care income volume variance and staffed at non premium rates

ii. Declared under-delivery on pay CIP schemes £**1.4m**

iii. Continued use of extra capacity wards to meet the emergency activity levels. Premium spend accounting for a significant amount of the associated staff costs.

iv. Rostering more doctors and nurses in Medicine and ED to ensure the flow of patients from ED to support the 4 hour target

Continued reliance on premium payments and the adverse impact on the run rate has continued into this financial year, with the rate falling to £3.5m per month in Q2 (9% non contracted pay Costs as %age of total pay bill in Month 6).

Workforce plan and workforce movement

The continued reliance on premium staff comes at the same time as our contracted staff numbers in medical and nursing professions have increased by 3.5%, equivalent to a net increase of 166 WTE since March 2012.

Our contracted WTE is currently 9864; in excess of our previous forecast year-end position of 9822. This together with premium rates is adversely impacting on the pay bill which reflects the consequences of a premium rate workforce, failure to close additional capacity and to manage pressures within our Emergency Care system.

The Trust Board is sighted on the in-year performance against our workforce plan through an OD Plan Quarterly paper which was presented to Trust Board in September.

CIP Delivery

The NTDA placed several conditions on the approval of our 2013/14 AOP. One specifically related to the delivery of our CIP plans such that:

i. The Trust will deliver CIP schemes with a recurrent, full year effect of at least £39.9m

ii. Non-recurrent actions will be identified and delivered to mitigate the risk of slippage in any specific schemes so that the total 2013/14 CIP value is delivered in year.

iii. All schemes have a signed off quality impact assessment that demonstrate any associated risks to patient safety are appropriately mitigated.

CIP delivery year-to-date is £14.7 million against a Plan of £15.7m representing a £1.0m adverse variance (94% delivery). This compares to Q1 delivery of £6.2m against a Plan £7.4m (83% delivery).

The 2013/14 CIP paper provides further details on CIP performance to date, year end forecasts, remedial action plans and RAG ratings however in respect of this review the headlines can be summarised as follows:

i. All CIP schemes are quality risk assessed and are subject to monthly performance reviews. Each individual CIP schemes is now rated either amber or green for delivery in year.

ii. Our original CIP target of £40.4m has been revised internally to £37.7m as a result of previously agreed schemes being deferred due to emergency activity pressures. This was important to maintain the internal integrity of the plan.

iii. Against that revised target, the latest forecast is for delivery of £37.7 million in-year (i.e.100%); this forecast is fully backed by Green/Amber rated schemes.

4.1.3. Capital

Progress against the Capital Plan is monitored via the Commercial Executive.

The capital Plan for 2013/14 is £39.781m.Year to date (YTD) expenditure at the end of Q2 £10.4m with further orders placed for another £10.9m of goods and services to be delivered within the current financial year. Combined this represents 53% of the plan. Some of the orders placed by Interserve (BAU) do not go through the Trust's cedar ordering system so this value may be understated although this is likely to be marginal rather than material in respect to the overall position.

Year end forecast remains at a breakeven £39.781m however on-going revenue deficits may lead to the capital programme having to be delayed to maintain an adequate cash balance in the bank. This will be monitored carefully as part of the financial recovery plan.

What is working well? - Interim works are being carried out in ED to improve the department until the main emergency floor scheme commences. IM&T have committed to spend their full allocation within the financial year and could potentially require additional funds of £0.75m to enable EPMA to be completed. The discharge lounge expansion at the LRI has been completed on time and on budget. The Theatre Assessment Area (TAA) work is progressing and is anticipated to complete in January. Work is on-going in respect of the Maternity Interim Development and it is running to plan (expected completion June 2014). It is anticipated that £2.127m will be received from the DoH Energy Efficiency fund to support new CHP units being installed at GGH & LRI.

What could be better? – The major areas of adverse variation are around the development of our reconfiguration business cases. Financial approval thresholds applied by the NTDA reduce when a Trust is viewed to be in financial difficulty. In this context, a number of our reconfiguration Strategic Outline Cases now require additional steps in the business case development process before a Full Business Case (FBC) will be considered for approval. The emergency floor scheme for example requires an Outline Business Case for example. The Stock Management System business case requires NTDA approval. Any significant delay in either approval being granted will start to push the forecast expenditure into next year.

4.2 YEAR END FORECAST AND RECOVERY PLANS

The Trust is completing a full-year bottom-up re-forecast based on divisional recovery plans which will be owned and delivered by the new Clinical Management Group structure from this point forward. The detail of this work is outside the scope

of this review and will be covered in a finance paper to be considered by Trust Board on 31 October

5. QUALITY AND PERFORMANCE

As described earlier, in early April the NTDA published the performance indicators for the 2013/14 in *Delivering High Quality Care for Patients: The Accountability Framework for NHS Trust Boards.*

The performance indicators are broken down into 3 groups:

i. Outcome Measures

ii. Quality Governance Measures

iii. Access Metrics

A high level overview of performance during Q2 is outlined below. This is reflected in more detail in the Quality and Performance Report to be considered by Trust Board in October, 2013. To avoid repetition, the focus for the Q2 review of our 2013/14 AOP will be by common theme.

Outcome Measures

Outcome Measures	Target	2012/13	Apr-13	May-13	Jun-13	Qtr1	Jul-13	Aug-13	Sep-13	Qtr2	YTD
30 day emergency readmissions	7.0%	7.8%	7.5%	7.8%	7.7%	7.7%	7.5%	7.5%			7.6%
Avoidable Incidence of MRSA	0	2	0	0	0	0	0	0	2	2	2
Incidence of C. Difficile	67	94	6	7	2	15	6	5	9	20	35
Incidence of MSSA		46	5	2	5	12	1	4	3	8	20
Safety Thermometer Harm free care		94.1%*	92.1%	93.7%	93.6%		93.8%	93.5%	93.1%		
Never events	0	6	1	0	0	1	0	0	1	1	2
C-sections rates	23%	23.9%	23.8%	26.1%	26.1%	25.3%	25.0%	25.2%	24.6%	24.9%	25.1%
Maternal deaths	0	0	0	0	0	0	0	0	0	0	1
Avoidable Pressure Ulcers (Grade 3 and 4)	0	98	11	4	8	23	8	8	5	21	44
SHMI	100	104.5	104.5	104.5	104.5		104.9	104.9	106.4		
VTE risk assessment	95%	94.5%	94.1%	94.5%	93.1%	93.9%	95.9%	95.2%	95.4%	95.3%	94.7%
Open Central Alert System (CAS) Alerts		13	14	9	15		36	10	10		
WHO surgical checklist compliance	100%	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes

Quality Governance Indicators

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

Operational Performance

Outcome Measures

Performance Indicator	Target	2012/13	Sep-12	Q2	Oct-12	Nov-12	Dec-12	Q3	Jan-13	Feb-13	Mar-13	Q4	Apr-13	May-13	Jun-13	Q1 2013	Jul-13	Aug-13	Sep-13	Q2 2013	YTD
A&E - Total Time in A&E (UHL+UCC)	95%	91.9%	96.8%	97.0%	94.2%	92.0%	92.0%	92.7%	84.9%	86.1%	84.7%	85.2%	82.0%	88.7%	85.3%	85.3%	88.3%	90.1%	89.5%	89.3%	87.3%
RTT waiting times – admitted	90%	91.3%	91.2%		91.2%	91.7%	91.9%		92.2%	91.9%	91.3%		88.2%	91.3%	85.6%	88.4%	89.1%	85.7%	81.8%	85.6%	
RTT waiting times – non-admitted	95%	97.0%	97.7%		97.1%	96.7%	97.3%		97.3%	97.0%	97.0%		97.0%	95.9%	96.0%	96.3%	96.4%	95.5%	92.0%	94.6%	
RTT - incomplete 92% in 18 weeks	92%	92.6%	94.0%		94.6%	93.9%	93.3%		93.4%	93.5%	92.6%		92.9%	93.4%	93.8%	93.8%	93.1%	92.9%	93.8%	93.8%	
RTT - 52+ week waits	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Diagnostic Test Waiting Times	<1%	0.5%	0.5%		0.4%	0.6%	1.1%		0.7%	1.0%	0.5%		1.6%	0.7%	0.5%		0.6%	0.8%	0.7%		
Cancelled operations re-booked within 28 days	95.0%	92.9%	100.0%	92.6%	91.0%	97.3%	89.0%	93.1%	97.1%	92.3%	94.2%	94.6%	90.4%	91.0%	86.4%	89.4%	99.1%	96.0%	98.5%	98.0%	94.4%
Cancelled operations on the day (%)	0.8%	1.2%	0.9%	0.8%	1.1%	1.6%	1.2%	1.3%	1.6%	1.6%	1.6%	1.6%	1.5%	1.5%	1.0%	1.3%	1.2%	1.4%	2.2%	1.6%	1.5%
Cancelled operations on the day (vol)		1247	74	202	100	149	91	340	137	130	137	404	125	134	81	340	114	124	203	441	781
Urgent operation being cancelled for the second time	0	1	0	0	0	0	1	1	0	0	0	0	0	0	0	0	0	0	0	0	0
2 week wait - all cancers	93%	93.4%	93.9%	94.1%	93.0%	90.6%	95.1%	92.8%	89.8%	95.9%	95.2%	93.7%	93.0%	95.2%	94.8%	94.4%	94.2%	94.6%			94.4%
2 week wait - for symptomatic breast patients	93%	94.5%	96.3%	95.3%	93.4%	93.9%	94.6%	93.9%	93.6%	93.1%	95.4%	94.0%	94.0%	94.8%	93.2%	94.1%	93.6%	92.0%			93.6%
31-day for first treatment	96%	97.4%	96.9%	98.3%	98.3%	97.5%	97.4%	97.8%	96.6%	97.6%	98.8%	97.6%	97.5%	97.0%	99.0%	97.8%	98.3%	99.7%			98.3%
31-day for subsequent treatment - drugs	98%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%			100.0%
31-day wait for subsequent treatment - surgery	94%	95.8%	100.0%	96.6%	98.1%	97.4%	94.6%	97.1%	94.6%	94.1%	92.7%	94.0%	97.2%	94.4%	97.5%	96.4%	100.0%	98.4%			97.6%
31-day wait subsequent treatment - radiotherapy	94%	98.5%	100.0%	98.8%	99.3%	98.9%	100.0%	99.4%	99.1%	98.9%	99.1%	99.0%	100.0%	97.8%	99.1%	98.8%	100.0%	100.0%			99.3%
62-day wait for treatment	85%	83.5%	86.5%	86.5%	85.6%	85.8%	84.6%	85.3%	79.5%	75.4%	81.5%	78.8%	80.9%	80.3%	85.9%	82.3%	85.8%	88.2%			84.1%
62-day wait for screening	90%	94.5%	92.2%	94.6%	96.8%	98.7%	92.3%	96.3%	91.7%	95.7%	95.8%	94.4%	98.6%	94.3%	95.0%	95.9%	90.6%	97.2%			95.0%
Stroke - 90% of Stay on a Stroke Unit	80%	79.8%	86.3%	82.2%	83.7%	79.5%	71.3%	77.9%	77.8%	81.4%	82.3%	80.6%	77.4%	80.0%	78.0%	78.5%	87.1%	88.6%			81.7%
Stroke - TIA Clinic within 24 Hours (Suspected TIA)	60%	68.4%	73.4%	63.9%	68.7%	72.5%	68.7%	70.0%	60.8%	85.1%	77.0%	73.1%	51.1%	69.2%	72.0%	63.9%	60.5%	73.6%	64.6%	66.0%	64.9%
Choose and Book Slot Unavailability	4%		11%		10%	13%	8%		5%	10%	9%		7%	9%	13%		15%	14%	11%		
Delayed transfers of care	3.5%	3.1%	3.2%	3.4%	3.4%	3.6%	2.7%	3.3%	2.8%	2.7%	3.7%	3.0%	3.7%	3.9%	3.1%	3.6%	3.6%	3.1%	3.9%	3.5%	3.5%

5.1 Quality Commitment

Our AOP outlined the activity we would undertake during 2013/14 to secure and maintain sustainable performance against the above. To deliver our vision of 'Caring at its best' we laid out an ambitious Quality Commitment. Our priorities are led through three over-arching strategic goals, each with a target to be delivered over the next 3 years. By 2016 we will aim to deliver a programme of quality improvements which will:

i. Save 1000 extra lives

ii. Avoid 5000 harm events

iii. Provide patient centred care so that 75% of our patients would recommend us

A detailed review of progress against Quality Commitment objectives in Q2 is outlined at Appendix 1. At a high level key points to note include:

What is working well?

There is growing evidence in Q2 of the benefit of tailored engagement in building capacity and capability. Progress has been seen across a number of workstreams:

Multidisciplinary team engagement

i. **Falls -** The older people's team engagement with targeted wards is resulting in an impressive drop in the number of fall observed in Datix reports and in the Safety Thermometer audit by adopting relatively simple initiatives such as cohorting patients in dedicated fall-risk bays.

ii. **Older People and Dementia Care –** Three Meaningful Activities Facilitators were appointed in September 2013 to support people with dementia and their carers whilst the Trust and Alzheimer's Society have implemented two 'Carers Support Programmes' for new carers of people with dementia.

Leadership

i. **Respiratory pathway** - Respiratory Pathway Dedicated pneumonia nurses are now in post (September). Their role will be pivotal in ensuring that the pneumonia care bundle is implemented across the LRI and GGH and compliance improved.

ii. Hospital 24/7 - Launched successfully at GH, LGH and LRI however a number of areas have been identified for further improvement including the culture around calling the consultant. A work plan to tackle the 'calling culture' is being developed under the leadership of the Consultant Respiratory Intensivist.

What could be better?

As in Q1 there are a small number of actions where progress has been slower we would ideally like.

Compliance with standards

i. **Respiratory pathway** - Recent audits have revealed a poor level of adherence to the application of the BTS care bundle (identified as key risk during initial audit). This will be an important priority for the pneumonia nurses going forward.

ii. **Ward rounds –** The checklist and template for ward rounds has now been agreed and Ward Round Leads capacity resolved. However the scale and pace with which this is adopted is of concern. Incremental implementation will not achieve the scale of improvement required to materially impact on patient experience and/or length of stay. It is therefore anticipated that long-term engagement will be required to drive uptake. This will be reflected in our 2014/15 priorities.

5.2 Mortality – Overall RAG rating

In our Q1 review we noted that whilst the most recently published SHMI at that time was above the England average of 100 it was within the range expected (104.5) however our seasonally adjusted crude mortality rate/1000 admissions was higher than we would like. Work was undertaken to analyse and better understand the drivers for this position and identify areas for improvement.

The LLR Health Community carried out a SHMI (Mortality) Review which extended into Q2 as there were difficulties matching Primary Care and UHL notes for all patients. The report following this review is expected in November and will be discussed at a primary and secondary care clinical meeting at the beginning of December.

The SHMI has recently been refreshed. It remains above the England average of 100 but is within the range expected (106.4). It is however higher than the Trust would like. We are committed to understanding this picture better. The Trust has recently subscribed to the Healthcare Evaluation Data (HED) system which will start to enable us to analyse the 'out of hospital' death aspect of the SHMI.

In parallel to the work being undertaken locally the Care Quality Commission have released the first of their new look 'Intelligent Monitoring' reports. This report is being used to assess which Trusts will be visited first in the next wave of CQC inspections.

The intelligent monitoring approach is based on 150 indicators that look at a range of information including patient experience, staff experience and statistical measures of performance for example whether a Trust is hitting the A&E 4 hour wait target. The indicators are weighted and therefore some have a greater effect on the overall score than others. The NTDAs assessment of our operational and financial performance is also taken into account.

Trusts are banded between 1 and 6, dependent on the number / severity of the risks the Trust is perceived to be dealing with. Band 1 represents a higher risk than Band 6. We are band 1, which means that the CQC currently assess us as being relatively higher risk. Of the 10 indicators which were seen as risks, the Trust already has plans in place for majority of them through things like the work on our Quality

Commitment however there is no room for complacency. In the context of the Trust's banding we expect a CQC inspection sometime early in Q4.

5.3 Patient Safety – Overall RAG rating

What is working well? Overall Q2 performance has reflected consistent improvement in patient safety as measured by the scorecard indicators.

CAS Compliance - In September CAS compliance reached a record level of 99% reflecting further progress in embedding the 5 Critical Safety Actions.

VTE assessment - In our Q1 report we highlighted that VTE risk assessment performance was at 93.9% against a threshold of 95% of all adult patients having a VTE risk assessment on admission to hospital. We are pleased to report that for Q2 the Trust achieved 95.3% primarily by addressing the weakness of data input onto Patient Centre in high throughput areas.

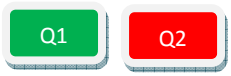
What could be better? Two clusters of incidents have been identified: medication errors and staffing incidents.

Staffing levels - The Chief Nurse has outlined the current position relating to staffing levels, vacancies, temporary staffing and the recruitment plans in place following the investment made in Q2 in response to the nursing review.

Medication errors - With respect to work on reducing ten times medication errors, a thematic review has been undertaken which has identified common areas of error and recommendations for improvement. Progress against the improvement plan will be reported in the Q3 report.

C-Section rates - C-Section rates have been 24.9% in Q2 against a target of 23%. The Trust typically benchmarks well against peer organisations and therefore the reasons for this are being explored further. Following discussion with the Women's and Children Commissioning Lead regarding the Maternity Dashboard threshold it was agreed on 17th September 2013 that a threshold of 23% is unrealistic - given the national C Section rates in 2011 were 24.8% (RCM, 2012). Therefore the dashboard thresholds will be altered from Quarter 3. Q2 performance is essentially in line with the revised threshold agreed.

5.4 Patient Experience - Overall RAG rating



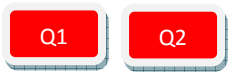
What is working well?

Performance against the CDiff trajectory to date is 35 reported cases against cumulative target of 37. All 9 cases of CDT reported in September have been fully investigated and there are no links between any of the cases identified. There is however no room for complacency.

What could be better?

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

5.5 Operational Performance – Emergency Department



As originally described in our AOP, despite significant effort sustainable improvement in ED target has not been achieved. This is subject to significant scrutiny locally, regionally and nationally.

Demand - The pattern of demand for ED has continued to be variable however overall, Type 1 and 2 ED attendance rates for the first 6 months in 2013/14 are now down by 5.1% compared to the same period in 2012/13. This is in contrast with Q1 which saw 0.8% increase when compared with the same period last year.

This is due to the redirection of all adult walk-in patients to a new 'Single Front Door' located in the Urgent Care Centre (UCC) and reflects the anticipated benefits of improved deflection from ED and reduction in overall demand for treatment in the ED. The pathway started in mid-July and we have seen August and September attendances to ED reduce significantly. This pattern of demand deflection is expected to continue. The activity deflected still forms part of the overall work undertaken on the LRI campus and is therefore reflected in the denominator for the 4 hour performance. Whilst this development is at an early stage of implementation it reflects the clear benefits of collaborative working.

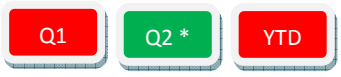
Performance - Performance year to date stands at 83.27% (Type 1&2) and 87.52% (including UCC), which are slight improvements from Q1. This still means that the Trust is one of the worst performing ED's in England.

In September 2013 the Urgent Care Board for Leicester, Leicestershire and Rutland, chaired by NHS England, agreed 5 key areas for collective work across the health economy to improve the emergency process. These areas are Admission Avoidance, ED flow, Ward Flow, Capacity/Bed Planning and Discharge. A series of meetings have taken place with some quick wins identified that appear to be having an impact. Illustrative examples include additional rehabilitation beds, process for discharging before 09:00 for rehabilitation capacity, system for diverting GP admissions directly AMU subject to bed availability.

In complement to the above the Trust with the support of the NTDA validated, confirmed and challenged current capacity assumptions. In addition the Trust looked to outside the local economy to see how others have recently turned around their own performance with a view to identifying any additional lessons learnt that we could consider locally.

ED performance is monitored in detail at Trust Board on a monthly basis and is not therefore repeated here in detail here.

5.6 62 day wait for cancer treatment (* forecast position) – 85% target



(NB: August and September not yet reported, reported 1 month behind)

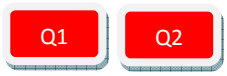
As originally explained in our 2013/14 AOP the Trust was been unable to deliver sustainable performance against this target during 2012/13. Our plans in 2013-14 are focussed on reducing unnecessary delays in early diagnosis in particular around the imaging stage of the pathway.

Performance in Q1 was 82.3% against a standard of 85%. A recovery trajectory and associated action plan was accepted by Commissioners.

What has gone well? In Q2 the Trust has appointed a Lead Cancer Clinician and Senior Manager to lead on this work. A weekly Cancer Action Board has been in operation since June 2013. The focus of attention has been on reducing delays, removing blockages and holding tumour site leads to account for delivery.

Performance in July (reported one month behind) was above trajectory at 85.7%. Early indications for August and September performance are positive, with performance anticipated to be above the agreed trajectory. This represents a significant achievement and shows the benefit of strong clinical leadership and a clear accountability framework.

5.7 Referral to Treatment Time (Admitted)



As explained in our AOP, from 2013/14 the Trust is required to achieve the admitted and non-admitted RTT targets at an aggregate and at an individual specialty level.

The Trust had been unable to deliver sustainable performance against this target across all specialties during 2012/13; Q1 and Q2 2013/14 (aggregate of 85.6% in Q2).

A priority action has been to address the backlog of long waiting patients which has had an adverse, but anticipated impact on achievement of the admitted RTT target in Q2 at an aggregate level and specialty level.

The failure to achieve the target at an aggregate level triggered a Contract Query Notice from Commissioners. A Remedial Action Plan (RAP) was submitted in August. In September a Failure to Agree Notice was received by the Trust.

In seeking to achieve the standard required the Trust has invited the National 18 Week Intensive Support Team (IST) to assist in the development of a sustainable recovery plan. Work is underway with the IST undertaking a detailed capacity and demand assessment in the key specialities. This initial phase of the plan will be completed by the 25th October. It is anticipated that an agreed Recovery Action Plan will be in place for the key specialities (Ophthalmology, ENT (Adult and Paediatrics), Orthopaedics and General Surgery) by November. The impact of this will be reported in the Q3 report.

6. ORGANISATIONAL DEVELOPMENT

A Q2 Organisational Development Report was provided to the Trust Board in September 2013 and therefore is not covered in detail in this report.

To deliver our vision of 'Caring at its Best' and to facilitate the necessary change the Trust has set out an ambitious Organisational Development (OD) Plan for UHL. Our priorities are led through six substantial work streams:-

i. Live our Values;

ii. Improve Two-way Engagement;

iii. Strengthen Leadership;

iv. Enhance Workplace Learning;

v. Improve External Relationships and Workplace Partnerships; and

vi. Encourage Creativity and Innovation.

What is going well? The Trust is pleased to report that all Q2 actions have progressed in line with plan and have been assigned a green RAG rating.

Building a culture of engagement – There are many examples of how targeted engagement is developing a culture of involvement and creating a sense of empowerment to change things for the better. Illustrative examples include the UHL Patient Experience Team working closely with Ward Sisters and Department Managers from targeted ward areas to provide a comprehensive programme of education and support in response to patient and family feedback, the first 12 LiA Pioneering Teams, delivery of LiA Quick Wins and 10 'Enabling our People' schemes.

Recognition - Our annual 'Caring at its Best Awards Event' took place on the 12th September attended by over 450 UHL staff including members of the Trust Board. Overall winners for all categories from 2012/13 were awarded during the evening along with awards for Highly Commended and Winner in our 'Volunteer of the Year' category. The nomination process is now open for the next quarterly awards to be presented in the workplace during December 2013.

Embedding our values - During Q2 the Trust values have continued to be further embedded into the Recruitment and Selection full day and half day refresher courses.

What could be better? The junior doctors of today are potentially the consultants of tomorrow and therefore junior doctor engagement in the LiA process is invaluable. There is room for improvement in the level of engagement of junior doctors in the projects underway. LiA leads are liaising with the Training Committee members in an effort to get more doctors in training involved.

7. IMPROVEMENT AND DEVELOPMENT PRIORITIES

The 2013/14 AOP set out a range of priorities which were designed to take forward the key themes identified in Section 3 and those of our Strategic Direction published last autumn. The actions reflect the breadth of the Trust's portfolio and are summarised below. The RAG rating applied indicates an assessment of the overall performance in Q2 of the portfolio of activities supporting each priority. The activities themselves are explained in more detail in Appendix 1.

PRIORITY	WHICH MEANS	THEME	STRATEGIC OBJECTIVE
Delivering our Quality Commitment	Save more lives, reduce avoidable harm, improve patient experience	Quality and Performance	Action to provide safe, high quality, patient-centred healthcare

Improving the emergency care process including the Emergency Department (ED)	Consistently deliver timely, safe care and a good patient experience	Emergency Care	Provide joined up emergency care
Improving theatre productivity (clinical service transformation)	Fewer cancelled operations, fewer delays for patients.	Quality and performance standards	Earn the right to be the provider of choice
Improving outpatients (clinical service transformation)	Fewer cancellations, fewer patients who do not attend (DNAs)	Quality and performance standards	Earn the right to be the provider of choice
Improving the estate (estate improvement)	A series of schemes to bring immediate benefits as well as well as to take forward medium term reconfiguration	Financial sustainability and quality and performance standards	Sustainable high performing NHS Foundation Trust
Improving IM&T (support service transformation)	Priority schemes to support clinical service delivery	Reconfiguration; Financial sustainability; quality and performance standards	Sustainable high performing NHS Foundation Trust
Developing Listening into Action as part of our Organisational Development Plan	Better engagement with staff, leading to better support for colleagues and clear leadership standards.	Quality and performance standards	Professional passionate and valued workforce
Developing our specialised services	For example, vascular, adult cardiac, children's cardiac, renal	Quality and performance standards. Financial sustainability	Sustainable high performing NHS Foundation Trust. Provider of choice. Enhanced reputation in Research, Innovation and Education
Developing medical education	Clinical Education Centre improvements at The Royal, better engagement with trainees, considering the shape of future medical workforce	Quality and performance standards Financial sustainability	Sustainable high performing NHS Foundation Trust. Enhanced reputation in Research, Innovation and Education
Developing research and development	Strengthening our three Biomedical Research Units, playing a leading role in the creation of the Academic Health Sciences Network, and securing funding from the National Institute for Health Research. (NIHR)	Quality and performance standards Financial sustainability	Enhanced reputation in Research, Innovation and Education
Developing as a Foundation Trust	Strengthening our membership and making progress towards our Strategic Direction	Quality and performance standards Financial sustainability	Sustainable high performing NHS Foundation Trust

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*

8. RECOMMENDATIONS

The Trust Board is asked to:

RECEIVE this report

NOTE the progress against Q2 delivery of our Annual Operational Plan and the high level RAG rating of key aspects (as per Section 3)

NOTE the key areas of variance and the outline action proposed to rectify the position

APPENDIX 1 IMPROVEMENT AND DEVELOPMENT PRIORITIES - PROGRESS AGAINST 2013/14 AOP – Q2

The Trust identified a range of priorities which are designed to take forward the key themes identified above and those of our Strategic Direction published last autumn. The actions reflect the breadth of the Trust's portfolio. Key progress against our AOP in quarter 2 (Q2) is outlined below:

PRIORITY	WHICH MEANS	ACTION PLANNED	PROGRESS Q2	KPIs	TRUST BOARD ASSURANCE AND SCRUTINY	ACTION RAG
IMPROVEMENT PRIORITY - DELIVERING OUR QUALITY COMMITMENT						
Save Lives	Reinforce Hospital 24/7 programme	Clinical notes audit	Audit completed. Final report prepared.	SHMI (6 month delay); OOH: cardiac arrests; Early warning signs response	Monthly Quality and Performance Reports to Trust Board	**5**
Save Lives	Reinforce Hospital 24/7 programme	Cultural changes - Identify key interventions to improve communications.	The Hospital 24/7 programme has been launched successfully at GH, LGH and LRI. Connectivity issues caused early problems but these were fixed ahead of the LRI launch. Handover processes, phlebotomy cover & culture around calling on call consultant have been identified as areas for further work. A work plan for calling culture is being developed under the leadership of the Consultant Respiratory Intensivist.	Response times	Monthly Quality and Performance Reports to Trust Board	**4**
Saving more lives	Respiratory Care Pathway	Redirect all respiratory pathway patients to Glenfield (either direct, or via LRI)	The pathway was successfully launched in July 2013 with exclusion criteria agreed by GH & LRI. Minor teething problems have been experienced and bed capacity issues have not materialised.	Percentage compliance to COST and COPD protocols	Monthly Quality and Performance Reports to Trust Board	**4**

PRIORITY	WHICH MEANS	ACTION PLANNED	PROGRESS Q2	KPIs	TRUST BOARD ASSURANCE AND SCRUTINY	ACTION RAG
Saving more lives	Respiratory Care Pathway	Utilise findings from care bundle audit (January 2013) to reinforce best practice May 2013	Recent audits have revealed a poor level of adherence to the application of the BTS care bundle (Adherence identified as key risk during initial audit). To be the focus of pneumonia nurses going forward.	Percentage compliance to COST and COPD protocols	Monthly Quality and Performance Reports to Trust Board	**3**
Saving more lives	Respiratory Care Pathway	Employ dedicated pneumonia nurses to support the implementation and adherence to the care bundle	Dedicated pneumonia nurses in post September – to ensure care bundle is implemented across the LRI and GGH.	Percentage compliance to COST and COPD protocols	Monthly Quality and Performance Reports to Trust Board	**5**
Avoiding 5000 harm events by 2016	Falls	Establish older people's team to coach under-performing wards	Well-focussed ward engagement (in the form of confirm and challenge) is producing excellent results. Impressive drops in fall numbers have been observed in Datix reports and in the Safety Thermometer audit. Initiatives being trialled include cohorting into dedicated fall-risk bays, risk assessment, identification systems and staff training.	Fall reports/1000 bed days aged > 65 years	Monthly Quality and Performance Reports to Trust Board	**4**
Avoiding 5000 harm events by 2016	Acting on results in ED	Agree standards for checking blood results and reporting imaging	The work component looking at within-radiology turnaround times is currently paused due to competing priorities. Consultant Radiologist has agreed to lead the engagement within radiology.	Percentage of results authorised (through ICE) (100% target) before patient discharge / transfer ED X-rays reported in < 24 hrs	Monthly Quality and Performance Reports to Trust Board	**3**
Avoiding 5000 harm events by 2016	Acting on results in ED	Baseline current performance and track improvement. Produce league tables. Reward / Hold to account.	See above	Percentage of results authorised (through ICE) (100% target) before patient discharge / transfer ; ED X-rays reported in < 24 hrs	Monthly Quality and Performance Reports to Trust Board	

PRIORITY	WHICH MEANS	ACTION PLANNED	PROGRESS Q2	KPIs	TRUST BOARD ASSURANCE AND SCRUTINY	ACTION RAG
Avoiding 5000 harm events by 2016	Acting on results on admission and subsequent delay	Ward rounds - Pilot and audit two key approaches on selected wards. Review pilot and select most impactful approach for roll-out. Monitor compliance (including spot checks)	The checklist and template have received wide-spread support from the heads of service, with few minor changes suggested. Issues with Ward Round Leads capacity have been resolved. Work has commenced with the audit team to progress work on an audit of ward round standards. The audit itself will be carried out in Q3.	Adherence to ward round template.	Monthly Quality and Performance Reports to Trust Board	**4**
Avoiding 5000 harm events by 2016	Acting on results on admission and subsequent delay	Notation - Agree standard minimum for notes entry: Up-to-date differential / working diagnosis, Daily entry of patient status, and clear plan of care. Engage doctors through training & education using case studies	Meeting with UCLH lead to discuss implementation of a ward round safety checklist into a large Trust. Ward round documentation amended following use in the acute division and discussion with clinical leads to be submitted to the Medical Director for approval.	% of entries that meet standards	Monthly Quality and Performance Reports to Trust Board	**4**
Providing patient centred care so that 75 of our patients would recommend us	Older People and Dementia Care	Multidisciplinary working - Offer opportunity for all to be Older People's Champions. Set up resource centre. Facilitate stronger utilisation of carers, volunteers and charities	275 members of staff , MDT, and volunteers have attended Older People Champions workshop – bringing a total to 1,975 Older Peoples Champions event took place in September to update 100 existing Champions.	Increase to a further 400 Older Peoples Champions over next year - 25% increase	Monthly reporting to Trust Board via the Quality & Performance Paper. Monthly meeting of the Quality Action Groups chaired by Director Lead and Director 0f Quality	**4**
Providing patient centred care so that 75 of our patients would recommend us	Older People and Dementia Care	Communicate effectively - Ensure completion of personal profile for all patients with dementia Utilise White board for communication with patients and carers). Increase patient / carer involvement in care	Repeated Patient Profile Audit in September 2013. Results show low level of compliance. Specific actions tasked to the CMGs by Nov 2013 3 Meaningful Activities Facilitators appointed September 2013 to support people with dementia and their carers	Improvement in the Friends and family Test scores. To achieve a Friends and family test score of 75 by 2015	Monthly reporting to Trust Board via the Quality & Performance Paper. Monthly meeting of the Quality Action Groups chaired by Director Lead and Director 0f Quality	**4**

PRIORITY	WHICH MEANS	ACTION PLANNED	PROGRESS Q2	KPIs	TRUST BOARD ASSURANCE AND SCRUTINY	ACTION RAG
			A Carers Support & Advice post currently being recruited. UHL and Alzheimer's Society implemented two 'Carers Support Programmes' for new carers of people with dementia Survey completed to understand how patients would like to be involved in care. Results available November 2013			
Providing patient centred care so that 75 of our patients would recommend us	Older People and Dementia Care	Track and hold to account - Agree metrics and track against them. Identify suitable method for increasing transparency (e.g. Ward Friends and family Score).	Wards are displaying Public Facing Dashboards FFT scores available nationally via NHS England and via the trusts Public website at ward level. 8 wards MDT completed baseline stage 1 of the National Quality Mark Scheme for Older People and identified key areas for improvement	Improvement in the Friends and family Test scores. To achieve a Friends and family test score of 75 by 2015 Improvement in three key Patient Experience Survey questions	Monthly reporting to Trust Board via the Quality & Performance Paper. Monthly meeting of the Quality Action Groups chaired by Director Lead and Director 0f Quality	**4**
Providing patient centred care:	Discharge experience	Deliver discharge plans standard - involve multi-disciplinary team and patient / carer. Co-ordinate discharge plan and communicate with patient / carer. Implement across all priority wards	Regular Board rounds being held on priority wards, further training around discharge plans being provided to all ward staff. The discharge workstream is 2-3 months behind schedule due to handover from the Discharge Project Lead to the Project Manager. This is compounded by concern over the decline in the last 12 months of discharge experience survey question scores.	Net Promoter Score Discharge survey	Monthly reporting to Trust Board via the Quality & Performance Paper. Monthly meeting of the Quality Action Groups chaired by Director Lead and Director 0f Quality	**2**

PRIORITY	WHICH MEANS	ACTION PLANNED	PROGRESS Q2	KPIs	TRUST BOARD ASSURANCE AND SCRUTINY	ACTION RAG
Providing patient centred care:	Discharge experience	Communication tools - Design and roll-out 'Ticket Home' tool including key information for every patient. Roll-out for every patient.	'Leaving hospital' and 'Now you are getting better' leaflets have been produced and are being introduced to ward areas as discharge training is taking place. The discharge workstream is 2-3 months behind schedule due to handover from the Discharge Project Lead to the Project Manager.	Net Promoter Score Discharge survey	Monthly reporting to Trust Board via the Quality & Performance Paper. Monthly meeting of the Quality Action Groups chaired by Director Lead and Director 0f Quality	**2**
IMPROVEMENT PRIORITY - EMERGENCY CARE INCLUDING THE EMERGENCY DEPARTMENT (ED)						
Emergency Care	**Achievement of the ED 4 Hour standard**	Redesign of ward processes and bed reconfiguration.	Ward round standard agreed and being implemented. Board rounds being rolled out across all areas. Bed reconfiguration agreed with CMGs and now being implemented	ED 4 hour standard Length of stay reduction	Monthly Quality and Performance Report ED Exception Report	**2**
Emergency care	**Ambulance turnarounds times**	Ambulance turnarounds times within contracted agreement Current performance 19mins	Trajectory for improvement on 60, 30 and 15 minute handover agreed. Action plan agreed with CCGs, being implemented.	Within contracted agreement (15mins for clinical handover time). Reduction in contractual penalties	Monthly Quality and Performance Report ED Exception Report	**3**
IMPROVEMENT PRIORITY - CLINICAL SERVICE TRANSFORMATION						
Theatre Productivity	Fewer cancelled operations, fewer delays for patients.	**Capacity and Demand and theatre info** - Review current capacity / demand; Define Future state; Develop Key Performance indicators and implementation plan ; Explore viability of further use of patient bar coding for real time information	Capacity and demand model developed by specialty – used in confirm and challenge sessions as data sharing. Scenarios presented for evaluation. Master schedule developed	Improved theatre throughput; Reduced cancellations Reduced backlog; Reduced WLIs	Theatre Transformation Board; Improvement and Innovation Board; Exec leadership; Regular reports to Trust Board	**4**

PRIORITY	WHICH MEANS	ACTION PLANNED	PROGRESS Q2	KPIs	TRUST BOARD ASSURANCE AND SCRUTINY	ACTION RAG
Theatre Productivity	Fewer cancelled operations, fewer delays for patients.	**Scheduling -** Define processes for scheduling; Review use of IT systems for theatre information and scheduling; Model patient selection for optimum use of theatre lists	Scheduling tool pilot in ophthalmology SIEVE tool for appropriate pre assessment developed and piloted in ophthalmology Will roll out to other specialties Scheduling meeting under review	Improved theatre throughput; Reduced cancellations Reduced backlog; Reduced WLIs	Theatre Transformation Board; Improvement and Innovation Board; Exec leadership; Regular reports to Trust Board	**4**
Theatre Productivity	Fewer cancelled operations, fewer delays for patients.	**Workforce Review** - Ensure Job planning matches scheduling and theatre list allocation; Review skill mix required for future state	Recruitment of staffing to fill substantial gaps continues in theatre. LIA approach at LGH to increase staff involvement and engagement	Improved workforce productivity	Theatre Transformation Board; Improvement and Innovation Board; Exec leadership; Regular reports to Trust Board	**4**
Theatre Productivity	Fewer cancelled operations, fewer delays for patients.	**Pre-operative assessment -** Standardise processes and systems; IT solution to record pre- operative assessment and booking of appointments; Review workforce and capabilities;	Work stream project plan produced. Slow progress in some areas.	Improved theatre throughput; Reduced cancellations	Theatre Transformation Board; Improvement and Innovation Board; Exec leadership; Regular reports to Trust Board	**2**
Theatre Productivity	Fewer cancelled operations, fewer delays for patients.	Implement Theatre arrivals (all sites) and advanced recovery (LGH)	Progress in line with plan. Due to open Jan 2014	Improved theatre throughput; Reduced cancellations	Theatre Transformation Board; Improvement and Innovation Board; Regular reports to T.Board	**4**
Outpatient Transformation	Improving clinic slot booking utilisation	Detailed analysis of top 25 specialties that result in 80% of outpatient income to identify opportunities for improvement	Approach modified. Top 40 specialities asked to provide baseline data by end July 13. Wave 1 of specialities (x8) to be reviewed in September & October - confirmed	Target 95% utilisation	Reports to the Improvement and Innovation Framework Board chaired by the CE.	**3**

PRIORITY	WHICH MEANS	ACTION PLANNED	PROGRESS Q2	KPIs	TRUST BOARD ASSURANCE AND SCRUTINY	ACTION RAG
Outpatient Transformation	Reducing the number of patients who do not attend (DNA)	SMS text message reminders. Pilot commenced January 2013 in 4 specialties to call top 10% of patients identified as high risk of DNA utilising bespoke software – "patient call optimiser". On-going pilot.	UHL has had approximately 2600 less DNA's in 2013/14 than for the 1st 5 months of 2012/13. Patient Call project on track to go live in October 2013	SMS - Target 80% of patients by end of 2013/14	Reports to the Improvement and Innovation Framework Board chaired by the CE.	**5**
Outpatient Transformation	Outpatient Clinic Template and Slot Management Policy	Support consistent clinic administration and enable robust and accurate metrics. Roll out as part specialty analysis.	Policy written and approved at Policy & Guidance Committee. Also approved at Outpatient Programme Board and endorsed at Cross Divisional meeting.	Improved OP clinic utilisation	Reports to the Improvement and Innovation Framework Board chaired by the CE.	**5**
Outpatient Transformation	Clinic observation - Improving patient experience	Clinic observation - develop methodology with view to improve patient experience and validate assumptions around capacity.	Not progressed in Q2 due to re-prioritised resource allocation. Approach to resource arrangements for clinic observation to be reviewed with the newly formed CMGs in Q3 2013/14	Improved OP clinic utilisation	Reports to the Improvement and Innovation Framework Board chaired by the CE.	**2**
Outpatient Transformation	Building capacity and capability - service improvement	Outpatient Improvement Team – Establish team to ensure common approach and sharing of best practice	Recruited one individual to band 5 post. Individual has now been seconded to support Ophthalmology.	Increased staff morale and staff productivity	Reports to the Improvement and Innovation Framework Board chaired by the CE.	**3**
IMPROVEMENT PRIORITY - SUPPORT SERVICE TRANSFORMATION						
Estates & Facilities Service Delivery	Implementation of LLR Facilities Management Consortium to act on behalf of all LLR Trusts to actively manage the	In working with private sector partners it is essential that their style and approach reflects the values and culture of the Trust. The relationship and partnering values	NHS Horizons (previously referred to as the LLR FMC) was been established from the 1st March 2013 and has been actively monitoring the contract against the specification and pre-	Year on year cost improvement from Lot1 without detriment to quality	Governance through Trust Board representation by DoF and NED representation of the NHS Horizons Programme Board	**3**

PRIORITY	WHICH MEANS	ACTION PLANNED	PROGRESS Q2	KPIs	TRUST BOARD ASSURANCE AND SCRUTINY	ACTION RAG
	Estates/FM Contract	will be managed by Interserve and the Health partners forming a joint board to drive the values and direction of the framework and services provided under it. This body is called the LLR FMC. The Trust's interests will be served by an intelligent client management team – who will manage the performance of the private sector partner and uphold the interests of the health partners.	defined KPI's. NHS Horizons continues to actively monitor contract service performance and provides monthly performance reports to the Horizons collaborative Board. The payment mechanism and service financial deductions to August 2013 have demonstrated an alignment between service performance and financial consequence. The intelligent client function has been formulated by way of Service Level Agreement. This is working well for lot 1 facilities services – for Lot 2 services and capital projects work upon gaining maximum benefit from the Procure 21 style framework is on-going.			
Estates & Facilities Service Delivery	Progress against lot 1 LLR EFM contract	Responsibility for the day to day operational management and delivery of core FM services would be undertaken by Interserve on 1 March 2013.	IFM have a 12 month transformation plan for services to be reconfigured to their bid model and specification. Retail Catering has been transformed with £1.2m investment. Patient Catering has been changed to Steamplicity – with all wards across the Trust migrated in July 2013. Cleaning service structures have migrated to 2007 NCS schedules and Microfibre technology between June and August 2013. Quality outcomes are being actively monitored and	Year on year cost improvement from Lot1 without detriment to quality	Governance through Trust Board representation by DoF and NED representation of the NHS Horizons Programme Board	**3**

PRIORITY	WHICH MEANS	ACTION PLANNED	PROGRESS Q2	KPIs	TRUST BOARD ASSURANCE AND SCRUTINY	ACTION RAG
			managed. IFM will now seek to migrate estates and portering models over the latter 2 quarters of 2013-14. Detailed operational plans for so doing will be vetted by Horizons and the Trust prior to implementation.			
Estates & Facilities Service Delivery	Progress against lot 2 A series of schemes to bring immediate benefits as well as well as to take forward medium term reconfiguration	In parallel Interserve will be working with the Trust to progress the early stages of the Strategic Estates Development and Investment Estates Transformation Plan in 2013/14	A detailed programme of business cases and capital projects are being progressed supporting the Reconfiguration Programme and other infrastructure rolling programmes	Long term foot print reduction Improved income per m2 of residual estate	Governance through Trust Board representation by DoF and NED representation of the NHS Horizons Programme Board	**3**
Reconfiguration and Estate Improvement	Day Case / Outpatient Hub	A Day Case / Outpatient Hub Feasibility study will be completed prior to the development of an Outline Business Case for a dedicated Day Case and Outpatient Hub. This would support the segmentation of ambulatory planned care flows from inpatient hospital care and will also be a critical enabler for the emergency floor development.	The project has yet to progress to the development of the FBC. The delay is as a consequence of the need to have the outcome of the Trust wide Strategic Outline Case (SOC) to detail a preferred option in terms of configuration for development of the Hub. The activity assumptions in relation to the Hub and left shift into it have been identified at a high level however further challenge will be required following the SOC outcome (the location of the hub would have an impact on the quantum and nature of activity being undertaken in that setting)	Reduced cancellations Improved ratio between income per m2 and occupancy per m2	Governance through Commercial Executive, Executive Team, Trust Board and NTDA. Public Consultation will be required on the development of the Hub.	**3**
Reconfiguration and Estate	Emergency model of care	Emergency model of care – early feasibility studies	Trust Board have signed-off the Strategic Outline Case and given approval to proceed to development	Sustainable achievement of ED	Governance through Commercial Executive, Executive Team, Trust	**3**

PRIORITY	WHICH MEANS	ACTION PLANNED	PROGRESS Q2	KPIs	TRUST BOARD ASSURANCE AND SCRUTINY	ACTION RAG
Improvement			of a Full Business Case (June 2013). The SOC has since been reviewed by the NTDA with amendments suggested to be incorporated into the document prior to final sign off. The NTDA recommended an Outline Business Case (OBC) be incorporated into the governance of the scheme prior to the FBC. The Emergency Floor OBC will be submitted for approval to the Trust Board in October 2013 Detailed design will continue to be progressed with zero abortive work during OBC period The Programme Board is established with strong clinical involvement.	standard	Board and NTDA.	
Reconfiguration and Estate Improvement	Theatres Arrival Area and Advanced Recovery	Completion of construction at the LRI	Theatres Arrivals Area progressing to plan with completion due December 2013. Advanced Recovery Business Case in production with anticipated internal approval Dec 2013	Reducing theatre delays -Reducing idle capacity (cost)	Governance through Theatres Programme Board, Executive Strategy Board and financial approval through the Commercial Executive	**4**
Reconfiguration and Estate Improvement	Maternity interim development	Construction of additional delivery rooms at the LGH and LRI to safely accommodate the increase in births	Construction work is on-going and running to plan. Work is planned to run through until the end of June 2014.	TBC	Governance through Project Board, Reconfiguration Board and Commercial Executive	**4**
Reconfiguration and Estate Improvement	Vascular	Enhance minimally invasive vascular and renal Interventional Radiology at GGH - Supporting the shift from inpatient to day case	Feasibility Study completed delivering high level costs and timescales. Executive Strategy Board approval to proceed to development of FBC and details design – to be completed by Dec 2013	Increased utilisation of lower cost facilities without detriment to clinical quality	Governance through Single Site Take Programme Board, Executive Strategy Board and financial approval through the Commercial Executive	**3**

PRIORITY	WHICH MEANS	ACTION PLANNED	PROGRESS Q2	KPIs	TRUST BOARD ASSURANCE AND SCRUTINY	ACTION RAG
Reconfiguration and Estate Improvement	As care moves closer to home our hospitals will become smaller and more specialised. To optimise clinical outcomes and safety, sites will need to be consolidated. Renal & Transplant Services	Relocation of Renal & Transplant Services from the LGH to the GGH. Approval given to complete a feasibility study	Estate feasibility undertaken to identify whether the renal and transplant services could be relocated into part new build and part retained estate. Output confirmed that this would be possible. Discussions on-going with the University of Leicester to ensure the potential Donor is aware of the feasibility output. Opportunity to develop a charitable appeal to support the capital funding of the relocation - initial discussions have been undertaken, detail to be developed further.	TBC	Governance through Commercial Executive, Executive Team, Trust Board and NTDA.	4
Reconfiguration and Estate Improvement	Welcome Centre LRI	New main entrance located in the Windsor Building. Approved to progress to detailed design and delivery of an Outline Business Case	Feasibility to focus on an enterprise development funded by Interserve. Stakeholder workshop proposed for early September (Q2)	Patient experience	Governance through Trust Board representation by DoF and NED representation of the NHS Horizons P. Board	3
Reconfiguration and Estate Improvement	Balmoral Access for the Emergency Department	Review of highways, traffic plans, pedestrian access, car parking, levels, gradients and Blue Light access. Approval given develop detailed designs and tender	This has now been superseded by the Emergency Model of Care programme	TBC	Governance through Trust Board representation by DoF and NED representation of the NHS Horizons P. Board	3
Reconfiguration and Estate Improvement	Refurbishment of Poppies Nursery	Approval given to proceed to detailed design and tender. Contract award subject to future review by Exec Team.	Detailed design and high level costings produced. To proceed at risk with regards planning and change of use.	TBC	Governance through Trust Board DoF and NED representation of the NHS Horizons P. Board	2
Reconfiguration and Estate Improvement	Clinical Education Centre at the LRI	Initial designs for the conversion of Odames Ward into a CEC have been reviewed. Approval has been given to develop an OBC	Strategic Outline Plan (SOP) now to be issued to progress to detailed design Anticipated delivery in April 2014 (not October 2013).	TBC	Governance through Trust Board representation by DoF and NED representation of the NHS Horizons P. Board	2
Reconfiguration and Estate	Energy Centre	Removal of existing life expired combined heat and power units (CHP) at	DoH Funding application successful	TBC	Governance through Trust Board representation by DoF and NED	3

PRIORITY	WHICH MEANS	ACTION PLANNED	PROGRESS Q2	KPIs	TRUST BOARD ASSURANCE AND SCRUTINY	ACTION RAG
Improvement		LRI and GH. Installation of new gas CHP units on all 3 acute sites. Lighting and building energy management upgrades across UHL			representation of the NHS Horizons P. Board	
Information Management and Information	Managed Business Partner	Implementation of the contract with our preferred Managed Business Partner: IBM. The Trust will work with IBM to progress the early stages of the Trust's IM&T Transformation Plan throughout 2013/14	Wave 1 - Transfer of IT services to IBM & NTT - The transfer of services and staff under TUPE commenced on 1 August 2013 with no impact to operational services and extended the service desk to 24/7. Within the first week, IBM and NTT DATA successfully managed the issuing of smartcards to over 300 junior doctors on their August rotation. Wave 1 includes Ancillary Services, Data Centre, Service Desk and Service Delivery Management, Application Management (wave 1) and IT Security	TBC	The board receives a monthly update paper and a fuller quarterly review through the Director of Finance. Joint Governance Board in place.	**4**
Information Management and Information	Electronic Document Record Management (EDRM) - project to deliver Electronic versions of our clinical notes	Develop the business case for EDRM and progress procurement options.	A procurement exercise has been undertaken for a document management system (EDRM) and a scanning service to digitise all of UHL medical records. A preferred supplier has been selected and we are in the final stages of selecting the scanning service. A FBC is expected to be presented by end of November 2013	TBC	Papers for the transformation projects have been taken through the Trust Board. Joint Governance Board in place.	**4**
Information Management and Information	Managed print solution	Develop the business case for Managed Print. Progress procurement options.	Prices have been received from multiple suppliers including the NHS framework for managed print services. A decision will be made based on the service provision and price. Following business case approval, the first phase of implementation will be at Glenfield	TBC	Papers for the transformation projects have been taken through the Trust Board. Joint Governance Board in place.	**4**

PRIORITY	WHICH MEANS	ACTION PLANNED	PROGRESS Q2	KPIs	TRUST BOARD ASSURANCE AND SCRUTINY	ACTION RAG
			Hospital.			
Information Management and Information	Clinical portal and Electronic Patient Record (EPR)	Develop the business case for Clinical Portal and EPR. Progress each project including consideration of procurement options.	IBM has met with the CMIOs and clinicians to understand their requirements and identify the benefits to develop the business case. Discussions with vendors and a number of visits to other hospitals with EPRs have been undertaken. The financial assessment for implementing an EPR is being assessed and due to be reviewed at the Executive Performance Board meeting at the end of September 2013.	TBC	Papers for the transformation projects have been taken through the Trust Board. Joint Governance Board in place.	**3**
DEVELOPMENT PRIORITY - IMPLEMENTING OUR ORGANISATIONAL DEVELOPMENT PLAN						
Professional, passionate and valued workforce	Live our values	Implement the "Putting People First" cultural shift programme	The UHL Patient Experience Team have been working closely with Ward Sisters and Department Managers from targeted ward areas to provide a comprehensive programme of education and support, in response to	Reduced complaints Patient Satisfaction (friends and family)	Organisational Development Plan Priorities (2013/15) - Quarterly Update Report (Quarter 2 – July to Sept 2013) presented to Trust Board 27/9/13	**4**

PRIORITY	WHICH MEANS	ACTION PLANNED	PROGRESS Q2	KPIs	TRUST BOARD ASSURANCE AND SCRUTINY	ACTION RAG
			patient and family feedback. The Head of Patient Experience in partnership with TMI (national leads), has put together a development programme titled 'Patient Experience – Development Tools to Support Cultural Shift'. A number of workshops have been delivered and incorporate a range of cultural shift tools and techniques including 'Putting People First' development modules endorsed by the national centre for Patient Leadership. Facilitated workshops have taken place during September and October 2013 and have focus on delivering patient centred services.			
Professional, passionate and valued workforce	Live our values	Fundamentals – Implement Values Based Recruitment Embed Values within Systems and Processes Continue 'Caring at its best' Awards	Recruitment and courses updated to include value based interview questions. Nine individuals and three teams were recognised for their excellence through our 'Caring at its Best' Awards. Our annual 'Caring at its Best Awards Event' took place on the 12th September and was attended by over 450 UHL staff including members of the Trust Board.	Increase in compliments Staff and Patient Satisfaction (friends and family)	Organisational Development Plan Priorities (2013/15) - Quarterly Update Report (Quarter 2 – July to Sept 2013) presented to Trust Board 27/9/13	**4**
Professional, passionate and valued workforce -	Improve two way engagement	Driving accelerated improvement through the adoption of Listening into Action (LiA).	During Q2, 12 Pioneering teams volunteered to adopt the LiA approach to improve patient outcomes, staff engagement and service quality. 10 Enabling Our people Schemes commenced working on corporate themes to address the issues raised by staff at the listening events. Each	Increased engagement and staff morale	Quarterly Update Report (Quarter 1 – April to June 2013) presented to Trust Board 27/6/13	**4**

PRIORITY	WHICH MEANS	ACTION PLANNED	PROGRESS Q2	KPIs	TRUST BOARD ASSURANCE AND SCRUTINY	ACTION RAG
			Pioneering Team and Enabling Our People Scheme has used the LiA Optimal Framework to listen to staff and turn their suggestions into a series of priority actions. During August the 10 Enabling Our People Schemes were integrated into the Improvement and Innovation Framework as Pillar One. In addition, during September the Trust introduced the concept of Thematic LiA to support the engagement of staff affected by the change from Divisions to Clinical Management Groups.			
Professional, passionate and valued workforce -	Improve two way engagement	Build our model employer approach by implementing medical engagement priorities identified through the Medical Engagement Strategy (2013/14) Change Management Achieve and maintain 'Excellent Employer' status	Key highlights include: The establishment of a Clinical Senate to build a strong level of involvement through a range of activities; Financial workshops have been delivered to more than 100 consultants supporting the ethos of Service Line Management; Medical leadership development sessions (aspiring leaders) cohorts 1-4 and a new consultant's development event took place in August supported by the Medical Director and Chief Executive (focussed on medical appraisal and revalidation). A further session will take place in November 2013. Computer Salary Maximising scheme was launched in August, the 25 year Dinner Event held in June and the UHL Fun Day Event in July.	Increased engagement and staff morale	Organisational Development Plan Priorities (2013/15) - Quarterly Update Report (Quarter 2 – July to Sept 2013) presented to Trust Board 27/9/13	**4**
Professional, passionate and valued workforce	Strengthen Leadership	Devise and implement Leadership Qualities and Behaviours	Communicate Leadership Qualities' and Behaviours - UHL Leadership Qualities and Behaviours were launched in July 2013 and selected as a Listening into Action 'Quick Win'. During July these behaviours were communicated out via the Chief Executive Briefings and a global e-mail to all staff. To	Increased recruitment, retention and succession planning	Organisational Development Plan Priorities (2013/15) - Quarterly Update Report (Quarter 2 – July to Sept 2013) presented to Trust Board 27/9/13	**4**

PRIORITY	WHICH MEANS	ACTION PLANNED	PROGRESS Q2	KPIs	TRUST BOARD ASSURANCE AND SCRUTINY	ACTION RAG
			demonstrate 'what good leadership looks like' we have developed short video interviews and case studies which can be accessed from iNsite. In showcasing leadership excellence, further case studies and interviews will be added over the next quarter and are currently being worked on. UHL 360 Feedback Tool – explorations with OCB media			
Professional, passionate and valued workforce	Strengthen Leadership	Agree Senior Leadership Development plans. Agree skills development in Finance and Business Acumen	Leadership into Action Event to inform strategy and action plan was held during August 2013. Conference event programme agreed Utilisation of East Midlands Leadership Academy (EMLA) Programmes - We have selected UHL leaders to attend the new national 'Professional Development Programmes' based on talent conversations and achievement of objectives. Programmes have commenced in September / October 2013.	Increased recruitment, retention and succession planning	Organisational Development Plan Priorities (2013/15) - Quarterly Update Report (Quarter 2 – July to Sept 2013) presented to Trust Board 27/9/13	**4**
Professional, passionate and valued workforce	Strengthen Leadership	Agree Board and Executive Leadership Development plans.	Continued Board Development Sessions To support talent management, succession planning and prioritising leadership development, work is underway in compiling the Talent Profile for the UHL senior leadership		Organisational Development Plan Priorities (2013/15) - Quarterly Update Report (Quarter 2 – July to Sept 2013) presented to Trust Board 27/9/13	**4**

PRIORITY	WHICH MEANS	ACTION PLANNED	PROGRESS Q2	KPIs	TRUST BOARD ASSURANCE AND SCRUTINY	ACTION RAG
			community			
Professional, passionate and valued workforce	Enhance workplace learning	Enhance Statutory and Mandatory Training	3 core e-learning modules developed Strengthened reporting against Statutory and Mandatory Training performance Communicated training requirements in a simplified way Extended internal training provision in key areas including Resuscitation Training	Compliance with statutory and mandatory training standards	Organisational Development Plan Priorities (2013/15) - Quarterly Update Report (Quarter 2 – July to Sept 2013) presented to Trust Board 27/9/13	**4**
Professional, passionate and valued workforce	Implement workforce plans	Each Division developed a Workforce Plan for 2013/14 which was based on predicted activity levels and Cost Improvement Schemes.	Key developments in the last quarter include a review of the appropriate staffing and skills mix relating to Urgent Care Centre to align with the Emergency Care Pathway. We have progressed in increasing the number of nursing staff and Health Care Assistants to support Hospital 24/7. Work is underway in introducing new roles to support the Theatre Transformation Programme. A number of schemes were removed from CIP in June 2013 as a result of 'overheating' these included bed base reduction schemes in Speciality Medicine and Length of Stay reduction schemes in GI and General Surgery. A significant in year nursing establishment review has taken place to incorporate 2 days supervisory time for ward managers and increased	Increased recruitment, retention and succession planning	Organisational Development Plan Priorities (2013/15) - Quarterly Update Report (Quarter 2 – July to Sept 2013) presented to Trust Board 27/9/13	**4**

PRIORITY	WHICH MEANS	ACTION PLANNED	PROGRESS Q2	KPIs	TRUST BOARD ASSURANCE AND SCRUTINY	ACTION RAG
			acuity. This has increased nursing vacancy levels. Robust recruitment plans are in place to close gaps between demand and supply. In the interim there is an increased cost pressure as a result of the use of non-contracted workforce to close this gap. Plans are being implemented to increase the supply of bank staff to reduce dependency on more costly agency staff. The contractual position at the end of month 6 is 9864.			
Professional, passionate and valued workforce -	Improve External Relationships and Workplace Partnerships	Develop Patient and Public Involvement Strategy	Commenced PPI Stakeholder Engagement Strategy Review Community Ambassador Training Bi-monthly Prospective Governor meetings continue to be well attended. In July 2013 we engaged the group on our plans for the new Emergency Floor and the proposed move of Outpatient activity. The group meets again on September 17th. 5 new patient advisors recruited Meeting held with Healthwatch	Evidence of increased engagement	Organisational Development Plan Priorities (2013/15) - Quarterly Update Report (Quarter 2 – July to Sept 2013) presented to Trust Board 27/9/13	**4**
Professional, passionate and valued workforce	Encourage creativity and Innovation	Produce Service Improvement Strategy / Skills Development to drive forward service improvement	IIF contents defined and approved IIF Communication Strategy developed IIF formally launched IIF projects mapped to framework	Increased evidence of project management training and service improvement tools and techniques	IIF Board chaired by CEO Reports to Trust Board Organisational Development Plan Priorities (2013/15) - Quarterly Update Report (Quarter 2 – July to Sept 2013) presented to Trust	**4**

PRIORITY	WHICH MEANS	ACTION PLANNED	PROGRESS Q2	KPIs	TRUST BOARD ASSURANCE AND SCRUTINY	ACTION RAG
					Board 27/9/13	
Professional, passionate and valued workforce	Encourage creativity and Innovation	Embedding Releasing Time to Care Build on Research and Development	RT2C with Phase 11 wards rolled out The Trust has been selected to host the East Midlands Clinical Research Network (23 million per annum for a five year period)	Increased staff morale, retention, staff satisfaction	Organisational Development Plan Priorities (2013/15) - Quarterly Update Report (Quarter 2 – July to Sept 2013) presented to Trust Board 27/9/13	**4**
DEVELOPMENT PRIORITY – SPECIALISED SERVICES						
Developing our specialised services	For example, vascular surgery	Plans are to be progressed to relocate Vascular Surgery from the LRI to the GGH thereby consolidating Cardio-Vascular Services onto one site. Enhance minimally invasive vascular and renal Interventional Radiology at GGH - Supporting the shift from inpatient to day case	Feasibility Study completed delivering high level costs and timescales. Executive Strategy Board approval to proceed to development of FBC and details design – to be completed by Dec 2013	Patient experience Patient outcome	Governance through Single Site Take Programme Board, Executive Strategy Board and financial approval through the Commercial Executive	4
Developing our specialised services	For example, Children's Cardiac Services	The outcome of the national Safe and Sustainable Review into Children's Cardiac Surgery was referred by the Secretary of State for Health to the Independent Reconfiguration Review Panel following challenge from various sources including our own local Health Overview and Scrutiny Committee. The outcome of the panel consideration was unknown at the time of the approval of our AOP. The Trust (with commissioner support) will implement the action	The Independent Review Panel (IRP) report was published in May 2013. During 2013-14 NHS England is conducting a new review to consider the whole lifetime pathway of care for people with congenital heart disease with the aim of bringing forward an implementable solution by the end of June 2014. Consultation on the standards proposed is forthcoming.	Retention of paediatric cardiac surgery	Reports to Executive Strategy Board	**3**

PRIORITY	WHICH MEANS	ACTION PLANNED	PROGRESS Q2	KPIs	TRUST BOARD ASSURANCE AND SCRUTINY	ACTION RAG
		required in response.				
Developing our specialised services	For example, Adult Cardiac Surgery Services	The Trust is engaging in early discussions with Nottingham University Hospitals (NUH) to explore the benefits of an East Midlands network approach towards adult cardiac surgery allowing opportunity to share and benefit from, best practice.	A sustainability, safety and access review has been undertaken. The service is developing a complex mitral valve service in conjunction with the TAVI program in cardiology. Work is on-going	Market share (value and volume)	Reports to Executive Strategy Board	
DEVELOPMENT PRIORITY – MEDICAL EDUCATION						
Medical Education	Improved infrastructure for clinical education at LRI	Conversion of Odames Ward to a library/learning centre and an option appraisal of other solutions to resolve lack of education and training space generally across LRI. Initial designs for conversion of Odames Ward into a Clinical Education Centre have been reviewed and approval given to develop an Outline Business Case for delivery in 2013/14.	Odames Library project group is up and running. Plan for delivery progressing with a target of April 2014.	Education dashboard as part of the Quality and Performance report is under discussion and development.	Quarterly review considered by Trust Board (last report June 2013). The Chairman has agreed to represent education and training issues to the UHL Board.	**4**
Medical Education	Accountability for education and training resources	Increase accountability for education and training resources and map resources to quality of education and training delivery	Improved understanding of SIFT funding in UHL via PLICs however further work has temporarily paused due to structural changes (previous discussions with people now not in post). Supporting documents prepared for future meetings.	Education dashboard as part of the Quality and Performance report is under discussion and development.	Quarterly review considered by Trust Board (last report June 2013)	**3**

PRIORITY	WHICH MEANS	ACTION PLANNED	PROGRESS Q2	KPIs	TRUST BOARD ASSURANCE AND SCRUTINY	ACTION RAG
Medical Education	Educational Governance	Develop a funded (SPA) CBU/Departmental Educational Lead role to improve links between clinical service and training, to deliver quality measures and respond to the challenges of increased accountability for education funding	New terms of reference for Medical education committee have been agreed. The job description agreed for CMG medical Education lead role has been developed and agreed. The education quality dashboard has been developed. Meetings are planned to discuss this with CMGs in Q3/4. Training of appraisers to appraise SPA education roles is ongoing.	Education dashboard as part of the Quality and Performance report is under discussion and development.	Quarterly review considered by Trust Board (last report June 2013)	**3**
Medical Education	Medical workforce planning (Medical Workforce group)	Agree the shape of the future medical workforce in UHL and the associated training implications	Discussion with 3 CBU's regarding education and training priorities. Work on-going.	Education dashboard as part of the Quality and Performance report is under discussion and development.	Quarterly review considered by Trust Board (last report June 2013)	**3**
Medical Education	Enhance trainee experience	Enhance trainee experience and engagement with UHL through processes including Listening into Action (LiA).		Education dashboard as part of the Quality and Performance report	Quarterly review considered by Trust Board (last report June 2013)	**3**
DEVELOPMENT PRIORITY – RESEARCH AND DEVELOPMENT						
Research and Development	Optimising the value added by our Biomedical Research Units (BRU)	To ensure the BRUs operate efficiently, effectively and are delivering on their objectives for example, developing new and effective treatments for severe asthma and chronic obstructive pulmonary disease (COPD) (LLR have a high incidence of COPD)	The BRUs are performing in line with Q2 plan.	Staff appointed Volume of clinical trials Value of grant income Accommodation	Performance monitored through the joint BRU Board UHL Research and Development Executive reports to Executive Strategy Board and by exception	**4**

PRIORITY	WHICH MEANS	ACTION PLANNED	PROGRESS Q2	KPIs	TRUST BOARD ASSURANCE AND SCRUTINY	ACTION RAG
				complete and occupied	to Trust Board	
Research and Development	Engaging with NIHR portfolio studies	Improving UHL's engagement with NIHR portfolio studies, thereby making significant progression towards every service taking part in this activity	Engagement in terms of patient recruitment to NIHR trials continues to improve; figures available up to mid-September show the Trust to be 48% ahead of target to date	Number of patients recruited to NIHR trials	UHL Research and Development Executive reports to Executive Strategy Board and by exception to Trust Board	**4**
Research and Development	Enhancing Leadership	Being a leading, influential partner in the development of the East Midlands Academic Health and Science Network (AHSN)	First AHSN Board Meeting took place 15/10/13 in Northamptonshire - Trust represented at meeting	Membership of substantive AHSN Board	UHL Research and Development Executive reports to Executive Strategy Board and by exception to Trust Board	**4**
Research and Development	Improving Communication	Developing and delivering a comprehensive communication strategy for R&D within the Trust	Research Communication Manager post agreed; job description and person spec have been agreed; post to go to advert	Staff awareness of R&D and how it fits with the Trust's overall strategy	UHL Research and Development Executive reports to Executive Strategy Board and by exception to Trust Board	**3**
DEVELOPMENT PRIORITY – FOUNDATION TRUST STATUS						
Foundation Trust Status	Board Development	Develop and agree Trust Board Development programme for 2013/14.	Board Development Programme for 2013/14 agreed in May 2013. Development sessions in Q2 included the Market Assessment, enabling strategies, the Quality Governance Framework, the Board Governance Memorandum, site reconfiguration and strategy development. The Development Programme will be reviewed in conjunction with the review of the Trust's FT application timeline	Delivery of programme for 2013/14	Actions arising from the Trust Board development sessions reported and monitored via the fortnightly FT Programme Board meetings (NED and Exec membership); FT Progress Reports received fortnightly by the FT Programme Board and monthly by the Trust Board; monthly NTDA / UHL Integrated Delivery meetings	**4**
Foundation Trust Status	Integrated Business Plan (IBP) and Long Term Financial Model	UHL is in stage 1 (diagnosis and due diligence) of the approvals model set out in the NTDA Accountability Framework.	Draft Strategic Planning Process presented at the September Executive Strategy Board meeting; planning	Milestone plan and associated products delivered on time to	FT Progress Reports received fortnightly by the FT Programme Board and monthly by the Trust	**4**

PRIORITY	WHICH MEANS	ACTION PLANNED	PROGRESS Q2	KPIs	TRUST BOARD ASSURANCE AND SCRUTINY	ACTION RAG
	(LTFM)	The next iteration of the IBP/LTFM is under development for completion of a first draft to be approved by the April 2014 Trust Board	process for 2014/15 presented at the September Finance and Performance Committee meeting; Trust Board Development session on strategy development held on 16th September 2013	quality standards	Board; monthly NTDA / UHL Integrated Delivery meetings	
Foundation Trust Status	Integrated Development Plan (IDP)	Develop an implement an Integrated Development Plan incorporating required developments in Quality Governance, Board Governance and Development and external assurance processes	Integrated Development Plan populated regularly reviewed by the FT Programme Board to ensure all outstanding actions resolved	Integrated Development Plan actions completed on time to quality standards	FT Progress Reports received fortnightly by the FT Programme Board and monthly by the Trust Board; monthly NTDA / UHL Integrated Delivery meetings	**4**
Foundation Trust Status	Service Line Management	Develop a Service Line Management (SLM) programme incorporating the key elements of business strategy, performance management, information and organisational structure	First SLM Programme Team meeting held. Actions assigned and Programme Plan developed	SLM KPI's to be developed during next stage of SLM implementation	Monthly SLM updates presented to the Executive Strategy Board	**4**
Foundation Trust Status	Blueprint	Further develop the Trust's Strategic Direction so that there is clarity about site configuration and annual priorities for the organisation in pursuit of that Direction	Trust Board Development session on strategy development held on 16th September 2013. Further session planned for November to be led by the new Director of Strategy		Fortnightly FT Programme Board meetings (NED and Exec membership); FT Progress Reports received fortnightly by the FT Programme Board and monthly by the Trust Board; Monthly NTDA / UHL Integrated Delivery meetings	**3**

CC

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST

Trust Board Bulletin – 31 October 2013

The following reports are attached to this Bulletin as items for noting, and are circulated to UHL Trust Board members and recipients of public Trust Board papers accordingly:-

- **Updated Declarations of Interest** – Lead contact point Mr S Ward, Director of Corporate and Legal Affairs (0116 258 8721) – **paper 1**.

- **2014 TB meeting dates** – Lead contact point Mr S Ward, Director of Corporate and Legal Affairs (0116 258 8721) – **paper 2.**

- **Keogh briefing note** – Lead contact point Ms R Overfield, Chief Nurse (0116 258 6111) – **paper 3.**

It is intended that this paper will not be discussed at the formal Trust Board meeting on 31 October 2013, unless members wish to raise specific points on the report.

This approach was agreed by the Trust Board on 10 June 2004 (point 7 of paper Q). Any queries should be directed to the specified lead contact point in the first instance. In the event of any further outstanding issues, these may be raised at the Trust Board meeting with the prior agreement of the Chairman.

NAME	POSITION	INTEREST(S) DECLARED
Mr I Sadd	Non Executive Director	Nil return.

Trust Board Bulletin 31 October 2013 – Paper 2

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST

TRUST BOARD MEETING DATES 2014

As a general rule, the formal Trust Board meetings will be held from 10am on the LAST Thursday of every month, with the public meeting commencing at approximately 1pm.

THURSDAY 30 JANUARY 2014 – venue to be confirmed

THURSDAY 27 FEBRUARY 2014 – venue to be confirmed

THURSDAY 27 MARCH 2014 – venue to be confirmed

THURSDAY 24 APRIL 2014 – venue to be confirmed

THURSDAY 29 MAY 2014 – venue to be confirmed

THURSDAY 26 JUNE 2014 – venue to be confirmed

THURSDAY 31 JULY 2014 – venue to be confirmed

THURSDAY 28 AUGUST 2014 – venue to be confirmed

THURSDAY 25 SEPTEMBER 2014 – venue to be confirmed

THURSDAY 30 OCTOBER 2014 – venue to be confirmed

THURSDAY 27 NOVEMBER 2014– venue to be confirmed

MONDAY 22 DECEMBER 2014 – venue to be confirmed

Foreword

Delivering high quality care for patients and communities sits at the heart of what the NHS is here for.

Sometimes that ambition falls short of expectations, as it did earlier this year when the Keogh review identified shortcomings in the care provided in 14 hospitals. As a result 11 of those hospitals were placed in special measures.

When failings of this nature occur it's often a reflection that the broader systems for supporting high quality care – how services are commissioned, provided and regulated, have fallen short as well. Every part of the NHS, locally and nationally, therefore needs to respond by working closely together to take the necessary steps to ensure that care can improve.

This will require every organisation in the NHS to have real focus and clarity on what role it should play in delivering the improvements needed.

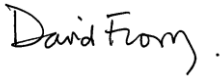
This short document sets out the roles, responsibilities and accountability of each of the organisations that are expected to play a part in enabling improvements in the hospitals involved in the Keogh Review, ensuring each part of the system understands the extent and limit of what it is meant to achieve.

More broadly, this document sets a blueprint for how the wider system should respond to future challenges where the quality of care comes under the spotlight.

Of course, even more than clarity of roles and responsibilities is the spirit of working together. No matter which part of the NHS you work in, our ambition is a shared one: to improve the care we provide for the patients and communities we serve. The values and behaviours we collectively demonstrate in forging the improvements set out in the Keogh review is what will determine whether we are ultimately successful in realising that ambition.

Yours sincerely




David Behan
Chief Executive
CQC

Ian Cumming
Chief Executive
NHS HEE

David Bennett
Chief Executive
Monitor

David Flory
Chief Executive
NHS TDA

Sir David Nicholson
Chief Executive
NHS England

Keogh review: roles, responsibilities and accountability

1. Introduction

1.1 The Keogh review highlighted concerns at 14 NHS hospitals. The review required that urgent action be taken to improve the quality and safety of some of the services they provide.

1.2 The review, which took place shortly after the recent reorganisation of the NHS and ahead of the Chief Inspector of Hospitals taking up post, set out the improvements needed in action plans for each individual provider; these were all agreed as part of the risk summits for the 14 hospital trusts.

1.3 The focus has now shifted to ensuring that those action plans are delivered and that the services provided to patients and communities improve.

1.4 Delivering those changes won't always be easy and requires all parts of the system to deliver the appropriate and necessary support to providers to improve the care they give patients.

1.5 This document is designed to support leaders from each part of the system – locally and nationally – to understand their roles, responsibilities and accountability in delivering the changes set out in the action plans for each provider. This is important not just to ensure that everyone plays their part in securing the improvements in services that patients demand, but also to ensure that efforts aren't duplicated or complicated and that accountability is clear.

1.6 To that end, it is also intended that this work on roles and responsibilities will inform the wider approach to handling quality concerns in the future with this document having been prepared and discussed as a shared statement supported by NHS England, the NHS Trust Development Authority, Monitor, the Care Quality Commission and Health Education England.

2. Key principles

2.1 Given the variety of bodies in the new NHS architecture there are some principles which underpin the implementation of work on quality across the system including:

- **clarity**: clarity about quality for all those responsible for the provision of patient care and treatment;

- **alignment**: if we are to be effective in maintaining and improving the quality of care and treatment it is vital that all the NHS bodies involved are aligned in their approach;

- **co-ordination**: there needs to be a co-ordinated approach to setting standards, providing support, reviewing progress to improve quality and follow up actions;

- **accountability:** roles and responsibilities for monitoring and holding to account for actions to improve quality need to be clear to ensure effective delivery of improvements and reduce wasted effort; and,

- **a shared view of success**: a single definition of success will enable the alignment of effort and a shared view of progress against the key quality standards.

3. Roles and responsibilities in the new NHS architecture

3.1 The roles and responsibilities introduced by the Health and Social Care Act 2012 are intended to improve quality and efficiency by reforming the organisations that commission, regulate and support health and care services.

3.2 From the point of view of **patients and the public**, people can continue to expect rapid access to high quality care and treatment through their local NHS services. They can expect greater involvement in their own health and care, services that are increasingly personalised around their own needs and greater transparency of information about the outcomes of their care and treatment.

3.3 **Clinical Commissioning Groups** have the responsibility for commissioning the majority of local health services for their populations and have a duty to secure continuous improvement in the quality of services provided to individuals.

3.4 **NHS England** has responsibility for allocating funding to clinical commissioning groups and supporting them to commission high quality services, as well as directly commissioning primary care and certain specialised services. It has a duty to secure continuous improvement in the quality of services provided to individuals.

3.5 **Monitor** is the sector regulator for health services in England. It protects and promotes the interests of patients by ensuring the whole health sector works for their benefit. It exercises a range of powers granted by Parliament, including making sure foundation hospitals, ambulance trusts and mental health and community care organisations are run well, so they can continue delivering good quality services for patients in the future.

3.6 **The Care Quality Commission (CQC)** is the independent regulator of health and social care in England. The CQC monitors, inspects and regulates services to make sure they meet fundamental standards of quality and safety. Changes to the way the CQC regulates quality have recently been consulted on as set out in *A new start: Consultation on changes to the way CQC regulates, inspects and monitors care* (June 2013).

3.7 The **NHS Trust Development Authority** has been established to oversee the performance of NHS trusts and support them to provide sustainable, high quality services as they work to achieve foundation trust status and hold them to account on their progress.

3.8 **Health Education England** works to improve the quality of health and healthcare for the people and patients of England, through educating, training and developing health and healthcare staff. HEE is employer-led and at a national level, and locally through its **local education and training boards (LETBs)**, is working with those who deliver health and healthcare services, to develop a workforce with the right skills and values, in the right place at the right time, to better meet the needs and wants of patients – now and in the future.

3.9 In taking forward the responsibilities for quality and safety in the new NHS landscape, it will be important to recognise that:

- Trust Boards are responsible for quality in their organisation, including making data transparently available on their results;
- commissioners take a lead role in driving improvement in the quality of care and treatment through the contracts they hold with providers;
- the CQC assesses against agreed standards and requires enforcement action where fundamental standards are at risk;
- Monitor and the NHS Trust Development Authority take enforcement action with the providers subject to their individual regulatory frameworks;
- Quality Surveillance Groups are a place where all the regulatory and commissioning bodies come together locally, where shared concerns can be highlighted and action agreed.

3.10 An overview of the roles and responsibilities in the NHS architecture is shown in Appendix 1. A case study illustration of how this would be applied in improving chemotherapy services for cancer patients is shown in Appendix 2.

3.11 Further details about the roles and responsibilities for quality in the new NHS architecture are set out by the National Quality Board in its document, Quality in the new health system (January 2013).

4. Responsibilities and accountability for implementing actions from the Keogh review

4.1 The roles and responsibilities in relation to the Keogh review are distinct for each element of the process:

- the Keogh review process;

- implementation of the Keogh review action plans;
- supporting and developing Trusts and their senior teams;
- re-inspections by the CQC through the Chief Inspector of Hospitals;
- assuring quality in the new NHS architecture.

The Keogh review process

4.2 Professor Sir Bruce Keogh as NHS Medical Director carried out the review process with support from NHS England through the relevant Area Teams.

4.3 Each individual Trust was required to submit a detailed action plan with milestones to implement the recommendations of the Keogh review. The review process concluded with agreed action plans, signed off by the Review Panel Chair, and a final Risk Summit.

4.4 The review process was, therefore, clearly the responsibility of the NHS Medical Director and concluded with publication of his report on 16 July 2013.

Implementation of the Keogh review action plans

4.5 In taking forward implementation of the Keogh review action plans, it is important to recognise that:

- the agreed action plans identify the owner of each specific action. The majority of actions are owned by the Trust. A number of actions are shared with the Clinical Commissioning Groups and the Area Teams of NHS England;
- some actions require support from other bodies including NHS Improving Quality, NHS Leadership Academy, Monitor, the NHS Trust Development Authority and Health Education England;
- Monitor and the NHS Trust Development Authority hold the trusts to account for delivery of their action plans;
- Health Education England is accountable for commissioning clinical placements in hospital trusts through a contract with the hospital trust. Health Education England will monitor the quality of education and training.

4.6 The responsibilities and accountability for implementing and overseeing the actions arising from the Keogh review are set out in Appendix 1.

4.7 Progress reports will be standardised and shared with commissioners to enable them to assure themselves that actions are being completed, support system-

wide solutions where these are needed and hold Trusts to account for the quality standards achieved for patients through the delivery of the contract;

4.8 Progress reports will also be shared with all other key partners to ensure the broader system is both taking the necessary actions to support the Trust to deliver the improvements in care required through the action plans but also to ensure that, where appropriate, additional support can be provided where required.

5. Supporting and developing trusts and their senior teams

5.1 The provision of high quality services is dependent on the capability and capacity of the organisations providing those services and the strength of their quality governance systems and processes.

5.2 To be successful in improving quality in the 14 hospital Trusts, it will be important that any training and development needs are met, tailored to the individual needs and circumstances of the Trusts. This will need to include consideration of:

- strengthening Board capability, both in quality oversight and patient voice;
- the role of national development bodies such as NHS Improving Quality and the NHS Leadership Academy;
- links for the 14 Trusts with their local Academic Health Science Networks as recommended by Bruce Keogh.

The development work by the 5 NHS Trusts and the 9 NHS Foundation Trusts will be overseen by the TDA and Monitor respectively.

5.3 NHS England is the lead body in relation to the commissioning and oversight of national support resources including NHS Improving Quality, the NHS Leadership Academy and the arrangements for Academic Health Science Networks.

5.4 NHS England will work nationally with the NHS Trust Development Authority and Monitor in clarifying the role of national improvement bodies to support training and development for the 14 hospital Trusts, with a particular initial focus on the role of NHS Improving Quality in training for chairs and non executive directors.

5.5 This will enable these improvement resources to be offered in a coherent and responsive way to meet the specific development and support needs identified by the NHS Trusts and NHS Foundation Trusts in their area.

Re-inspections by the CQC through the Chief Inspector of Hospitals

5.6 The CQC, through the Chief Inspector of Hospitals, is accountable for the re-inspection of the 14 hospital trusts.

Assuring quality in the new NHS architecture

5.7 The overall approach to handling quality issues in the new NHS architecture includes the established systems for standard setting, inspection, contract monitoring, quality surveillance and risk summits.

5.8 As well as having a core responsibility for securing high quality services on behalf of their patients, commissioners are also in a unique position to look across each local health system and develop solutions to which each of the local participants can contribute. Commissioners carry out these roles through their planning and contract management processes and through their role in chairing Quality Surveillance Groups.

5.9 Quality Surveillance Groups are a vital part of the quality architecture and will include consideration of progress on the Keogh reviews alongside other quality issues in line with the agreed arrangements for quality surveillance.

5.10 NHS England has a key role in convening and chairing effective Quality Surveillance Groups. The Chair's primary objective is to foster a sense of collaboration and inclusion amongst members, ensuring that strong working relationships are built across the local area or region.

5.11 The role of Quality Surveillance Groups is principally about alignment, not accountability. The Quality Surveillance Groups enable all parties in the system to meet, share intelligence on current quality concerns, receive updates from participating organisations and provide co-ordinated feedback. Quality Surveillance Groups are not an accountable body in themselves for implementation and delivery. The relevant accountable body will oversee actions agreed at Quality Surveillance Groups. Other members are not directly accountable to the Chair and the Chair cannot direct members in how they discharge their statutory responsibilities, though members will hold each other to account.

5.12 Risk summits can be called in line with the agreed trigger criteria and process. However, it is not normally the case that risk summits are planned ahead as a method of reviewing progress over a period of time. In the same vein, rapid responsive reviews have defined criteria and processes for their initiation and would not normally be planned as a method of reviewing progress with implementation of the Keogh reviews.

5.13 Further risk summits and rapid responsive reviews will, therefore, be called where necessary if the agreed criteria are triggered. Escalation actions such as risk summits or rapid responsive reviews can be agreed at Quality Surveillance Groups, if considered necessary by the membership of the group.

6. Conclusion

6.1 In summary, as highlighted by the National Quality Board in its document, Quality in the new health system (January 2013):

- individual health and care professionals, their ethos, behaviours and actions, are the first line of defence in maintaining quality;
- the leadership within provider organisations is ultimately responsible for the quality of care being provided by that organisation;
- commissioners are responsible for commissioning services that meet the needs of their local populations and for driving improvements in quality. They must assure themselves of the quality of care that they have commissioned;
- regulators should perform their statutory functions with the best interests of patients at heart;
- commissioners, regulators and other national bodies should share information and intelligence on the quality of services in an open and transparent way, and take coordinated action where appropriate in the event of an actual or potential quality failure.

6.2 The roles and responsibilities for taking forward the Keogh review are distinct for each stage in the process:

- the review process, now completed, was the responsibility of the NHS Medical Director;
- the responsibility for implementation is with each relevant body:
    - each individual hospital Trust Board is accountable for the actions for which they are the identified owner;
    - Monitor and the NHS Trust Development Authority will have oversight of the implementation of the Keogh review action plans within NHS Foundation Trusts and NHS Trusts respectively;
    - commissioners are accountable for the quality of services under their contracts with providers, driving improvements in quality and for satisfying themselves that appropriate action is being taken to address the quality concerns raised by the Keogh review;
    - Health Education England is accountable for the quality of education under its contracts with providers and for satisfying themselves that appropriate actions are being taken to address the quality concerns in education and training;

- the responsibility for the re-inspection process, to be carried out in the next 12 months, is with the CQC through the Chief Inspector of Hospitals to judge if improvements to patient care has been made and maintained.

6.3 The lessons learned about the approach to the implementation of the Keogh review will be used to inform the future approach to assuring quality in the new NHS architecture.

6.4 The future approach will clearly be influenced by the changes in the way the CQC monitors, inspects and regulates services to meet fundamental standards of quality and safety in the light of the current consultation.

7. Next steps

7.1 The roles and responsibilities outlined above have been considered and agreed by:

- NHS England;
- NHS Trust Development Authority;
- Monitor;
- Care Quality Commission;
- Health Education England.

7.2 Each of the above bodies will now work together to:

- build a clear understanding of the agreed roles and responsibilities for the Keogh review throughout the local organisations within their part of the NHS architecture;
- develop the understanding of roles and responsibilities set out in this document to inform the approach to assuring quality in the new NHS architecture.

Appendix 1

Organisation	Responsibility	Accountability	
Provider Board	To deliver the individual actions identified to the Trust through an action plan	To the NHS Trust Development Authority (NHS Trusts); to Monitor (NHS FTs)	Quality Surveillance Groups, chaired by NHS England, bring the system together to ensure alignment and to ensure that all parties are playing their part
Clinical Commissioning Groups and Area Teams	As director commissioners, to monitor progress against the action plan through the contract, and, where actions are shared, to ensure the contract reflects any necessary changes	NHS England Board	
NHS England	To hold local commissioners to account for their part in implementation and ensure access to appropriate support from national support bodies for the 11 providers	NHS England Board	
Monitor & NHS TDA	TDA and Monitor lead on special measures processes for NHS Trusts and FTs respectively, using aligned approaches to hold organisations to account	TDA Board and Monitor Board respectively	
CQC	Through the Chief Inspector of Hospitals, re-inspect all 14 providers subject to a review within 12 months to judge if improvements to patient care have been made and maintained	CQC Board	

Appendix 2

Case study illustration: chemotherapy services