University Hospitals of Leicester NHS
NHS Trust

Agenda Item: Trust Board Paper J

TRUST BOARD – 22nd DECEMBER 2014

QUALITY AND PERFORMANCE REPORT – NOVEMBER 2014

DIRECTOR:	Rachel Overfield, Chief Nurse Kevin Harris, Medical Director Richard Mitchell, Chief Operating Officer Kate Bradley, Director of Human Resources
AUTHOR:	
DATE:	22nd December 2014
PURPOSE:	The following report provides an overview of the November 2014 Quality & Performance report highlighting NTDA/UHL key metrics and escalation reports where required.
PREVIOUSLY CONSIDERED BY:	**In view of the timings of the meetings this month the Quality & Performance Report has been submitted directly to the Trust Board.**
Objective(s) to which issue relates *	☑ 1. Safe, high quality, patient-centred healthcare ☑ 2. An effective, joined up emergency care system ☑ 3. Responsive services which people choose to use (secondary, specialised and tertiary care) ☑ 4. Integrated care in partnership with others (secondary, specialised and tertiary care) ☑ 5. Enhanced reputation in research, innovation and clinical education ☑ 6. Delivering services through a caring, professional, passionate and valued workforce ☑ 7. A clinically and financially sustainable NHS Foundation Trust ☐ 8. Enabled by excellent IM&T
Please explain any Patient and Public Involvement actions taken or to be taken in relation to this matter:	
Please explain the results of any Equality Impact assessment undertaken in relation to this matter:	
Organisational Risk Register/ Board Assurance Framework *	☑ **Organisational Risk Register** ☑ **Board Assurance Framework** ☐ **Not Featured**
ACTION REQUIRED *	For decision ☐ For assurance ☑ For information ☐

♦ We treat people how we would like to be treated ♦ We do what we say we are going to do
♦ We focus on what matters most ♦ We are one team and we are best when we work together
♦ We are passionate and creative in our work

* tick applicable box

Caring at its best

University Hospitals of Leicester NHS
NHS Trust

Quality and Performance Report

November 2014

One team shared values

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UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST

REPORT TO: **TRUST BOARD**

DATE: **22nd DECEMBER 2014**

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

SUBJECT: **NOVEMBER 2014 QUALITY & PERFORMANCE SUMMARY REPORT**

1.0 Introduction

The following report provides an overview of the November 2014 Quality & Performance report highlighting NTDA/UHL key metrics and escalation reports where required.

Performance for RTT indicators are not due for submission until next week and are subject to validation. Any minor amendments will be reflected in next month's Q&P.

Estates and Finance KPI's for November were not available at the time of producing the Quality & Performance report.

2.0 Performance Summary

Domain	Page Number	Number of Indicators	Indicators with target to be confirmed	Number of Red Indicators this month
Safe	4	19	2	2
Caring	5	15	1	2
Well Led	6	14	7	2
Effective	7	17	0	1
Responsive	8	26	0	16
Research	9	13	0	2
Estates & Facilities	10	10	0	0
Total		114	10	25

Exception reports:

Safe – CDIFF local target and avoidable pressure ulcers grade 2

Effective - #NOF

Responsive – ED (separate report), RTT, diagnostic waits, cancer waits, cancelled operations, choose and book, delayed transfers and ambulance handovers.

Research - Proportion of NHS Trusts recruiting each year into non-commercial NIHR CRN Portfolio studies, Proportion of NHS Trusts recruiting each year into commercial NIHR CRN Portfolio studies

3.0 Research - NIHR Clinical Research Network: East Midlands

UHL is the Host Organisation for the CRN: East Midlands. As Host, UHL will receive £22.3 million from the National Institute of Health Research (NIHR) to fund NIHR CRN Portfolio research across the East Midlands. Funding for 2014/15 has been distributed through 16 NHS Trusts and 19 Clinical Commissioning Groups. The Trust has established a CRN: East Midlands Executive Group chaired by Dr Kevin Harris. The purpose of the group is to oversee and deliver good governance of the CRN: East Midlands as defined by the Host contract and CRN Performance and Operating Framework. The framework outlines the key performance metrics for the Network. These include seven High Level Objectives (HLOs) and 8 Host Performance Indicators.

The dashboard on page 9 shows current Network performance against these metrics. Only 1 Host Performance Indicator is included in the dashboard, the remaining 7 are not monitored in year but assessed at the end of the financial year. These will be included in future reports as data becomes available.

	KPI Ref	Indicators	Board Director	Lead Director/Officer	14/15 Target	Target Set by	Red RAG/ Exception Report Threshold (ER)	13/14 Outturn	Nov-13	Dec-13	Jan-14	Feb-14	Mar-14	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	YTD
Safe	S1a	Clostridium Difficile	RO	DJ	FYE = 81	NTDA	Red / ER for Non compliance with cumulative target	66	6	5	10	0	4	4	6	5	7	2	5	7	7	43
	S1b	Clostridium Difficile (Local Target)	RO	DJ	FYE = 50	UHL	Red >5 per month, ER when YTD red	66	6	5	10	0	4	4	6	5	7	2	5	7	7	43
	S2a	MRSA Bacteraemias (All)	RO	DJ	0	NTDA	Red = >0 ER = 2 consecutive mths >0	3	0	0	0	0	0	0	0	0	0	0	1	1	0	2
	S2b	MRSA Bacteraemias (Avoidable)	RO	DJ	0	UHL	Red = >0 ER = 2 consecutive mths >0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	S3	Never Events	RO	MD	0	NTDA	Red = >0 in mth ER = in mth >0	3	0	0	0	1	0	0	0	0	0	0	0	1	0	1
	S4	Serious Incidents	RO	MD	tbc	NTDA	tbc	60	8	4	3	4	5	4	6	3	7	2	3	4	2	31
	S5	Proportion of reported safety incidents that are harmful	RO	MD	tbc	NTDA	tbc	2.8%			2.3%			1.7%			2.2%					1.9%
	S6	Overdue CAS alerts	RO	MD	0	NTDA	Red = >0 in mth ER = in mth >0	2	0	0	0	0	0	2	2	2	3	0	0	0	0	9
	S7	RIDDOR - Serious Staff Injuries	RO	MD	FYE = <47	UHL	Red / ER = non compliance with cumulative target	47	4	4	7	2	5	3	5	1	2	2	1	2	2	18
	S8	Safety Thermometer % of harm free care (all)	RO	EM	tbc	NTDA	Red = <92% ER = in mth <92%	93.6%	93.9%	94.0%	93.8%	94.8%	93.6%	94.6%	94.7%	94.2%	94.9%	94.4%	93.9%	94.9%	93.3%	94.9%
	S9	% of all adults who have had VTE risk assessment on adm to hosp	KH	SH	95% or above	NTDA	Red = <95% ER = in mth <95%	95.3%	96.7%	96.1%	95.6%	95.0%	95.6%	95.7%	95.9%	95.9%	96.3%	95.5%	96.2%	95.4%	95.5%	95.8%
	S10	Medication errors causing serious harm	RO	MD	0	NTDA	Red = >0 in mth ER = in mth >0	New NTDA Indicator - Definition to be confirmed														
	S11	All falls reported per 1000 bed stays for patients >65years	RO	EM	<7.1	QC	Red >= YTD >8.4 ER = 2 consecutive reds	7.1	7.0	7.0	6.6	7.0	6.9	6.6	7.4	7.0	8.2	7.4	5.6	5.6	6.6	6.8
	S12	Avoidable Pressure Ulcers - Grade 4	RO	EM	0	QS	Red / ER = Non compliance with monthly target	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	S13	Avoidable Pressure Ulcers - Grade 3	RO	EM	<8 a month	QS	Red / ER = Non compliance with monthly target	71	4	5	7	3	6	5	5	5	5	6	6	4	6	42
	S14	Avoidable Pressure Ulcers - Grade 2	RO	EM	<10 a month	QS	Red / ER = Non compliance with monthly target	120	8	5	10	8	9	6	6	6	7	9	4	8	13	59
	S15	Compliance with the SEPSIS6 Care Bundle	RO	MD	All 6 >75% by Q4	QC	Red/ER = Non compliance with Quarterly target	27.0%			27.0%			47.0%			Audit underway					47.0%
	S16	Nutrition and Hydration Metrics - Fluid Balance and Nutritional Assessment	RO	MD	Q2 80%, Q3 85%, Q4 90%	QC	Red >2% below threshold ER = 2 mths red							≥71%	≥77%	≥75%	Action Planning	≥74%	≥85%	≥84%		≥84%
	S17	Maternal Deaths	KH	IS	0	UHL	Red / ER = Non compliance with monthly target	3	0	0	1	2	0	0	0	0	0	0	0	0	0	0

	KPI Ref	Indicators	Board Director	Lead Director/Officer	14/15 Target	Target Set by	Red RAG/ Exception Report Threshold (ER)	13/14 Outturn	Nov-13	Dec-13	Jan-14	Feb-14	Mar-14	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	YTD
Caring	C1a	Inpatient Friends and Family Test - Score	RO	CR	72 (Eng Avge - Mar 14)	NTDA	Red if <3SD. ER if <3SD or 3 mths deteriorating performance	68.8	70.3	68.7	71.8	69.0	69.9	69.6	71.0	74.5	73.8	73.8	76.1	71.1	70.3	72.4
	C1b	Inpatient Friends and Family Test - Score (Local Target)	RO	CR	75	UHL	Red/ ER =<=69.9 Green >74.9	68.8	70.3	68.7	71.8	69.0	69.9	69.6	71.0	74.5	73.8	73.8	76.1	71.1	70.3	72.4
	C2a	A&E Friends and Family Test - Score	RO	CR	54 (Eng Avge - Mar 14)	NTDA	Red if <3SD. ER if <3SD or 3 mths deteriorating performance	58.5	58.6	67.4	67.6	58.7	65.5	69.4	66.0	71.4	71.7	56.3	66.1	71.1	72.3	67.7
	C2b	A&E Friends and Family Test - Score (Local Target)	RO	CR	75	UHL	Red/ ER =<=64.9 Green >74.9	58.5	58.6	67.4	67.6	58.7	65.5	69.4	66.0	71.4	71.7	56.3	66.1	71.1	72.3	67.7
	C3	Outpatients Friends and Family Test - Score	RO	CR	75	UHL	Red / ER =<=64.9	New Indicator													58.7	58.7
	C4	Daycase Friends and Family Test - Score	RO	CR	75	UHL	Red / ER =<=69.9	New Indicator						79.0	80.2	79.7	77.5	74.3	81.7	80.1		78.9
	C5	Maternity Friends and Family Test - Score	RO	CR	75	UHL	Red/ ER =<=61.9	64.3	62.1	63.7	67.3	62.1	66.7	61.2	63.5	69.5	69.7	67.3	63.0	64.1	67.7	65.8
	C6	Complaints Rate per 100 bed days	RO	MD	tbc	NTDA	tbc		0.3	0.3	0.3	0.5	0.4	0.4	0.3	0.3	0.4	0.4	0.4	0.4	0.4	0.4
	C7	Complaints Re-Opened Rate	RO	MD	<9%	UHL	Red = >10% ER = 3 mths Red or any month >15%	New Indicator for 14/15						8%	5%	8%	11%	10%	9%	11%	11%	9%
	C8	Single Sex Accommodation Breaches	RO	CR	0	NTDA	Red = >0 ER = in mth >0	2	2	0	0	0	0	4	2	0	0	0	0	0	0	6
	C9	Improvements in the FFT scores for Older People (65+ year)	RO	CR	75	QC	Red / ER = End of Yr Targets non recoverable.	New Indicators for 14/15						73.7	73.2	75.7	76.1	78.5	83.0	76.4	72.9	76.0
	C10	Responsiveness and Involvement Care (Average score)	RO	CR	0.8 improve-ment	QC	tbc							87.6	87.5	87.5	87.8	88.1	88.4	87.4	87.9	87.8
	C10a	Q15. When you used the call button, was the amount of time it took for staff to respond generally:	RO	CR	FYE 89.7	QC	Red = <87.9 ER = Red or 3 mths deterioration							88.9	89.3	88.8	89.0	88.9	90.0	88.4	88.6	89.0
	C10b	Q16. If you needed help from staff getting to the bathroom or toilet or using a bedpan, did you get help in an acceptable amount of time?	RO	CR	FYE 92.9	QC	Red = <91.1 ER = Red or 3 mths deterioration							92.1	91.9	91.2	91.7	91.9	92.4	92.2	92.4	92.0
	C10c	Q11. Were you involved as much as you wanted in decisions about your care and treatment?	RO	CR	FYE 85.5	QC	Red = <83.6 ER = Red or 3 mths deterioration							84.6	84.3	84.9	84.9	85.6	85.2	84.6	85.1	84.9

	KPI Ref	Indicators	Board Director	Lead Director/Officer	14/15 Target	Target Set by	Red RAG/ Exception Report Threshold (ER)	13/14 Outturn	Nov-13	Dec-13	Jan-14	Feb-14	Mar-14	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	YTD
Well Led	W1	Inpatient Friends and Family Test - Coverage	RO	CR	30% - Q4. 40% - Mar 15	NTDA / CQUIN	Red = Non compliance with monthly target ER = 2 consecutive mths non compliance	24.3%	25.4%	23.3%	24.5%	28.2%	28.8%	36.8%	38.1%	32.6%	30.8%	28.9%	33.4%	36.3%	36.0%	34.0%
	W2	A&E Friends and Family Test - Coverage	RO	CR	15% Q1-Q3 20% for Q4	NTDA	Red = Non compliance with monthly target ER = 2 consecutive mths non compliance	14.9%	18.4%	16.4%	15.6%	18.4%	16.1%	15.2%	17.8%	14.9%	10.2%	16.1%	19.1%	15.9%	14.0%	15.4%
	W3	Outpatients Friends and Family Test - Valid responses	RO	CR	tbc	UHL	tbc	New Indicator available from October 2014					271	175	286	1879	1535	785	927	1255	1506	8348
	W4	Maternity Friends and Family Test - Coverage	RO	CR	tbc	UHL	tbc	25.2%	30.3%	24.8%	20.9%	23.7%	23.9%	27.2%	36.4%	25.2%	29.2%	29.9%	18.7%	15.8%	21.7%	25.5%
	W5	Friends & Family staff survey: % of staff who would recommend the trust as place to work	KB	ES	tbc	NTDA	tbc	New NTDA Indicator - Definition to be confirmed						53.6%			53.7%				53.7%
	W6	Friends & Family staff survey: % of staff who would recommend the trust as place to receive treatment	KB	ES	tbc	NTDA	tbc	New NTDA Indicator - Definition to be confirmed						68.3%			67.2%				67.2%
	W7	Data quality of trust returns to HSCIC	KS	JR	tbc	NTDA	tbc	New NTDA Indicator - Definition to be confirmed														
	W8	Turnover Rate	KB	ES	<10.5%	UHL	Red = 11% or above ER = Red for 3 Consecutive Mths	10.0%	9.7%	10.2%	10.6%	10.4%	10.0%	9.9%	10.0%	10.2%	10.0%	10.5%	10.3%	10.8%	10.7%	10.7%
	W9	Sickness absence	KB	ES	> 3.5%	UHL	Red = >3.5% ER = 3 consecutive mths >3.5%	3.4%	3.5%	3.8%	3.8%	3.7%	3.5%	3.4%	3.3%	3.3%	3.4%	3.5%	3.8%	4.3%		3.6%
	W10	Total trust vacancy rate	KB	ES	tbc	NTDA	tbc	New NTDA Indicator - Definition to be confirmed														
	W11	Temporary costs and overtime as a % of total paybill	KB	ES	tbc	NTDA	tbc	New Indicator for 14/15						9.4%	9.4%	8.1%	8.5%	8.9%	8.5%	9.5%	9.0%	8.9%
	W12	% of Staff with Annual Appraisal	KB	ES	95%	UHL	Red = <90% ER = 3 consecutive mths <90%	91.3%	91.8%	92.4%	91.9%	92.3%	91.3%	91.8%	91.0%	90.6%	89.6%	88.6%	89.7%	91.8%	92.3%	92.3%
	W13	Statutory and Mandatory Training	KB	ES	Jun 80%, Sep 85%, Dec 90%, Mar 95%	UHL	Red / ER for Non compliance with Quarterly incremental target	76%	60%	65%	69%	72%	76%	78%	79%	79%	80%	83%	85%	86%	87%	87%
	W14	% Corporate Induction attendance	KB	ES	95.0%	UHL	Red = <90% ER = 3 consecutive mths <90%	94.5%	87%	89%	93%	89%	95%	96%	94%	92%	96%	98%	98%	98%	98%	98%

Effective

KPI Ref	Indicators	Board Director	Lead Director/Officer	14/15 Target	Target Set by	Red RAG/ Exception Report Threshold (ER)	13/14 Outturn	Nov-13	Dec-13	Jan-14	Feb-14	Mar-14	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	YTD
E1	Mortality - Published SHMI	KH	PR	Within Expected	NTDA	Higher than Expected				107 (Jul12-Jun13)			106 (Oct12-Sept13)			106 (Jan13-Dec13)					106 (Jan13-Dec13)
E2	Mortality - Rolling 12 mths SHMI (as reported in HED)	KH	PR	100 or below	QC	Red = >expected ER = >Expected or 3 consecutive mths increasing SHMI >100	105	107	108	107	106	105	103	103	103	Awaiting HED Update					103
E3	Mortality HSMR (DFI Quarterly)	KH	PR	Within Expected	NTDA	Red = >expected ER = >Expected or 3 consecutive increasing mths >100	88			83			87			Awaiting DFI Update					83
E4	Mortality - Rolling 12 mths HSMR (Rebased Monthly as reported in HED)	KH	PR	100 or below	QC	Red = >expected ER = >Expected or 3 consecutive increasing mths >100	99	102	101	100	100	99	97	97	97	95	Awaiting HED Update				95
E5	Mortality - Monthly HSMR (Rebased Monthly as reported in HED)	KH	PR	100 or below	QC	Red = >expected ER = >Expected or 3 consecutive increasing mths >100	91	101	94	89	103	91	83	103	101	83	Awaiting HED Update				93
E6	Mortality - Rolling 12 mths HSMR Emergency Weekday Admissions - (HED) OVERALL Rebased Monthly	KH	PR	Within Expected	NTDA	Red = >expected ER = >Expected or 3 consecutive increasing mths >100	100	102	102	101	101	100	99	98	99	96	Awaiting HED Update				96
E7	Mortality - Monthly HSMR Emergency Weekday Admissions - (HED) OVERALL Rebased Monthly	KH	PR	Within Expected	NTDA	Red = >expected ER = >Expected or 3 consecutive increasing mths >100	100	107	95	93	102	94	86	95	105	80	Awaiting HED Update				91
E8	Mortality - rolling 12 mths HSMR Emergency Weekend Admissions - (HED) OVERALL Rebased Monthly	KH	PR	Within Expected	NTDA	Red = >expected ER = >Expected or 3 consecutive increasing mths >100	99	105	103	101	102	99	96	97	96	95	Awaiting HED Update				95
E9	Mortality - Monthly HSMR Emergency Weekend Admissions - (HED) OVERALL Rebased Monthly	KH	PR	Within Expected	NTDA	Red = >expected ER = >Expected or 3 consecutive increasing mths >100	99	93	93	84	106	82	71	128	87	93	Awaiting HED Update				95
E10	Deaths in low risk conditions	KH	PR	Within Expected	NTDA	Red = >expected ER = >Expected or 3 consecutive increasing mths >100	94	52	129	164	35	63	48	60	78	59	47				59
E11	Emergency 30 Day Readmissions (No Exclusions)	KH	PR	Within Expected	NTDA	Higher than Expected	7.9%	7.8%	8.0%	8.7%	9.0%	8.8%	8.8%	8.7%	8.6%	8.3%	8.9%	8.4%	8.6%		8.6%
E12	No. of # Neck of femurs operated on 0-35 hrs - Based on Admissions	KH	RP	72% or above	QS	Red = <72% ER = 2 consecutive mths <72%	65.2%	73.6%	72.2%	68.2%	73.7%	54.7%	56.9%	40.6%	60.3%	76.9%	59.0%	68.6%	69.6%	59.4%	61.8%
E13	Stroke - 90% of Stay on a Stroke Unit	RM	CF	80% or above	QS	Red = <80% ER = 2 consecutive mths <80%	83.2%	78.0%	81.8%	89.3%	83.7%	83.5%	92.9%	80.3%	87.1%	78.1%	84.5%	82.2%	69.4%		81.6%
E14	Stroke - TIA Clinic within 24 Hours (Suspected High Risk TIA)	RM	CF	60% or above	QS	Red = <60% ER = 2 consecutive mths <60%	64.2%	76.8%	65.7%	60.5%	40.7%	77.9%	79.7%	58.8%	71.3%	62.8%	65.5%	72.7%	67.8%	69.0%	68.4%
E15	Communication - ED, Discharge and Outpatient Letters - Compliance with standards	KH	SJ	90% or above	QS	Red = <80% ER = Qrtly ER if <90% and deterioration	New Indicator for 14/15										60% (InPt)	83% (ED)	Poilcy out for consultation		83% (ED)
E16	Published Consultant Level Outcomes	KH	SH	>0 outside expected	QC	Red = >0 Quarterly ER = >0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
E17	Non compliance with 14/15 published NICE guidance	KH	SH	0	QC	Red = in mth >0 ER = 2 consecutive mths Red	New Indicator for 14/15						0	0	0	0	0	0	0	0	0

Responsive

KPI Ref	Indicators	Board Director	Lead Director/Officer	14/15 Target	Target Set by	Red RAG/ Exception Report Threshold (ER)	13/14 Outturn	Nov-13	Dec-13	Jan-14	Feb-14	Mar-14	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	YTD
R1	ED 4 Hour Waits UHL + UCC	RM	CF	95% or above	NTDA	Red = <95% ER via ED TB report	88.4%	88.5%	90.1%	93.6%	83.5%	89.3%	86.9%	83.4%	91.3%	92.5%	91.0%	91.6%	90.2%	88.6%	89.3%
R2	12 hour trolley waits in A&E	RM	CF	0	NTDA	Red = >0 ER via ED TB report	5	1	0	0	0	0	0	1	1	0	0	0	1	0	3
R3	RTT Waiting Times - Admitted	RM	CC	90% or above	NTDA	Red /ER = <90%	76.7%	83.2%	82.0%	81.8%	79.1%	76.7%	78.9%	79.4%	79.0%	80.9%	82.2%	81.6%	84.4%	85.5% Early View	85.5% Early View
R4	RTT Waiting Times - Non Admitted	RM	CC	95% or above	NTDA	Red /ER = <95%	93.9%	91.9%	92.8%	93.4%	93.5%	93.9%	94.3%	94.4%	95.0%	94.9%	95.6%	94.6%	94.9%	95.2% Early View	95.2%
R5	RTT - Incomplete 92% in 18 Weeks	RM	CC	92% or above	NTDA	Red /ER = <92%	92.1%	92.4%	91.8%	92.0%	92.6%	92.1%	93.9%	93.6%	94.0%	93.2%	94.0%	94.3%	94.8%	95.0% Early View	95.0%
R6	RTT 52 Weeks+ Wait (Incompletes)	RM	CC	0	NTDA	Red /ER = >0	0	0	1	1	0	0	0	0	0	15	1	3	3	2	2
R7	6 Week - Diagnostic Test Waiting Times	RM	SK	1% or below	NTDA	Red /ER = >1%	1.9%	0.8%	1.4%	5.3%	1.9%	1.9%	0.8%	0.9%	0.8%	0.7%	1.0%	1.0%	0.7%	1.8%	1.8%
R8	Two week wait for an urgent GP referral for suspected cancer to date first seen for all suspected cancers	RM	MM	93% or above	NTDA	Red = <93% ER = Red for 2 consecutive mths	94.8%	95.7%	94.9%	95.3%	95.9%	95.3%	88.5%	94.7%	93.5%	92.2%	92.0%	90.6%	92.0%		91.9%
R9	Two Week Wait for Symptomatic Breast Patients (Cancer Not initially Suspected)	RM	MM	93% or above	NTDA	Red = <93% ER = Red for 2 consecutive mths	94.0%	91.3%	95.5%	96.8%	93.4%	94.3%	80.0%	95.0%	98.9%	94.9%	94.4%	95.2%	98.6%		94.9%
R10	31-Day (Diagnosis To Treatment) Wait For First Treatment: All Cancers	RM	MM	96% or above	NTDA	Red = <96% ER = Red for 2 consecutive mths	98.1%	96.2%	97.4%	97.2%	98.5%	98.2%	97.2%	92.9%	93.6%	94.4%	97.9%	91.9%	95.9%		94.8%
R11	31-Day Wait For Second Or Subsequent Treatment: Anti Cancer Drug Treatments	RM	MM	98% or above	NTDA	Red = <98% ER = Red for 2 consecutive mths	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	98.8%	100.0%	97.1%		99.4%
R12	31-Day Wait For Second Or Subsequent Treatment: Surgery	RM	MM	94% or above	NTDA	Red = <94% ER = Red for 2 consecutive mths	96.0%	97.1%	92.3%	94.8%	96.4%	98.6%	95.2%	97.0%	90.8%	90.1%	87.8%	94.0%	81.9%		90.6%
R13	31-Day Wait For Second Or Subsequent Treatment: Radiotherapy Treatments	RM	MM	94% or above	NTDA	Red = <94% ER = Red for 2 consecutive mths	98.2%	98.5%	98.1%	94.8%	96.3%	99.1%	97.3%	95.6%	93.9%	97.3%	99.0%	96.5%	96.0%		96.6%
R14	62-Day (Urgent GP Referral To Treatment) Wait For First Treatment: All Cancers	RM	MM	85% or above	NTDA	Red = <85% ER = Red in mth or YTD	86.7%	85.7%	89.4%	89.1%	89.1%	92.4%	92.7%	88.5%	73.1%	85.6%	78.8%	75.5%	80.4%		81.8%
R15	62-Day Wait For First Treatment From Consultant Screening Service Referral: All Cancers	RM	MM	90% or above	NTDA	Red = <90% ER = Red for 2 consecutive mths	95.6%	97.0%	96.6%	97.1%	95.1%	91.7%	91.1%	67.4%	73.9%	73.0%	100.0%	87.5%	75.0%		80.6%
R16	Urgent Operations Cancelled Twice	RM	PW	0	NTDA	Red = >0 ER = >0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
R17	Cancelled patients not offered a date within 28 days of the cancellations UHL	RM	PW	0	NTDA	Red = >2 ER = >0	85	4	8	9	2	8	10	3	1	1	1	2	2	1	21
R18	Cancelled patients not offered a date within 28 days of the cancellations ALLIANCE	RM	PW	0	NTDA	Red = >2 ER = >0	New Indicator for 14/15						0	0	0	0	6	0	0	1	7
R19	% Operations cancelled for non-clinical reasons on or after the day of admission UHL	RM	PW	0.8% or below	Contract	Red = >0.9% ER = >0.8%	1.6%	1.8%	1.7%	1.6%	2.1%	1.5%	1.1%	0.8%	1.1%	0.7%	0.6%	0.9%	0.8%	1.2%	0.9%
R20	% Operations cancelled for non-clinical reasons on or after the day of admission ALLIANCE	RM	PW	0.8% or below	Contract	Red = >0.9% ER = >0.8%	1.6%	1.8%	1.7%	1.6%	2.1%	1.5%	0.6%	0.6%	0.3%	2.7%	0.0%	0.9%	1.0%	0.0%	0.8%
R21	% Operations cancelled for non-clinical reasons on or after the day of admission UHL + ALLIANCE	RM	PW	0.8% or below	Contract	Red = >0.9% ER = >0.8%	New Indicator for 14/15						1.1%	0.8%	1.0%	0.9%	0.6%	0.8%	0.8%	1.1%	0.9%
R22	No of Operations cancelled for non-clinical reasons on or after the day of admission UHL + ALLIANCE	RM	PW	N/A	UHL	tbc	1739	172	141	152	178	139	106	77	98	94	55	90	94	108	722
R23	Delayed transfers of care	RM	PW	3.5% or below	NTDA	Red = >3.5% ER = Red for 3 consecutive mths	4.1%	4.4%	3.6%	4.6%	4.3%	3.8%	4.4%	4.2%	4.0%	3.9%	3.9%	4.5%	4.6%	5.2%	4.3%
R24	Choose and Book Slot Unavailability	RM	CC	4% or below	Contract	Red = >4% ER = Red for 3 consecutive mths	13%	17%	14%	10%	16%	19%	22%	25%	26%	25%	26%	25%	20%	17%	23%
R25	Ambulance Handover >60 Mins (based on weekly figures)	RM	CF	0	Contract	Red = >0 ER = Red for 3 consecutive mths	868	59	102	52	207	111	173	253	88	71	50	106	253	235	1,229
R26	Ambulance Handover >30 Mins and <60 mins (based on weekly figures)	RM	CF	0	Contract	Red = >0 ER = Red for 3 consecutive mths	7,075	689	722	573	818	601	720	951	671	591	805	736	1,147	1,072	6,693

Research

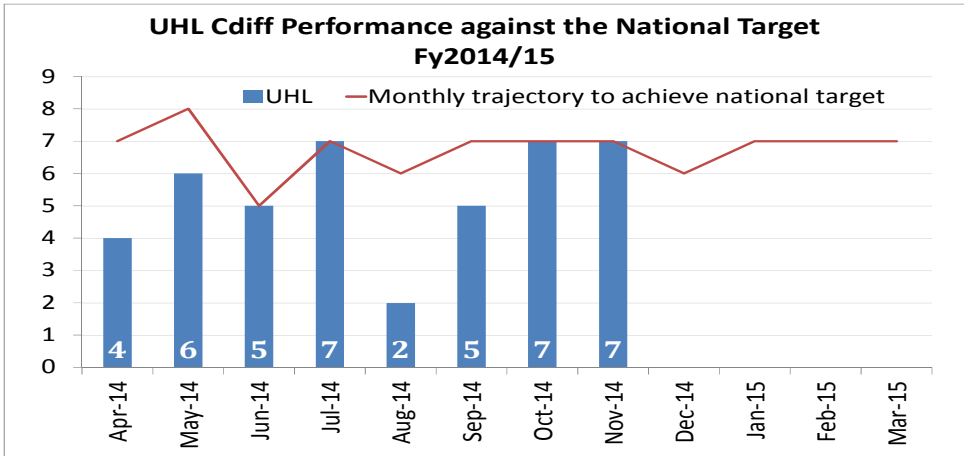
KPI Ref	Indicators	Board Director	Lead Director/Officer	14/15 Target	Target Set by	Red RAG/ Exception Report Threshold (ER)	Sep-14	Oct-10	Nov-10	YTD
RS1	Number of participants recruited in a reporting year into NIHR CRN Portfolio studies	KH	DR	England 650,000 East Midlands 50,000	NIHR CRN	Red / ER = <90%	92%	93%	94%	94%
RS2a	A: Proportion of commercial contract studies achieving their recruitment target during their planned recruitment period.	KH	DR	England 80% East Midlands 80%	NIHR CRN	Red / ER = <60%	67%	64%	68%	68%
RS2b	B: Proportion of non-commercial studies achieving their recruitment target during their planned recruitment period	KH	DR	England 80% East Midlands 80%	NIHR CRN	Red / ER = <60%	81.0%	81.0%	73%	73%
RS3a	A: Number of new commercial contract studies entering the NIHR CRN Portfolio	KH	DR	600	NIHR CRN	tbc				
RS3b	B: Number of new commercial contract studies entering the NIHR CRN Portfolio as a percentage of the total commercial MHRA CTA approvals for Phase II-IV studies	KH	DR	75%	NIHR CRN	Red <75%				
RS4	Proportion of eligible studies obtaining all NHS Permissions within 30 calendar days (from receipt of a valid complete application by NIHR CRN)	KH	DR	80%	NIHR CRN	Red <80%	90.0%	89.0%	84.0%	84.0%
RS5a	A: Proportion of commercial contract studies achieving first participant recruited within 70 calendar days of NHS services receiving a valid research application or First Network Site Initiation Visit	KH	DR	80%	NIHR CRN	Red <80%				
RS5b	B: Proportion of non-commercial studies achieving first participant recruited within 70 calendar days of NHS services receiving a valid research application	KH	DR	80%	NIHR CRN	Red <80%				
RS6a	A: Proportion of NHS Trusts recruiting each year into NIHR CRN Portfolio studies	KH	DR	England 99% East Midlands 99%	NIHR CRN	Red <99%	81.0%	81.0%	81.0%	81.0%
RS6b	B: Proportion of NHS Trusts recruiting each year into NIHR CRN Portfolio commercial contract studies	KH	DR	England 70% East Midlands 70%	NIHR CRN	Red <70%	56.0%	56.0%	56.0%	56.0%
RS6c	B: Proportion of General Medical Practices recruiting each year into NIHR CRN Portfolio studies	KH	DR	England 25% East Midlands 25%	NIHR CRN	Red <25%	45.0%	45.0%	51.0%	51.0%
RS7	Number of participants recruited into Dementias and Neurodegeneration (DeNDRoN) studies on the NIHR CRN Portfolio	KH	DR	England 13500 East Midlands 510	NIHR CRN	Red <510 Q4	325	438	448	448
RS8	Deliver robust financial management using appropriate tools - % of financial returns completed on time	KH	DR	England 100% East Midlands 100%	NIHR CRN	Red <100%	100% *Q2			100% *Q2

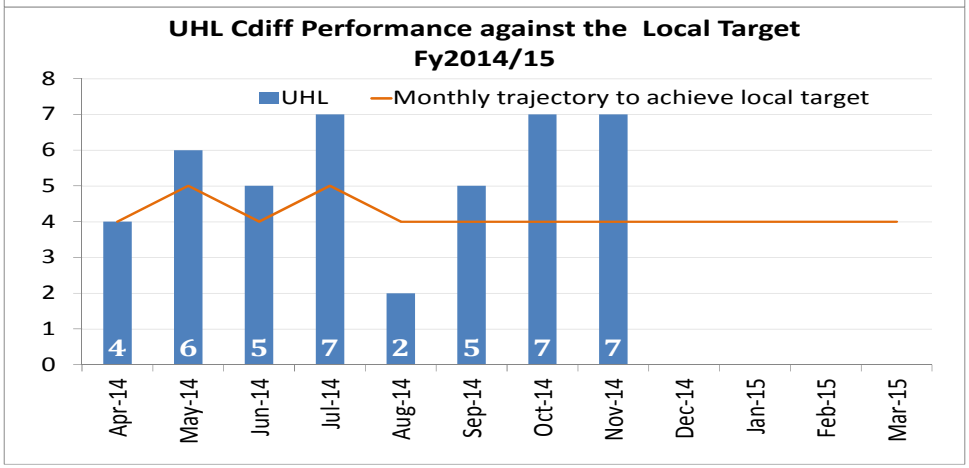
Estates and Facilities

KPI Ref	Indicators	Board Director	Lead Director/Officer	14/15 Target	Target Set by	Red RAG/ Exception Report Threshold (ER)	Sep-14	Oct-14	YTD
E&F1	Percentage of statutory inspection and testing completed in the Contract Month measured against the PPM schedule.	AC	GL	100%	Contract KPI	Red = ≤ 98%	100.0%	100.0%	100.0%
E&F2	Percentage of non-statutory PPM completed in the Contract Month measured against the PPM schedule	AC	GL	100%	Contract KPI	Red = ≤ 80%	91.5%	81.2%	81.2%
E&F3	Percentage of Estates Urgent requests achieving rectification time	AC	LT	95%	Contract KPI	Red = ≤ 75%	100.0%	100.0%	100.0%
E&F4	Percentage of scheduled Portering tasks completed in the Contract Month	AC	LT	99%	Contract KPI	Red = ≤ 98%	100.0%	100.0%	100.0%
E&F5	Number of Emergency Portering requests achieving response time	AC	LT	100%	Contract KPI	Red = >2	0	0	0
E&F6	Number of Urgent Portering requests achieving response time	AC	LT	95%	Contract KPI	Red = ≤ 95%	95.1%	96.2%	96.2%
E&F7	Percentage of Cleaning audits in clinical areas achieving NCS audit scores for cleaning above 90%	AC	LT	100%	Contract KPI	Red = ≤ 98%	100.0%	99.1%	99.1%
E&F8	Percentage of Cleaning Rapid Response requests achieving rectification time	AC	LT	92%	Contract KPI	Red = ≤ 80%	99.6%	89.9%	89.9%
E&F9	Percentage of meals delivered to wards in time for the designated meal service as per agreed schedules	AC	LT	97%	Contract KPI	Red = ≤ 95%	99.4%	99.5%	99.5%
E&F10	Overall percentage score for monthly patients satisfaction survey for catering service	AC	LT	85%	Contract KPI	Red = ≤ 75%	96.7%	97.3%	97.3%

S1b – CDIFF local target

What is causing underperformance?	What actions have been taken to improve performance?	Target (mthly / end of year)	Latest month performance	YTD performance	Forecast performance for next reporting period
The cases of CDT have been the subject of Root Cause Analysis and there are no discernible factors that link these cases. All occurred in different locations within the trust. In line with the 'updated guidance in the diagnosis and reporting of Clostridium difficile' the cases have been sent to Commissioning Group that has been established to review each case individually. The comments from this group will be received within seven working days. This process commenced in October and sample positive cases that are the subject of RCA will be sent monthly for review.	Action plans that have resulted from the RCA are to be presented to the CMG Infection Prevention Groups and will follow the RCA process flow chart as described in the Infection Prevention Toolkit	5	7	43	N/A





Expected date to meet standard / target	TBA
Revised date to meet standard	TBA
Lead Director / Lead Officer	Elizabeth Collins

S14 - Avoidable Pressure Ulcers – Grade 2

What is causing underperformance?	What actions have been taken to improve performance?	Target (mthly / end of year)	Latest month performance	YTD performance	Forecast performance for next reporting period
Grade 3 and Grade 4 pressure ulcers are within the agreed trajectory and are included in the exception report for information. There has been an increase in avoidable pressure Grade two pressure ulcers in Nov 14. (5 ESM, 3 RRC, 3 CHUGGS, 2 MSS) There are 4 Grade 2 pressure ulcers above trajectory, further analysis indicates that 3 are as a result of device damage ie oxygen tubing pressure to the ears and catheter tubing pressure to sacrum. There has been an increase in reporting of such pressure ulcers following an internal awareness campaign. All pressure ulcer incidents have been subject to internal validation. There is insufficient evidence in 6 cases to confirm whether the ulcer was unavoidable for this month due to insufficient evidence these have been reported as avoidable The common themes identified for November in the development of avoidable ulcers include:- • Gaps in documentation • Pressure damage as a result of medical devices x 3 • Limited or lack of analysis of patient factors, such as condition of the patient and external influences which affect the delivery of care. • Limited evidence that lessons from previous incidents has been Implemented	From November 2014, oversight and management of the tissue viability service transferred to the Head of Safeguarding. Keys messages from the November performance will be shared with Heads of Nursing. Further work to improve the quality of validation reports has commenced, and key learning is shared monthly across nursing forums. Work is ongoing to monitor performance, and if prevalence remains above trajectory a further plan of action will be developed	**G2 = ≤9 per mth** **G3 = ≤7 per mth** **G4 = 0 per mth**	**G2 = 13** **G3 = 6** **G4 = 0**	**G2 = 57** **G3 = 37** **G4 = 0**	**tbc**

Table one - Avoidable Grade 2 Pressure Ulcers April - November 2014

Trajectory for Grade 2 Avoidable Pressure Ulcers 2014/15													
Month	**Apr**	**May**	**Jun**	**Jul**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**	**YTD**
Trajectory	**9**	**9**	**9**	**9**	**9**	**9**	**9**	**9**	**9**	**9**	**9**	**9**	
Incidence	6	6	6	7	9	4	8	13					**59**

Table two - Avoidable Grade 3 Pressure Ulcers April - November 2014

Trajectory for Grade 3 Avoidable Pressure Ulcers 2014/15													
Month	**Apr**	**May**	**Jun**	**Jul**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**	**YTD**
Trajectory	**7**	**7**	**7**	**7**	**7**	**7**	**7**	**7**	**7**	**7**	**7**	**7**	
Incidence	5	5	5	5	6	6	4	6					**42**

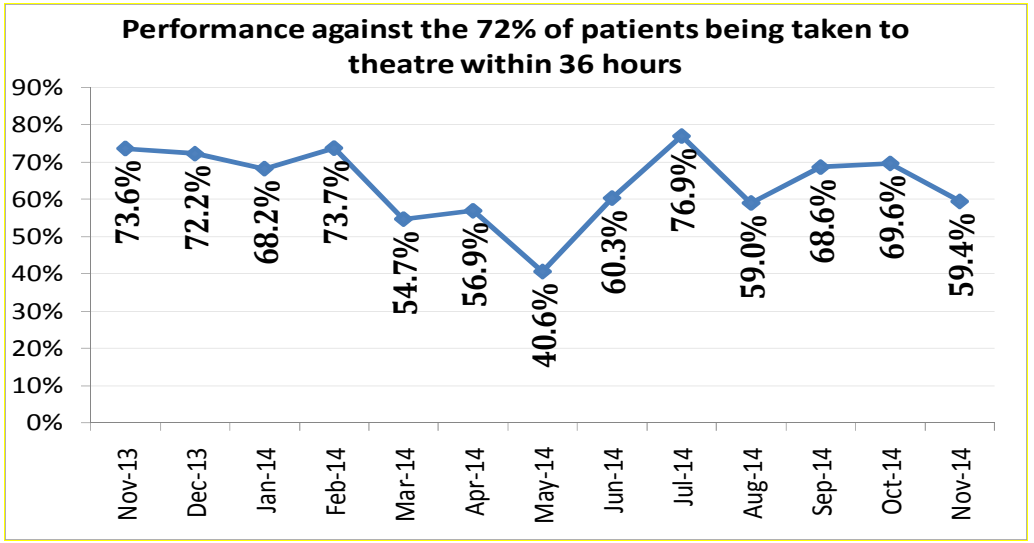
Table three - Avoidable Grade 4 Pressure Ulcers April - November 2014

Trajectory for Grade 4 Avoidable Pressure Ulcers 2014/15													
Month	**Apr**	**May**	**Jun**	**Jul**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**	**YTD**
Trajectory	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Incidence	0	0	0	0	0	0	0	0					**0**

Expected date to meet standard / target	Dec 14
Revised date to meet standard	
Lead Director / Lead Officer	Carole Ribbins/Michael Clayton

E12 – No. of # Neck of femurs operated on 0-35 hrs - Based on Admissions

What is causing underperformance?	What actions have been taken to improve performance?	Target (mthly / end of year)	Latest month performance	YTD performance	Forecast performance for next reporting period
Whilst the 'time to surgery within 36 hours' threshold was achieved for July and there has been an improvement since Quarter 1, it is still below the 72% threshold year to date Admissions for September to December are high with October and November seeing admission of 144 patients. There is still significant in month variability with peak weeks in September, October and November seeing over 20 admissions with a large proportion arriving in one day. This sort of activity flux is difficult to plan for from a ward bed and theatre capacity point of view.	An action plan has been drafted which details the work that is currently being scoped and implemented. Specific blockers include Theatre List start and finish times, Orthogeriatric capacity and Theatre process delays. A Listening into Action application has been submitted in the hope that this will support the specialty and CMG with getting greater input and sign up from all of the pathway stakeholders and lead to quicker implementation of changes that are already recognised as essential. The specialty are looking at pathway improvements which reduce the demand in other areas such as fracture clinic which would positively impact on the ability to see patients in a more timely way when they are admitted with a fractured neck of femur. The influx of spinal activity has had an effect on the capacity to operate on other trauma cases including #NOF patients. Extension of theatre lists to accommodate displaced activity has been difficult to arrange at short notice due to anaesthetic and theatre staffing.	**72%**	**59.4%**	**61.8%**	



Performance by Quarter

13/14 FYE	14/15 Q1	14/15 Q2	14/15 Q3 (Oct&Nov)	14/15 Q4
65%	52%	68%	63%	

Expected date to meet standard / target	December 2014
Revised date to meet standard	March 2015
Lead Director / Lead Officer	Richard Power, MSS CD / Maggie McManus, MMS Deputy CMG Manager

R3, R4 and R6 Referral to Treatment – Admitted, Non-Admitted and 52+ Weeks

Introduction

RTT plans in the Trust have made good progress but clearly there is more to do. Achievement of the RTT standards remains a priority for the organisation in a challenging environment. Speciality level plans have been shared with CCGs with the assumptions they are build on. A number of these remain at risk but are being worked through by the CMGs. The trajectories for both backlog reduction and future RTT performance is an output of these assumptions.

Progress made

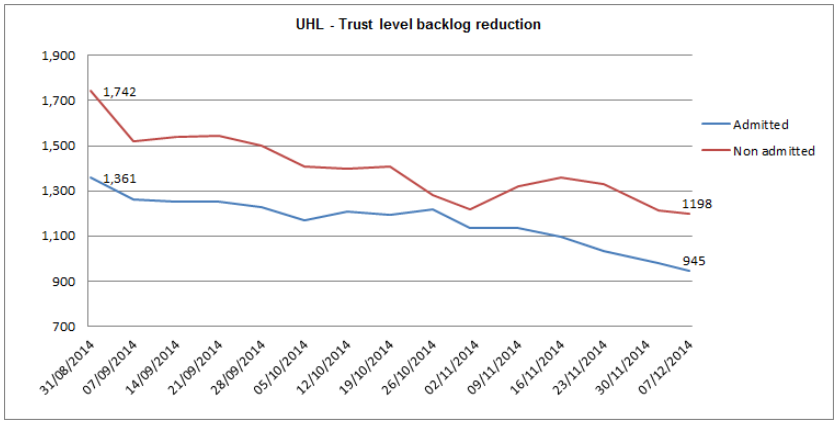
Performance at the end of November is as follows:

Performance	Target	UHL only	UHL and Alliance
Admitted	**90%**	**83.8%**	**85.5%**
Non admitted	**95%**	**94.7%**	**95.2%**
Incompletes	**92%**	**94.3%**	**94.9%**

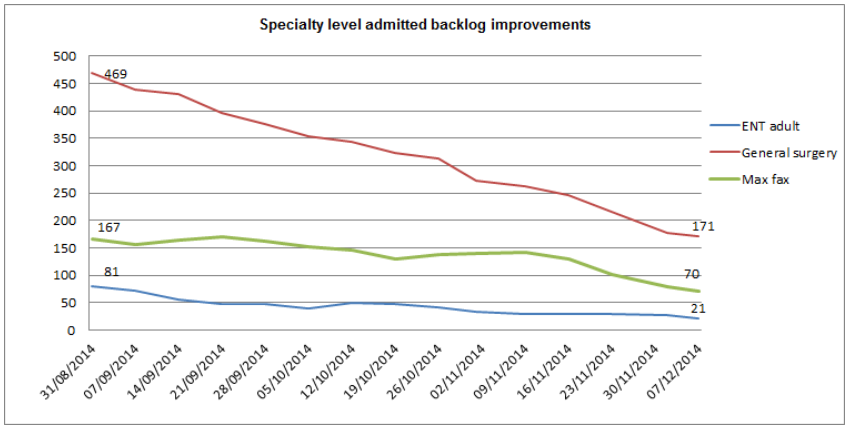
There were 2 patients waiting over 52 weeks at the end of November, both were treated in early December.

The graph below shows the total Trust level reductions in both non-admitted and admitted backlogs. These significant backlog reductions have been achieved by a combination of actions including the following:

- Additional elective and outpatient activity , within hours and at weekends at UHL
- A limited amount of outsourcing of both electives and outpatients to other providers
- Ongoing waiting list validation to 14 weeks



Speciality specific admitted backlog reductions are demonstrated in the graph below.



Problems

Increased referral rates

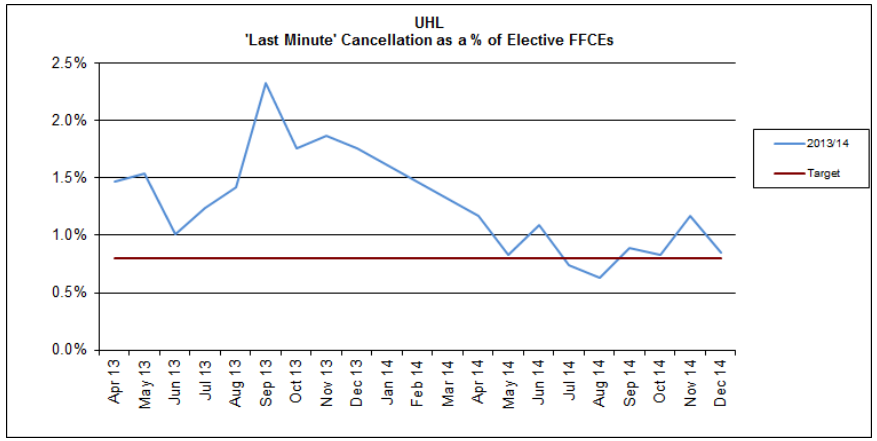
A number of RTT specialities have seen an increase in GP referrals which will have impacted on the ability of the speciality to deliver RTT performance. These are in the table below showing increases of greater than 3% (April to November 2013 v 2014)

Specialty	2013/2014	2014/2015	Variance	% Variance
ENT	5,622	5,859	237	4.20%
Gastroenterology	4,214	4,994	780	18.50%
General Surgery	4,786	5,285	499	10.40%
Maxillofacial Surgery	4,865	5,044	179	3.70%

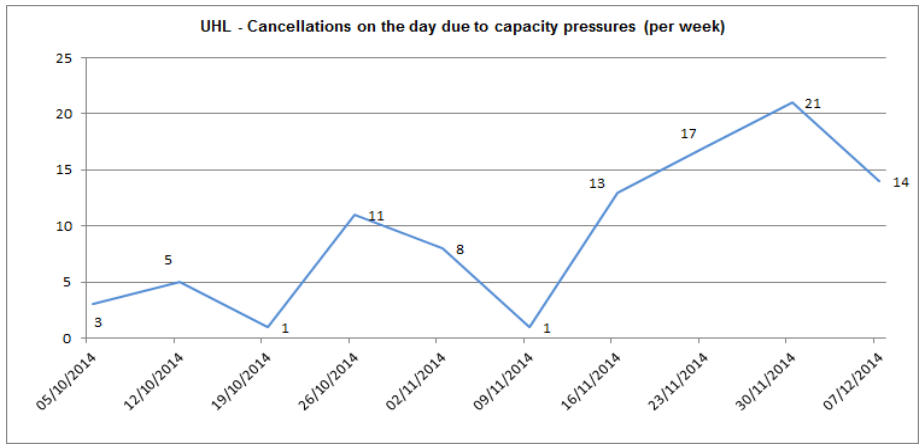
Although there has been no overall increase in MSK referrals during this period, during the 3 months September to November 2014, compared to the same period in 2013 there was an increase of 9%. This fluctuation in levels of referrals is difficult to manage on a month by month basis, the impact of increases is immediately felt on new OPD capacity, any impact on RTT backlog is clearly not seen until 18 weeks later.

Cancelled operations

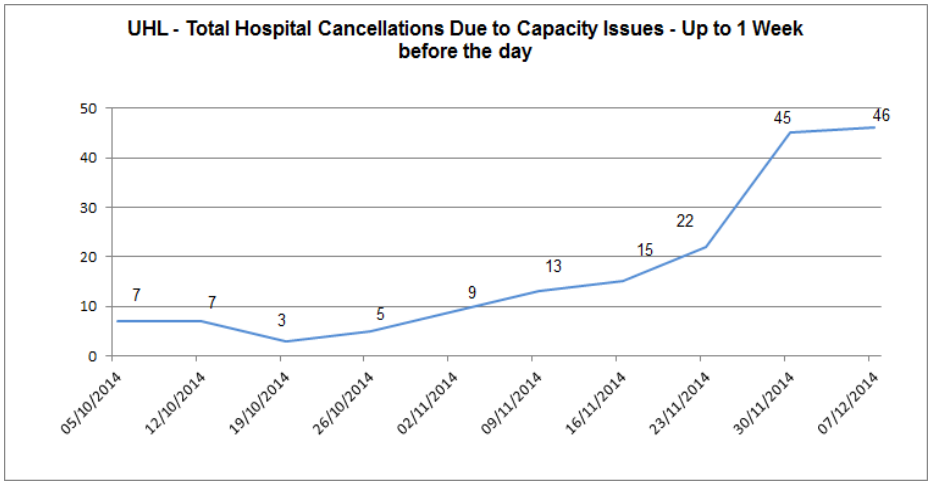
The Trust has made significant improvements in reducing the number of cancellations on the day over the past 12 months, this is demonstrated by the graph below.



Since October 1st there has been an increase in the number of operations cancelled on the day due to capacity pressures (94 in total), with a notable increase in November and into December. The impact of this being particularly on the paediatric specialities, a direct result of increased winter related admissions in paediatrics. See graph below.



The Trust has been proactively managing these cancellations by making earlier decisions to reduce elective capacity. There has been a marked increase of this in past 2 weeks, with 39 of the 91 patients cancelled within 1 week of TCI being paediatric patients. See graph below:



The impact of this during the winter period will be a growing backlog of the affected RTT specialities with increased waiting times.

Forecast recovery

The forecast is based on a number of assumptions within the speciality plans which the CMGs are working iteratively to firm up to reduce the risks associated with them.

	Dec-14	Jan-15	Feb-15	Mar-15
Admitted (including Alliance)	85%	83%	90%	90%
Non admitted (including Alliance)	95%	95%	95%	95%

The anticipated reduction in admitted performance in January is due to the anticipated continued backlog reduction

Further actions

- Ongoing additional inpatient and outpatient activity in UHL and within the Independent sector.
- All currently achieving specialities to continue to achieve at current rate or above.
- Specialities with small numbers of monthly breaches are tasked with eradicating backlogs in January.
- Specific targeting list to ensure patients booked beyond breach are brought forward wherever possible.
- Ongoing validation of all specialities to 14 weeks RTT.

R6 - 6 Week Diagnostics Tests Waiting Time

<table>
<tr><th>What is causing underperformance?</th><th>What actions have been taken to improve performance?</th><th>Standard</th><th>November 2014</th><th>YTD performance</th><th>Forecast performance for next reporting period</th></tr>
<tr><td rowspan="5">The Trust is measured on the waiting times of the top 15 diagnostic modalities reported at the end of each month.

NB: these modalities cross all CMG's

There are a number of factors that have caused this underperformance:

Imaging (accounting for 26% of breaches)

- Cardiac CT and MRI, there remains insufficient capacity – this is ongoing issue and these are supervised scans so need consultant radiologist availability
- MSK MRI , these are consultant specific test

Dexa (accounting for 36%of breaches)
- During November there was a system failure resulting in the breaching of the standard. No alternative capacity available

Endoscopy (accounting for 22% of breaches)
- Colonoscopy / Flexi sigmoidoscopy / Gastroscopy

Additionally, there were small volumes of breaches of the standard in a number of other modalities.

Collectively these have caused a breach of the standard a total of 219 patients waiting over 6 weeks.</td><td rowspan="5">Cardiac CT and MRI

Additional sessions being carried out by cardiologists during December to February. With a business case for substantive capacity increase going to the CMG board in January

MSK imaging capacity

New MSK radiologist starts in January 20I5

Dexa

Scanner now repaired. Contingency plan between Imaging and Rheumatology being finalised

All other modalities

Robust waiting list management, additional capacity where there is risk of breaching , dating patients in date order</td><td><1% over 6 weeks</td><td>1) UHL 2.0%
2) UHL and Alliance combined 1.8%</td><td>1.8%</td><td><1.0%</td></tr>
<tr><td colspan="4">Risks:
There remain risks to achievement of this standard due to the instability of a number of diagnostic modalities which collectively make up this standard.</td></tr>
<tr><td colspan="2">Expected date to meet standard / target</td><td colspan="2">November 2014</td></tr>
<tr><td colspan="2">Revised date to meet standard</td><td colspan="2">December 2014</td></tr>
<tr><td colspan="2">Lead Director / Lead Officer</td><td colspan="2">Richard Mitchell
Suzanne Khalid / Jo Fawcus / Jane Edyvean</td></tr>
</table>

R8, R10, R12, R14 and R15 - Cancer Waiting Times Performance

What is causing underperformance?	What actions have been taken to improve performance?	Target (mthly / end of year)	Latest month performance October	Performance to date 2014/15	Forecast performance for November
R8 1) There has been an annualised increase of 18% in 2WW suspected cancer referrals in 2014/15 to date 2) This is likely to continue to grow 3) This has not been matched by increased provision of carved out availability, nor sufficient response to individual cancer type awareness campaigns **R10, 12, 14, 15** The system for the integration of complex cancer pathways remains in place (**R14, R15**) Access to cancer diagnostics remains good. The delivery of timely treatments (**R10, R12**) lies within the gift of services for surgery, and the oncology department for chemotherapy and radiotherapy. Chemotherapy and radiotherapy treatments have remained timely for the most part. The issue is adequate access to surgical capacity. There is no shortage of overall surgical capacity, the poor performance results from the failure to appropriately prioritise cancer pathways in the face of competing priorities.	The actions recommended by the Cancer Centre to the trust are; 1) Build in 20% increase in capacity upon current demand year on year and carve this out for 2WW referrals 2) Direct CMGs and services to produce and work to SOPs which prioritise cancer 3) That weekly Cancer Action Board meetings are attended by CMG general managers or their deputies 4) That there is executive representation at the weekly Cancer Action Board The actions taken include; 1) Work streams with the commissioners to rationalise 2WW demand (interactive 2WW forms to improve compliance with guidelines and CCG policing of inappropriate referrals) 2) Focus on tumour site specific issues with the relevant CMG and service managerial and clinical leads **Addendum 15.12.14** Please note these actions now form the basis of the recommended response to the CCG contract query notice for cancer performance	**R8 2WW 93%**	**92%**	**91.9%**	**91.3%**
		R10 31 day 1st 96%	**95.9%**	**94.8%**	**89.7%**
		R12 31 day sub (Surgery) 94%	**81.9%**	**90.6%**	**68%**
		R14 62 day RTT 85%	**80.4%**	**81.8%**	**77.9%**
		R15 62 screening 90%	**75%**	**80.6%**	**85.7%**

Performance by Quarter

	13/14 FYE	14/15 Q1	14/15 Q2	14/15 Q3	14/15 Q4
R8	94.8%	92.2%	91.6%		
R10	98.1%	94.6%	94.6%		
R12	98.2%	94.2%	90.5%		
R14	86.7%	84.1%	79.9%		
R15	95.6%	78%	85%		

Expected date to meet standard / target	R8 – Recovery possible December R10,12 – Recovery possible January '15 R14,15 – Recovery possible February '15
Revised date to meet standard	Each target has slipped one month since the last report
Lead Director / Lead Officer	Richard Mitchell Matt Metcalfe

R17 – R22 Operations Cancelled on the Day and 28 Day Re-books

Operations cancelled on the day for Non-clinical reasons					
Performance indicators	**What actions have been taken to improve performance?**	**Target (mthly) 1)On day= 0.8% 2) 28 day = 0**	**Latest month performance – Oct 14**	**YTD performance (inc Alliance)**	**Forecast performance for next reporting period**
The cancelled operations target comprises of three components: 1.The % of cancelled operations for non clinical reasons on the day of admission 2.The number of patients cancelled who are offered another date within 28 days of the cancellation 3. The number of urgent operations cancelled for a second time.	The key action is to ensure on-going performance is the daily expediting of patients at risk of cancellation on the day, following the UHL cancelled escalation policy. For those cancelled on the day, it is vital that they adhere to the Trust policy of escalating to CMG General Managers for resolution prior to agreeing any cancellations. A number of work streams have started to reduce cancellations including a LIA project. 29% (31/108) of the on the day cancellations were due to ward bed unavailability. High emergency pressures 18 paediatric patients to be cancelled in November. <u>Risks to delivery of recovery plan</u> Paediatric bed availability is still a high risk to on the day cancellations. The situation has been monitored on a daily basis to prevent on the day cancellations, by cancelling patients electively whenever possible. There are significant risks to reducing cancellations on the day. These are mainly associated with bed availability and emergency patients taking priority. The high number of paediatric cancellations on November is a high risk to 28 day breaches in December.	UHL 1) 1.2% 2) 1	UHL 1) 0.8% 2) 2	UHL + Alliance 1) 0.89% 2) 28	UHL 1) 0.8% 2) 0

UHL performance against standards

1. The percentage of operations cancelled on/after the day for non-clinical reasons during November 2014 was 1.2% *(108/9271)* against a target of 0.8%.

2. One patient breached on the 28 day target in November 2014. The patient was a complex case required a very rare drug. The patients is booked for treatment in December.

3. The number of urgent operations cancelled for a second time ; zero

Alliance performance

0.0% *(0/875)* cancelled on the day. One breaches of the 28 day standard.

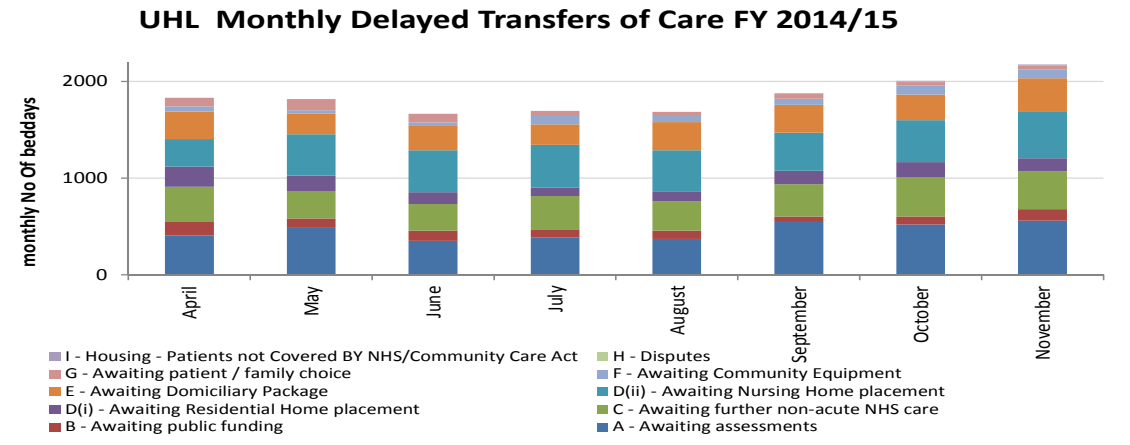
13/14 FYE	**14/15 Q1**	**14/15 Q2**	**14/15 Q3**	**14/15 Q4**
1.6%	0.97%	0.8%		

Expected date to meet standard / target	1) December 2014 2) December 2014
Revised date to meet standard	2) December 2014
Lead Director / Lead Officer	Richard Mitchell Phil Walmsley

R23 Delayed Transfers of Care

What is causing underperformance?	What actions have been taken to improve performance?	Target (mthly / end of year)	Latest month performance	YTD performance	Forecast performance for next reporting period
There has been an increase in delays due to DTOC in November. There remain concerns over availability of packages of care in the County Local Authority. This can be seen with the increase in bed days allocated to 'Awaiting domiciliary care'. There continue to be a number of DTOCs due to slow discharges to care homes. This is caused by families being slow to find appropriate care homes, care homes being slow to come in to assess the patient as suitable or waiting for a bed to become available.	ICRS and ICS teams continue to attend wards to identify patients that they could take directly in to their home based services. This has been particularly successful with the City services and lessons learnt are being discusses with county colleagues Further discussions are taking taken place with local commissioners regarding extending current actions to reduce the rate of DTOC. A team of staff have been commissioned by UHL to provide interim care for patients waiting to go home, starting in December. This has been an on-going issue with progressing discharges so it is expected that this will help speed up discharges	3.5%	5.2%	4.3%	4.8%

Row Labels	A - Awaiting assessments	B - Awaiting public funding	C - Awaiting further non-acute NHS care	D(i) - Awaiting Residential Home placement	D(ii) - Awaiting Nursing Home placement	E - Awaiting Domiciliary Package	F - Awaiting Community Equipment	G - Awaiting patient / family choice	H - Disputes	I - Housing - Patients not Covered BY NHS/Community Care Act	Grand Total
April	407	148	356	207	285	285	55	87			1830
May	494	90	277	166	425	218	34	113			1817
June	353	103	277	122	433	253	36	89			1666
July	387	77	353	82	444	215	85	54			1697
August	371	87	302	98	430	294	61	41			1684
September	546	57	333	141	394	286	65	57			1879
October	520	84	402	159	434	266	95	40	4	3	2007
November	561	119	392	134	484	343	88	46		9	2176
Grand Total	**3639**	**765**	**2692**	**1109**	**3329**	**2160**	**519**	**527**	**4**	**12**	**14756**



Performance by Quarter

13/14 FYE	14/15 Q1	14/15 Q2	14/15 Q3 to date	14/15 Q4
4.1%	4.2%	4.1%	4.9%	

Expected date to meet standard / target	TBA
Revised date to meet standard	TBA
Lead Director / Lead Officer	Richard Mitchell/Phil Walmsley

R24 Choose and Book

<table>
<tr><td></td><td></td><td>Target</td><td></td><td></td><td></td></tr>
<tr><td>What is causing underperformance?</td><td>What actions have been taken to improve performance?</td><td><4% ASI</td><td>October</td><td>YTD performance</td><td>Forecast performance for next reporting period</td></tr>
<tr><td rowspan="5">The Trust is measured on the % of Appointment Slot Unavailability (ASI) per month.

The Trust has not met the required the <4% standard for circa 2 years and where it has met this standard it has been unable to maintain it for consecutive months.

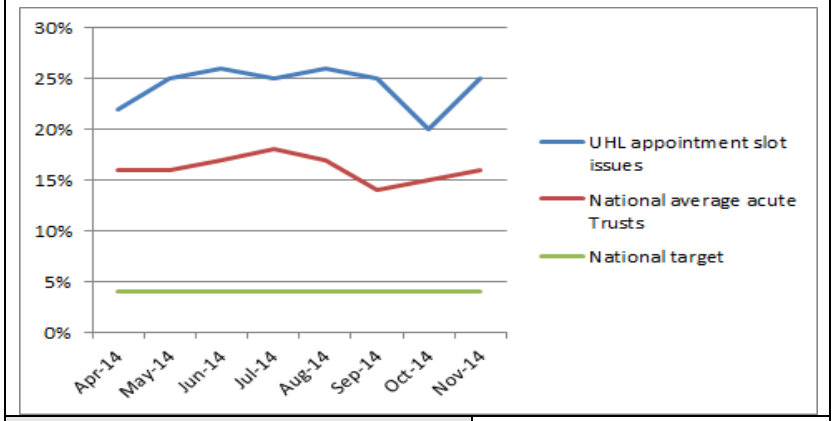
The two most significant factors causing underperformance are:

- Shortage of capacity in outpatients
- Inadequate recurrent training and education of administrative staff in the set up and use of the choose and book process

The appointment slot issues have increased in November after a promising reduction on October Notably: General Surgery and orthopaedics.
.</td><td rowspan="5">Capacity

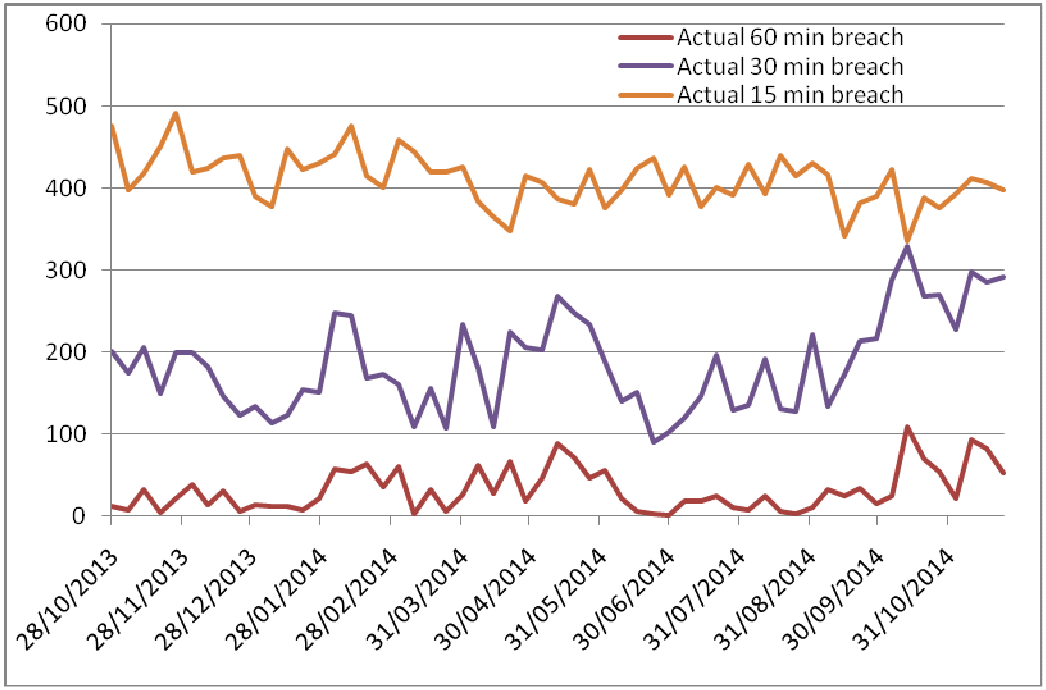
Additional capacity in key specialties is part of the RTT recovery plans

Training and education

The comprehensive training and education of relevant staff in key specialties continues, to ensure that choose and book is correctly set up and that supporting administrative purposes are fit for purpose.
A speciality level ‘score card’ to highlight areas required for improvement is now being distributed weekly to CMGs.</td><td><4%</td><td>UHL - 25%</td><td>UHL -25%</td><td>UHL - 20%</td></tr>
<tr><td colspan="4">National performance varies significantly by Trust, with average performance of Acute Trusts nationally at 16% in November
 
</td></tr>
<tr><td colspan="2">Expected date to meet standard / target</td><td colspan="2">January 2014</td></tr>
<tr><td colspan="2">Revised date to meet standard</td><td colspan="2">March 2014</td></tr>
<tr><td colspan="2">Lead Director / Lead Officer</td><td colspan="2">Richard Mitchell
Charlie Carr</td></tr>
</table>

R25 and R26 Ambulance Handover > 30 Minutes and > 60 Minutes

What is causing underperformance?	What actions have been taken to improve performance?	Target (mthly / end of year)	Latest month performance	YTD performance	Forecast performance for next reporting period
Pressures in accessing beds continue to lead to a backlog in the assessment area of ED. This delays movement out of the assessment area and delays handover. This has been made worse by higher number of acutely unwell patients. Patterns of ambulance attendance continue to show grouping of arrivals. This also compounds the issue	An audit of patients being handed over in resuscitation is currently under way. This will inform the time that EMAS can be allocated for handover after a patient has been in resuscitation. New processes in ED regarding booking in patient are being reinforced with EMAS. A review of the over 60 minute delays on the 14th October shows considerable discrepancy with the EMAS data. This audit will be repeated in the w/c 22/12/15 with EMAS present to agree where the issues may lie. The discrepancy may lie with different collection points in the patient journey, but it appears that there are also significant issues with difference in times recorded against handover. The ambulance audit staff in ED will be working closely with the Hospital Ambulance Liaison Officer to highlight best practice and ensure that this is applied across all ambulance staff.	0 delays over 30 minutes	> 60 min 6% 30-60 min – 24%	> 60 min 3% 30-60 min – 17%	



Expected date to meet standard / target	
Revised date to meet standard	
Lead Director / Lead Officer	Richard Mitchell

RS6A : Proportion of NHS Trusts recruiting each year into non-commercial NIHR CRN Portfolio studies

What is causing underperformance?	What actions have been taken to improve performance?	Target (mthly / end of year)	Latest month performance	YTD performance	Forecast performance for next reporting period
Proportion of NHS Trusts recruiting each year into non-commercial NIHR CRN Portfolio studies There are 16 Trusts within the East Midlands region, with 13 Trusts currently reporting recruitment. The three who have not reported any recruitment are: • East Midlands Ambulance Service NHS Trust (EMAS) • Derbyshire Community Health Services NHS Foundation Trust (DCHS) • Lincolnshire Community Health Services (LCHS)	1. EMAS: have received funding for a Research Paramedic. This post currently supports two NIHR Portfolio studies that do not report recruitment in the traditional way due to patient assent taken rather than consent. EMAS have four studies in the pipeline that are due to open this financial year that will report participant recruitment. 2. DCHS: this Trust is unlikely to have recruitment directly attributed as all the studies that are supported by funded staff, occur in primary care settings. Therefore the recruitment will be allocated to a Clinical Commissioning Group within the East Midlands. 3. LCHS: this Trust supports several studies however the consent event occurs in the primary care setting so the recruitment is attributed to Clinical Commissioning. There is scope for research within the community services (paediatrics, district nursing) that is being investigated.	**99%**	**81% (red)**	**81% (red)**	**81%**

Expected date to meet standard / target	It is unlikely we will make the 99% target due to the nature of the services provided by DCHS and LCHS. We are likely to reach 85% by April 2015.
Revised date to meet standard	
Lead Director / Lead Officer	Elizabeth Moss, Chief Operating Officer

RS6b Proportion of NHS Trusts recruiting each year into commercial NIHR CRN Portfolio studies

<table>
<tr><th>What is causing underperformance?</th><th>What actions have been taken to improve performance?</th><th>Target (mthly / end of year)</th><th>Latest month performance</th><th>YTD performance</th><th>Forecast performance for next reporting period</th></tr>
<tr><td rowspan="5">HLO6B: Proportion of NHS Trusts recruiting each year into commercial NIHR CRN Portfolio studies

There are 16 Trusts within the East Midlands region, with 9 Trusts currently recruiting to commercial studies. The seven who have not reported any recruitment are:
East Midlands Ambulance Service NHS Trust (EMAS)
Derbyshire Community Health Services NHS Foundation Trust (DCHS)
Lincolnshire Community Health Services (LCHS)
Leicestershire Partnership NHS Trust (LePT)
Lincolnshire Partnership NHS Trust (LiPT)
Nottinghamshire Healthcare NHS Foundation Trust (NHFT)
Derbyshire Healthcare NHS Foundation Trust (DHFT)</td><td rowspan="5"><ol start="4">
EMAS: Currently no open commercial studies nationally run by ambulance services on the NIHR portfolio, therefore unlikely that EMAS will open a commercial study this financial year. Industry team currently reviewing studies previously run at other ambulance services across the country to gain insight.
DCHS: due to the nature of research within this Trust, they are unlikely to be involved in commercial research, Have met with Trust and a preliminary plan is in place to take this forward.
LCHS: due to the nature of research within this Trust, they are unlikely to be involved in commercial research. Meeting on the 18th December with Trust to discuss and plan.
LePT: Selected for one study, due to open by the end of 2014. One study also being taken forward with sponsor and awaiting confirmation if selected
LiPT: have been involved in commercial research in the past and the site is actively seeking commercial opportunities
NHFT: One trial initiated at the end of November 2014, 2nd UK site to open
DHFT: One trial recently opened to recruitment, yet to recruit</td><td>70%</td><td>56% (red)</td><td>56% (red)</td><td>62%</td></tr>
<tr><td colspan="4"></td></tr>
<tr><td>Expected date to meet standard / target</td><td colspan="3">April 2015</td></tr>
<tr><td>Revised date to meet standard</td><td colspan="3">April 2015</td></tr>
<tr><td>Lead Director / Lead Officer</td><td colspan="3">Daniel Kumar, Industry Delivery Manager</td></tr>
</table>

2014/15 NTDA METRICS AND WEIGHTINGS

Responsiveness Domain

Metric	Standard	Weighting
Referral to Treatment Admitted	90	10
Referral to TreatmentNon Admitted	95	5
Referral to Treatment Incomplete	92	5
Referral to Treatment Incomplete 52+ Week Waiters	0	5
Diagnostic waiting times	1	5
A&E All Types Monthly Performance	95	10
12 hour Trolley waits	0	10
Two Week Wait Standard	93	2
Breast Symptom Two Week Wait Standard	93	2
31 Day Standard	96	2
31 Day Subsequent Drug Standard	98	2
31 Day Subsequent Radiotherapy Standard	94	2
31 Day Subsequent Surgery Standard	94	2
62 Day Standard	85	5
62 Day Screening Standard	90	2
Urgent Ops Cancelled for 2nd time (Number)	0	2
Proportion of patients not treated within 28 days of last minute cancellation	0	2
Delayed Transfers of Care	3.5	5
TOTAL - 18 Indicators		78

Effectiveness Domain

Metric	Standard	Weighting
Hospital Standardised Mortality Ratio (DFI)		5
Deaths in Low Risk Conditions		5
Hospital Standardised Mortality Ratio - Weekday		5
Hospital Standardised Mortality Ratio - Weekend		5
Summary Hospital Mortality Indicator (HSCIC)		5
Emergency re-admissions within 30 days following an elective or emergency spell at the Trust		5
TOTAL - 6 Indicators		30

Safe Domain

Metric	Standard	Weighting
Clostridium Difficile - Variance from plan		10
MRSA bactaraemias	0	10
Never events	0	5
Serious Incidents rate	0	5
Patient safety incidents that are harmful		5
Medication errors causing serious harm	0	5
CAS alerts	0	2
Maternal deaths	1	2
VTE Risk Assessment	95	2
Percentage of Harm Free Care	92	5
TOTAL - 11 Indicators		51

Caring Domain

Metric	Standard	Weighting
Inpatient Scores from Friends and Family Test	60	5
A&E Scores from Friends and Family Test	46	5
Complaints		5
Mixed Sex Accommodation Breaches	0	2
Inpatient Survey Q 68 - Overall, I had a very poor/good experience		2
TOTAL - 5 Indicators		19

Well Led Domain

Metric	Standard	Weighting
Inpatients response rate from Friends and Family Test	30	2
A&E response rate from Friends and Family Test	20	2
NHS Staff Survey: Percentage of staff who would recommend the trust as a place of work		2
NHS Staff Survey: Percentage of staff who would recommend the trust as a place to receive treatment		2
Data Quality of Returns to HSCIC		2
Trust turnover rate		3
Trust level total sickness rate		3
Total Trust vacancy rate		3
Temporary costs and overtime as % of total paybill		3
Percentage of staff with annual appraisal		3
TOTAL - 10 Indicators		25

CQC – Intelligent Monitoring Report

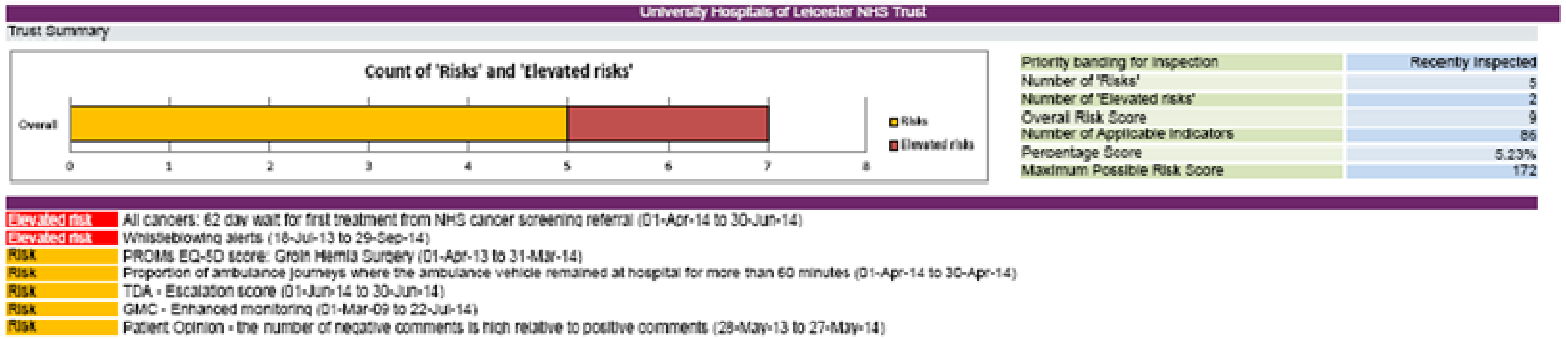
The latest CQC Intelligent Monitoring Report (IMR) was published on 3rd December 2014.

The IMR evaluates against a range of indicators relating to the five key questions used by the CQC as part of their inspections - is the organisation safe, effective, caring, responsive, and well-led?

Within each area of questions a set of indicators has been developed and each indicator has then been analysed to identify the following levels of risk for each organisation:

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

One elevated risk remains unchanged (whistleblowing alerts), one new elevated risk has been added (cancer waiting times), three indicators are unchanged at risk (ambulance times, TDA and GMC) and PROMs (groin hernia surgery) and patient opinion comments are new risks (not flagged in the previous IMR).



Quality Schedule and CQUIN Performance Summary – Predicted RAG for Quarter 3

Ref	Indicator Title	Q1 RAG	Q2 RAG	Q3 RAG	Commentary
	QUALITY SCHEDULE				
PS01	Infection Prevention and Control Reduction. - C Diff	G	A	G	Monthly reporting of C Diff. Threshold for 14/15 is 81. UHL is aiming to achieve a reduction on last year's total of 66 and has given itself a Target of 50 . 43 cases as at end of November which is below the NTDA trajectory (54 YTD) Amber RAG to be revised upon receipt of MultiDrug Resistant Bacteraemia data.
PS02	HCAI Monitoring - MRSA	0	1	1	1 in September and 1 in October. Reviews confirmed both Unavoidable.
PS03	Patient Safety – SIs, Never Events	G	1	tbc	0 Never Events in Q1. 1 in October relating to 'Retained Swab ties). Reduction in Patient Safety Incidents but increase in % causing harm. Further increase in number of PSIs awaiting review. Increase in GP concerns
PS04	Duty of Candour	0	0	0	No breaches.
PS05	Complaints and user feedback Management (excluding patient surveys).	A	tbc	tbc	Complaints responses performance improved slightly although still below threshold. Deterioration for responding to 're-opened complaints.
PS06	Risk Assurance and CAS Alerts	A	A	G	Amber RAG for Q2 relates to overdue CAS alerts for July. No overdue CAS alerts and all risk reviews and actions on Track
PS07	Safeguarding – Adults and Children	G	G	G	Assurance documentation due to be sent to CCG Safeguarding leads for their review ahead of their observational visit to the Trust. Discussions underway regarding CONI requirements (Care of Next Infant) and changes proposed to the SAAF.
PS08	Reduction in Pressure Ulcer incidence.	G	G	A	Monthly thresholds met for G3 HAPUs and no G4s, however 4 above the monthly trajectory for Grade 2 HAPUs in November.
PS09	Medicines Management Optimisation	A	G	G	Commissioners noted improvement in Controlled Drugs audit report. Progress made with developing LLR Medicines Optimisation Strategy.
PS10	Medication Errors	G	G	G	Increased reporting of errors and actions being taken.
PS11	Venous Thromboembolism (VTE) and RCAs of Hospital Acquired Thrombosis	95.7%	96.1%	95.4%	Performance continues to be above the national set threshold of 95% RCAs in progress for Q2 Hospital Acquired Thrombosis.
PS12	Nutrition and Hydration	G	>80%	tbc	Nursing Metrics amended to better monitor fluid and nutritional care. Work programme on track for nutrition, some delays with hydration actions. On track to achieve 90% across all CMGs by Q4
PE1	Same Sex Accommodation Compliance and Annual Estates Monitoring	2	0	0	0 breaches reported for Q2 or Q3 to date.
PE2	Patient Experience, Equality and Listening to and Learning from Feedback.	G	G	G	Good progress made with triangulation of data. Waiting time main area for improvement.
PE3	Improving Patient Experience of Hospital Care (NPS)	N/A	N/A	N/A	Not due to be reported until March 15
PE4	Equality and Human Rights	G	G	G	Progress reported to the September CQRG with further information provided in October – relating to actions being taken to capture BME data
CE01	Communication – Content (ED, Discharge & Outpatient Letters)	A	A	A	ED letters audit undertaken and identified 29% of letters did not contain relevant information. Several specialities experiencing backlogs with outpatient letters. Meeting held to discuss D/N letters on ICE. Clinical Problem Solving Group held to agree key priorities.
CE02	Intra-operative Fluid Management	G	>80%	tbc	Q4 RAG dependent upon confirmation of 80% trajectory being maintained.
CE03	Clinical Effectiveness Assurance – NICE and Clinical Audit	A	A	tbc	Responses outstanding for several NICE Clinical Guideline / Quality Standards documents. Reported to EQB separately. Actions being taken where audits behind schedule National Quality Dashboard no longer being published.
CE04	Women's Service Dashboard	A	A	tbc	Amber RAG anticipated due to increase in C Section Rate. 3 SIs reported all related to perinatal death – 1 baby imm after transfer from St Mary's.
CE05	Children's Service Dashboard	A	G	tbc	Assurance provided to Commissioners in respect of SpR training

Ref	Indicator Title	Q1 RAG	Q2 RAG	Q3 RAG	Commentary
CE06	Patient Reported and Clinical Outcomes (PROMs and Everyone Counts)	A	A	G	Groin Hernia PROMs deteriorated and reported as a Risk in the embargoed CQC Intelligent Monitoring Report. Individual patient data now obtained. Initial review against patient case notes not identified any clinical issues. Consultant Outcomes published and all consultants in line with national average
CE07	#NOF - Dashboard	51%	67.9%	64.5%	72% threshold not met for any month in Q2. Action plan in place. – Appendix 3.
CE08a	Stroke monitoring	86%	81.6	tbc	**69.4%** in October - Head of Service reviewing notes to confirm whether patients wrongly coded and why stroke patients not admitted to Stroke Unit.
CE08b	TIA monitoring	76%	67%	68.4%	Threshold achieve for each month for high risk patients and performance improved for low risk patients being seen within 7 days.
CE09	Mortality (SHMI, HSMR)	A	A	A	UHL's SHMI remains above 100. Mortality alert reviews completed on track and MRC work programme is on schedule.
CE10	Making Every Contact Count (MECC)	A	G	G	Referrals to STOP and ALW continue. 'Healthy Eating and Physical Activity publicity campaign due to commence in General Surgery and Sleep Clinics.
AS01	Cost Improvement Programme (CIP) Assurance	A	tbc	G	Q2 RAG to be reviewed upon receipt of QAC report.
AS02	Ward Healthcheck (Nursing Establishment, Clinical Measures Scorecard)	Report Submitted	Report Submitted	Report Submitted	Recruitment of additional nurses continues. Not all wards meeting N2BR but actions in place.
AS03	Staffing governance	A	A	A	Thresholds not met for Appraisal, Sickness and Corporate Induction or Turnover although improvement noticed.
AS04	Involving employees in improving standards of care. (Whistleblowing)	G	G	G	Actions taken to address concerns raised.
AS05	Staff Satisfaction	G	G	G	
AS06	External Visits and Commissioner Quality Visits	G	G	G	
AS07	CQC Registration	A	G	G	
	NATIONAL CQUINS				
Nat 1.1a	F&FT 1a - Staff	G	G	G	Implemented
Nat 1.1b	F&FT 1b - OutPt & Day Case	G	G	G	F&FT already happening in Day Case and has started in Outpatients.
Nat 1.2	F&FT 1.2 - Increased participation - ED	16.%	15.1%	15.%	Performance dropped significantly in July but back on track with an YTD rate of 15.6% .
Nat 1.3	F&FT 1.3 - Inpt increase in March	35.8%	31%	36.2%	Performance dropped to 28% for August but still achieved the end of year threshold in Q2.
Nat 2.1	ST 2.1 - ST data submission	G	G	G	Data collection continues.
Nat 2.2	ST 2.2 - LLR strategy	G	G	G	UHL contributing to the LLR Pressure Ulcer group and workstreams
Nat 3.1	Dementia 3.1 - FAIR	G	G	G	90% thresholds met for all parts of the Dementia FAIR CQUIN.
Nat 3.2	Dementia 3.2 - Training & Leadership	G	G	tbc	Nicky Morgan is new Clinical Lead Dementia Training Programme reviewed and revised. Q3 RAG dependent on evidence of increased staff attending training.
Nat 3.3	Dementia 3.3 - Carers	G	G	G	Surveys carried out and evidence of actions being taken
	LOCAL CQUINS				
Loc 1	Urgent Care 1 (Discharge)	G	G	G	Thresholds to be revised in order to reflect 2 year timescale of CQUIN scheme

Ref	Indicator Title	Q1 RAG	Q2 RAG	Q3 RAG	Commentary
Loc 2	Urgent Care 2 (Consultant Assessment)	G	G	A	60% Q2 threshold achieved due to significant improvement in AMU. Audit underway to confirm performance for other units.
Loc 3	Improving End of Life Care (AMBER)	G	G	G	AMBER implemented on 4 wards during Q2 and progress made with training. New facilitators in post and so should be back on track by end of Q3
Loc 4	Quality Mark	G	G	G	Quality Mark achieved for 6 out of the 8 wards to date.
Loc 5	Pneumonia	A	G	tbc	CQUIN payments reapportioned and so reduced loss of income for Q1. Q2 threshold achieved for all aspects of CQUIN scheme
Loc 6	Think Glucose	G	G	G	Think Glucose programme on track.
Loc 7	Sepsis Care pathway	≥47%	≥60%	tbc	Care Bundle thresholds achieved and good progress made against action plan.
Loc 8	Heart Failure	≥49.5 %	≥63%	tbc	Commissioner reviewed progress with both the Care Bundle and also IV diuretic Service.
Loc 9	Medication Safety Thermometer	G	G	G	90% of Wards participating in the Medication Safety Thermometer
	SPECIALISED CQUINS				
SS1	National Quality Dashboards	G	G	t of CQUIN scheme.Q1 as although threshold just missed, acknowledged increased activity and good progress made with other aspect bc	Dashboards now open for data submission at end of Q3
SS2	Breast Feeding in Neonates	61%	66%	tbc	Thresholds achieved for Q2 and on track for Q3.
SS3	Clinical Utilisation Review of Critical Care	N/A*	G	tbc	CCMDS and ICNARC data now being collected for ACB
SS4	Acuity Recording	N/A*	G	G	Acuity recording in place for all areas.
SS5	Critical Care Standards - Disch	N/A*	G	tbc	4 hr delays baseline data provided for Critical Care Units
SS6	Critical Care Outreach Team	N/A*	G	tbc	Baseline data partially provided and improvement thresholds agreed
SS7	Consultant Assessment	G	G	tbc	Links to the CCG CQUIN.
SS8	Highly Specialised Services Collaborative Workshop	G	G	G	Update provided regarding participation in Clinical Benchmarking workshops in November for both ECMO and PCO.

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: 22 December 2014

COMMITTEE: Finance and Performance Committee

CHAIR: Ms J Wilson, Non-Executive Director

DATE OF COMMITTEE MEETING: 26 November 2014

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

- **Confidential Minute 122/14 – report by the Chief Executive**

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

- **Minute 126/14/3 – update on the Emergency Floor OBC, and**
- **Minute 127/14/4 – operational performance (including RTT).**

DATE OF NEXT COMMITTEE MEETING: 18 December 2014

Ms J Wilson
16 December 2014

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST

MINUTES OF A MEETING OF THE FINANCE AND PERFORMANCE COMMITTEE, HELD ON WEDNESDAY 26 NOVEMBER 2014 AT 8.30AM IN SEMINAR ROOMS A AND B, CLINICAL EDUCATION CENTRE, LEICESTER GENERAL HOSPITAL

Present:
Ms J Wilson – Non-Executive Director (Acting Committee Chair)
Mr J Adler – Chief Executive
Colonel (Retired) I Crowe – Non-Executive Director
Mr R Mitchell – Chief Operating Officer (excluding Minutes 123/14 and 124/14)
Mr P Traynor – Director of Finance
Mr G Smith – Patient Adviser (non-voting member)

In Attendance:
Ms L Bentley – Head of Financial Management and Planning
Mr J Clarke – Chief Information Officer (for Minute 122/14)
Dr S Dauncey – Non-Executive Director (excluding Minutes 123/14 to 125/14)
Mr P Gowdridge – Head of Strategic Finance (for Minutes 122/14 and 126/14/3 to 126/14/4)
Ms J Fernihough – IBM Executive Partner (for Minute 122/14)
Dr S Jackson – Chief Medical Information Officer (for Minute 122/14)
Ms E MacLellan-Smith – Ernst Young (for Minute 128/14/2)
Ms D Mitchell – Interim Alliance Director (for Minute 126/14/2)
Mrs K Rayns – Trust Administrator
Mr P Richards – IBM Executive Partner (for Minute 122/14)
Mr I Scudamore – Clinical Director, Women's and Children's CMG (for Minute 126/14/1)
Mr K Singh – Trust Chairman
Mr M Traynor – Non-Executive Director
Mr D Yeomanson – General Manager, Women's and Children's CMG (for Minute 126/14/1)

RECOMMENDED ITEM **ACTION**

122/14 REPORT BY THE CHIEF EXECUTIVE

Recommended – that this Minute be classed as confidential and taken in private on the grounds of commercial interests.

RESOLVED ITEMS

123/14 APOLOGIES AND WELCOME

An apology for absence was received from Ms K Shields, Director of Strategy. The Acting Committee Chair welcomed Mr P Traynor, Director of Finance to his first meeting of the Finance and Performance Committee.

Members noted that the Finance and Performance Committee was due to be replaced by the Integrated Finance, Performance and Investment Committee (IFPIC) in January 2015. These meetings would be scheduled on the final Thursday of each month to commence at 9am (instead of 8.30am).

124/14 MINUTES

Resolved – that the Minutes of the 29 October 2014 Finance and Performance Committee meeting be submitted to the 18 December 2014 meeting.

125/14 MATTERS ARISING PROGRESS REPORT

The Acting Committee Chair confirmed that the matters arising report provided at paper A detailed the status of all outstanding matters arising. Members received updated information in respect of the following items:-

(a) Minute TBC (21) of 29 October 2014 – the Trust Chairman voiced his concerns regarding the pace of progress with the Empath 5-year Business Plan. An update on this item was due to be consider later in the agenda (Minute 126/14/4 below refers);

(b) Minute 103/14/5(c) of 24 September 2014 – the update on landlord elements of University occupied UHL premises had been deferred to the 18 December 2014 Finance and Performance Committee meeting, to allow for appropriate prior consideration by the Executive Performance Board (on 16 December 2014);

(c) Minute 104/14/3(b) of 24 September 2014 – an update on the focused workstream with the Renal Respiratory and Cardiac CCG was due to be provided later in the agenda (Minute 127/14/3 below refers). However, this was not expected to include any proposals for the development of a single technical solution, which might link with the development of the Electronic Patient Record;

(d) Minute 91/14/2(c) of 27 August 2014 – Colonel (Retired) I Crowe, Non-Executive Director queried the timescale for resolution of the issues relating to revised patient restraint guidance and appropriate intervention by security staff. It was agreed that the Trust Administrator would seek an update from the Chief Nurse on this matter for circulation outside the Committee, and **TA**

(e) Minute 91/14/3 of 27 August 2014 – proposals for the development of continuous improvement in the FM contract had been deferred to the 18 December 2014 Finance and Performance Committee meeting, to allow for appropriate prior consideration by the Executive Performance Board (on 16 December 2014).

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

126/14 STRATEGIC MATTERS

126/14/1 <u>CMG Presentation – Women's and Children's Services</u>

Mr I Scudamore, Clinical Director and Mr D Yeomanson, General Manager attended the meeting from the Women's and Children's CMG to present an overview of current financial and operational performance (as detailed in paper C). Introductions took place. The presentation was taken as read and the CMG team was invited to comment on the top 3 current issues that were causing the most concern. In response, the CMG team reported verbally on the following key issues:-

(a) RTT performance – non-admitted performance in clinical genetics for October 2014 stood at 76%, reflecting a considerable increase in activity over the last 5 years and a reduction in the Consultant body (following 2 retirements and a replacement Consultant relocating to Scotland). Recruitment in this specialist area had proved challenging, but a further advertisement was due to be placed (in the hope of attracting 2 available potential candidates) and registrars were being trained locally with a view to succession planning.

Theatre capacity in Gynaecology had previously been supported through utilisation of other CMGs' cancelled sessions, but this opportunity had reduced as the CMGs improved their utilisation rates. In addition, some Gynaecology activity (60 to 70 cases) had been lost as a result of theatre refurbishment works. To mitigate this, additional ambulatory Gynaecology cases would be delivered in an OPD setting and

work was taking place to improve day case utilisation. Approximately 20 cases had been transferred to the private sector that week;

(b) East Midlands Congenital Heart Service – the Trust's response to the NHS England Congenital Cardiac Services Review would require children's cardiac services to be co-located with other children's services and each centre would be required to undertake a total of 500 procedures per year (125 each for 4 Consultants). The timescale for the required changes was not yet clear but it was expected to be between 18 months and 5 years. In the interim period, it was intended to strengthen Children's services provided from Glenfield Hospital, uncouple them from the adult services and develop appropriate networking engagement with other centres to increase activity levels, and

(c) Future configuration of Maternity Services – subject to public consultation, UHL's strategic 5 year plan focused upon provision of obstetric-led maternity services from a single site. Level 3 ITU provision was expected to cease being provided on the LGH site within the next 12 months and arrangements would be required to manage a small number of low risk patients (eg 10 to 12 patients per year out of 4,300 deliveries) who might need level 3 care as a result of an unexpected deterioration in their condition. During the interim period, arrangements were being made to provide additional level 2 intensive care and HDU support for Maternity Services on the LGH site until 2017-18 with outreach into the delivery suite. Discussion took place regarding the process for sighting the Trust Board to this issue and it was agreed that the vehicle for this would be the Better Care Together Strategic Outline Case.

In discussion on the issues raised, Finance and Performance Committee members:-

(1) considered the workforce issues associated with embedding HDUs and ITUs within Maternity Services, given that the career path for Midwives was now direct entry (without prior nurse training). To mitigate this, a focus was being maintained in respect of skill mix and additional conversion courses for trained nurses were being offered through DeMontfort University;
(2) confirmed that the proposal to build up networking opportunities with other paediatric congenital heart centres was felt to be the most realistic scenario for building UHL's activity levels to achieve the national standard;
(3) queried whether there were any particular contributory factors affecting medical staffing recruitment, noting in response that the fill rate for training vacancies was good but it was proving challenging to recruit Consultants. Historically, the split site service, disjointed shift patterns and lack of training continuity had adversely affected recruitment and retention of staff. Feedback had also been provided that the service requirements were not always aligned with individual training needs, and
(4) noted that the business cases for development of a single Children's Hospital and a single Women's Hospital could now progress to Outline Business Cases (OBCs) due to the BCT programme setting out the Strategic Outline Case (SOC) for these changes.

The Acting Chair summarised by congratulating the CMG on their consistent financial and operational performance and robust approach to CIP delivery. She sought and received assurance regarding the process for converting 2015-16 CIP schemes from red to green RAG ratings, noting that the milestone to complete this work by the end of November 2014 was unlikely to be met, but work continued with EY to ensure that all the schemes were deliverable and this work would be completed by mid-December 2014. As in previous years, the CMG had set itself a target of 120% CIP delivery, to create a contingency to mitigate any slippage on individual schemes. In respect of RTT delivery, it was confirmed that the most challenged specialties were receiving additional support to maximise capacity and additional weekend lists would be continued.

Resolved – that the presentation and discussion on financial and operational

performance of the Women's and Children's CMG be received and noted.

126/14/2 Alliance Contract – High Level Programme for Transformation of Clinical Services

The Interim Director of the Alliance attended the meeting to present paper C, providing a summary of the high level programme for transforming identified UHL clinical services into the community setting. Appendix 1 provided an overview of the Better Care Together Planned Care Pathway Transformation workstream.

Particular discussion took place regarding the arrangements for transferring pain services into the community setting with effect from the fourth quarter of the year (January to March 2015) as this was recognised as the proof of concept case study. A recent change in clinical leadership had shifted the balance of clinical engagement in the scheme and the present clinical lead had highlighted some issues relating to clinical job planning. UHL had also raised concerns surrounding the expected loss of income and the duration of built in financial support to manage fixed cost pressures.

Other planned service changes would include ocular plastics, local anaesthetic hernia, and Barrett's Oesophagus (endoscopy) activity. Assurance was provided that the relevant business cases were being prepared for consideration by UHL's Revenue and Investment Committee and that the Trust would be supporting the principles of "left shift" into the community setting in accordance with the principles of Better Care Together Programme which aimed to provide the right services in the right place for patients, subject to the technical execution of the Alliance agreement that no organisation would suffer financial detriment as a result of the changes.

The Acting Chair requested that a further progress report on the transformation of UHL's clinical services to the Alliance be provided in January 2015. Finally, the Interim Alliance Director noted the need to clarify UHL's membership of the Alliance Management Board and the Alliance Leadership Board. **DS** **COO/ DF**

Resolved – that (A) the update and discussion on transformation of clinical services to the Alliance be received and noted;

(B) a further update be provided to the 29 January 2015 meeting, and **DS**

(C) UHL's membership of the Alliance Management Board and the Alliance Leadership Board be confirmed (outside the meeting) **COO/ DF**

126/14/3 Update on the Emergency Floor Outline Business Case (OBC)

The Chief Executive introduced paper E, particularly noting the pragmatic approach adopted towards activity assumptions and the letter of Commissioner support. The OBC was now scheduled for review by the regional TDA capital group in December 2014 and the national TDA capital investment group on 4 March 2015. Subject to TDA approval, the Full Business Case (FBC) would continue to be developed in parallel and it was expected that the main scheme would be ready to commence in April 2015.

In discussion on the report, the Finance and Performance Committee:-

(a) noted the potential impact of the 2015 general election (given that the purdah period would commence on 18 March 2015);
(b) sought and received additional information regarding the arrangements for re-commissioning Urgent Care provision on the LRI site and integrate this with the out of hours service. The contract was due to be re-tendered with a commencement date of April 2016 and UHL had already expressed a desire to be involved in the procurement process (as host of this service);
(c) confirmed that the proposed activity assumptions (provided on page 4 of paper E)

reflected a worst case scenario and that the sizing of capacity reflected a robust financial business case;

(d) queried the impact of marginal rate emergency tariff (MRET) upon the proposals, noting in response the Chief Operating Officer's view that the Trust should seek to re-set the 2008-09 MRET baseline once the Emergency Floor was opened and the assessment units were co-located in the new facilities, and

(e) requested that the activity scenarios be worked through in more depth as part of the work on the FBC. **DF**

Resolved – that (A) the proposed emergency activity assumptions be worked through in more depth, and **DF**

(B) the Emergency Floor FBC be presented to the Finance and Performance Committee in December 2014 or January 2015. **CE**

126/14/4 Progress Report on the Development of the Empath Business Case

The Director of Finance and the Head of Strategic Finance reported verbally, providing feedback from a recent meeting of the Empath Shareholders Group and commenting generally on the level of understanding (both within and outside of the host Trusts) in respect of the Empath model and the associated governance arrangements.

Mr N Calow, the Empath Finance Director was preparing a briefing paper on this subject and opportunities were being explored to separate the different components of the Empath service and establish a proper arms length body. Colonel (Retired) I Crowe, Non-Executive Director noted that Internal Audit had flagged 2 risks surrounding Empath governance arrangements. It was agreed that an update on this workstream would be presented to the Integrated Finance, Performance and Investment Committee in January 2015, alongside the Full Business Case.

Resolved – that the Empath FBC and a briefing paper on the Empath governance structure be presented to the 29 January 2015 meeting of the Integrated Finance, Performance and Investment Committee. **DF**

127/14 PERFORMANCE

127/14/1 Month 7 Quality and Performance Report

Paper F provided an overview of UHL's quality, patient experience, operational targets, and HR performance against national, regional and local indicators for the month ending 31 October 2014. The Chief Operating Officer reported on the following operational aspects of the report:-

(a) Emergency care 4 hour waits – a detailed update would be provided to the Trust Board on 27 November 2014 and this was expected to focus on patient inflow, outflow, attendance levels, delayed discharges, internal effectiveness, advice on ways of reducing clinical variability and the LLR response to the report produced by Dr I Sturgess;

(b) RTT 18 weeks (Minute 127/14/2 below refers);

(c) Cancer performance continued to be variable – the Executive Performance Board had considered this issue on 25 November 2015 and noted that small teams of pathway validation resources were shared between RTT and the cancer centre. Regular meetings were being held with the 5 most challenged tumour site teams;

(d) Cancelled operations performance had improved significantly and was now compliant with the target of no more than 0.8% of on the day cancellations. Only 2 of these cancellations had breached the target to rebook within 28 days, and

(e) Choose and Book slot availability stood at 20% – although compliant performance had not been achieved previously, a great deal of work was taking place in this area and it was expected that compliance with the 4% target would be achieved in the near future.

In respect of diagnostics performance, Dr S Dauncey, Non-Executive Director and Quality Assurance Committee (QAC) chair highlighted an issue affecting mammography pathways which was due to be considered at that afternoon's QAC meeting. The Chief Operating Officer advised that UHL had recently appointed a Director of Performance and Information who would be commencing in post in January 2015.

Resolved – that the month 7 Quality and Performance report (paper F) and the subsequent discussion be received and noted.

127/14/2 Progress Report on RTT Improvement Plan

The Chief Operating Officer referred members to the RTT exception report, as provided on pages 13 to 16 of the Quality and Performance report (paper F). He advised that the November 2014 target to achieve 95% RTT admitted compliance had not been met and that the earliest that compliance could be expected now was January 2015. Some robust improvements had been made within all the challenged specialties but the early pace of embedding the changes had not been as fast as required. Within the non-admitted target, Orthopaedics waiting lists were causing the most concern.

The Acting Chair queried whether any additional support would be required to improve RTT performance within the Orthopaedics speciality and it was agreed to invite the service to attend the Integrated Finance, Performance and Investment Committee meeting in January or February 2015 to explore any additional areas of support that might be required. Members noted that the Trust Board walkabout on 27 November 2014 would include some of the Orthopaedics services based at Glenfield Hospital and that additional weekend operating lists were being held in order to address an increase in referrals which was also being experienced at a national level. **COO**

The Chief Executive noted the need to brief Trust Board members on the revised RTT trajectory ahead of the Board to Board meeting with the NTDA on 7 January 2015 and he suggested that a detailed review of the Trust's trajectory towards RTT compliance be undertaken at the 18 December 2014 Finance and Performance Committee meeting. **COO**

Resolved – that (A) the exception report and discussion on RTT performance be received and noted,

(B) representatives from the Orthopaedics service be invited to attend the Integrated Finance, Performance and Investment Committee meeting in January or February 2015 to explore any additional areas of support required to improve RTT performance, and **COO**

(C) a detailed review of UHL's trajectory towards achieving a compliant RTT position be undertaken at the 18 December 2014 Finance and Performance Committee meeting. **COO**

127/14/3 Clinical Letters Performance

The Chief Operating Officer reported verbally on improvements in clinical letters performance within the Renal, Respiratory and Cardiac CMG following a focused piece of work within that CMG over the last 6 weeks. The backlog of letters awaiting typing had reduced from approximately 1,400 to 400 and all of the vacant administrative and clerical positions had been recruited to. Arrangements were being made with the IM&T

department regarding the arrangements for further embedding Dictate IT and the associated CMG entry on the risk register was due to be re-scored accordingly.

This rapid improvement had provided the evidence required for proof of concept and arrangements were now being made to roll-out this robust approach to the remaining CMGs, recognising the importance of timely discharge and clinic correspondence. A further update on progress would be provided to the 18 December 2014 meeting. **COO**
Subject to the outcome of this workstream, proposals to implement a single technical solution for the Trust had been put on hold.

Resolved – that the improved clinical letters performance in the RRC CMG be noted and an update on proposals to roll-out the same approach within the remaining CMGs be provided on 18 December 2014. **COO**

127/14/4 Update on the Ambulance Turnaround Action Plan

Paper G provided a short position statement on the contractual elements of ambulance turnaround times and the process for gathering robust data to support accurate performance reporting.

Since paper G had been circulated, Commissioners had agreed to change UHL's data capture mechanism to the more widely used RFID tagging. This system was generally accepted to be more accurate and this was expected to be in place by the fourth quarter of 2014-15. In the meantime, UHL would continue to work with EMAS to improve ambulance handover processes. An update on the impact of the new data capture mechanism would be provided in February 2015. The Trust Chairman commented that **COO**
he would be meeting with the EMAS Chairman in the near future and that this issue was likely to feature in their discussions.

Resolved – that an update on ambulance turnaround times and the impact of the new data capture mechanism be provided to the Integrated Finance, Performance and Investment Committee on 26 February 2015. **COO**

128/14 FINANCE

128/14/1 2014-15 Financial Position to Month 7

The Director of Finance introduced papers H and H1 providing an update on UHL's performance against the key financial duties surrounding delivery of the planned deficit, achievement of the External Financing Limit (EFL) and achievement of the Capital Resource Limit (CRL), as submitted to the 27 November Trust Board and the 25 November Executive Performance Board (respectively). He particularly drew members' attention to the following key risks:-

(a) data warehouse errors which had led to the month 7 income position being estimated. Some immediate IBM resources had been agreed to address the problem which had arisen from some experienced UHL staff leaving and not being replaced. Assurance was provided that additional monitoring and scrutiny arrangements had been implemented. Since the reports had been circulated, the confirmed income position had improved by £600,000;
(b) the contractual position with Commissioners and the process for handling activity query notices. A memorandum of understanding had been signed off to agree a collaborative framework of principles to handle specific areas of dispute, although this had already been superseded by subsequent discussions, and
(c) the ability of CMGs to deliver their control totals whilst handling winter pressures. With effect from January 2015, weekly meetings would be held with each CMG to monitor their performance.

In response to Non-Executive Directors' questions on the financial report, the Director of Finance advised that:-

(i) the cash flow forecast was robust for 2014-15 and an update on the longer-term cash flow position would be included in future iterations of the financial performance reports; **DF**
(ii) premium pay expenditure trends were increasing and the most noticeable increase in nursing agency use within Emergency and Specialist Medicine. For 2015-16, one of the 4 cross-cutting CIP schemes would specifically focus on workforce, and
(iii) the Musculoskeletal and Specialist Surgery CMG was being held to account for its revised year end control total and a significant portion of the data warehouse additional income had been attributed to this CMG. A detailed review of the first half year performance was being undertaken and the CMG was expected to deliver a break-even position for the second half of the financial year (which would be a positive improvement on the earlier forecast position).

Resolved – that the briefings on UHL's Month 7 financial performance (papers H and H1) and the subsequent discussion be noted.

128/14/2 Cost Improvement Programmes for 2014-15 and 2015-16

Ms E MacLellan-Smith, EY attended the meeting to present paper I, providing the monthly update on CIP performance for 2014-15 and plans for 2015-16. Members noted that the total forecast CIP value for 2014-15 stood at £48.16m and that the value of green RAG-rated schemes had now exceeded the £45m target for the first time (£45.14m). Work was continuing to convert the remaining £3m red and amber schemes to green, but in the event of any slippage, arrangements would be made to bring forward some of the early 2015-16 schemes to make up the difference. The main risks to full delivery of the required savings for 2014-15 relating to management of operational pressures during the winter period and recruitment of nursing staff in Emergency and Specialist Medicine to reduce agency nursing expenditure.

For the 2015-16 programme, the Trust was not likely to meet the end of November 2014 milestone to have 60% of its plans (against the £41m target) RAG rated green or amber, but this was expected to be achieved during the early part of December 2014. Wave 2 of the service reviews in loss-making specialties was underway – this included dermatology, cardiology and general surgery. A more joined-up approach was being developed to reduce the risk of double-counting CIP benefits within wider business case development and the Better Care Together Programme.

In respect of the 4 high impact cross-cutting CIP themes for 2015-16, the Chief Operating Officer had been confirmed as the SRO for (1) beds, (2) theatres and (3) outpatients and the Director of Finance had been confirmed as the SRO for (4) workforce. Substantive appointments had been made for 2 of the 7 PMO support roles for the CMGs and interviews for the remaining 5 posts would be held in December 2014. Appropriate EY and UHL training and development programmes would be provided for all these postholders.

Colonel (Retired) I Crowe, Non-Executive Director noted that no progress had been reported in respect of the Research and Development Directorate's CIP target for 2015-16 and he queried whether there were any issues that the Committee should be aware of. In response, it was noted that the Directorate had not appreciated the scale of the target or the milestones required. It was agreed that an update on this issue would be incorporated into the next iteration of the CIP report. **COO**

The Director of Finance reported verbally on the new PMO assurance processes, noting that weekly meetings would be held on a Monday afternoon starting in January 2015. He also endorsed the strategic approach to 2015-16 CIP planning, noting that December

was a key month for assessing the progress of CIP plans for the next financial year.

Resolved – that (A) the CIP update (paper I) and the subsequent discussion be noted, and

(B) an update on the R&D Directorate's progress with 2015-16 CIP planning be included in the December 2014 CIP update. **COO**

128/14/3 Patient Level Information and Costing System (PLICS), Service Line Reporting (SLR) and Reference Costs Update

Paper J provided the quarterly update on the continued development of PLICS and SLR and an update on the Trust's 2013-14 Reference Cost submission. Appendix 1 set out the SLR position broken down by CMG and service and appendix 2 provided a comparison of the index scores with other peer group Trusts. In view of time constraints at this meeting, and the limited opportunity for the Director of Finance to comment on the accuracy of this data or the embedded position, it was agreed to defer a substantive discussion on this item to the next meeting. **DF**

The Committee noted a need for Non-Executive Directors and the wider Trust Board membership to receive some form of financial awareness training in order to fully interpret and appreciate the impact of the Reference Cost scores. In summary, the Director of Finance noted the purpose of the reference costs information and confirmed that UHL's draft position for 2013-14 had worsened to 101 (from 97 in the previous 2 years). **DF**

Resolved – that (A) a substantive discussion on the PLICS/SLR and Reference Cost update be deferred to the 18 December 2014 meeting, and **DF**

(B) the Director of Finance be requested to explore the scope to provide financial awareness training for all Trust Board members. **DF**

129/14 SCRUTINY AND INFORMATION

129/14/1 Clinical Management Group (CMG) Performance Management Meetings

Colonel (Retired) I Crowe, Non-Executive Director commented on the lack of some CMGs' responses to the identified actions arising from these meetings.

Resolved – that the action notes arising from the October 2014 Performance Management meetings (paper K) be received and noted.

129/14/2 Executive Performance Board

Resolved – that the notes of the 28 October 2014 Executive Performance Board meeting (paper L) be received and noted.

129/14/3 Quality Assurance Committee (QAC)

Resolved – that the 29 October 2014 QAC Minutes (paper M) be received and noted.

129/14/4 Revenue Investment Committee

Resolved – that the 17 November 2014 Revenue Investment Committee notes (paper N) be received and noted.

129/14/5 Capital Monitoring and Investment Committee

Resolved – that the 17 November Capital Monitoring and Investment Committee notes (paper O) be received and noted.

130/14 ITEMS FOR DISCUSSION AT THE NEXT FINANCE AND PERFORMANCE COMMITTEE

Paper P provided a draft agenda for the 18 December 2014 meeting and it was agreed that the agenda would be revised following discussion at today's meeting and re-circulated accordingly.

Resolved – that the items for consideration at the Finance and Performance Committee meeting on 18 December 2014 be revised and re-circulated. **TA**

131/14 ANY OTHER BUSINESS

Resolved – that no other items of business were noted.

132/14 ITEMS TO BE HIGHLIGHTED TO THE TRUST BOARD

Resolved – that the following issues be highlighted verbally to the Trust Board meeting on 27 November 2014:- **Acting Chair**

- **Confidential Minute 122/14 – Report by the Chief Executive;**
- **Minute 126/14/3 – update on the Emergency Floor OBC, and**
- **Minute 127/14/1 – operational performance (including RTT performance).**

133/14 DATE OF NEXT MEETING

The Trust Administrator was requested to change the venue for the 18 December 2014 Finance and Performance Committee meeting to the Leicester Royal Infirmary. **TA**

Resolved – that the next Finance and Performance Committee be held on Thursday 18 December 2014 from 8.30am – 11.30am in the Board Room, Victoria Building Leicester Royal Infirmary (please note change of venue).

The meeting closed at 11:45am

Kate Rayns, Acting Senior Trust Administrator

Attendance Record 2014-15

Name	Possible	Actual	% attendance	Name	Possible	Actual	% attendance
J Wilson (Acting Chair from 29.10.14)	8	7	87%	P Hollinshead	3	3	100%
R Kilner (Chair up to 24.9.14)	6	6	100%	S Sheppard	4	4	100%
J Adler	8	7	87%	G Smith *	8	8	100%
I Crowe	8	7	87%	P Traynor (from 26.11.14)	1	1	100%
R Mitchell	8	8	100%				

* non-voting members

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: 22 December 2014

COMMITTEE: Quality Assurance Committee

CHAIR: Dr S Dauncey, Acting QAC Chair

DATE OF COMMITTEE MEETING: 26 November 2014

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

- **None.**

OTHER KEY ISSUES IDENTIFIED BY THE COMMITTEE FOR THE INFORMATION OF THE TRUST BOARD:

- **Minute 99/14/1 (Breast Screening Performance – in particular regarding data quality), and**
- **Minute 103/14/1 (Renal Satellite Service in Corby).**

DATE OF NEXT COMMITTEE MEETING: 15 December 2014

Dr S Dauncey
Acting QAC Chairman
15 December 2014

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST

MINUTES OF A MEETING OF THE QUALITY ASSURANCE COMMITTEE HELD ON WEDNESDAY 26 NOVEMBER 2014 AT 12:30PM IN SEMINAR ROOMS A & B, LEICESTER GENERAL HOSPITAL

Present:
Dr S Dauncey – Non-Executive Director (Acting Chair)
Mr J Adler – Chief Executive
Mr M Caple – Patient Adviser (non-voting member)
Ms R Overfield – Chief Nurse
Mr P Panchal – Non-Executive Director
Ms J Wilson – Non-Executive Director

In Attendance:
Mrs G Belton – Trust Administrator
Mr I Crowe – Non-Executive Director
Miss M Durbridge – Director of Safety and Risk
Mrs S Hotson – Director of Clinical Quality
Mrs S Khalid – Clinical Director, CSI (for Minute 99/14/1)
Dr N Moore – Clinical Director, RRC CMG (for Minute 99/14/2)
Ms C Ribbins – Deputy Chief Nurse
Mr I Scudamore – Clinical Director, Women's and Children's CMG (for Minute 99/14/3)
Mr K Singh – Trust Chairman (up to and including Minute 99/14/4, with the exception of Minute 99/14/2)

RESOLVED ITEMS **ACTION**

96/14 APOLOGIES

Apologies for absence were received from Ms C O'Brien, Chief Nurse and Quality Officer, East Leicestershire CCG, Dr K Harris, Medical Director and Professor D Wynford-Thomas, Non-Executive Director and Dean of the University of Leicester Medical School.

97/14 MINUTES

Resolved – that the Minutes of the Quality Assurance Committee meeting held on 29 October 2014 (papers A and A1 refer) be confirmed as a correct record.

98/14 MATTERS ARISING REPORT

98/14/1 Matters Arising Report

Members received and noted the contents of paper 'B', noting that those actions now reported as complete (level 5) would be removed from future iterations of this report. **ASTA**
Members specifically reported on progress in respect of the following actions:-

(i) Minute 88/14/1d (regarding progress with the Complaints Process Review) – the Director of Safety and Risk reported verbally to advise that she had previously submitted an action plan to the Trust Board regarding this matter. It was currently anticipated that a full update on progress against the plan would be submitted to the Trust Board in December 2014, and this would include an update on the proposed External Complaints Panel which was expected to go live in pilot form in the New Year. This Panel would report into EQB and to QAC by exception. The Director of Safety and Risk was requested to submit a report to QAC in February 2015 regarding progress to-date in relation to the External Complaints Panel. It was also agreed that discussions should continue, outwith the meeting, as to whether it would be appropriate for a Non-Executive Director from the Trust to sit on the External Complaints Panel; **DSR/ ASTA**

(ii) the fact that actions relating to the following Minute references had now been

completed or were scheduled for receipt within other Trust forums, and could therefore be closed down on the QAC Matters Arising log (Minute references 88/14/1e, 89/14/1, 89/14/3, 90/14/5); **ASTA**

(iii) Minute 76/14 (regarding the draft QAC work programme) – discussions remained in progress, and an update would be provided when these had been concluded; **QAC Chair/ ASTA**

(iv) Minute 77/14/4 (regarding the Patient Safety Annual Report 2013/14) and Minute 79/14/2 (regarding the Complaints Annual Report 2013/14) – it was agreed that these reports would both be submitted to the QAC meeting on 29 January 2015; **DSR/ ASTA**

(v) Minute 82/14/1 (regarding the submission of a report to QAC in relation to the learning from claims and inquests, including Regulation 28 letters) – it was noted that this report was due to be submitted to EQB on 2 December 2014, and thereafter QAC on 15 December 2014, and the log required updating accordingly, and **ASTA**

(vi) Minute 34/14/3 from 30 July 2014 (regarding the provision of an update to QAC in November 2014 by the Women's and Children's CMG on how they sought assurance that the recommendations from a review relating to a SUI (retained vaginal swab) had been followed through and that a relevant audit mechanism was in place) – the Acting QAC Chair reported verbally, advising members of the confirmation provided by the Clinical Director, W&C CMG that an audit had been undertaken and would be repeated, the outcome of which would be reported to the EQB, with any issues escalated to QAC if required.

Resolved – that the matters arising report (paper B refers) and the actions outlined above be noted and undertaken by those staff members identified.

99/14 SAFETY

99/14/1 Breast Screening Performance

The Clinical Director of the Clinical Support and Imaging CMG attended to present paper 'C', the purpose of which was to brief the Committee of the reason for breaching against the 62 day screening target, which was as a result of incorrect start dates being recorded on the National Breast Screening Service (NBSS) computer system and to advise of the action undertaken as a consequence. This same report had also been submitted for discussion at the Clinical Quality Review Group held on 20 November 2014. The process now undertaken for breast screening was to be repeated for all other screening and the 62 day screening target would also undergo UHL Data Quality Diamond Review in November 2014.

In discussion on this item, members queried how they could be assured that indicators RAG-rated 'green' in the various Trust metrics were actually green and that the data leading to a 'green' rating was actually correct. It was noted that it was the purpose of the Audit Committee to seek such assurance (through Internal Audit and other such mechanisms) and that assurance could also be provided through the planned Data Quality Diamond Review. In conclusion, it was noted that the results of the Data Quality Diamond Review (once known) would be reported through to EQB and CQRG, with any specific issues escalated to QAC as appropriate. **CD,CSI**

Resolved – that (A) the contents of this report be received and noted, and

(B) the Clinical Director, CSI be requested to report back to EQB and CQRG with the results of the Data Quality Diamond Review (once known), with any specific issues then escalated to QAC as appropriate. **CD,CSI**

99/14/2 Report by the Clinical Director, Renal, Respiratory and Cardiac

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

99/14/3 Update on Perinatal Mortality

Further to Minute 34/14/1 of 28 May 2014, Mr I Scudamore, Clinical Director, Women's and Children's CMG, attended to present paper 'E', which reported on perinatal mortality at UHL and the plan to manage and reduce perinatal mortality. The Perinatal Mortality Working Group had been established in 2012 and had developed a strategy for reviewing and analysing all perinatal deaths, identifying trends and themes and developing strategies to develop the principle local issues.

Mr Scudmore particularly highlighted the following in his presentation of the report:

(1) the current perinatal mortality data – there was no national comparator currently for the Trust's stillbirth rate. A national comparator would be available when MBRRACE produced their first report containing the data for 2013 (expected for publication in Summer 2015);
(2) all perinatal deaths continued to be reviewed on a monthly basis by the Perinatal Mortality Review Panel with any learning points fed back via the CMG risk management structure, and
(3) strategies to reduce perinatal mortality, i.e. through the identification of undiagnosed growth restriction and improving the detection and management of reduced fetal movements.

The report also made note of changes to the coding of perinatal deaths and local scrutiny of the 2012 perinatal mortality data in comparison to the 2009 data.

Particular discussion took place regarding the following:

(i) a query was raised as to when the IGUR pathway would be implemented (noting that this was currently stated as January 2015, but that staff training was due to be undertaken in February 2015) – Mr Scudamore confirmed that it would be implemented in February 2015, and members requested that the action plan was updated to reflect this; **CD,W&C**

(ii) whether there existed any issues in relation to perinatal mortality in respect of particular groups within the health community (e.g. patients with diabetes, patients whose ethnic origin could make them susceptible to particular health issues etc). Note was also made of the potential benefits to be achieved by working in partnership with the CCGs and establishing links with particular community groups themselves. Also noted was the potential to establish best practice from the Patient Experience Surveys and utilise this in communication with those patient groups who were traditionally harder to reach. Mr Scudamore noted that there were particular patient groups who received dedicated specialist midwifery support, and that a main driver in reducing perinatal mortality would be through the identification of undiagnosed growth restriction, and

(iii) the fact that the MBRRACE data would be available by Summer 2015 and members requested that Mr Scudamore present the results of this, when available, to the Mortality Review Committee, EQB, CQRG and QAC. **CD, W&C**

Resolved – that (A) the contents of this report, and the additional information provided, be received and noted, and

(B) Mr Scudamore, Clinical Director of the Women's and Children's CMG, be requested to undertake the actions outlined under points (i) and (iii) above. **CD,W&C**

99/14/4 Patient Safety Report

The Director of Safety and Risk presented paper 'F', which provided a monthly update

on internal safety issues and serious incidents and external safety news and developments. In her presentation of the report, the Director of Safety and Risk particularly highlighted those points outlined on the first covering page, in particular the two key safety issues this month.

The Committee was particularly invited to:-

(a) note the updated information received with regard to the Sign up to Safety initiative and the Trust's progress to date;
(b) note the changes to the NHS England Never Events Framework 2015/16 (as detailed in appendix 2 to the report), and
(c) consider whether this Committee wished to continue to receive this level of detail in respect of SUIs, RCA performance and quarterly reports, noting that the Executive Quality Board also received this information.

In discussion on this item, members:

(i) debated the content they would wish to see in future iterations of the Patient Safety Report, noting the need to be strategic in focus but also to retain a certain level of detail. Note was also made that much of the detail was contained within the dashboard in the Quality and Performance report, which could be discussed at greater length at future QAC meetings. Note was also made that all Non-Executive Directors saw the details of SUIs via other mechanisms. In conclusion on this point, it was agreed to further discuss the actual content of future iterations of this report outwith the meeting. The Director of Safety and Risk was requested to provide information relating to patient safety developments in a new format for a trial period of three months from January 2015; **DSR/TA**
(ii) noted that it was occasionally difficult for non-clinical members of the Committee to understand why particular incidents were determined as SUIs (if this was not clear in the description of the incident when logged into the system by relevant staff), and
(iii) noted the details of a recent Never Event that had occurred, as verbally reported by the Director of Safety and Risk.

<u>Resolved</u> - that (A) the contents of this report, and the additional verbal information provided, be received and noted,

(B) further discussion be held outwith the meeting regarding the actual content of future iterations of patient safety reports, and **DSR/CN**

(C) the Director of Safety and Risk be requested to provide information relating to patient safety developments in a new format for a trial period of three months from January 2015. **DSR**

100/14 QUALITY

100/14/1 <u>CQC Action Plan (compliance actions)</u>

The Director of Clinical Quality presented paper 'G', which provided an update against compliance actions detailed in the CQC action plan and had been submitted to QAC following detailed discussion at the EQB on 4 November 2014.

Particular discussion took place regarding the following points:

(i) the challenge that lay in remaining RAG-rated 'green' against the estates-related actions;
(ii) review of data in relation to the over 70s;
(iii) assurance was sought that the key metrics were being presented – it was noted that updates would be provided as part of this on-going regular report;

(iv) particular workstreams relating to the CDU at Glenfield Hospital and Emergency Care;
(v) the fact that a report on the CQC 'Should do' actions was shortly due to be submitted to EQB, and thereafter would be submitted to QAC, and
(vi) whistleblowing – the Trust had a policy relating to this issue which was a workforce policy and was referenced under item 5.2 on the agenda (paper H refers).

Resolved – that the contents of this report be received and noted.

100/14/2 CQC Intelligent Monitoring Report

The Director of Clinical Quality presented paper 'H', which informed the Committee of the findings from the latest draft CQC Intelligent Monitoring Report (IMR) which was due to be published on 3 December 2014. Note was made that, as a recently inspected Trust, UHL had not been given a 'banding'.

Particular discussion took place in respect of the following:

(i) whistleblowing, which was an 'elevated risk' for the Trust;
(ii) the fact that it would be helpful to triangulate staff views (as well as patient views);
(iii) appendix II to the report detailed items of risk and elevated risk and noted the actions on-going within the Trust in response to these;
(iv) anticipated changes in respect of the way in which ambulance waiting times would be recorded (as agreed with Commissioners), and
(v) note was made that the information documented was historical (i.e. 9 month's old).

Resolved – that the contents of this report be received and noted.

100/14/3 Update against PwC Review of Quality Assurance Arrangements Recommendations

The Director of Clinical Quality presented paper 'I', which informed members of the results of PWC's review of the UHL Quality Assurance Framework. Appendix 1 of paper I detailed a copy of the full report and Appendix 2 detailed an extract of agreed actions, nominated lead officers and progress to-date, which was monitored through the TrAction online audit system.

Resolved – that the contents of this report be received and noted.

100/14/4 Quality Impact Assessment of CIP Schemes

The Chief Nurse presented paper 'J', which provided the Committee with a report of Quality Impact Assessment at quarter 2 for the 2014/15 Cost Improvement Scheme, and particularly highlighted that there were no significant quality and safety impacts for this year.

In discussion on this item, members:

(i) noted the detail presented in this report, which was useful to see upon its first receipt at the Committee, however agreed that a summary report could be provided when this document was next submitted to the Committee in February 2015; **CN**
(ii) made note of the Confirm and Challenge meetings which took place every month, and of the focus of these meetings on finance, performance and quality and safety, and of the intention to have four cross-cutting themes in the next financial year around which quality assurance would be undertaken, the process for which was briefly discussed, and

(iii) noted that if any of these transformational streams had resulted in quality or safety impacts, these would have been identified through the various metrics which was regularly monitored.

Resolved – that the contents of this report be received and noted.

100/14/5 Nursing Workforce Report

The Chief Nurse presented paper 'K', which detailed information in respect of the latest nursing staffing in post figures, the current recruitment position and the mitigation of workforce gaps.

In discussion on this item, members:

(i) queried, in light of the continuing need to seek additional nursing staff from overseas, whether the pool from which such staff could be recruited was diminishing given that nurse recruitment was a national issue and that an increasing number of Trusts would be seeking additional nursing staff from overseas – it was noted that whilst the pool of overseas nursing staff available to work in the UK was decreasing, the most important element was retention and UHL had a very good retention rate of its staff in light of its good reputation in this respect;
(ii) feedback received from the overseas nursing staff in terms of their experience to-date of working in the NHS;
(iii) noted the importance of continuing focus on the training and subsequent recruitment of UK-based nursing staff in light of the training period required prior to practice;
(iv) noted the importance of retaining high calibre caring individuals within nursing, as it moved to a degree-based profession, and
(v) queried whether the use of agency nurses was likely to increase this Winter – whilst this was possible, there were significantly less substantive vacancies this year than in previous years. The areas where increased agency nurses were most likely to be required was in Medicine and Paediatrics.

Resolved – that the contents of this report and the additional verbal information provided, be received and noted.

100/14/6 Month 7 – Quality and Performance Update

The Chief Nurse presented paper 'L', which provided an overview of the October 2014 Quality and Performance report highlighting NTDA / UHL key metrics and escalation reports where required.

In discussion on this item, members:

(i) agreed to schedule 15 minutes for discussion on this item at future QAC meetings; **TA**
(ii) requested that the Medical Director nominate and arrange for an appropriate Deputy to attend QAC meetings in his absence, and speak to this report alongside the Chief Nurse, where required; **MD**
(iii) noted that the Director of Estates and Facilities would be producing a quarterly report, the first of which was due next month;
(iv) made note of the unannounced cleaning audits, the results of which would be detailed within the next Q & P report;
(v) noted Mr Caple's observations with regard to a Food Forum meeting he had recently attended;
(vi) made note of the latest FFT figures, in particular those in maternity, and noted that the Deputy Chief Nurse would be meeting with the Head of Midwifery and Head of Nursing, Women's and Children's CMG regarding

their plan to improve their response rates and target the feedback they had been receiving.

Resolved – that (A) the contents of this report be received and noted,

(B) the Trust Administrator be requested to schedule fifteen minutes for discussion on the Q & P reports at future meetings to allow time for more detailed discussions, and **TA**

(C) the Medical Director be requested to nominate and arrange for an appropriate Deputy to attend QAC meetings in his absence. **MD**

101/14 ITEMS FOR THE ATTENTION OF QAC FROM EQB

91/14/1 EQB Meeting of 4 November 2014 – Items for the attention of QAC

Resolved – that relevant items of business arising from the EQB meeting of 4 November 2014 had been addressed elsewhere on the agenda.

102/14 MINUTES FOR INFORMATION

102/14/1 Finance and Performance Committee

Resolved – that it be noted that the public Minutes of the 26 October 2014 meeting of the Finance and Performance Committee would be submitted to the Quality Assurance Committee meeting on 15 December 2014.

102/14/2 Executive Performance Board

Resolved – that the action notes of the 28 October 2014 Executive Performance Board meeting (paper M refers) be received and noted.

103/14 ANY OTHER BUSINESS

103/14/1 Renal Satellite Service in Corby

The Director of Clinical Quality verbally briefed members in respect of the proposal (for Trust Board agreement) that UHL would assume responsibility for the staff working at the Renal Satellite Service in Corby from 1 December 2014 (with these staff due to be TUPED over to UHL) and explained the background to this proposal. It was noted that the Director of Corporate and Legal Affairs would be briefing the Trust Board Chairman on this proposal ahead of the Trust Board meeting due to be held the following day, and that the Acting QAC Chair would raise this matter, for Trust Board approval, during her verbal report to the Trust Board at tomorrow's meeting on items arising from today's QAC meeting.

Resolved – that (A) this verbal report be noted, and

(B) the Acting QAC Chair be requested to raise this matter at tomorrow's Trust Board meeting. **AQC**

103/14/2 PHSO Report on Complaints

The Director of Safety and Risk verbally briefed members in respect of the contents of the (currently embargoed) PHSO report on complaints for Acute Trusts, and the resulting media enquiries received. It was noted that the Chief Nurse would respond on this matter should it be raised at the Trust Board meeting the following day.

Resolved – that this verbal information be noted.

103/14/3 Servicing of QAC

The Acting QAC Chair expressed her thanks to Mrs Belton, currently Acting Senior Trust Administrator, for her work in servicing the QAC Committee. Mrs Belton would no longer be servicing QAC in December 2014 or in 2015 due to the change in the Committee's meeting day.

Resolved – that this be noted.

104/14 IDENTIFICATION OF ANY KEY ISSUES FOR THE ATTENTION OF THE TRUST BOARD

Resolved – that the QAC Chair be requested to bring the following issues to the attention of the Trust Board at its meeting the following day:

- **Minute 99/14/1 (Breast Screening Performance – in particular regarding data quality),**
- **Minute 99/14/2 (Report from the Clinical Director of Renal, Respiratory and Transplant), and**
- **Minute 103/14/1 (Renal Satellite Service in Corby).**

105/14 DATE OF NEXT MEETING

Resolved – that the next meeting of the Quality Assurance Committee be held on Monday 15 December 2014 from 12.30pm until 3.30pm in the Large Committee Room, Leicester General Hospital.

The meeting closed at 2.58pm.

Cumulative Record of Members' Attendance (2014-15 to date):

Name	*Possible*	*Actual*	*% attendance*	*Name*	*Possible*	*Actual*	*% attendance*
J Adler	8	6	75%	*R Overfield*	8	7	88%
*M Caple**	8	6	75%	*P Panchal*	8	5	63%
S Dauncey (Acting Chair)	8	7	88%	*J Wilson*	8	7	88%
K Harris	8	6	75%	*D Wynford-Thomas*	8	3	38%
K Jenkins	1	0	0%				
*C O'Brien – East Leicestershire/Rutland CCG**	8	4	50%				

** non-voting members*

Gill Belton – **Acting Senior Trust Administrator**

University Hospitals of Leicester NHS
NHS Trust

Agenda Item: Trust Board Paper K

TRUST BOARD MEETING – 22ND DECEMBER 2014

2014/15 FINANCIAL POSITION (MONTH 8)

DIRECTOR:	Paul Traynor - Director of Finance
AUTHOR:	Paul Traynor - Director of Finance
DATE:	22nd December 2014
PURPOSE:	This paper provides the Trust Board with an update on performance against the key financial duties: • Delivery against the planned deficit • Achieving the External Financing Limit (EFL) • Achieving the Capital Resource Limit (CRL) The paper also provides further commentary on the key risks
PREVIOUSLY CONSIDERED BY:	Not applicable
Objective(s) to which issue relates *	☐ 1. Safe, high quality, patient-centred healthcare ☐ 2. An effective, joined up emergency care system ☐ 3. Responsive services which people choose to use (secondary, specialised and tertiary care) ☐ 4. Integrated care in partnership with others (secondary, specialised and tertiary care) ☐ 5. Enhanced reputation in research, innovation and clinical education ☐ 6. Delivering services through a caring, professional, passionate and valued workforce ☑ 7. A clinically and financially sustainable NHS Foundation Trust ☐ 8. Enabled by excellent IM&T
Please explain any Patient and Public Involvement actions taken or to be taken in relation to this matter:	Considered but not relevant to this paper
Please explain the results of any Equality Impact assessment undertaken in relation to this matter:	Considered but not relevant to this paper
Organisational Risk Register/ Board Assurance Framework *	☑ **Organisational Risk Register** ☑ **Board Assurance Framework** ☐ **Not Featured**
ACTION REQUIRED *	For decision ☐ For assurance ☑ For information ☐

♦ We treat people how we would like to be treated ♦ We do what we say we are going to do
♦ We focus on what matters most ♦ We are one team and we are best when we work together
♦ We are passionate and creative in our work

* tick applicable box

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST

REPORT TO: **TRUST BOARD**

DATE: **22 DECEMBER 2014**

REPORT FROM: **PAUL TRAYNOR - DIRECTOR OF FINANCE**

SUBJECT: **2014/15 FINANCIAL POSITION TO MONTH 8**

1. INTRODUCTION AND CONTEXT

1.1. This paper provides the Trust Board with an update on performance against the Trust's key financial duties, namely:

- Delivery against the planned deficit
- Achieving the External Financing Limit (EFL)
- Achieving the Capital Resource Limit (CRL)

1.2. The paper provides further commentary on financial performance by the CMGs and Corporate Directorates, risk and assumptions and makes recommendations for the relevant Directors.

1.3 The paper also provides detail on the forecast outturn for 2014/15 including risk and opportunities.

2. KEY FINANCIAL DUTIES

2.1. The following table summarises the year to date position and full year forecast against the financial duties of the Trust:

Financial Duty	YTD Plan £'Ms	YTD Actual £'Ms	RAG	Forecast Plan £'Ms	Forecast Actual £'Ms	RAG
Delivering the Planned Deficit	(24.6)	(26.0)	R	(40.7)	(40.7)	G
Achieving the EFL	33.5	16.3	G	50.3	50.3	G
Achieving the Capital Resource Limit	34.2	19.8	A	46.2	46.2	G

2.2 As well as the key financial duties, a subsidiary duty is to ensure suppliers invoices are paid within 30 days – the Better Payment Practice Code (BPPC). The year to date performance is shown in the table below:

Better Payment Practice Code	April - November YTD 2014	
	Number	Value £000s
Total bills paid in the year	89,628	426,667
Total bills paid within target	45,194	298,402
Percentage of bills paid within target	**50%**	**70%**

Key issues

- In month favourable movement to plan of £0.3m, with a year to date deficit to plan of £1.4m
- The in month position was as it was forecast to be
- Year end forecast of £40.7m can be delivered. CMGs and Directorates must deliver to control totals to ensure this
- CIP programme has identified £48.1m of plans against the £45m target. Development of plans for 2015/16 has begun

3. FINANCIAL POSITION (MONTH 8)

3.1. The Month 8 results may be summarised as follows and as detailed in Appendix 1:

	November 2014			April - November 2014		
	Plan £m	Actual £m	Var (Adv) / Fav £m	Plan £m	Actual £m	Var (Adv) / Fav £m
Income						
Patient income	57.7	58.6	0.9	468.2	466.7	(1.6)
Teaching, R&D	6.8	6.9	0.1	54.3	54.5	0.1
Other operating Income	3.1	3.0	(0.1)	24.8	25.3	0.5
Total Income	**67.6**	**68.5**	**1.0**	**547.3**	**546.4**	**(0.9)**
Operating expenditure						
Pay	42.0	42.0	0.0	330.2	326.9	3.3
Non-pay	27.1	27.6	(0.6)	212.2	215.9	(3.7)
Total Operating Expenditure	**69.1**	**69.6**	**(0.5)**	**542.4**	**542.8**	**(0.4)**
EBITDA	**(1.5)**	**(1.1)**	**0.4**	**4.9**	**3.6**	**(1.3)**
Net interest	0.0	0.0	0.0	0.1	0.0	0.0
Depreciation	(2.0)	(2.0)	(0.1)	(22.5)	(22.5)	(0.1)
PDC dividend payable	(1.0)	(1.0)	0.0	(7.1)	(7.1)	0.0
Net deficit	**(4.5)**	**(4.2)**	**0.3**	**(24.6)**	**(26.0)**	**(1.4)**
EBITDA %		**-1.6%**			**0.7%**	

3.2 In the month of November, the Trust delivered a deficit of £4.2m against a planned deficit of £4.5m, a favourable variance of £0.3m.

3.3 Year to date, the deficit at the end of November is £26.0m, £1.4m worse than the £24.6m planned deficit.

3.4 The significant reasons for the in month and year to date variances against income and operating expenditure are:

Income

Income is £1.0m favourable to plan in month. YTD income is £0.9m adverse to plan:

- Daycase and elective activity £0.1m better than plan
- Emergency and non-elective activity £0.1m worse than plan after MRET adjustment
- Outpatients £0.4m better than plan
- A&E £0.1m better than plan
- Critical Care £0.3m better than plan

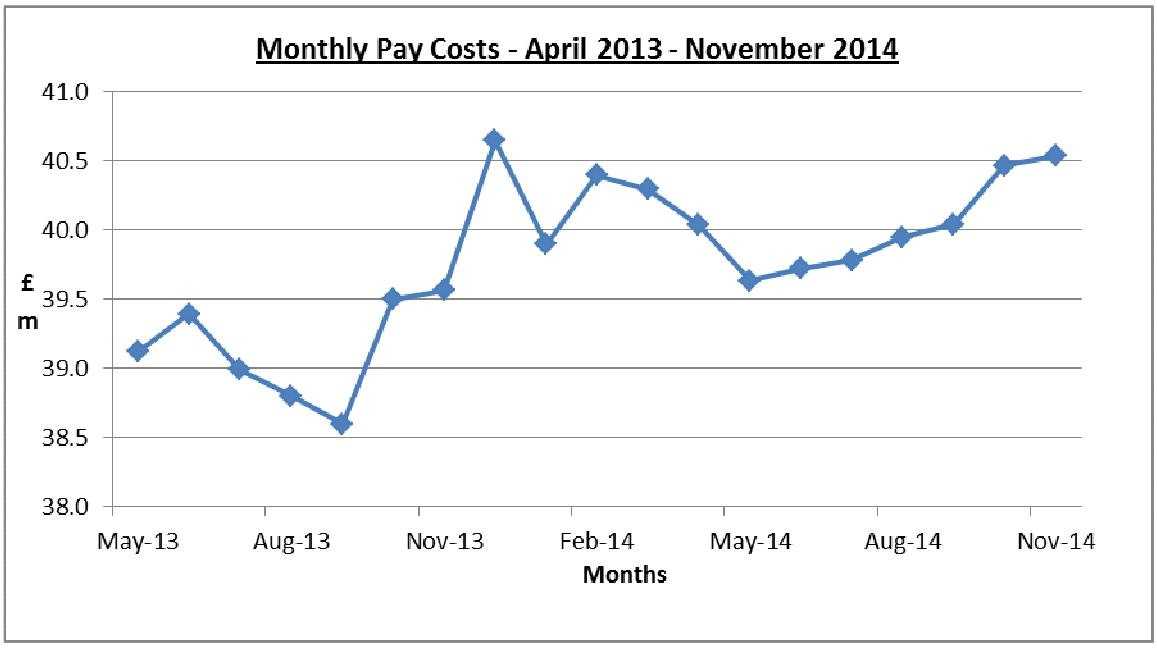
- Diagnostic Imaging £0.2m better than plan
- Maternity £0.2m better than plan

Further detail on income can be seen in Appendix 2.

Pay

Pay costs are on plan in November and £3.3m under plan year to date:

- Pay costs climbed slightly again in November reflecting ongoing recruitment and costs to deliver RTT. The chart below shows the pay cost trend, after excluding the impact of the Alliance Contract, VSS costs and 2014/15 pay award
- Premium pay spend has reduced slightly in November relative to October, however still remains at £4m. Spend has fallen less rapidly than expected due to slower than forecast nursing recruitment, a particular impact being had in ESM. In addition, WLI sessions continue to ensure delivery of RTT



Non Pay

Operating non pay spend is £0.6m adverse to plan in November and £3.7m adverse to plan YTD:

- In month overspends relates to security for patients £0.1m, postage and printing £0.1m, bed hire £0.1m, consumables £0.5m offset with a phased release of reserves of £0.2m
- Year to date, the key drivers of the overspend relate to consumables £4.5m, printing and postage £0.6m, consultancy £0.5m, international nurse recruitment cost £0.3m, offset with phased release of reserves and supplier discounts of £2.2m

A more detailed financial analysis of CMG and Corporate performance (see Appendix 3) is provided through the Executive Performance Board financial report and reviewed by the Finance & Performance Committee.

Cost Improvement Programme

Appendix 3 shows CIP performance in October by CMG and Corporate Directorate against the 2014/15 CIP plan. This currently shows an over-delivery against the target YTD of £1.2m.

The year end forecast reflects identified schemes of £48.3m against a target of £45m. Planning has now begun for identification of 2015/16 schemes with an indicative target of £41m.

4. FORECAST OUTTURN

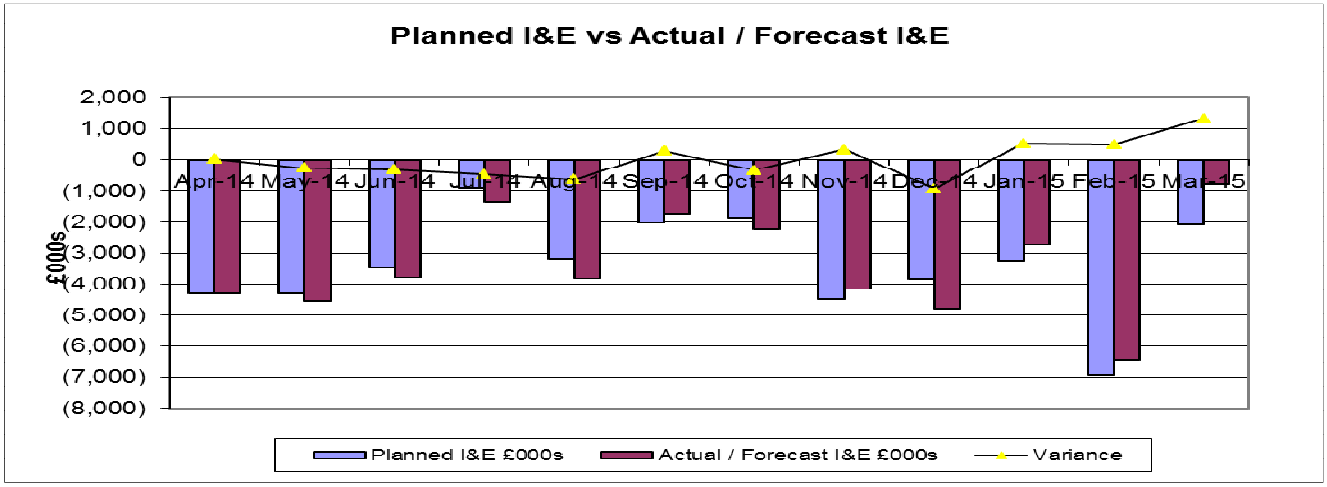
4.1 The table below details the forecast outturn delivering in line with the planned deficit:

	Year End Forecast		
	Plan £m	Forecast £m	Var (Adv) / Fav £m
Income			
Patient income	732.9	737.4	4.5
Teaching, R&D	81.5	81.4	(0.1)
Other operating Income	6.2	6.6	0.4
Total Income	**820.6**	**825.3**	**4.8**
Operating expenditure			
Pay	499.7	496.3	3.4
Non-pay	319.0	326.2	(7.2)
Total Operating Expenditure	**818.7**	**822.5**	**(3.8)**
EBITDA	**1.9**	**2.9**	**1.0**
Net interest	0.1	0.1	0.0
Depreciation	(32.3)	(32.4)	(0.0)
PDC dividend payable	(10.4)	(11.3)	(1)
Net deficit	**(40.7)**	**(40.7)**	**0.1**
EBITDA %		**0.3%**	

4.2 The assumptions included are as follows:

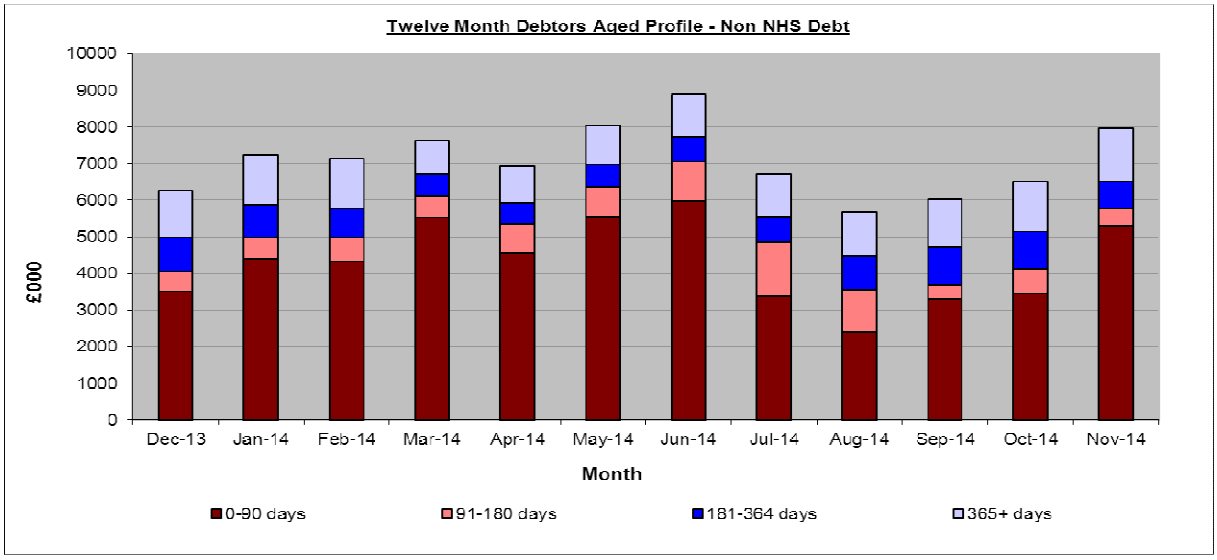
- CMGs and Directorates deliver to agreed control totals
- Ambulance penalties re-investment of £1m
- Commit to a release of reserve contingency of £1m to support the position, making it unavailable for commitment elsewhere
- Receipt of operational resilience funding of £3m for winter
- Receipt of operational resilience funding of £2.9m for RTT
- Costs of £1.9m for delivery of RTT and winter above those already in the plan

4.3 It can be seen that key to meeting the forecast is the delivery of CMG and Directorate positions. The chart below shows the planned and actual/forecast deficit for each month. The forecast shows that each month will deliver a position better than forecast going from November onwards.



5. BALANCE SHEET AND CASHFLOW

5.1. The effect of the Trust's financial position on its balance sheet is provided in Appendix 4.The retained earnings reserve has reduced by the Trust's deficit for the year to date. The level of non-NHS debt has fluctuated across the year as shown in the following table:



5.2. The overall level of non-NHS debt at the end of November has increased from £6.5m in the previous month to £7.9m. Total debt over 90 days is £2.7m and this has decreased by £0.4m from £3.1m.

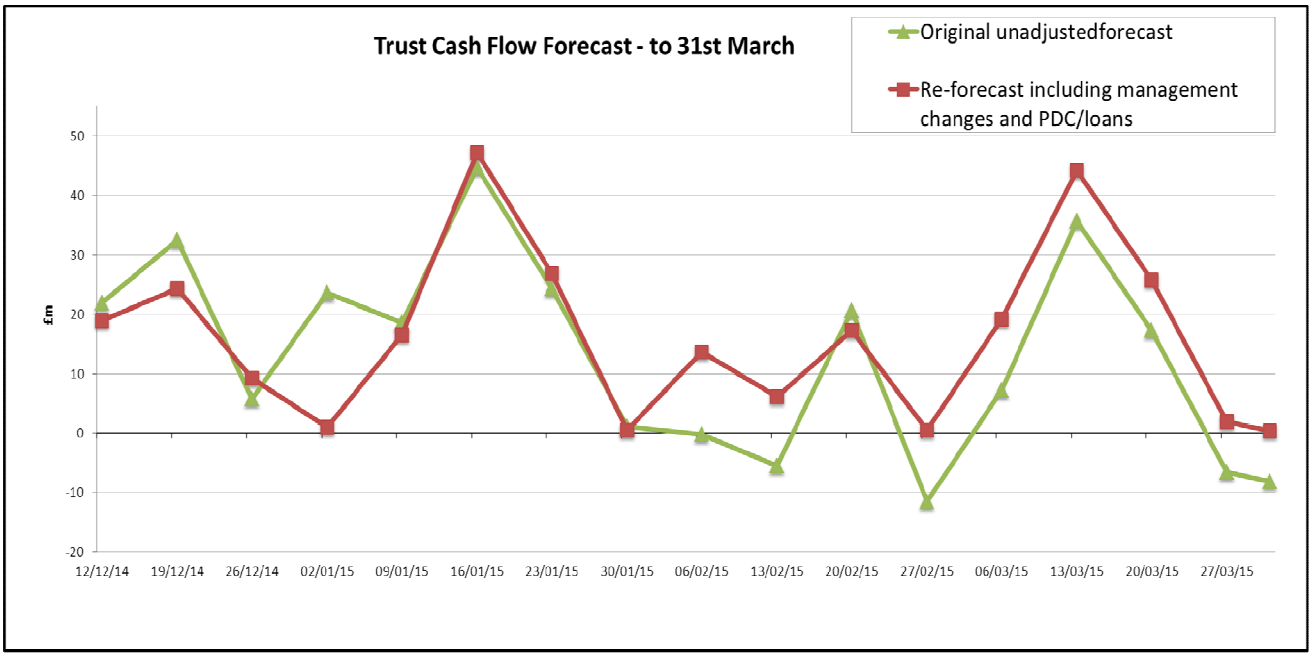
5.3. The proportion of total debt over 90 days has reduced from 47% to 34%. £1.8m of this debt relates to overseas patients where we expect a low recovery rate of approximately 25%. All overseas patient debt over 90 days old is provided for in full within the Trust's bad debt provision.

5.4. The Better Payments Practice Code (BPPC) performance for end of November YTD, shown in the table below, shows a slight deterioration in terms of the percentage of invoices paid within 30 days by volume.

	By Volume Number	By Value £000s
Current Month YTD		
Total bills paid in the year	89,628	426,667
Total bills paid within target	45,194	298,402
Percentage of bills paid within target	**50%**	**70%**
Prior month YTD		
Total bills paid in the year	84,028	386,858
Total bills paid within target	44,076	270,648
Percentage of bills paid within target	**52%**	**70%**

5.5. The Trust's cashflow forecast is consistent with the income and expenditure position. The cash balance at the end of November was £9.4m which is £9.2m above plan. This is partly due to the late receipt on 30th November 2014 of £4m SIFT and MADEL funding and differences in the timing of the payment of capital invoices.

5.6. The Trust's cash forecast to the year-end is shown in the graph below. This indicates that without any management actions or additional external financing above current levels, we will be significantly overdrawn on several occasions before the year end.



5.7. We have submitted a further application for £17m of temporary borrowing to be received on 22nd December 2014. This will take our total temporary borrowing to £46m and this total will be repaid once we have received our long term financing. This will improve our cash position to an acceptable level indicated by the re-forecast line on the graph and we will end the financial year with the planned cash level of £277k.

5.8. The NTDA are still in discussions with the Department of Health (DoH) over the type of financing that we will receive. The Independent Trust Financing Facility (ITFF) approved our application for £58m of PDC funding to:

- Fund our £40.7m deficit for 2014/15
- Improve our liquidity by £5.3m
- Fund £12m of capital expenditure

5.9. PDC is the preferred financing option of the NTDA, however the DoH are looking to provide this financing to us as a loan. We are expecting to draw down loan/PDC funding of £46m on 2nd February 2015 and this will be used to repay our temporary borrowing.

5.10. We will apply to draw down the remaining £12m relating to capital expenditure on 23rd February 2015 once we are in a position to demonstrate that we will use all of our internally generated capital cash, as we are unable to draw this amount down prior to need.

5.11. Our initial cash requirement to improve liquidity was £12.7m, and £5.3m was finally approved following discussions with the NTDA. Due to this shortfall, we expect to have a backlog of authorised and unpaid invoices of £8.5m at the end of 2014/15 compared to a balance of £12.7m at the end of 2013/14.

5.12. These invoices will require payment in 2015/16 and we will apply for temporary borrowing to be received in early April to enable us to make these payments and minimise the potential impact on our suppliers. As all temporary borrowing has to be repaid in the same financial year that it is received, we cannot use temporary borrowing to pay invoices at the year end.

5.13. We will also not achieve the BPPC target for 2014/15 as the value of the approved funding will enable us to achieve 72% against the BPPC by value.

6. CAPITAL

6.1 The total capital expenditure at the end of November 2014 was £20.0m against the year to date plan of £23.8m, an underspend of £3.8m (16%). The capital plan and expenditure to date can be seen in Appendix 5.

6.2 At the end of November, there was a total of £14.2m of outstanding orders. The combined position is that we have spent or committed £34.2m, or 74% of the annual plan.

6.3 The table below details the capital plan at the start of the year compared with the revised plan at the end of October as well as forecast expenditure. We reduced our external capital funding requirement by £4.3m following advice from the NTDA. After a detailed review of schemes, forecast spend has reduced from £55.0m to £49.7m. The over-commitment against the capital funding has therefore reduced from £6.1m to £3.2m.

6.4 The capital programme over commitment was reviewed by the Capital Monitoring and Investment Committee in November 2014. Actions to ensure a revised plan that is fully funded will be delivered by January's Committee.

Capital plan and forecast spend

	Original plan	Revised plan	Movement
	£000's	£000's	£000's
Capital Resource Limit	34,207	34,207	-
Plus Donations	300	300	-
Plus Anticipated PDC	16,322	12,000	(4,322)
TOTAL Funding	**50,829**	**46,507**	**(4,322)**
Forecast Spend	(54,932)	(49,667)	5,265
Over Commitment	**(4,103)**	**(3,160)**	**943**

7. RISKS

7.1 Within the financial position and year end plan, there continues to be the following potential risks:

- **Delivery of the forecast outturn position** has become challenged following revised forecasts from CMGs and Corporate Directorates. All areas must deliver to control totals

  Mitigation: Regular performance meetings with CMGs to monitor performance against plan and forecast and agreed control totals

- **Capacity requirements** for theatres and beds beyond the levels planned resulting in premium costs not forecasted or planned for

  Mitigation: The Trust is planning to open an additional 15 beds for which capital and revenue costs are within the financial plan. Work is ongoing on a theatres capacity plan

- **CCG Contract (including contractual fines and penalties)**

  The CCG contract has been signed with a penalty cap of £10m. In addition, CCGs have raised Activity Query Notices around emergency admissions and outpatients, Letters of Enquiry regarding Critical Care activity and Imaging activity and a number of contractual queries

  Mitigation: Work is ongoing to identify a revised process for resolution of queries. In addition, regular discussions with CCGs have begun regarding the forecast outturn of which all queries form part of

- **Referral To Treat (RTT) and Elective/Day Case Activity**

  There is a risk to the delivery of the RTT target resulting in additional premium costs to ensure delivery of income lower than forecast in particular theatre costs not identified. In addition, there is a risk that activity continues to be lower than the plan and forecast

  Mitigation: RTT plan performance managed through fortnightly meeting with CCG/NTDA and IST to review robustness of the plan. Additional costs to weekend theatre sessions have been identified within the forecast and embedded in proposed control totals

- **CIP Delivery**

  The Trust's annual financial plan is predicated on delivery of £45m CIPs, which is in excess of the national efficiency rate (4%) built into tariff. The additional amount is required to reduce the underlying deficit

  Mitigation: External consultancy support from Ernst & Young, along with revised CIP governance arrangements, a weekly CIP Board and CMG Performance Management meetings. £48m has been identified for 2014/15 and the programme for development of plans for £41m for 2015/16 is in place

- **Liquidity**

  The projected £40.7m deficit creates liquidity issues for the Trust

Mitigation: Application and successful receipt of Temporary Borrowing. £15.5m received in April and a further £13.5m in June. Further application has been made for long term borrowing for discussion at the Independent Trust Financing Facility

- **Unforeseen Events**

  The Trust has very little flexibility and no contingency remains in reserves

  Mitigation: The Trust is aware of commitments made and the constraints of specific funding streams

- **Contractual Challenges (Non Patient Care)**

  The Trust is aware of potential contract challenges around the Interserve Contract, particularly relating to the impact of TUPE transfers and catering volumes

  Mitigation: The Trust has reviewed the contract and has further contractual claims to more than negate the counter claims. Further legal advice will be sought to confirm the value and timescales for resolution

8. CONCLUSION

8.1. The Trust, at the end of Month 8, has an adverse position of £1.4m against the planned deficit of £24.0m but is forecasting the delivery of all its financial duties at year end.

9. NEXT STEPS AND RECOMMENDATIONS

9.1. The Trust Board is **recommended** to:

- **Note** the contents of this report
- **Discuss and agree** the actions required to address the key risks/issues

Paul Traynor
Director of Finance

22nd December 2014

Appendix 1

	November 2014			April - November 2014		
	Plan £ 000	Actual £ 000	Variance (Adv) / Fav £ 000	Plan £ 000	Actual £ 000	Variance (Adv) / Fav £ 000
Elective	5,918	5,955	36	49,312	**48,185**	(1,126)
Day Case	4,814	5,006	192	40,867	**39,307**	(1,560)
Emergency (incl MRET)	14,474	14,428	(46)	117,051	**116,844**	(207)
Outpatient	8,490	8,927	438	70,784	**69,901**	(883)
Penalties	(292)	(1,029)	(737)	(2,333)	**(4,824)**	(2,491)
Non NHS Patient Care	483	467	(16)	3,734	**4,155**	421
Resilience Funding	0	366	366	0	**1,433**	1,433
Other	23,824	24,483	659	188,795	**191,651**	2,856
Patient Care Income	**57,711**	**58,603**	**892**	**468,210**	**466,654**	**(1,556)**
Teaching, R&D income	6,774	6,897	123	54,333	**54,464**	131
Other operating Income	3,086	3,033	(53)	24,792	**25,308**	516
Total Income	**67,571**	**68,533**	**962**	**547,335**	**546,426**	**(909)**
Pay Expenditure	**42,008**	41,987	**21**	**330,231**	**326,892**	**3,339**
Non Pay Expenditure	**27,066**	27,624	**(558)**	**212,205**	**215,936**	**(3,731)**
Total Operating Expenditure	**69,074**	**69,611**	**(537)**	**542,436**	**542,828**	**(392)**
EBITDA	**(1,503)**	**(1,078)**	**425**	**4,899**	**3,598**	**(1,301)**
Interest Receivable	8	4	(4)	64	**54**	(10)
Interest Payable	0	(3)	(3)	0	**(23)**	(23)
Depreciation & Amortisation	(1,952)	(2,049)	(97)	(22,458)	**(22,548)**	(90)
Surplus / (Deficit) Before Dividend and Disposal of Fixed Assets	**(3,447)**	**(3,126)**	**321**	**(17,495)**	**(18,919)**	**(1,424)**
Profit / (Loss) on Disposal of Fixed Assets	(2)	0	2	(10)	**0**	10
Dividend Payable on PDC	(1,040)	(1,040)	0	(7,123)	(7,095)	28
Net Surplus / (Deficit)	**(4,489)**	**(4,166)**	**323**	**(24,628)**	**(26,014)**	**(1,386)**

Appendix 2

Patient Care Activity and Income – YTD Performance and Price / Volume Analysis

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	66,450	65,256	(1,193)	(1.80)	40,867	39,307	(1,560)	(3.82)
Elective Inpatient	15,820	14,663	(1,157)	(7.32)	49,312	48,185	(1,126)	(2.28)
Emergency / Non-elective Inpatient	67,000	69,054	2,054	3.07	121,386	123,024	1,638	1.35
Marginal Rate Emergency Threshold (MRET)	0	0	0	0.00	(4,334)	(6,180)	(1,845)	42.58
Outpatient	615,428	609,568	(5,860)	(0.95)	70,784	69,901	(883)	(1.25)
Emergency Department	95,163	102,156	6,993	7.35	10,321	11,299	978	9.47
Penalties	0	0	0		(2,333)	(4,824)	(2,491)	106.74
Other	5,605,920	5,563,248	(42,671)	(0.76)	182,208	185,940	3,733	2.05
Grand Total	**6,465,781**	**6,423,945**	**(41,835)**	**(0.65)**	**468,210**	**466,654**	**(1,556)**	**(0.33)**

Average tariff	Price Variance YTD %	Volume Variance YTD %	Price / Mix Variance (£000)	Volume Variance (£000)	Variance YTD (£000)
Day Case	(2.1)	(1.8)	(826)	(734)	(1,560)
Elective Inpatient	5.4	(7.3)	2,481	(3,608)	(1,126)
Emergency / Non-elective Inpatient	(1.7)	3.1	(2,083)	3,721	1,638
Marginal Rate Emergency Threshold (MRET)			(1,845)	0	(1,845)
Outpatient	(0.3)	(1.0)	(209)	(674)	(883)
Emergency Department	2.0	7.3	219	758	978
Penalties			(2,491)		(2,491)
Other			0	3,733	3,733
Grand Total	**0.3**	**(0.6)**	**(4,753)**	**3,197**	**(1,556)**

Appendix 3

Financial Performance by CMG & Corporate Directorate

I&E and CIP – to November 2014

	Year to Date					
	I&E			CIP		
CMG / Directorate	YTD Budget £000s	YTD Actual £000s	Variance £000s	YTD Plan £000s	YTD Actual £000s	Variance £000s
CMGs:						
C.H.U.G.S	29,720	29,881	161	3,534	3,604	70
Clinical Support & Imaging	-24,732	-24,822	-89	3,277	3,200	-77
Emergency & Specialist Med	11,909	13,654	1,745	3,699	4,259	560
I.T.A.P.S	-28,972	-30,591	-1,619	2,775	2,473	-302
Musculo & Specialist Surgery	27,477	23,532	-3,945	3,213	3,141	-73
Renal, Respiratory & Cardiac	21,520	20,987	-533	3,816	4,164	348
Womens & Childrens	29,148	29,158	10	4,255	4,273	18
	66,070	**61,799**	**-4,270**	**24,570**	**25,114**	**544**
Corporate:						
Communications & Ext Relations	-483	-449	34	40	40	0
Corporate & Legal	-2,292	-2,326	-34	50	63	14
Corporate Medical	-1,550	-1,539	11	56	56	0
Facilities	-26,791	-25,873	918	2,568	3,032	464
Finance & Procurement	-4,575	-4,104	471	192	374	182
Human Resources	-3,082	-3,110	-28	126	212	86
Im&T	-6,692	-6,649	43	34	43	9
Nursing	-14,172	-13,871	301	206	237	31
Operations	-4,789	-4,898	-109	80	108	28
Strategic Devt	-1,800	-1,550	250	118	121	3
	-66,227	**-64,370**	**1,857**	**3,469**	**4,285**	**816**
Other:						
Alliance Elective Care	24	24	-0			
R&D	3	133	130			
Central	-24,498	-23,601	897	4	0	-4
	-24,471	**-23,444**	**1,027**			
Total	**-24,628**	**-26,014**	**-1,386**	**28,042**	**29,399**	**1,357**

Balance Sheet

	Mar-14 £000's Actual	Apr-14 £000's Actual	May-14 £000's Actual	Jun-14 £000's Actual	Jul-14 £000's Actual	Aug-14 £000's Actual	Sep-13 £000's Actual	Oct-13 £000's Actual	**Nov-14 £000's Actual**	**Mar-15 £000's Forecast**
Non Current Assets										
Property, plant and equipment	362,465	360,188	359,769	358,289	359,152	359,238	359,534	361,704	399,441	380,902
Intangible assets	8,019	7,788	7,555	7,338	7,109	6,877	6,636	6,408	6,180	5,327
Trade and other receivables	3,123	3,311	3,152	3,115	3,002	3,004	3,043	3,065	3,087	2,503
TOTAL NON CURRENT ASSETS	**373,607**	371,287	370,476	368,742	369,263	369,119	369,213	371,177	**408,708**	**388,732**
Current Assets										
Inventories	13,937	13,711	14,633	14,627	15,390	14,894	14,579	15,215	15,040	14,200
Trade and other receivables	49,892	44,492	44,580	51,192	47,903	38,966	32,335	36,344	36,383	46,932
Cash and cash equivalents	515	13,850	5,838	13,662	14,954	8,430	7,560	3,205	9,931	277
TOTAL CURRENT ASSETS	**64,344**	72,053	65,051	79,481	78,247	62,290	54,474	54,764	**61,354**	**61,409**
Current Liabilities										
Trade and other payables	(109,135)	(102,381)	(100,604)	(100,725)	(100,661)	(88,023)	(86,892)	(91,232)	(102,723)	(92,743)
Dividend payable	0	(1,025)	(1,894)	(2,763)	(3,632)	(4,540)	0	0	(2,080)	0
Borrowings	(6,590)	(6,590)	(6,590)	(6,590)	(6,590)	(6,590)	(2,919)	(2,919)	(3,753)	(2,800)
Provisions for liabilities and charges	(1,585)	(1,585)	(1,585)	(1,585)	(1,585)	(1,585)	(1,585)	(1,585)	(1,585)	(426)
TOTAL CURRENT LIABILITIES	**(117,310)**	(111,581)	(110,673)	(111,663)	(112,468)	(100,738)	(91,396)	(95,736)	**(110,141)**	**(95,969)**
NET CURRENT ASSETS (LIABILITIES)	**(52,966)**	(39,528)	(45,622)	(32,182)	(34,221)	(38,448)	(36,922)	(40,972)	**(48,787)**	**(34,560)**
TOTAL ASSETS LESS CURRENT LIABILITIES	**320,641**	331,759	324,854	336,560	335,042	330,671	332,291	330,205	**359,921**	**354,172**
Non Current Liabilities										
Borrowings	(5,890)	(5,794)	(5,785)	(5,730)	(5,676)	(5,683)	(9,179)	(9,186)	(8,075)	(9,356)
Other Liabilities	0	0	0	0	0	0	0	0	0	0
Provisions for liabilities and charges	(2,070)	(2,048)	(2,022)	(2,006)	(1,830)	(1,207)	(1,171)	(1,156)	(1,110)	(1,873)
TOTAL NON CURRENT LIABILITIES	**(7,960)**	(7,842)	(7,807)	(7,736)	(7,506)	(6,890)	(10,350)	(10,342)	**(9,185)**	**(11,229)**
TOTAL ASSETS EMPLOYED	**312,681**	323,917	317,047	328,824	327,536	323,781	321,941	319,863	**350,736**	**342,943**
Public dividend capital	282,625	298,125	298,125	311,625	311,625	311,625	311,625	311,625	311,625	353,602
Revaluation reserve	64,598	64,598	64,598	64,598	64,598	64,598	64,598	64,598	104,278	64,628
Retained earnings	(34,542)	(38,806)	(45,676)	(47,399)	(48,687)	(52,442)	(54,282)	(56,360)	(65,167)	(75,287)
TOTAL TAXPAYERS EQUITY	**312,681**	323,917	317,047	328,824	327,536	323,781	321,941	319,863	**350,736**	**342,943**

Capital Plan

November 2014	Annual Budget £'000	Actual Spend £'000	Outstanding Commitments £'000	Total £'000	Variance £'000	Full Year Forecast Outurn £'000	Full Year Forecast Variance £'000
CHUGGS CMG							
Endoscopy GH	309	231	0	231	78	250	59
Lithotripter Machine	430	430	1	430	(0)	430	0
Sub-total: CHUGGS CMG	**739**	**661**	**1**	**662**	**77**	**680**	**59**
CSI CMG							
Aseptic Suite	400	288	123	410	(10)	400	0
MES Installation Costs	1,302	1,070	180	1,249	53	1,750	(448)
Sub-total: CSI CMG	**1,702**	**1,357**	**302**	**1,660**	**42**	**2,150**	**(448)**
Women's and Children's CMG							
Maternity Interim Development	1,000	801	13	813	187	1,000	0
Bereavement Facilities	62	113	0	113	(51)	162	(100)
Life Studies Centre	650	1	48	49	601	325	325
Sub-total: Women's & Children's CMG	**1,712**	**914**	**61**	**975**	**737**	**1,487**	**225**
Renal, Respiratory & Cardiac CMG							
Renal Home Dialysis Expansion	708	142	0	142	566	535	173
Sub-total: Renal, Respiratory & Cardiac CMG	**708**	**142**	**0**	**142**	**566**	**535**	**173**
Emergency & Specialist Medicine CMG							
Brain Injury Unit (BIU) Works	47	49	0	49	(2)	49	(2)
Equipment: 8th Resus Bay	40	42	0	42	(2)	42	(2)
DVT Clinic Air Conditioning	30	14	0	14	16	14	16
Sub-total: Emergency & Specialist Medicine CMG	**117**	**104**	**0**	**104**	**13**	**105**	**12**
ITAPS CMG							
da Vinci Robot equipment	103	103	0	103	0	103	0
GH Theatre 6 Equipment	177	138	0	138	39	138	39
Sub-total: ITAPS CMG	**280**	**241**	**0**	**241**	**39**	**241**	**39**
Corporate / Other Schemes							
Stock Management Project	2,212	5	0	5	2,207	6	2,206
Medical Equipment Executive	3,237	2,056	272	2,327	910	3,237	0
LiA Schemes	250	70	35	105	145	250	0
Odames Library	1,500	404	944	1,348	152	1,500	0
Safecare Module	66	0	0	0	66	66	0
Other Developments	0	362	43	405	(405)	393	(393)
Donations	300	277	0	277	23	300	0
Sub-total: Corporate / Other Schemes	**7,565**	**3,173**	**1,293**	**4,466**	**3,099**	**5,752**	**1,813**
IM&T Schemes							
IM&T Sub Group Budget	2,000	420	536	955	1,045	2,000	0
Safer Hospitals Technology Fund	1,150	87	222	309	841	1,150	0
EDRM System	3,300	249	704	954	2,346	3,300	0
EPR Programme	3,100	964	383	1,348	1,752	3,100	0
LRI Managed Print	412	0	413	413	(0)	413	(1)
Unified Comms	1,850	5	130	135	1,715	850	1,000
Sub-total: IM&T Schemes	**11,812**	**1,725**	**2,387**	**4,113**	**7,700**	**10,813**	**999**
Facilities / NHS Horizons Schemes							
Facilities Backlog Budget	5,500	1,109	1,303	2,411	3,089	5,500	0
Accommodation Refurbishment	1,200	10	12	22	1,178	52	1,148
CHP Units LRI & GH	800	627	4	630	170	940	(140)
Multi-Storey Car Park (MSCP)	250	0	308	308	(58)	250	0
Sub-total: Facilities / NHS Horizons Schemes	**7,750**	**1,745**	**1,626**	**3,063**	**4,437**	**6,742**	**1,008**
Reconfiguration Schemes							
Theatre Recovery LRI	2,785	788	592	1,380	1,405	2,350	435
Interim ITU LRI	590	340	200	540	50	590	0
Ward 4 LGH	1,000	890	32	921	79	1,000	0
Additional Beds (GH & LRI)	2,000	28	70	99	1,901	400	1,600
Feasibility Studies	100	2	4	6	95	100	0
Sub-total: Reconfiguration Schemes	**6,475**	**2,048**	**897**	**2,945**	**3,530**	**4,440**	**2,035**
Over Commitment	(8,675)					(3,160)	(5,515)
Total Schemes funded via internal sources	**30,185**	**12,110**	**6,568**	**18,678**	**20,182**	**29,785**	**400**
Schemes to be funded via external loan / PDC							
ED Enabling Schemes							
Modular Wards LRI	3,700	4,361	736	5,097	(1,397)	5,000	(1,300)
Clinic 1 & 2 Works	814	43	13	56	758	814	0
Old Cancer Centre Conversion	1,050	740	202	942	108	1,050	0
Oliver Ward Conversion	1,260	1,266	38	1,304	(44)	1,260	0
Clinical Genetics	158	37	4	41	117	158	0
Chapel Relocation	315	68	35	103	212	315	0
Victoria Main Reception	525	51	26	77	448	525	0
Sub-total: ED Enabling schemes	**7,822**	**6,566**	**1,054**	**7,620**	**202**	**9,122**	**(1,300)**
Emergency Floor	6,000	1,282	4,977	6,259	(259)	6,400	(400)
GGH Vascular Surgery	2,500	79	1,578	1,657	843	1,200	1,300
Sub-total: External Loans	**16,322**	**7,927**	**7,609**	**15,536**	**786**	**16,722**	**(400)**
Total Capital Plan	**46,507**	**20,037**	**14,177**	**34,214**	**20,968**	**46,507**	**0**

University Hospitals of Leicester NHS
NHS Trust

Agenda Item: Trust Board Paper L

TRUST BOARD – 22 DECEMBER 2014

UHL Organisational Development Quarterly Update Report

DIRECTOR:	Kate Bradley, Director of Human Resources
AUTHOR:	Bina Kotecha, Assistant Director of Learning and Organisational Development
DATE:	22 December 2014
PURPOSE:	**(concise description of the purpose, including any recommendations)** This report highlights progress with implementing the Trust's Organisational Development Plan specifically focusing on 'Live our Values' and 'Improve Two-Way Engagement and Empower our People' work streams. We have also set out progress with creating an 'Organisational Health Dashboard' ensuring alignment with the Trust's Organisational Development Plan in monitoring the impact of delivery.
PREVIOUSLY CONSIDERED BY:	N/A
Objective(s) to which issue relates *	☐ 1. Safe, high quality, patient-centred healthcare ☐ 2. An effective, joined up emergency care system ☐ 3. Responsive services which people choose to use (secondary, specialised and tertiary care) ☐ 4. Integrated care in partnership with others (secondary, specialised and tertiary care) ☐ 5. Enhanced reputation in research, innovation and clinical education ☑ 6. Delivering services through a caring, professional, passionate and valued workforce ☐ 7. A clinically and financially sustainable NHS Foundation Trust ☐ 8. Enabled by excellent IM&T
Please explain any Patient and Public Involvement actions taken or to be taken in relation to this matter:	Patient representative involvement ensured in all key development activity
Please explain the results of any Equality Impact assessment undertaken in relation to this matter:	Priorities have been assessed against the nine protected characteristics under the Equality Act 2010.
Organisational Risk Register/ Board Assurance Framework *	☐ **Organisational Risk Register** ☑ **Board Assurance Framework** ☐ **Not Featured**
ACTION REQUIRED *	For decision ☐ For assurance ☑ For information ☐

♦ We treat people how we would like to be treated ♦ We do what we say we are going to do
♦ We focus on what matters most ♦ We are one team and we are best when we work together
♦ We are passionate and creative in our work

* tick applicable box

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST

REPORT TO: **Trust Board**

REPORT FROM: Kate Bradley, Director of Human Resources

DATE: 22 December 2014

SUBJECT: **Organisational Development Plan Update**

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1. Introduction

To deliver our vision of 'Caring at its Best' and to facilitate the necessary change we have set out an ambitious Organisational Development (OD) Plan for UHL, as previously reported to the Trust Board in June 2014. Our priorities are led through five substantial work streams:-

These work streams have been aligned to UHL values, vision and strategic objectives particularly our objective to support the development of a professional, passionate and valued workforce.

This report highlights progress with implementing the Trust's Organisational Development Plan specifically focusing on 'Live our Values' and 'Improve Two-Way Engagement and Empower our People' work streams.

We have also set out progress with creating an 'Organisational Health Dashboard' ensuring alignment with the Trust's Organisational Development Plan in monitoring the impact of delivery. The Trust's Organisational Health Dashboard will be reviewed by the Trust's Executive Workforce Board at quarterly intervals.

We have attached our latest Learning into Action Newsletter (December Edition) to update the Trust Board on a range of our impressive 'Learning into Action' successes and events including our Caring at its best and Leadership award winners, our apprenticeship showcase, salary maxing benefits and well-being initiatives.

2. Living our Values Work Stream

In this section we have set out progress with implementing the 'Live our Values' priorities of the Trust's Organisational Development Plan:-

2.1 Values Based Recruitment

The values based questions for consultant recruitment have been launched and we have received positive feedback. From January 2015 the presentation title used in consultant interviews will be announced during the interview process rather than in advance. Plans are currently underway to commence Stakeholder Focus Groups as part of the interview process in order to provide more opportunities to assess 'team fit' involving key colleagues. Ongoing discussions are taking place to bring in Assessment Centre's for recruitment into key positions and enable the assessment of behaviors and values.

A generic values based question is now included in the Standard Application Form on NHS Jobs 2 and this is currently being evaluated.

Recruitment and selection training has been revised to promote values throughout the process and the training has been updated to reflect the new national NHS Employers Values Based Interview Toolkit.

2.2 Caring at its best Awards Ceremony

On 25 September 2014, over 500 staff including members of the Trust Board gathered at the Athena for our Caring at its best 2014 Awards Evening. An overall winner in each award category, as well as a Volunteer of the Year, was selected by our external judges from the finalists of the quarterly awards and announced during the event.

This year's award ceremony was hosted by the Chief Executive and opened with an inspirational video, created by our Communication Team to showcase the great work of our staff who go above and beyond expectations to show strength, pride and Caring at its best.

2.3 Accountability into Action Development Programme

Influential leadership is a key attribute that will support our leaders to deliver Caring at its best. In addition, to underpin the Trust Values some key behaviours have been identified as crucial to success these include our staff having the confidence, motivation and ability to speak up effectively and for our staff to have the ability to hold people to account for their behaviour whilst building relationships.

To support our staff to develop these essential skills and behaviours, as set out in the Organisational Development Plan and subsequent Leadership into Action Strategy (presented to the Board in September 14), we will be commissioning a sustainable, evidence based, development initiative for our leadership community at UHL. This development will be presented to the Executive Workforce Board on the 23 December 2014 and agreement reached on initial pilot activity.

Accountability into Action is a sustainable development initiative which consists of three essential components as listed below and set out in Appendix 1:-

1) Crucial Influencer
2) Crucial Conversations
3.) Crucial Accountability

Each component will be delivered internally at UHL by Graham Rob Associates the sole provider of Vital Smarts within the UK.

3. Improving Two-Way Engagement and Empower our People Work Stream

In this section we have set out progress with implementing the 'Improve Two-Way Engagement and Empower our People' priorities of the Trust's Organisational Development Plan:-

3.1 Listening into Action (LiA)

Classic LiA: Wave 3 Pioneering teams celebrated their achievements at the November Pass It On event. A further 12 Pioneering Teams commenced in Wave 4 in November 2014. A Pass It On Newsletter has been distribution with the December wage slips to share success stories.

Thematic LiA: A LiA Administration and Clerical Leads Event is scheduled to take place on 29 January to provide an overview of process, key resources and develop Corporate and Clinical Management Group specific plans. Clinical Management Groups and Directorates have nominated leads to take this work stream forward and attend the event.

Management of Change LiA: Human Resources continue to support Management of Change (MoC) impacting on 25 or more staff as required. LiA is being utilised to support roll out of EDRM with 3 events held during October to November 2014 for Administration and Clerical staff, in recognition of the significant impact this may have on their roles and duties.

Enabling LiA: A series of LiA Events have been held with Alliance Staff in September 2014 led by the Chief Executive and Alliance Interim Director. In addition, a LLR Clinical Summit to respond to and engage with staff on the Mortality Review Report was held in October 2014 using the LiA approach.

Nursing into Action (NiA): Three sets of 14 teams have commenced since July 2014. There is high demand from ward Managers to get involved with places full until September 2015. Each team holds a listening event specifically on improving quality of care and patient experience, undertakes a pulse check for the team and turns ideas and suggestions into tangible actions. A bespoke Pass It On event for Nursing into Action is currently being planned for April 2015.

3.2 Mutuals in Health Pathfinder Programme

As reported previously to the Trust Board, we are one of 9 Trusts nationally to be selected to participate in the "Mutuals in Health Pathfinder Programme". National milestones have been set for each Pathfinder Trust. Resources are available from the Cabinet Office / Department of Health to procure expert support and eight external agencies have expressed an interest in working with UHL. Intention to award letters for the Mutuals in Health Pathfinder Programme have been issued.

The provider that was successful in securing a contract with UHL is Hempsons**.** Hempsons bring a wealth of experience and bid across a number of Lots however we were their number

one preferred Trust. They scored particularly strongly in all sections of their bid and therefore we are confident that we will be working with a strong team who understand the needs of our Trust. Hempsons will also be partnering with Norfolk and Norwich University Hospital NHS Trust.

A Mutuals in Health Programme Board has been established and the first meeting of this Board will take place on 16 December 2014. In addition to the UHL wide approach being explored as part of the Pathfinder programme, two local integrated teams i.e. Elective Orthopaedics and Orthopaedic Theatres, have been identified to take part within the UHL approach with specific focus on the development of autonomous, incentivised teams on a pilot basis.

A further more detailed report on the Mutuals in Health Pathfinder Programme will be presented to the Trust Board in January 2015 by the Chief Executive.

3.3 Medical Engagement

The Clinical Senate hosted on the 21st November focused on Medical leadership and medical leaders continue to access Medical Leaders development. The UHL Clinical Senate hosted a UHL 'Yule Meet' Event on the 5th December 2014 with Consultants, Clinical Commissioning Groups and General Practitioners.

The Doctors in Training Committee (DiTC) continue to develop with cross specialty representation. Committee members are involved in Trust wide projects including the Executive Quality Board, ePMA, Medical Optimisation Group and the Odames Library Project Board. A Development Day was held in November for the members. Development of the DiTC has been presented at the National Patient Safety Congress and at the Royal Society of Medicine meeting. A DiTC website has been developed and is accessible at http://insite.xuhl-tr.nhs.uk/homepage/clinical/clinical-education/doctors-in-training-committee

4. Measuring the Impact of our actions - Organisational Health Dashboard

This report provides an update on progress made in the development of an Organisation Health Dashboard. The Organisational Health Dashboard will provide Trust level information and has been designed to provide Directorates and Clinical Management Groups (CMG) the ability to drill down into the information.

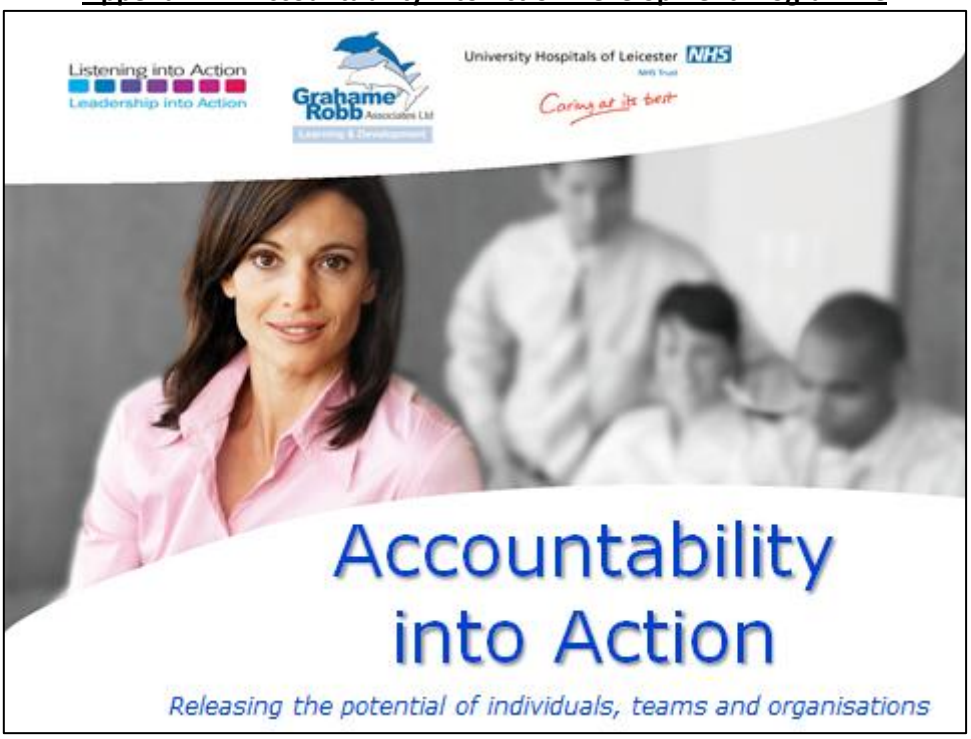
The Organisational Health Dashboard will link directly to the five Organisational Development (OD) work streams confirmed by the Executive Workforce Board and Trust Board in June 2014. The Organisational Health Dashboard tracks a variety of measures as shown in Appendix 2a. Performance can be tracked over a selected quarter or month, as shown in Appendix 2b. Performance for a single measure can be tracked over time, as shown in Appendix 2c for Appraisal Performance.

5. Recommendations

The Trust Board is asked to comment on key organisational development activity specific to 'Live our Values' and 'Improve Two-Way Engagement and Empower our People' work streams.

The Trust Board is also asked to note progress with creating an 'Organisational Health Dashboard' ensuring alignment with the Trust's Organisational Development Plan in monitoring the impact of delivery.

Appendix 1 – Accountability into Action Development Programme



UHL Context - *delivering caring at its best*

University Hospitals of Leicester NHS

A key attribute in support of UHL's strategic objective is:

- Influential leadership

Behaviours identified as crucial to achieving UHL's Vision:

- People having the confidence, motivation and ability to speak up effectively
- People being held accountable for their behaviour whilst building relationships

Build on UHL approach to system wide improvement:

- Integrated into the Trust's Quality Improvement Programme

One team shared values

Why Grahame Rob Associates?

Listening into Action
Leadership into Action

University Hospitals of Leicester NHS

- 25 years of experience within Learning and Development
- Specialising in Leadership Development, Organisational Strategy and Vision Implementation
- Exclusive UK and Republic of Ireland licensee for VitalSmarts
- Global training provider

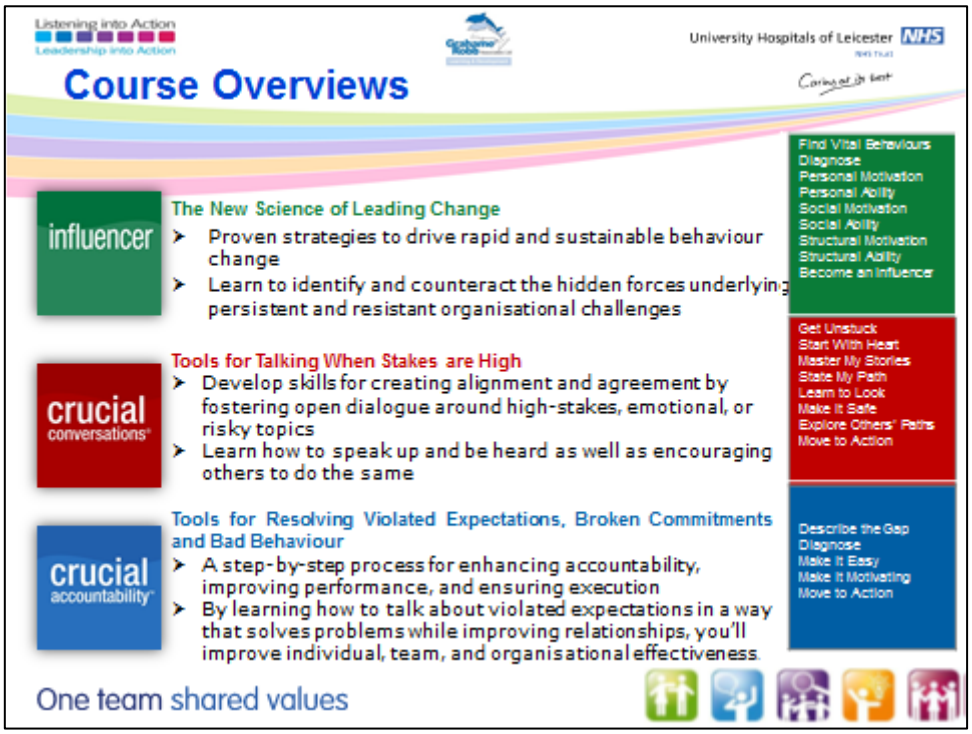
Click here to visit the GRA website

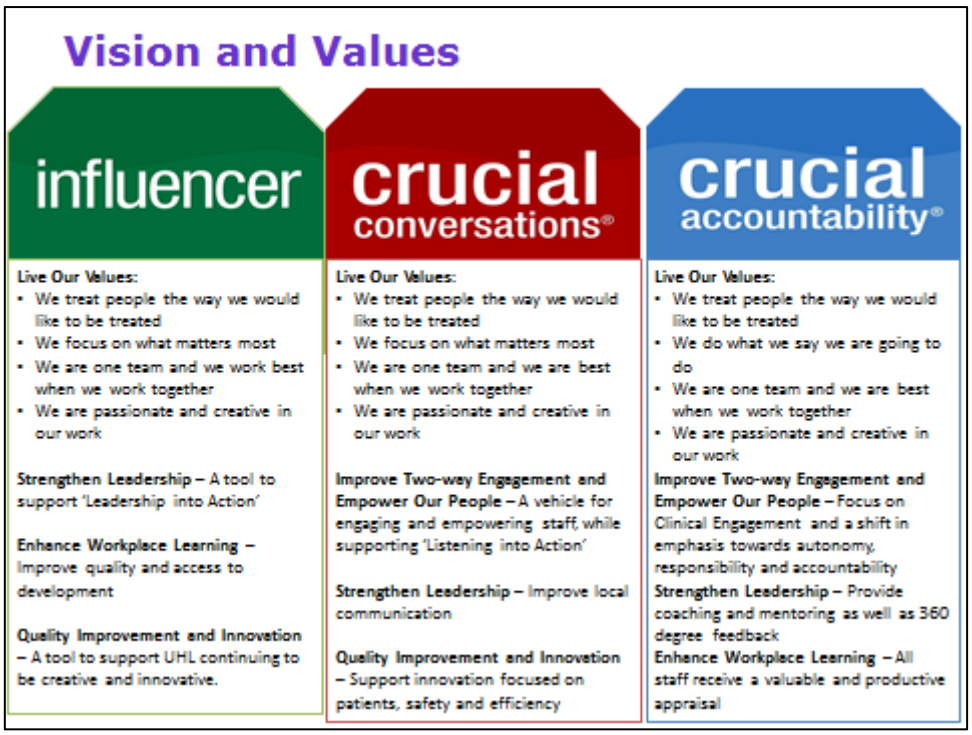
Click here to meet the GRA Trainers who will lead the pilot

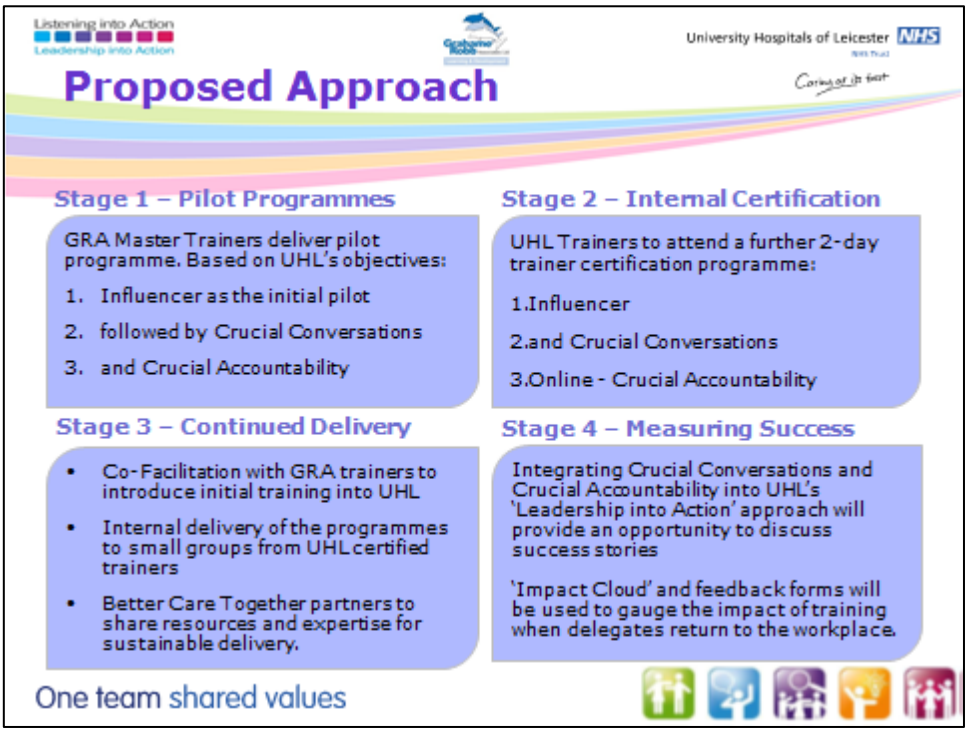
NHS South Commissioning Support Unit
Kent Community Health NHS
Sheffield Health and Social Care NHS
gsk GlaxoSmithKline
NOVARTIS

One team shared values


Listening into Action
Leadership into Action
University Hospitals of Leicester NHS
References
Dallas Housing Authority, a US-based non-profit organisation,
• eliminated boundaries between departments
• increased accountability around poor performance and disrespectful behaviour, through the introduction of Crucial Accountability
Newmont Mining
• reduced serious accidents on a global scale by 73% within 2 years by applying the Influencer model
Utilising the Influencer principles, a Trust
• reduced absenteeism from 5% to 3% within 3 years, this represented a saving of £1million.
Through Influencer an NHS Trust
• reduced grade 3 and 4 pressure ulcers to 0% over 12 months.
One team shared values


Listening into Action
Leadership into Action
University Hospitals of Leicester NHS
Course Overviews
influencer
The New Science of Leading Change
➢ Proven strategies to drive rapid and sustainable behaviour change
➢ Learn to identify and counteract the hidden forces underlying persistent and resistant organisational challenges
Find Vital Behaviours
Diagnose
Personal Motivation
Personal Ability
Social Motivation
Social Ability
Structural Motivation
Structural Ability
Become an Influencer
crucial conversations
Tools for Talking When Stakes are High
➢ Develop skills for creating alignment and agreement by fostering open dialogue around high-stakes, emotional, or risky topics
➢ Learn how to speak up and be heard as well as encouraging others to do the same
Get Unstuck
Start With Heart
Master My Stories
State My Path
Learn to Look
Make It Safe
Explore Others' Paths
Move to Action
crucial accountability
Tools for Resolving Violated Expectations, Broken Commitments and Bad Behaviour
➢ A step-by-step process for enhancing accountability, improving performance, and ensuring execution
➢ By learning how to talk about violated expectations in a way that solves problems while improving relationships, you'll improve individual, team, and organisational effectiveness.
Describe the Gap
Diagnose
Make It Easy
Make It Motivating
Move to Action
One team shared values


Vision and Values
influencer
Live Our Values:
• We treat people the way we would like to be treated
• We focus on what matters most
• We are one team and we work best when we work together
• We are passionate and creative in our work
Strengthen Leadership – A tool to support 'Leadership into Action'
Enhance Workplace Learning – Improve quality and access to development
Quality Improvement and Innovation – A tool to support UHL continuing to be creative and innovative.
crucial conversations®
Live Our Values:
• We treat people the way we would like to be treated
• We focus on what matters most
• We are one team and we are best when we work together
• We are passionate and creative in our work
Improve Two-way Engagement and Empower Our People – A vehicle for engaging and empowering staff, while supporting 'Listening into Action'
Strengthen Leadership – Improve local communication
Quality Improvement and Innovation – Support innovation focused on patients, safety and efficiency
crucial accountability®
Live Our Values:
• We treat people the way we would like to be treated
• We do what we say we are going to do
• We are one team and we are best when we work together
• We are passionate and creative in our work
Improve Two-way Engagement and Empower Our People – Focus on Clinical Engagement and a shift in emphasis towards autonomy, responsibility and accountability
Strengthen Leadership – Provide coaching and mentoring as well as 360 degree feedback
Enhance Workplace Learning – All staff receive a valuable and productive appraisal


Listening into Action
Leadership into Action
University Hospitals of Leicester NHS
Proposed Approach
Stage 1 – Pilot Programmes
GRA Master Trainers deliver pilot programme. Based on UHL's objectives:
1. Influencer as the initial pilot
2. followed by Crucial Conversations
3. and Crucial Accountability
Stage 2 – Internal Certification
UHL Trainers to attend a further 2-day trainer certification programme:
1.Influencer
2.and Crucial Conversations
3.Online - Crucial Accountability
Stage 3 – Continued Delivery
• Co-Facilitation with GRA trainers to introduce initial training into UHL
• Internal delivery of the programmes to small groups from UHL certified trainers
• Better Care Together partners to share resources and expertise for sustainable delivery.
Stage 4 – Measuring Success
Integrating Crucial Conversations and Crucial Accountability into UHL's 'Leadership into Action' approach will provide an opportunity to discuss success stories
'Impact Cloud' and feedback forms will be used to gauge the impact of training when delegates return to the workplace.
One team shared values

Listening into Action
Leadership into Action

University Hospitals of Leicester NHS

Investment

Pilot Programme

Pilot	Duration	Master Trainer Delivery (£2,300* per day)	Training Materials	Maximum Delegates
Influencer	2 days	£4,600	£160** per person	25
Crucial Conversations	2 days	£4,600	£160** per person	25
Crucial Accountability***	1 day	£2,300	£120** per person	25

*This is a discounted rate from the standard Master Training delivery rate of £3,350+ VAT
**Discounts are available for bulk orders of training materials
***The 1-day Crucial Accountability programme is specifically for graduates of the 2 day Crucial Conversations course.

Internal Certification for UHL Organisational Development Leads

Pilot	Duration	Cost of Master Trainer (£2,300 per day)	Cost of Trainer Guide	Maximum Delegates
Influencer	2 days	£4,600	£100 per person	12
Crucial Conversations	2 days	£4,600	£100 per person	12

One team shared values

Next Steps

- ✓ Present programme to Senior Teams during December 2014
- ✓ CEO / Senior Leader to nominate delegates by end Jan 15 (25 places on pilot programme)
- ✓ **Stage 1.** Pilot Programmes:

Influencer	2 days – April/May 2015
Crucial Conversations	2 days – May/June 2015
Accountability	1 day - July 2015

- ✓ **Stage 2.** Develop UHL Trainers (between 6-8 trainers) from May to July 2015
- ✓ **Stage 3.** Co-facilitated delivery across UHL from September 15
- ✓ **Stage 4.** Measure impact and sustain learning
- ✓ Partnership working locally across LLR and with South West Yorkshire Partnership NHS Foundation Trust & Rotherham Clinical Commissioning Group

Appendix 2a – Home Page of the Organisational Health Dashboard

University Hospitals of Leicester NHS
NHS Trust
Caring at its best

Organisational health at UHL - Creating the right culture and conditions today for high performance tomorrow. Creating a culture of engagement which promotes openness, trust and conditions which enable continuous learning and improvement to ensure we deliver Caring at it best...

Quarterly Report	Monthly Report
Currently Displaying: Q2 2014/2015	*Currently Displaying: October 2014*

To change the Quarter or Month use the dropdown box located in cell M1.

ORGANISATIONAL DEVELOPMENT PLAN - workstreams

Live our values

Caring at its best nominations
Number of staff nominated for Caring at its best awards - No RAG currently set.

Improve two way Engagement & Empower our people

Number of LiA Listening Events
(waiting for commentary)
FFT Staff - How likely are you to recommend as a place of care or treament?
% staff scoring positive (Extremely likely or Likley) to recommend UHL to Friends & Family. No RAG currently set.
FFT Staff - How likely are you to recommend as a place of work?
% staff scoring positive (Extremely likely or Likley) to recommend UHL as a place of work to Friends & Family. No RAG currently set.
Exit Interviews
Development programme to commence February 2015

Strengthen our leadership

Mentoring/Coaching/Buddying Utilisation
(waiting for commentary)
Medical Consultant Contribution to Education/Leadership
Number of Programmed Activities (blocks of 4 hours) decidated to educational activity and leadership. Only available Quarterly.

Enhance workplace development & learning

Appraisal Performance
Percentage of eligible staff who have had an appraisal in the last 12 months.
Local Induction
Percentage of staff recorded local induction completion
Corporate Induction
Percentage of staff recorded corporate induction completion
Sickness Absence
Percentage of staff off sick
Statutory & Mandatory Training
Percentage of staff currently trained and compliant with their Statutory and Mandatory Training
Turnover (12 months)
Percentage of leavers against average headcount. Calculated on a rolling 12 month basis.
Turnover (6 months)
Number of leavers within 6 months. Calculated on a rolling 6 month basis.
Training Utilisation
(waiting for commentary)
Apprenticeships
Number of apprentices
Revalidation
(waiting for commentary)
Medical Education
(waiting for commentary)
AHP, Nursing & Midwifery Education
(waiting for commentary)
Assistant Practitioners
Development programme to commence March 2015

Quality Improvement and Innovation

Consultant Job Plans (Submitted & Approved)
No. of Consultants & SAS grade doctors that have an agreed job plan approved by the Consistency Committee on the Trust's choice of electronic system.

Key

Data not available		No data to present	-
No RAG rating	71%	Red RAG	2.7%
Amber RAG	60%	Green RAG	100%
Increase from Previous Month / Quarter	↑ 98%	Decrease from Previous Month / Quarter	↓ 2.7%
No change from Previous Month / Quarter	↔ 53%		

Appendix 2b – Monthly performance – October 2014, Organisational Health Dashboard

ORGANISATIONAL HEALTH DASHBOARD: October 2014 Back to home page

OD PLAN - workstreams	LIVE OUR VALUES	IMPROVE TWO WAY ENGAGEMENT & EMPOWER OUR PEOPLE				STRENGTHEN LEADERSHIP		ENHANCE WORKPLACE DEVELOPMENT & LEARNING												QUALITY IMPROVEMENT AND INNOVATION
	Caring at its best nominations	Number of LiA Listening Events	FFT Staff - Place of care or treatment	FFT Staff -Place to Work	Exit Interviews	Mentoring/Coaching /Buddying Utilisation	Medical Consultant Contribution to Education/Leadership	Appraisal Performance	Local Induction	Corporate Induction	Sickness Absence	Statutory & Mandatory Training	Turnover (12 Months)	Turnover (6 months)	Training Utilisation	Apprenticeships	Revalidation	Medical Education	AHP, Nursing & Midwifery Education	Assistant Practitioners	Consultant Job Plans (Submitted & Approved)
GREEN THRESHOLD	TBC	TBC	TBC	TBC	TBC	TBC	TBC	>= 95%	>= 95%	<= 95.0%	<= 3.5%	>= 90%	< 10.5%	TBC	TBC	TBC	TBC	TBC	TBC	TBC	TBC
RED THRESHOLD	TBC	TBC	TBC	TBC	TBC	TBC	TBC	< 90%	< 95%	>= 95%	> 4.0%	< 85%	> 12.5%	TBC	TBC	TBC	TBC	TBC	TBC	TBC	TBC
UHL TRUST LEVEL	↑ 38	7			Development Programme to commence February 2015	13		↑ 92%	↑ 33%	↓ 91%	↑ 4.4%		↑ 10.5%	108	↓ 295	↓ 0	↑ 88%		Under Development	Development Programme to commence March 2015	-
ALLIANCE	↔ 0	-				-		↔ 100%	↔ 0%	↔ 100%	↑ 5.2%	87%		14	↔ 0	↔ 0	-				-
UHL TRUST LEVEL (INCL. ALLIANCE)	↑ 38	7				13		↑ 92%	↑ 32%	↓ 91%	↑ 4.5%	86%	↑ 10.5%	122	↓ 295	↓ 0	↑ 88%				-
CHUGGS	↑ 9	-				1		↑ 95%	↓ 25%	↔ 100%	↓ 4.3%	83%	↑ 8.1%	14	↑ 43	↔ 0					-
CSI	↑ 4	-				2		↑ 94%	↑ 45%	↑ 97%	↑ 4.3%	89%	↑ 9.9%	16	↓ 50	↓ 0					-
EMERGENCY & SPECIALIST MEDICINE	↑ 4	2				-		↓ 92%	↑ 33%	↓ 90%	↑ 4.4%	83%	↓ 11.5%	29	↑ 24	↓ 0					-
ITAPS	↔ 3	2				2		↑ 94%	↑ 100%	↔ 100%	↑ 5.4%	89%	↑ 9.1%	5	↓ 19	↓ 0					-
MSK & SPECIALIST SURGERY	↔ 5	-				3		↑ 97%	↓ 11%	↓ 50%	↓ 4.0%	85%	↑ 8.2%	6	↓ 37	↓ 0					-
RENAL, RESPIRATORY & CARDIAC	↑ 4	1				2		↓ 93%	↓ 29%	↑ 100%	↑ 5.1%	87%	↑ 7.7%	13	↓ 44	↔ 0					-
WOMEN'S & CHILDRENS	↔ 6	1				1		↓ 88%	↓ 13%	↓ 91%	↑ 4.5%	85%	↑ 13.3%	12	↓ 30	↓ 0					-
CORPORATE	↔ 3	1				2		↓ 86%	↑ 44%	↓ 78%	↑ 3.7%	86%	↑ 17.2%	13	↑ 48	↓ 0					-

Appendix 2c –Appraisal Performance, Organisational Health Dashboard

ORGANISATIONAL HEALTH DASHBOARD | ENHANCED WORKPLACE DEVELOPMENT & LEARNING | **Appraisal Performance** | Back to home page

GREEN THRESHOLD >= 95% | RED THRESHOLD < 90%

		Apr	May	June	Q1	July	Aug	Sept	Q2	Oct	Nov	Dec	Q3	Jan	Feb	Mar	Q4
UHL TRUST LEVEL		91.8%	↓ 91%	↓ 91%	↑ 91%	↓ 90%	↓ 89%	↑ 90%	↓ 90%	↑ 92%	↑ 92%		-				
ALLIANCE		100.0%	↔ 100%	↔ 100%	↑ 100%	↔ 100%	↔ 100%	↔ 100%	↔ 100%	↔ 100%	↓ 94%		-				
UHL TRUST LEVEL (INCL. ALLIANCE)		91.8%	↓ 91%	↓ 91%	↑ 91%	↓ 90%	↓ 89%	↑ 90%	↓ 90%	↑ 92%	↑ 93%		-				
CHUGGS		88.6%	↓ 88%	↑ 88%	↑ 88%	↓ 87%	↓ 86%	↑ 88%	↓ 87%	↑ 95%	↑ 95%		-				
CSI		94.6%	↓ 94%	↑ 95%	↑ 94%	↓ 93%	↑ 93%	↓ 91%	↓ 92%	↑ 94%	↑ 95%		-				
EMERGENCY & SPECIALIST MEDICINE		90.9%	↓ 91%	↓ 89%	↑ 90%	↑ 89%	↓ 89%	↑ 92%	↑ 90%	↓ 92%	↓ 90%		-				
ITAPS		91.6%	↓ 88%	↑ 90%	↑ 90%	↑ 93%	↓ 83%	↓ 83%	↓ 86%	↑ 94%	↑ 96%		-				
MSK & SPECIALIST SURGERY		95.9%	↓ 95%	↓ 91%	↑ 94%	↑ 93%	↓ 89%	↓ 88%	↓ 90%	↑ 97%	↓ 96%		-				
RENAL, RESPIRATORY & CARDIAC		90.7%	↑ 91%	↑ 92%	↑ 91%	↑ 93%	↑ 94%	↑ 95%	↑ 94%	↓ 93%	↓ 91%		-				
WOMEN'S & CHILDRENS		91.3%	↓ 91%	↓ 90%	↑ 91%	↓ 86%	↓ 86%	↑ 90%	↓ 87%	↓ 88%	↑ 90%		-				
CORPORATE		90.0%	↓ 89%	↓ 86%	↑ 89%	↓ 84%	↓ 80%	↑ 87%	↓ 84%	↓ 86%	↑ 91%		-				
CHUGGS	Bone Marrow Transplantation	-	-	-	-	-	-	-	-	-	-		-				
	Clinical Oncology	95.0%	↑ 96%	↑ 99%	↑ 97%	↓ 98%	↓ 94%	↑ 97%	↓ 97%	↑ 100%	↔ 100%		-				
	Endoscopy	90.9%	↓ 89%	↑ 91%	↑ 90%	↓ 88%	↑ 90%	↓ 89%	↓ 89%	↑ 95%	↑ 98%		-				
	Gastroenterology	97.3%	↑ 100%	↓ 86%	↑ 94%	↓ 81%	↓ 72%	↑ 97%	↓ 83%	↑ 98%	↑ 100%		-				
	General Surgery	85.6%	↓ 83%	↑ 84%	↑ 84%	↓ 83%	↓ 82%	↑ 83%	↓ 83%	↑ 92%	↓ 92%		-				
	Haematology	92.4%	↑ 94%	↔ 94%	↑ 93%	↓ 91%	↑ 93%	↓ 89%	↓ 91%	↑ 97%	↑ 98%		-				
	Hepatology	-	-	-	-	-	-	-	-	-	-		-				
	Medical Oncology	-	-	-	-	-	-	-	-	-	-		-				
	Paediatric Haemophilia	-	-	-	-	-	-	-	-	-	-		-				
	Palliative Medicine	-	-	-	-	-	-	-	-	-	-		-				
	Urology	85.5%	↑ 88%	↓ 86%	↑ 87%	↑ 89%	↓ 85%	↑ 89%	↑ 88%	↑ 97%	↑ 98%		-				

University Hospitals of Leicester NHS
NHS Trust

Caring at its best

Learning into Action Newsletter

Our future depends on it

2nd Edition, Dec 14

Dear colleagues

Once again this newsletter highlights the enormous number of exciting events and initiatives going on across the organisation and how linking with external partners helps to improve learning, recruitment and benefits to all our staff across UHL.

We have celebrated and recognised many achievements and successes over recent months including our **'Caring at its Best Annual Award Winners'** and regional **'Leadership and Recognition Award Winners'**. It has been great to hear of the successes and achievements of our young apprentices at our recent **'Apprenticeship Showcase Event'** and celebrate the difference they make to the Trust.

We have also successfully piloted the **'Graduate Internship Programme'** as well new exciting projects and initiatives from **Health & Well Being** and **Salary Maxing** schemes.

The Learning and Organisational Development and Listening into Action Teams have been shortlisted for the **'Learning Team of the Year'** category in the 2015 Learning Awards. The awards are hosted by the Learning and Performance Institute (LPI), the UK's leading Institute for workplace learning professionals, are an annual celebration of outstanding achievement, best practice and excellence in corporate learning and performance. The team have been recognised for all their successes around improving and enhancing learning at UHL. They will be joined by Dell, Virgin Holidays and Metro Bank, in the final which is being held at The Dorchester, Park Lane, London on 5th February 2015. We wish them the very best of luck in winning the award.

On behalf of the Trust Board, I would like to send season's greetings to you and your families and best wishes for a happy and prosperous 2015. I would like to encourage you to keep learning as I am sure you will agree when you read this newsletter that learning really counts!

John Adler
Chief Executive

Apprenticeship Showcase
Celebrating apprenticeships in LLR!

Apprenticeships
Good for our Business

Apprenticeship Stories: Learner, Employer & Provider Views in Leicester

Health Education East Midlands Workforce Team (HEEM Leicestershire) in conjunction with University Hospital Leicester and Leicester Partnership Trust hosted the first Apprenticeship Showcase Event at The Big Shed, on Friday 28th November 2015.

The showcase raised the profile of apprenticeships across the region and brought together a wide range of organisations in one place where people obtained a wealth of information about the benefits of apprenticeships in practice, as well as demonstrating the diversity and range of Apprenticeships in just a couple of hours.

The main feature of the apprenticeship showcase was a presentation from Kate Bradley, Director of Human Resources, summarising progress over a number of years. Also there was an opportunity for participants to meet some of our existing UHL Apprentices and appointing managers and listen to and learn about their personal experiences and journeys:-


Kate Bradley

UHL apprentice Asif Mohemmed *said "I was pleased to have chosen the vocational training route instead of going to university, my experience has given me a sense of loyalty to UHL. By doing the apprenticeship it has made it possible for me to become Clinic Co-ordinator in Children's. I have been able to get stuck in and do things while learning from some really great, experienced people ."*

Keira Wall (Apprentice Cardiographer) said "Doing *the apprenticeship has been the best thing I have ever done, it has given me the confidence and knowledge to pursue a career in the health service" .*

Rachel Williams(Senior Service Manager) is really passionate and supportive of apprentices, Rachel has employed 7 of her apprentices into substantive posts and she has a further 4 in training at the moment. Rachel explained that *"Apprenticeships are an attractive way of recruiting and training the next generation of workers. It has given us a route to engage and inspire young people who can learn from our ageing workforce, so we are breeding our own workers."*

For more information, visit www.apprenticeships.org.uk

Congratulations

LEICESTER DOCTOR CROWNED
'Innovator of the Year'

Dr Rakesh Patel, Honorary Specialist Registrar in Nephrology at Leicester's Hospitals and NIHR Academic Clinical Lecturer in Medical Education for the University of Leicester, has won the East Midlands Leadership Academy's 'NHS Innovator of the Year' award.

The NHS Leadership Recognition Awards 2014 celebrate leaders at all levels and across all professions who have ultimately improved people's health, the public's experience of the NHS and those leaders others are truly proud to work alongside.
NHS Leaders from across the East Midlands came together on the 20th November at Leicester's King Power Stadium to celebrate the winners of this year's NHS Recognition Awards.

Rakesh will now be considered by a panel of national judges and will be up against peers from across the country all hoping to be crowned national winner of their categories at the London ceremony in March 2015.

Director of the East Midlands Leadership Academy, Paul O'Neill said, "A fantastic night was had by all and I'm delighted that Rakesh Patel walked away as Innovator of the Year. I'll look forward to supporting him at the national award ceremony next year and think he has a real chance of walking away with a national prize."

The NHS Innovator of the year category focuses on individuals who put quality improvement at the heart of what they do to transform patient care. Rakesh's nomination focused on a project he led to improve the training of junior doctors.

Over the past two years Dr Patel has been working in partnership with Health Education East Midlands (HEEM) on the ePIFFany (Prescribing Insight for the Future) project. The aim of ePIFFany is to improve the prescribing performance and safety behaviours of junior doctors, while also creating a strong ethic for learning within the workplace. ePIFFany provides an innovative, multifaceted, 'just-in time' educational approach, personalised to the needs of junior doctors. ePIFFany was associated with approximately 500 bed days saved from potential avoidable harm. Length of stay for patients on wards that implemented ePIFFany well reduced by one day. The potential cost avoided from medication errors during ePIFFany was more than £300,000.

Almost 150 nominations were received in total from a spread of organisations which included those in both primary and secondary care as well as those from other parts of the health and social care sector

Other UHL nominees on the night were:

Julia Todd shortlisted for Emerging Leader Category
Joan Morrissey shortlisted for Patient Champion Award
John Adler and Karamjit Singh shortlisted for NHS Board / Governing Body of the Year

Dr Rakesh Patel receiving his award

Congratulations Congratulations

THE DIRECTIONS SERVICE
Confidential information, advice and guidance
available to all UHL staff

The Directions Service has again successfully been awarded the MATRIX Quality Standard which we have held for over 9 years.

The team would like to thank all our learners and learning partners for their tremendous support in maintaining this recognised quality mark. We offer a free confidential, impartial provision that can access many resources to offer information, advice and guidance to staff on a range of development and career progression routes

- ***Our expert service offers you the opportunity to discuss the career and development options available.***
- ***Enables you to make informed choices about learning opportunities.***
- ***Our impartial service will signpost you to the most relevant and appropriate source of information, advice or guidance.***

Can we help you!

Telephone: LGH 0116 258 4288, GH 0116 250 2488 or LRI 0116 258 5397
Email: *thedirectionsservice@uhl-tr.nhs.uk*

Well done

Congratulations

2014 Annual Awards Ceremony

On 25 September 2014, over 500 staff, volunteers and supporters of Leicester's Hospitals gathered at The Athena for our Caring at its Best Awards 2014. An overall winner in each award category, as well as a Volunteer of the Year, selected by our external judges from the finalists of the quarterly awards were announced at the ceremony. This year's awards ceremony, hosted by John Adler, was opened with an inspirational video, created by the communications team, to showcase the fantastic work of our staff who go above and beyond to show strength, pride and Caring at its Best!

We do what we says we are going to do
WINNER: Paul Harrison,
Material Management Assessment, LRI

We are passionate and creative in our work
WINNER: Mr Javed Uddin,
ENT Consultation Surgeon, LRI

We treat people how we wish to be treated
WINNER: Sue Bell,
Senior Cardiology Sister, GH

We focus on what matters most
WINNER: Rebecca Brennan, Acting Deputy Sister, Cancer & Haem LRI

We are one team and we work best when we work together
Leicester and Loughborough Renal Community Team

Caring at its Best Award
WINNER: **Laura Coulson**, Midwife, LRI

Volunteer of the Year Award
WINNER: Brian Ashley
Highly Commended: June Miles

Caring at its best Awards

If you would like to nominate an individual or team for one of the Awards then please visit The Caring at is Best Awards page in Insite

You can see lots more about the event, a short film of the evening and the Everybody Counts Video by visiting the Caring at its Best page on Insite
Link to Caring at its Best

Link to the Everybody Counts short videos are also on INsite
Link to Everybody Counts

Everybody Counts... Playing your part

Congratulations to Lesley Crawley, HR Trainer, who has successfully graduated after completing her two year DTTLS course, (Diploma To Teach In the Life Long Learning Sector). Lesley said *"that although the studying was challenging at times it was all worthwhile. I would like to thank all my colleagues for their support and encouragement."*

UHLs Core Training Lead, Ed Thurlow, recently organised the 8th Zombie Festival, attended by hundreds of horror film fans. The event held at the Phoenix Cinema in Leicester City centre saw the undead rise to stalk the earth again.

'Innovation in Learning'

Last year, the University Hospitals of Leicester in partnership with Health Education East Midlands and De Montfort University, launched a successful pilot for an internship programme. The aim of this scheme was to both give new graduates invaluable work experience to support their transition from university to work and give an insight into the wealth of non clinical opportunities available in the NHS. UHL benefitted from the range of transferable skills on offer and the opportunity to apply these skills to the delivery of a tangible project.

New graduates from these universities successfully competed for paid short placements (six months) which involved a variety of projects from developing the Route to Recruit System in Recruitment Services to supporting the theatre productivity scheme. Throughout this programme the interns received a development programme which was delivered via the University of Leicester and included an introduction to the NHS and understanding public sector management. The interns were also supported by a series of action learning sets. The programme evaluated very well and some of the interns have joined us in longer term appointments.

Having engaged with last year's learners we have developed and improved the scheme and this year we are hosting five placements once again. Our interns joined us in October to support programmes of work in such areas as information and the emergency department. We hope to continue to improve and expand the scheme and use our learning as a basis for developing a local graduate training scheme.

Amritpal Chohan, Project Support Officer, tells her story:

"Following graduating in Psychology from the University of Leicester, I joined the internship scheme in September 2013 as an Intern in the Improvement & Transformation team. The 6 months that ensued was a crash course in all things NHS and UHL with a focus on how to implement change in an Acute Trust. During this time I was given the opportunity to get involved with a variety of significant projects and trusted with real responsibility. This was an extremely steep learning curve but I had incredible support from the Improvement team, my Line Manager and Mentors - and 1 year and 3 months on I'm still here! "

"Prior to this scheme I hadn't considered the NHS as a place I could build my career. I knew very little about the work that went on behind the front line and the vast array of opportunities available. Through this scheme, UHL have provided a doorway for Graduates to gain invaluable experience and exposure in jumpstarting their career in a variety of functions at the local level; increasing the accessibility for development into Public Sector Healthcare leadership. I'm excited to see where this journey takes me next."

WIDER WORKFORCE DEVELOPMENT FUNDING (WWD)

Are you aware that there are still funds remaining in our 2014/15 WWD Funding allocation?

Applications are welcome for this funding to support training and development and all bands 1 to 4 are eligible.

Accredited courses funded previously included vocational qualifications such as QCF and Apprenticeships in Clinical Healthcare Support, Healthcare Support Services, Business Administration, Customer Service, ILM courses (Institute of Leadership and Management), 7300 Introduction to Trainer Skills, ESOL (English for Speakers of Other Languages), ECDL (European Computer Driving Licence) and Functional Skills in Maths or English.

We are now inviting applications for **both accredited and non-accredited programmes.**

Applications should be completed and submitted before end of December 2014 for consideration.

For further details on the application process please contact: **Ballie Dhinsa, HR Training & Development Administrator, (WWD) Tel 0116 258 2488 or email bajinder.dhinsa@uhl-tr.nhs.uk**

'SALARY MAXING' SCHEMES

LATEST UPDATES

It's been all go for the '***HR Systems and Payroll – Operations and Projects***' plus '***Salary Maxing***' teams since the last newsletter, all focussed on enhancing your experience of staff benefits!

Total Reward Statements have arrived!

The 14th October saw the launch of **Total Reward Statements** ('***TRS***') for UHL Staff! Statements include a personalised summary that shows details of your full employment package throughout the year including

- Basic pay
- Allowances
- Pension benefits *(for NHS Pension Scheme members only)*
- Details of your Salary Exchange schemes such as '***UHL's Childcare Voucher Scheme***', ***'Salary Maxing'* Car Scheme**, ***'Salary Maxing'* Take IT Home Scheme**, '***Park and Save***' ***'Salary Maxing'* for Accommodation, etc.**

Visit InSite/TotalRewardStatements for more information

'*Salary Maxing*' Benefits Portal

Our '***Salary Maxing***' **Benefits Portal** is the first place to visit for all our '***Salary Maxing***' schemes. We're working hard to make things even easier for you by enabling Total Reward Statements ('***TRS***') to launch from the portal. We're also working on some really exciting integration with some of our other schemes so they can be accessed through the portal – watch out for our launch announcements!

'*Salary Maxing*' Car Scheme—Winter Driving Tips!

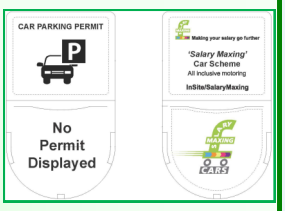
With the wintery weather starting now look out for the '***Salary Maxing***' **Car Scheme**'s winter driving tips on InSite over the coming months, all designed to keep you safe!

'*Salary Maxing*' Car Scheme – Have you spotted our electric vehicle?

Lots of people have spotted our '***Salary Maxing***' – Electric Vehicle, have you? It's been seen in Leicester, Leicestershire, Nottingham and Derbyshire by avid spotters! It's done thousands of miles enabling colleagues to test drive our car which hasn't consumed a drop of petrol as it's 100% electric. Watch out for feedback in the next newsletter.

VISIT OUR INSITE PAGES : InSite/SalaryMaxing

'*Salary Maxing*' Car Scheme— provides new Car Parking Permit holders for UHL staff!



The Trust's '***Salary Maxing***' team secured external sponsorship to provide thousands of brand new Car Parking Permit holders for staff all at no cost to the NHS or staff! These have been well received so staff can ensure they have a modern secure way to hold their Staff Parking Permit.

'Salary Maxing' Cycles Scheme

Lots of colleagues are now cycling and keeping fit thanks to the ***'Salary Maxing'* Cycles Scheme**. The scheme ran during the summer and it was a roaring success!

'*Salary Maxing*' Take IT Home – A raving success!

October saw our '***Salary Maxing***' **Take IT Home** scheme take orders from lots of colleagues all benefiting from the latest technology for use at home. We even had access in late October to the latest iPads just released by Apple. We then extended the scheme opening by a couple of days to enable colleagues to celebrate their arrival!

'*Salary Maxing*' - at the Trust's Annual Public Meeting

At the Trust's Annual Public Meeting the '***Salary Maxing***' stand were busy with members of the public and colleagues visiting to see our exclusive range of employee benefits!

Picture shows one of the many visitors, Kate Bradley – Director of Human Resources visiting the '***Salary Maxing***' stall staffed by Glenis and Laura from the '***HR Systems and Payroll – Operations and Projects***' Team.

As a UHL employee you can access WellBeing@Work activities and Events—meet new people, get healthy and have fun!

For more information go to the Well Being@Work pages on Insite, contact your local Well Being Champion (*a list of Champions can be found on Insite)* or contact Marcella Burgess at Wellbeing@uhl-tr.nhs.uk

AMICA

Well-being discussion group

Amica Staff Counselling recently launched its first pilot Wellbeing Group at the LRI. The purpose of the group was to provide a welcoming safe environment to discuss wellbeing, top tips for mental health and other relevant topics. The group was supportive and attendees evaluated the session positively and stated that they valued being able to take time out and talk with like minded individuals. The group is delivered by the experienced supportive Amica counselling team and Amica looks forward to further groups in the future.
Click the link to find out more *Well Being*

Statutory & Mandatory
TRAINING UHL
Excellence in Training
Excellence in Care

Ed Thurlow, the Core Training Lead for UHL, has 2 big secrets... One is that the Trust will become 95% compliant in its Mandatory & Statutory Training by 31st March, 2015 and the other is that he is the Director of the UKs longest running Zombie Festival… **(see page 3)** Although his obsession with all things horrific is not work related, hoping we will reach 95% compliance is!
The Mandatory & Statutory Training levels in the Trust are still heading onwards and upwards, from 40% in July 2013, the Trust now stands at a whopping 87%, but there is still a way to go until March next year and the target of 95%.
In summary, please complete as much training as you can before the end of the year. Just turn your required training to green and, if nothing else, it will simply stop the flow of email you receive. If you have any questions please email 'Zombie' Ed Thurlow at Edward.Thurlow@uhl-tr.nhs.uk

Leadership into Action Strategy (2014-16)

A key objective of the UHL Organisational Development Plan (OD) (2014-16) is to 'Strengthen Leadership' and as a result the Learning and Organisational Development Team held a LiA event to establish how to take this forward. As a direct result of the feedback from the listening event and a strong evidence base the Leadership into Action Strategy was co-created and like the OD Plan has 5 key work streams:

Strengthen Leadership: Implement the 5 work streams of the 'Leadership into Action' Strategy, (2014-16):

* **Learn to lead**
* **Feedback to improve**
* **Build shared networks**
* **Harness talent to grow**
* **Cultivate team excellence**

The detailed Leadership into Action Strategy can be accessed on Insite. For further information please contact:
Helen Mancini, Organisational Development Specialist

Coming Soon

New Appraisal System for Agenda for Change Staff

Coming Soon

The appraisal process plays a critical role in identifying staff contributions to the delivery of Trust objectives, it also provides our staff with clarity about expectations and identifies learning and development needs to support delivery of these expectations and progress towards future career plans.

From April 2015 the appraisal documentation will change for all staff employed on Agenda for Change Terms and Conditions

NEW APPRAISAL SYSTEM UPDATE SESSIONS

To update appraisers / line managers on the changes we will be providing 1.5 hour update sessions from January to March 2015 covering the key elements.

All appraisers must book onto and attend an update session on a mandatory basis.

***Book your place now* via https://www.euhl.nhs.uk/**

(Course Title: Appraiser Update Training 2014/2015)

or for further information contact

Sharon Baines, Training and Development Manager,

sharon.baines@uhl-tr.nhs.uk

Book Now

We wish you all a Merry Christmas and a Very Happy & Peaceful New Year

University Hospitals of Leicester NHS
NHS Trust

Agenda Item: Trust Board Paper M

TRUST BOARD – 22 DECEMBER 2014

Quarterly Research and Development Report

DIRECTOR:	Director of Research and Development
AUTHOR:	Nigel Brunskill, Director of R&D
DATE:	22 December 2014
PURPOSE:	Quarterly update on R&D issues, for Board information and assurance.
PREVIOUSLY CONSIDERED BY:	**n/a**
Objective(s) to which issue relates *	[x] 1. Safe, high quality, patient-centred healthcare [ ] 2. An effective, joined up emergency care system [ ] 3. Responsive services which people choose to use (secondary, specialised and tertiary care) [ ] 4. Integrated care in partnership with others (secondary, specialised and tertiary care) [x] 5. Enhanced reputation in research, innovation and clinical education [ ] 6. Delivering services through a caring, professional, passionate and valued workforce [ ] 7. A clinically and financially sustainable NHS Foundation Trust [ ] 8. Enabled by excellent IM&T
Please explain any Patient and Public Involvement actions taken or to be taken in relation to this matter:	PPI is embedded within all areas of Trust R&D activity
Please explain the results of any Equality Impact assessment undertaken in relation to this matter:	
Organisational Risk Register/ Board Assurance Framework *	[x] **Organisational Risk Register** [x] **Board Assurance Framework** [ ] **Not Featured**
ACTION REQUIRED *	For decision [ ] For assurance [x] For information [x]

♦ We treat people how we would like to be treated ♦ We do what we say we are going to do
♦ We focus on what matters most ♦ We are one team and we are best when we work together
♦ We are passionate and creative in our work

- tick applicable box

UHL R&D Quarterly Trust Board Report December 2014

1. Introduction

This report describes current R&D performance against metrics, projects under development, new challenges and potential threats.

2. Research Performance

The activity of UHL in initiating and delivering clinical research is performance monitored by both the NIHR Central Commissioning Facility (NIHR CCF) and the East Midlands Clinical Research Network (EM CRN). In turn the UHL R&D Office reports research CMG level activity and performance to each CMG via the R&D Executive Committee.

2.1 *NIHR CCF*

In Q1 14/15 UHL initiated 91 clinical trials, making UHL the 17th most prolific trust (previously 11th). This is a slight drop over previous quarters (see Table 1). There are many potential reasons for this, but it does not represent a trend and it is anticipated that performance will return to previous levels. These performance figures will be closely monitored.

Table 1: UHL Performance in initiating clinical research trials

	Number of Trials Initiated	
	2013/14	2014/15
Q1	111	91
Q2	125	
Q3	121	
Q4	116	

UHL is also judged by its performance in recruiting patients into initiated trials – the benchmark is to recruit the first patient into a trial within 70 days of submission by the investigator of a valid research application. Here UHL's performance in Q4 13/14 was 36.1%, thus leaving significant room for improvement. NIHR has indicated that Trusts failing to show significant improvements will face a 5% 'top-slice' of Research Capability Funding (RCF) for 2015/16.

Therefore for Q2 14/15 we instituted:

- '70 days to consent' (Figure 1) communications strategy and action plan
- new managed process to monitor quality and accuracy of data return to NIHR CCF

According to our recently submitted data, UHL's performance for Q2 14/15 is **75%** - a significant improvement in performance which should protect RCF for 2015/16.

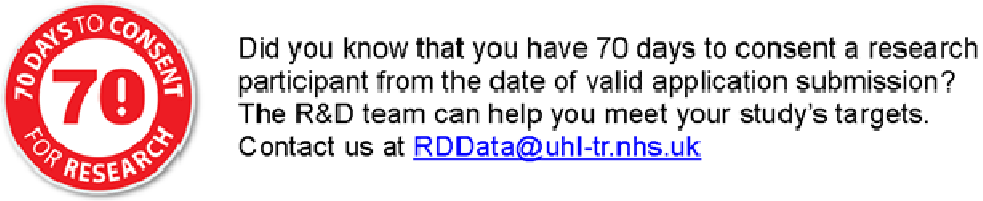


Figure 1. UHL's logo and reminder to researchers of 70 day target

2.2. EM CRN

The last report received from the EM CRN was received in Dec 2014. The EM CRN is currently in the process of refining its data reports for trusts, but the data show that for the year 14/15 UHL is exceeding patient recruitment targets based on a 9% increase over 2013/14 recruitment. This is a significantly positive outcome (Table 2).

Table 2: Cumulative Recruitment Numbers of Patients into UHL Studies 2014/15

	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
Aspirational target = 13/14 + 9%	910	1820	2730	3640	4550	5460	6370	7280	8190
Cumulative Recruitment 14/15	939	2029	2989	4063	5295	6202	7147	7266	

3. Projects under development

There are currently 4 major projects in development.

3.1. *Adult and Children's Clinical Research Facility.*
There is an intention to refurbish the Union Offices in LRI into a Children's Clinical Research Facility. This will be adjacent to the existing clinical research facility at LRI and will enable the establishment of a new joint Adult and Children's Clinical Research Facility. This will increase capacity for clinical research and maximise potential income from commercial studies. UHL has received some capital funding for this project but there is currently a shortfall and negotiations are underway to meet this from Charitable Funds.

3.3 *Hope Unit at Glenfield Hospital*
The Hope Against Cancer Charity has offered funding support to refurbish a suitable clinical area into a satellite recruitment centre at Glenfield Hospital, associated with a small laboratory for clinical sample processing. Discussions are underway to identify suitable space.

3.2 *The Life Study.*
UHL has developed a strategic partnership with academic colleagues from University College London to host the Life Study in Leicester. Life Study will collect information about babies and the determinants of their health, wellbeing and development. UHL will be the second Life Study Centre and we aim to recruit at least 50% of 11,000 deliveries annually at UHL beginning in first 3-4 months 2015. Participation will result in significant reputational enhancement for UHL and will generate significant R&D income from the Clinical Research Network based on recruitment levels.
The disused Sports and Social Club building at Leicester General Hospital has been identified for refurbishment into the Life Centre and the costs are included in the 2014/15 Capital Plan. A Steering Committee chaired by Director of R&D is supporting the project with input from Women and Children's CMG, HR, IT, CCGs, EM CRN
The aim is to have The Life Study Centre completed and supporting recruitment by early 2015.

3.3. *The 100,000 Genome Project*.
Since August 2014 UHL has developed a partnership with:

- Cambridge University Hospitals NHS Foundation Trust
- Norfolk and Norwich University Hospitals NHS Foundation Trust
- Nottingham University Hospitals NHS Trust

The consortium has made first and second stage applications to NHS England, and hosted a site visit by NHS England as part of an application to become a Genomic

Medicine Centre. CUH will be the host organisation. If successful this will become the East of England Genomic Medicine Centre (EEC GMC).
This is an NHS transformation project that aims to deliver advances in genomics directly into the clinical care of patients with rare/inherited diseases and cancer. Successful implementation will require significant alterations to care pathways and job plans of clinical staff. Attainment of GMC status will help with recruitment of high calibre staff into vacant posts.
The EEC GMC bid has been supported by:

- EM AHSN
- Eastern AHSN
- Health Education England
- empath

4. Contracting and Innovation Activities

The R&D Office team are handling an increasing number of contracts relating to research and innovation activities, both commercial and non-commercial.
Two examples of recent innovation projects:

- Optimal project - £50k awarded by AHSN to evaluate
- Activate Your Heart – £75k National NHS Innovation Challenge Finalist

5. New/Existing Challenges

5.1 EM CRN Financial Allocation Process2015/16

The EM CRN has not yet finalised how it will be managing its financial allocation process to Trusts for 2015/16. This is leading to some uncertainty, but UHL will have a greater ability to direct funding strategically. We have begun constructive discussions with CRN Division Leads and with NUH R&D to ensure a unified approach where possible. We are optimistic that the process and outcome will be fair and equitable.

5.2 Health Research Authority Research (HRA) Approvals Process

From late 2015 a new mechanism of research approvals will be introduced. HRA Approval will provide a single approval for research in the NHS that will incorporate assessments by NHS staff employed by the HRA alongside the independent Research Ethics Committee opinion. This essentially replaces parts of what is currently known as R&D or Trust Approval. The HRA will provide a general NHS permission and will be available for all studies, NIHR portfolio and non-portfolio alike. This will be implemented to incorporate ALL research by December 2015. Whilst the purpose is to streamline and speed processes, there is the potential for confusion in the early stages and impact on job roles currently undertaken by current staff members in R&D and CMGs.
The following steps will be taken to mitigate this risk:
Stage 1 – Complete by end November 2014

- A scoping exercise to establish job descriptions, funding streams and individuals currently employed within CMGs who currently undertake an Ethics & Regulatory Affairs role
- Identify current work load of individuals
- Identify areas where this role does not exist and also areas where this role is a part of a wider role

Stage 2 – Complete by end January 2015

- Review job descriptions
- Seek authorisation from the employing CMG for discussions with the individuals to roll out a new process
- Engage with HR as required – there may be a management of change process required to amend Job Descriptions

- Begin development of Trust wide SOP for study feasibility / delivery

Stage 3 – Complete by end June 2015

- Complete and finalising of Trust wide SOP for study feasibility / delivery
- Finalise all relevant staff / finance / HR negotiations as relevant
- Begin to embed new process within CMGs

6. Research Office Issues

The following changes to trust R&D activity are proposed

6.2 Office Re-naming

We propose that Research and Development Office (R&D) be renamed ***'Research and Innovation Office'*** (R&I) to take account of the role in supporting innovation throughout the Trust and in line with naming in other Trusts.

6.1 New Website

To support the new name of the office and to refresh UHLs R&I profile a new website will be launched.

Figure 2: New Logo for re-vamped R&I website

Nigel Brunskill
Dec 2014

University Hospitals of Leicester NHS
NHS Trust

Agenda Item: Trust Board Paper N

TRUST BOARD – 22 DECEMBER 2014

FIT AND PROPER PERSONS, DIRECTORS; AND DUTY OF CANDOUR

DIRECTOR:	Director of Corporate and Legal Affairs
AUTHOR:	Director of Corporate and Legal Affairs
DATE:	22 December 2014
PURPOSE:	**(concise description of the purpose, including any recommendations)** To brief the Trust Board on the implementation of new health and social care standards and specifically the fit and proper persons requirements and duty of candour, effective from 27 November 2014.
PREVIOUSLY CONSIDERED BY:	**(name of Committee)** N/A
Objective(s) to which issue relates *	[√] 1. Safe, high quality, patient-centred healthcare [√] 2. An effective, joined up emergency care system [√] 3. Responsive services which people choose to use (secondary, specialised and tertiary care) [√] 4. Integrated care in partnership with others (secondary, specialised and tertiary care) [√] 5. Enhanced reputation in research, innovation and clinical education [√] 6. Delivering services through a caring, professional, passionate and valued workforce [√] 7. A clinically and financially sustainable NHS Foundation Trust [√] 8. Enabled by excellent IM&T
Please explain any Patient and Public Involvement actions taken or to be taken in relation to this matter:	The implementation of the new requirements is at the heart of the Government's approach to increasing transparency and accountability in the health and social care systems.
Please explain the results of any Equality Impact assessment undertaken in relation to this matter:	Will be considered as part of the Trust's programme to implement the new fundamental standards.
Organisational Risk Register/ Board Assurance Framework *	[ ] **Organisational Risk Register** [ ] **Board Assurance Framework** [√] **Not Featured**
ACTION REQUIRED *	For decision [ ] For assurance [√] For information [√]

♦ We treat people how we would like to be treated ♦ We do what we say we are going to do
♦ We focus on what matters most ♦ We are one team and we are best when we work together
♦ We are passionate and creative in our work

* tick applicable box

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST

REPORT TO: **TRUST BOARD**

DATE: **22 DECEMBER 2014**

REPORT BY: **DIRECTOR OF CORPORATE AND LEGAL AFFAIRS**

SUBJECT: **FIT AND PROPER PERSONS : DIRECTORS; AND DUTY OF CANDOUR**

---

1. INTRODUCTION

1.1 Against the backdrop of the Francis Inquiry report into Mid-Staffordshire NHS Foundation Trust and failings at the Winterbourne View Hospital the Government has legislated (via the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014) and made important changes to health and social care standards which are regulated by the Care Quality Commission (CQC).

1.2 Key changes are that breaches of some fundamental standards are strict liability offences and (where breaches of fundamental standards are criminal offences) the CQC can now prosecute without giving prior notice. The risk of prosecution and conviction is therefore significantly increased. Whilst fines can be imposed for breaches, the level is relatively modest and the real damage in the event of prosecution and conviction is likely to be reputational.

1.3 This report summarises the key changes and identifies immediate actions to be taken in response.

1.4 Further reports on the new standards will be submitted to the Trust Board in due course.

2. FUNDAMENTAL STANDARDS OF CARE

2.1 The 2014 Regulations introduce 12 fundamental standards which replace the previous CQC essential standards.

2.2 The fundamental standards provide that:

(a) care and treatment must be appropriate and reflect service users' needs and preferences (Regulation 9);

(b) service users must be treated with dignity and respect (Regulation 10);

(c) care and treatment must only be provided with consent (Regulation 11);

(d) care and treatment must be provided in a safe way (Regulation 12);

(e) service users must be protected from abuse and improper treatment (Regulation 13);

(f) service users' nutritional and hydration needs must be met (Regulation 14);

(g) all premises and equipment used must be clean, secure, suitable and used properly (Regulation 15);

(h) complaints must be appropriately investigated and appropriate action taken in response (Regulation 16);

(i) systems and processes must be established to ensure compliance with the fundamental standards (Regulation 17);

(j) sufficient numbers of suitably qualified, competent, skilled and experienced staff must be deployed (Regulation 18);

(k) persons employed must be of good character, have the necessary qualifications, skills and experience, and be able to perform the work for which they are employed (Regulation 19);

(l) health service bodies must be open and transparent with service users about their care and treatment (Regulation 20).

2.3 The new standards will come into force in April 2015 except that two Regulations for NHS bodies came into force on 27th November 2014: Regulation 5 fit and proper persons: Directors; and Regulation 20 duty of candour.

3. REGULATION 5 : FIT AND PROPER PERSONS: DIRECTORS

3.1 Creating a fit and proper person test for healthcare leaders was one of the key recommendations of the Francis Report.

3.2 The test applies to all health service bodies, ie NHS Trusts, NHS Foundation Trusts and Special Health Authorities.

3.3 Health service providers currently have a general obligation to ensure that they only employ individuals who are fit for their role.

3.4 The introduction of the fit and proper persons requirement for Directors imposes an additional requirement. The purpose is to require providers to take proper steps to ensure that their Directors (or equivalent) are fit and proper for the role.

3.5 The fit and proper persons test will apply to Directors (both Executive Directors and Non-Executive Directors) and individuals "performing the functions of, or functions equivalent or similar to the functions of, such a Director". The test will therefore apply to senior managers who exercise functions similar to the Directors of the organisation.

3.6 The Regulations provide that health service bodies must not appoint or have in place an individual as a Director or equivalent unless:-

- the individual is of good character;
- the individual has the qualifications, competence, skills and experience which are necessary for the relevant office or position or the work for which they are employed;
- the individual is able by reason of their health, after reasonable adjustments are made, of properly performing tasks which are intrinsic to the office or position for which they are appointed or to the work for which they are employed;
- the individual has not been responsible for, been privy to, contributed to or facilitated any serious misconduct or mismanagement (whether unlawful or not) in the course of carrying on a regulated activity or providing a service elsewhere which, if provided in England, would be a regulated activity;
- none of the grounds of unfitness specified in the Regulations apply to the individual: bankruptcy; on a barred list; legal impediment.

3.7 To meet the requirements, a provider has to:-

- provide evidence that appropriate systems and processes are in place to ensure that all new Directors and existing Directors or equivalent are, and continue to be, fit, and that no appointments meet any of the unfitness criteria set out in the Regulations;
- make every reasonable effort to assure itself about an individual by all means available;
- make specified information about Board Directors available to the CQC;
- be aware of the various best practice guidelines available and to have implemented procedures in line with this best practice;
- where a Board member no longer meets the fit and proper persons requirement, inform the regulator in question where the individual is

registered with a healthcare or social care regulator, and take action to ensure the position is held by a person meeting the requirements.

3.8 It is important to note that it is for the Trust to ensure that the requirements of the fit and proper persons test are met. The CQC will not undertake a fit and proper persons test of a Director or determine what is serious mismanagement or misconduct but will examine how the Trust has discharged its responsibility under the new Regulation.

3.9 It is a breach of the Regulation to have in place someone who does not satisfy the test. Evidence of this could be if:

- a provider does not have a proper process in place to enable it to make the assessments required by the fit and proper person test;
- a Director is unfit on a 'mandatory' ground, such as a relevant conviction or bankruptcy (to be determined by the provider);
- on receipt of information about a Director's fitness, a decision is reached on the fitness of the Director that is not in a range of decisions that a reasonable person would make.

4. CQC APPROACH TO THE FIT AND PROPER PERSONS REQUIREMENTS FOR DIRECTORS

4.1 On 20 November 2014, the CQC published guidance for NHS bodies on the fit and proper persons requirement for Directors.

4.2 The guidance describes how the CQC will approach the fit and proper persons requirement during the registration process; during the inspection process; during a 'focused' inspection (ie, where there is a serious systemic failure of a provider); and when information is received from a member of the public or the provider's staff about an existing Board member (here, the CQC will also have regard to its Whistleblowing and Safeguarding protocols, respectively, where relevant).

4.3 During the registration process, the CQC will require the Chair of the NHS provider to declare that appropriate checks have been undertaken in reaching a judgement that all Directors are deemed to be fit and none meet any of the unfit criteria. This will be a self-declaration.

4.4 During the inspection process, the CQC will use the following key line of enquiry (KLOE) and prompts under the 'well-led' key question, as follows:

- **W3 How does the leadership and culture reflect the vision and values, encourage openness and transparency and promote good quality care?**

- Prompt : Do leaders have the skills, knowledge, experience and integrity that they need – both when they are appointed and on an ongoing basis?

- Prompt : Do leaders have the capacity, capability and experience to lead effectively?

4.5 The CQC will seek to confirm that the provider has undertaken appropriate checks and is satisfied that, on appointment and subsequently, all new and existing Directors are of good character and are not unfit. This may involve checking personnel files and Directors' appraisal records.

4.6 The CQC will report on the fit and proper persons test under 'well-led' in its inspection reports. If the CQC find that providers do not reflect the characteristics of 'good', it will assess whether they 'require improvement' or are 'inadequate'. The CQC will also consider whether a regulation has been breached, including Regulation 5.

4.7 Where a concern arises about the fitness of a Director following the CQC's receipt of information from a member of the public or the provider's staff, the CQC will convene a panel, led by the Chief Inspector of Hospitals (or a person designated by them), to determine whether the information is significant and should be considered by the provider.

4.8 Where the provider is asked by the CQC to respond, the response received will either satisfy the Chief Inspector that due process has been followed or lead to a request for further dialogue with the provider, a follow-up inspection, or regulatory action using the CQC's current enforcement policy.

4.9 Interestingly, in its guidance the CQC states that "there are some core public information sources about providers that we believe are relevant for providers to use as part of their fit and proper persons requirement due diligence. For example, this includes, but is not limited to, information from public inquiry reports, serious case reviews and Ombudsman reports….".

4.10 In circumstances where a provider is unable to demonstrate that it has undertaken the appropriate checks in respect of its Directors, and the CQC decides to take regulatory action, providers may appeal to the first-tier Tribunal. The Tribunal hears appeals against decisions of the Secretary of State to restrict or bar an individual from working with children or vulnerable adults and decisions to cancel, vary or refuse registration of certain health care, child care and social care provision.

4.11 Providers may also challenge by way of judicial review if they consider that a decision breaches public law principles such as being unreasonable, irrational and unfair.

4.12 The CQC states in its guidance that, as the fit and proper persons requirement is a new Regulation, it expects to learn from what they find. This learning will inform the development of the CQC's guidance on meeting all of the new fundamental standards which is to be issued before 1 April 2015.

5. FIT AND PROPER PERSONS : IMMEDIATE ACTIONS TO BE TAKEN

5.1 Having regard to the 2014 Regulations, the CQC guidance and advice from the NHS Trust Development Authority about the impact on NHS Trust Chairman and Non-Executive Director appointments, the Director of Human Resources will prepare and submit a report to the Trust Board on 5th February 2015.

(a) clarifying (for confirmation by the Board) the Trust 'Director equivalent' postholders to whom it is judged that the fit and proper person test applies;

(b) identifying how the Trust meets/will meet the specific requirements of the fit and proper person test and assure itself of the suitability of individuals, both in post and to be appointed in future;

(c) setting out recommendations relating to any necessary changes to the Trust's recruitment, performance management and disciplinary arrangements for Chief Executives, Directors and Director equivalents and also, specifically, in relation to:-

(I) contracts of employment for the Chief Executive, Executive Directors and Director equivalents;

(II) reference requests for Directors and Director equivalents;

(iii) pre-employment checks for Directors and Director equivalents;

(iv) annual fit and proper person declarations for Directors and Director equivalents;

(v) checklists for recruitment to Director and Director equivalent posts.

6. REGULATION 20 DUTY OF CANDOUR

6.1 The introduction of Regulation 20 is a direct response to the Francis Inquiry's recommendation that a statutory duty of candour be imposed on healthcare providers.

6.2 Like most NHS bodies, UHL is already subject to a contractual duty of candour under the NHS Standard Contract.

6.3 To meet the requirements of the new Regulation, an NHS body has to:-

(a) make sure it acts in an open and transparent way with relevant persons in relation to care and treatment provided to people who use services in carrying on a regulated activity;

(b) tell the relevant person in person as soon as reasonably practicable after becoming aware that a notifiable safety incident has occurred, and provide support to them in relation to the incident, including when giving the notification;

(c) provide an account of the incident which, to the best of the health service body's knowledge, is true of all the facts the body knows about the incident as at the date of the notification;

(d) advise the relevant person what further enquiries the health service body believes are appropriate;

(e) offer an apology;

(f) follow this up by giving the same information in writing, and providing an update on the enquiries;

(g) keep a written record of all communication with the relevant person.

6.4 The Regulations provide definitions as follows:-

(i) **Notifiable safety incident** means any unintended or unexpected incident that occurred in respect of a service user during the provision of a regulated activity that, in the reasonable opinion of a health care professional, could result in, or appears to have resulted in the death of the service user, where the death relates directly to the incident rather than to the natural course of the service user's illness or underlying condition, or severe harm, moderate harm or prolonged psychological harm to the service user;

(ii) **Severe harm** means a permanent lessening of bodily, sensory, motor, physiologic or intellectual functions, including removal of the wrong limb or organ or brain damage, that is related directly to the incident and not related to the natural course of the service user's illness or underlying condition;

(iii) **Moderate harm** means harm that requires a moderate increase in treatment, and significant, but not permanent harm;

(iv) **Moderate increase in treatment** means an unplanned return to surgery, an unplanned re-admission, a prolonged episode of care, extra time in hospital or as an outpatient, cancelling of treatment, or transfer to another treatment area (such as intensive care);

(v) **Prolonged psychological harm** means psychological harm which a service user has experienced, or is likely to experience, for a continuous period of at least 28 days;

(vi) **Apology** means an expression of sorrow or regret in respect of a notifiable safety incident.

7. CQC APPROACH TO THE DUTY OF CANDOUR

7.1 On 20th November 2014, the CQC published guidance for NHS bodies on the duty of candour.

7.2 The guidance describes how the CQC will approach the duty of candour requirement during the registration process; during the inspection process; and when information is received from a member of the public or the provider's staff relating to the statutory duty of candour (here, the CQC will also have regard to its Whistleblowing and Safeguarding protocols, respectively, where relevant).

7.3 During the registration process, the CQC will test with the provider that it understands the requirement of the Regulation and ask what systems are in place to ensure that they will be able to meet the requirements.

7.4 During the inspection process, the CQC will use the following two specific key lines of enquiry (KLOEs) to assess whether the provider is delivering good quality care:-

- **S2: Are lessons learned and improvements made when things go wrong?**

  Prompt: Are people who use services told when they are affected by something that goes wrong, given an apology and informed of any actions taken as a result?

- **W3: How does the leadership and culture reflect the vision and values, encourage openness and transparency and promote good quality care?**

  Prompt: Does the culture encourage candour, openness and honesty?

7.5 The CQC will report on the duty of candour under the safety key question in its inspection report at provider level. If the CQC finds care that does not reflect the characteristics of 'good' as they are described in the CQC provider handbook, the CQC will assess whether the service 'requires improvement' or is 'inadequate'. The CQC will also consider whether a Regulation has been breached.

7.6 As the statutory duty of candour is a new Regulation, the CQC states that it expects to learn from what they find. This learning will inform the development of the CQC's guidance on meeting all of the new fundamental standards which is to be issued before 1st April 2015.

7.7 It is worth noting that, in parallel, the General Medical Council and Nursing and Midwifery Council are consulting on a new Professional Duty of Candour which would mean that there would be an obligation on doctors, nurses and other health professionals to inform patients when something goes wrong.

8. DUTY OF CANDOUR : IMMEDIATE ACTIONS TO BE TAKEN

8.1 Having regard to the 2014 Regulations and the CQC guidance, the Chief Nurse will prepare and submit a report to the Quality Assurance Committee meeting to be held on 29th January 2015 identifying how the Trust meets/will meet the specific requirements of the statutory duty of candour.

8.2 The report to be submitted to the January 2015 Quality Assurance Committee will : (a) use as a checklist the 32 specific points of CQC guidance which providers must have regard to in meeting the requirements of the statutory duty of candour; and

(b) set out initial thoughts on how staff will be trained so that they are aware of their duties and understand how the duty of candour fits alongside their existing professional responsibilities; and to discharge the duty.

8.3 The Quality Assurance Committee will report to the Trust Board on 5th February 2015 the outcome of its consideration of the report identified above.

9. RECOMMENDATIONS

9.1 The Trust Board is recommended to:

(a) receive and note this report,

(b) agree that the Director of Human Resources will prepare and submit a report to the Trust Board on 5th February 2015 on how the Trust meets/will meet the specific requirements of the fit and proper persons test (section 5 of this reports refers);and

(c) agree that the Chief Nurse will prepare and submit a report to the Quality Assurance Committee on 29th January 2015 on how the Trust meets/will meet the specific requirements of the statutory duty of candour (section 8 of this report refers).

Stephen Ward
Director of Corporate and Legal Affairs

12th December 2014

University Hospitals of Leicester NHS
NHS Trust

Agenda Item: Trust Board Paper O

TRUST BOARD – 22 DECEMBER 2014

BOARD AND BOARD COMMITTEE GOVERNANCE

DIRECTOR:	Director of Corporate and Legal Affairs
AUTHOR:	Director of Corporate and Legal Affairs
DATE:	22 December 2014
PURPOSE:	**(concise description of the purpose, including any recommendations)** To summarise the outputs of the Trust Board development session of 13th November 2014 and to identify recommendations to give effect formally to new governance arrangements.
PREVIOUSLY CONSIDERED BY:	**(name of Committee)** Trust Board Development Session 13th November 2014
Objective(s) to which issue relates *	[√] 1. Safe, high quality, patient-centred healthcare [√] 2. An effective, joined up emergency care system [√] 3. Responsive services which people choose to use (secondary, specialised and tertiary care) [√] 4. Integrated care in partnership with others (secondary, specialised and tertiary care) [√] 5. Enhanced reputation in research, innovation and clinical education [√] 6. Delivering services through a caring, professional, passionate and valued workforce [√] 7. A clinically and financially sustainable NHS Foundation Trust [√] 8. Enabled by excellent IM&T
Please explain any Patient and Public Involvement actions taken or to be taken in relation to this matter:	N/A
Please explain the results of any Equality Impact assessment undertaken in relation to this matter:	N/A
Organisational Risk Register/ Board Assurance Framework *	[ ] **Organisational Risk Register** [ ] **Board Assurance Framework** [√] **Not Featured**
ACTION REQUIRED *	For decision [√] For assurance [ ] For information [ ]

♦ We treat people how we would like to be treated ♦ We do what we say we are going to do
♦ We focus on what matters most ♦ We are one team and we are best when we work together
♦ We are passionate and creative in our work

* tick applicable box

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST

REPORT TO: **TRUST BOARD**

DATE: **22 DECEMBER 2014**

REPORT BY: **DIRECTOR OF CORPORATE AND LEGAL AFFAIRS**

SUBJECT: **BOARD AND BOARD COMMITTEE GOVERNANCE**

---

1. INTRODUCTION

1.1 The Trust Board discussed Board Governance at its development session on 13th November 2014. This paper summarises the outputs of that development session and identifies recommendations for consideration and approval by the Trust Board to give effect formally to new governance arrangements.

2. TRUST BOARD AND BOARD COMMITTEE CYCLE

2.1 Dates for Trust Board meetings in 2015 have now been confirmed. The Trust Board will meet on the first Thursday of each month, with dates also confirmed for monthly Trust Board development sessions ("thinking sessions") in 2015.

2.2 Dates for meetings in 2015 of the Integrated Finance, Performance and Investment Committee (previously, Finance and Performance Committee) and Quality Assurance Committee have also been confirmed. Work continues to finalise dates for the Audit Committee, Charitable Funds Committee and Remuneration Committee.

2.3 In setting the Trust Board and Board Committee cycle, the following aims have been borne in mind:-

- to maximise the effectiveness of the Committees;
- to reduce the amount of time taken up at Board meetings in 'covering the same ground';
- to create space and time in Board meetings to focus on strategic decision-making;
- to reduce the volume of paper for Board meetings.

3. BOARD COMMITTEE STRUCTURE

3.1 Following discussion and agreement at the Trust Board development session on 13th November 2014, the Trust Board is recommended to confirm the Trust Board committee structure as set out at appendix A.

3.2 The terms of reference for each of the Committees are currently under review and final versions will be submitted to the Trust Board on 8th January 2015 for formal approval.

4. BOARD COMMITTEE MEMBERSHIP

4.1 Following discussion at the Trust Board development session on 13th November 2014 and, subsequently, with the Chairman and Chief Executive, the Trust Board is recommended to confirm the membership of/attendance at Board committees as set out at appendix B.

4.2 Again, as discussed and agreed at the Trust Board development session in November 2014, all Non-Executive Directors are encouraged to attend all meetings of all Board committees. Such attendance will ensure that all Non-Executive Directors are appraised simultaneously of Board committee business and lessen the need for duplication of discussions at the Board itself.

5. IMPROVING THE QUALITY OF TRUST BOARD REPORTS

5.1 The Trust Board has entered into an agreement with Board Intelligence to work with them to improve Trust Board reports, to provide clearer visibility of performance and to support robust decision-making.

5.2 Board Intelligence will conduct an initial workshop with the Board on 8th January 2015, details of which will be confirmed separately.

5.3 The outputs of the Trust's work with Board Intelligence will include:-

- a clearer sense of the Board's key decision-making priorities over the next 12 months, documented in a refreshed Board calendar of business and providing the basis for a revised Trust Board dashboard;

- training on a suite of template reports that will make it quicker and easier for Directors to prepare high quality discussion papers for the Trust Board.

5.4 It is intended that the outputs described above will be in place as soon as possible and no later than the commencement of the 2015/16 financial year.

6. RECOMMENDATIONS

6.1 The Trust Board is recommended to:

(a) confirm the Trust Board Committee structure as set out at appendix A;

(b) confirm the membership of/attendance at Board Committees as set out at appendix B;

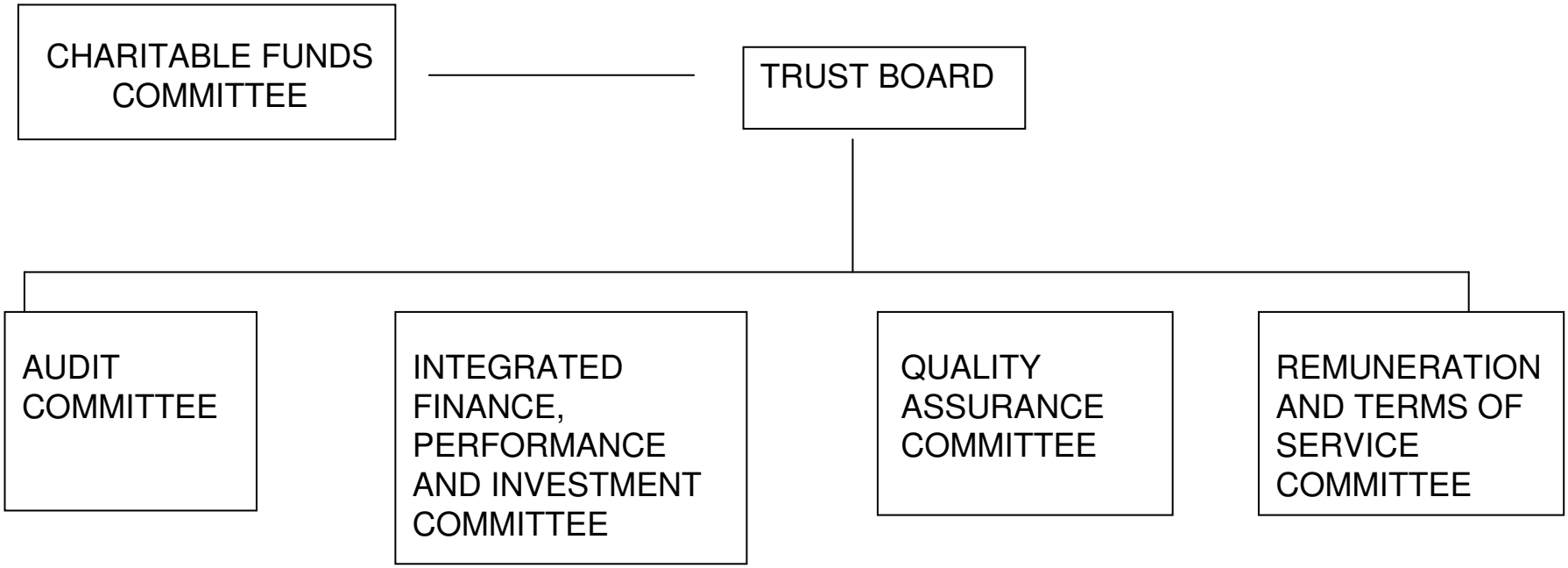
(c) note the ongoing work with Board Intelligence as set out in section 5 of the report; and

(d) receive a further report on Board Committees' terms of reference on 8th January 2015.

Stephen Ward
Director of Corporate and Legal Affairs

16th December 2014

Appendix A - BOARD COMMITTEE STRUCTURE (2) : PROPOSED



APPENDIX B

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST

MEMBERSHIP OF BOARD COMMITTEES

	Karamjit Singh **Chairman**	Ian Crowe **NED**	Sarah Dauncey **NED**	Prakash Panchal **NED**	Martin Traynor **NED**	Mike Williams **NED**	Jane Wilson **NED**	David Wynford-Thomas **NED**	John Adler **Chief Executive**	Kevin Harris **Medical Director**	Richard Mitchell **Chief Operating Officer**	Rachel Overfield **Chief Nurse**	Kate Bradley **Director of Human Resources**	Kate Shields **Director of Strategy**	Paul Traynor **Director of Finance**	Stephen Ward **Director of Corporate and Legal Affairs**	Mark Wightman **Director of Marketing and Communications**
Audit Committee		√	√	√		Chair						A			A	A	
Charitable Funds Committee		√		Chair	√							√			√	A	A
Integrated Finance, Performance and Investment Committee		√	√	√	√		Chair		√		√			A	√		
Quality Assurance Committee			Chair	√			√	√	√	√		√					
Remuneration Committee	Chair	√	√	√	√	√	√	√	A				A			A	

A denotes Director is in attendance at this meeting

University Hospitals of Leicester NHS
NHS Trust

Agenda Item: Trust Board Paper P

TRUST BOARD – 22 December 2014

NHS Trust Oversight Self-Certification

DIRECTOR:	Stephen Ward – Director of Corporate and Legal Affairs
AUTHOR:	Kate Rayns – Acting Senior Trust Administrator
DATE:	22 December 2014
PURPOSE:	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. Copies of the self certifications submitted in November 2014 (October 2014 position) are attached as Appendices A and B. Subject to discussion at the December 2014 Trust Board meeting on matters relating to operational and financial performance, and review of the month 8 quality and performance exception reports, the Trust Board is recommended to authorise the Director of Corporate and Legal Affairs to finalise and submit the return to the NHS Trust Development Authority in consultation with the Chief Executive.
PREVIOUSLY CONSIDERED BY:	**N/A**
Objective(s) to which issue relates *	[x] 1. Safe, high quality, patient-centred healthcare [x] 2. An effective, joined up emergency care system [x] 3. Responsive services which people choose to use (secondary, specialised and tertiary care) [ ] 4. Integrated care in partnership with others (secondary, specialised and tertiary care) [ ] 5. Enhanced reputation in research, innovation and clinical education [x] 6. Delivering services through a caring, professional, passionate and valued workforce [x] 7. A clinically and financially sustainable NHS Foundation Trust [ ] 8. Enabled by excellent IM&T
Please explain any Patient and Public Involvement actions taken or to be taken in relation to this matter:	None
Please explain the results of any Equality Impact assessment undertaken in relation to this matter:	Not applicable

Organisational Risk Register/ Board Assurance Framework *	☐ **Organisational Risk Register** ☒ **Board Assurance Framework** ☐ **Not Featured**

ACTION REQUIRED *

For decision ☒ For assurance ☐ For information ☐

♦ We treat people how we would like to be treated ♦ We do what we say we are going to do
♦ We focus on what matters most ♦ We are one team and we are best when we work together
♦ We are passionate and creative in our work

* tick applicable box

NHS TRUST DEVELOPMENT AUTHORITY

tda Trust Development Authority
Quality. Delivery. Sustainability.

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: * 28/11/2014 Reporting Year: * 2014/15

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NHS TRUST DEVELOPMENT AUTHORITY

Quality. Delivery. Sustainability.

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

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16% Complete

NHS TRUST DEVELOPMENT AUTHORITY

Quality. Delivery. Sustainability.

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	
2. Condition G5 Having regard to monitor Guidance. *	Yes	
3. Condition G7 Registration with the Care Quality Commission. *	Yes	

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18% Complete

NHS TRUST DEVELOPMENT AUTHORITY

Quality. Delivery. Sustainability.

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

4. Condition G8
Patient eligibility and selection criteria. *

Yes

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39% Complete

NHS TRUST DEVELOPMENT AUTHORITY

Quality. Delivery. Sustainability.

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

5. Condition P1
Recording of information. *
Yes

6. Condition P2
Provision of information. *
Yes

7. Condition P3
Assurance report on submissions to Monitor. *
Yes

8. Condition P4
Compliance with the National Tariff. *
Yes

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45% Complete

NHS TRUST DEVELOPMENT AUTHORITY

Quality. Delivery. Sustainability.

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

9. Condition P5
Constructive engagement concerning local tariff modifications. *

Yes

Prev Next Page 6 of 7

73% Complete

NHS TRUST DEVELOPMENT AUTHORITY

Quality. Delivery. Sustainability.

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

10. Condition C1
The right of patients to make choices. *

Yes

11. Condition C2
Competition oversight. *

Yes

12. Condition IC1
Provision of integrated care. *

Yes

Prev Submit Page 7 of 7

NHS TRUST DEVELOPMENT AUTHORITY

tda Trust Development Authority
Quality. Delivery. Sustainability.

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: * 28/11/2014 Reporting Year: * 2014/15

Select the Month *

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

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NHS TRUST DEVELOPMENT AUTHORITY

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.

NHS TRUST DEVELOPMENT AUTHORITY

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

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16% Complete

NHS TRUST DEVELOPMENT AUTHORITY

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

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22% Complete

NHS TRUST DEVELOPMENT AUTHORITY

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

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28% Complete

NHS TRUST DEVELOPMENT AUTHORITY

Quality. Delivery. Sustainability.

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

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34% Complete

NHS TRUST DEVELOPMENT AUTHORITY

Quality. Delivery. Sustainability.

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

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40% Complete

NHS TRUST DEVELOPMENT AUTHORITY

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

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46% Complete

NHS TRUST DEVELOPMENT AUTHORITY

Quality. Delivery. Sustainability.

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

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52% Complete

NHS TRUST DEVELOPMENT AUTHORITY

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

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58% Complete

NHS TRUST DEVELOPMENT AUTHORITY

Quality. Delivery. Sustainability.

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

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64% Complete

NHS TRUST DEVELOPMENT AUTHORITY

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. *

Risk

Timescale for compliance: *

31/03/2015

RESPONSE:

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

The 27 November 2014 UHL NHS Trust Board received reports identifying the causes of underperformance on the following indicators, and endorsed the remedial actions being taken to achieve compliance. The individual anticipated compliance dates submitted to the Trust Board are shown against relevant indicators:-

S1a Clostridium Difficile; S2a MRSA Bacteraemia; S3 Never Event; R1 ED 4-hour waits; R2 12 hour trolley wait in ED; R3 RTT waiting times (admitted) (January 2015); R4 RTT waiting times (non-admitted) (November 2014); R6 RTT 52 weeks+ waits (November 2014); R8 Cancer 2-week waits (December 2014); R10 Cancer 31-day wait for first treatment (January 2015); R14 Cancer 62-day wait for first treatment from GP referral (January 2015); R15 Cancer 62-day wait for first treatment from Consultant screening referral (February 2015), and R23 DTOCs

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70% Complete

NHS TRUST DEVELOPMENT AUTHORITY

Quality. Delivery. Sustainability.

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

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76% Complete

NHS TRUST DEVELOPMENT AUTHORITY

Quality. Delivery. Sustainability.

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

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82% Complete

NHS TRUST DEVELOPMENT AUTHORITY

Quality. Delivery. Sustainability.

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

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88% Complete

NHS TRUST DEVELOPMENT AUTHORITY

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

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