UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST

TRUST BOARD

MEETING TO BE HELD ON THURSDAY 28 AUGUST 2014 FROM 10.30AM IN SEMINAR ROOMS A & B, CLINICAL EDUCATION CENTRE, LEICESTER GENERAL HOSPITAL

Public meeting commences at 12noon

AGENDA

Please take papers as read

Item no.	Item	Paper ref:	Lead	Discussion time
1.	**EXCLUSION OF THE PRESS AND PUBLIC** It is recommended that, pursuant to the Public Bodies (Admission to Meetings) Act 1960, the press and members of the public be excluded from the following items of business, having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest (items 1-10).			-
2.	**APOLOGIES AND WELCOME** To receive apologies for absence, including Dr K Harris, Medical Director. Mr A Furlong, Deputy Medical Director will attend in his absence.	**-**	**Acting Chairman**	-
3.	**DECLARATIONS OF INTERESTS** Members of the Trust Board and other persons attending are asked to declare any interests they may have in the business on the agenda (Standing Order 7 refers). Unless the Trust Board agrees otherwise in the case of a non-prejudicial interest, the person concerned shall withdraw from the meeting room and play no part in the relevant discussion or decision.			
4.	**ACTING CHAIRMAN'S AND CHIEF EXECUTIVE'S OPENING COMMENTS**	**-**	**Acting Chairman and Chief Executive**	10.30 – 10.35am
5.	**CONFIDENTIAL MINUTES** Confidential Minutes of the 31 July 2014 Trust Board meetings. *For approval*	**A**	**Acting Chairman**	10.35 – 10.37am
6.	**MATTERS ARISING** Confidential action log from the 31 July 2014 Trust Board. *For approval*	**B**	**Acting Chairman**	10.37 – 10.45am
7.	**REPORT BY THE CHIEF EXECUTIVE** *commercial interests*	**C**	**Chief Executive**	10.45 – 11am
8.	**REPORT FROM THE CHIEF NURSE** *commercial interests*	**Additional paper 1**	**Chief Nurse**	11 – 11.15am
9.	**REPORTS FROM BOARD COMMITTEES**			11.15 – 11.20am
9.1	**FINANCE AND PERFORMANCE COMMITTEE** Confidential Minutes of the 30 July 2014 meeting for noting and endorsement of any recommendations. *Prejudicial to the conduct of public affairs*	**D**	**Finance and Performance Committee Chair**	

9.2	**QUALITY ASSURANCE COMMITTEE** Confidential Minutes of the 30 July 2014 meeting for noting and endorsement of any recommendations. *Prejudicial to the conduct of public affairs*	**E**	**QAC Non-Executive Director**	
9.3	**REMUNERATION COMMITTEE** Confidential Minutes of the 31 July 2014 meeting for noting and endorsement of any recommendations. *Prejudicial to the conduct of public affairs*	**F**	**Acting Chairman**	
10.	**ANY OTHER BUSINESS**	**-**	**Acting Chairman**	11.20 – 11.25am
	Comfort break until 12noon			
11.	**DECLARATION OF INTERESTS**	**-**	**Acting Chairman**	
	Members of the Trust Board and other persons attending are asked to declare any interests they may have in the business on the public agenda (Standing Order 7 refers). Unless the Trust Board agrees otherwise in the case of a non-prejudicial interest, the person concerned shall withdraw from the meeting room and play no part in the relevant discussion or decision.			
12.	**ACTING CHAIRMAN'S OPENING COMMENTS**	**-**	**Acting Chairman**	
13.	**MINUTES**			
	Minutes of the 31 July 2014 Trust Board meeting. *For approval*	**G**	**Acting Chairman**	12noon – 12.01pm
14.	**MATTERS ARISING**			
	Action log from the 31 July 2014 meeting. *For approval*	**H**	**Acting Chairman**	12.01 – 12.10pm
15.	**KEY ISSUES FOR DECISION/DISCUSSION**			
15.1	**CONGENITAL HEART DISEASE REVIEW** *For discussion and decision*	**I (to follow)**	**Director of Strategy**	12.10 – 12.25pm
15.2	**EMERGENCY FLOOR OUTLINE BUSINESS CASE** *For approval*	**J (to follow)**	**Director of Strategy**	12.25 – 12.40pm
15.3	**UPDATE ON NURSE STAFFING** *for assurance*	**K**	**Chief Nurse**	12.40 – 12.50pm
15.4	**EQUALITY GOVERNANCE 6-MONTH REPORT** *for assurance and approval*	**L**	**Director of Human Resources**	12.50 – 1.05pm
15.5	**CORE STANDARDS REVIEW ASSURANCE PROCESS** *for assurance and approval*	**M & N**	**Chief Operating Officer**	1.05 – 1.20pm
16.	**MONTHLY UPDATE REPORT BY THE CHIEF EXECUTIVE – AUGUST 2014**	**O**	**Chief Executive**	1.20 – 1.25pm
17.	**STRATEGY, FORWARD PLANNING AND RISK**			
17.1	**BLOOD TRANSFUSION LABORATORY IT SYSTEM** *For approval*	**P**	**Chief Executive**	1.25 – 1.35pm

17.2	**PILOT SCHEME BID TO INCREASE STAFF INVOLVEMENT** *for discussion*	**Q**	**Chief Executive**	1.35 – 1.50pm
17.4	**BOARD ASSURANCE FRAMEWORK** *For discussion and assurance*	**R**	**Chief Nurse**	1.50 – 2.05pm
18.	**QUALITY AND PERFORMANCE** *For assurance*			
18.1	**NEW FORMAT QUALITY, FINANCE AND PERFORMANCE REPORT – MONTH 4** *For assurance* The Non-Executive Director Chairs of the Quality Assurance Committee and the Finance and Performance Committee will be invited to highlight any month 4 issues from their most recent meeting (27 August 2014). At each meeting, the Acting Trust Chairman will then invite the Chief Executive and another Executive/Non-Executive Director colleague to identify key priority issues from within the month 4 report, for wider Trust Board consideration.	**S** **(to follow)**	**QAC Non-Executive Director/ Acting Chairman** **Acting Chairman/CE**	2.05 – 2.30pm
18.2	**2014-15 MONTH 4 FINANCIAL POSITION** *For assurance*	**T**	**Acting Director of Finance**	2.30 – 2.40pm
18.3	**EMERGENCY CARE PERFORMANCE AND RECOVERY PLAN** *For discussion and assurance*	**U**	**Chief Operating Officer**	2.40 – 2.50pm
19.	**RESEARCH & DEVELOPMENT**			
19.1	**QUARTERLY UPDATE ON R&D** *for assurance*	**V**	**Deputy Medical Director**	2.50 – 2.55pm
20.	**GOVERNANCE**			
20.1	**NHS TRUST OVER-SIGHT SELF CERTIFICATION** *For discussion and approval*	**W**	**Director of Corporate and Legal Affairs**	2.55 – 3pm
21.	**REPORTS FROM BOARD COMMITTEES**			3pm – 3.05pm
21.1	**FINANCE AND PERFORMANCE COMMITTEE** Minutes of the 30 July 2014 meeting for noting and endorsement of any recommendations (including approval of the **working capital strategy** appended to the Minutes).	**X**	**Acting Chairman**	
21.2	**QUALITY ASSURANCE COMMITTEE** Minutes of the 30 July 2014 meeting for noting and endorsement of any recommendations.	**Y**	**QAC Non-Executive Director**	
22.	**TRUST BOARD BULLETIN – AUGUST 2014**	**Z**	**-**	-
23.	**QUESTIONS FROM THE PUBLIC RELATING TO BUSINESS TRANSACTED AT THIS MEETING**	**-**	**Acting Chairman**	3.05 – 3.20pm
24.	**ANY OTHER BUSINESS**	**-**	**Acting Chairman**	3.20 – 3.25pm
25.	**DATE OF NEXT MEETING**			
	The Trust's **Annual Public Meeting** (APM) will be held on **Tuesday 9 September 2014** at the Big Shed, 93 Commercial Square, Freeman's Common, Leicester LE2 7SR. A health and wellbeing fair will be held between 4pm	**-**		

	– 6pm, with the formal APM starting at 6pm (until 8pm). The next Trust Board meeting will be held on **Thursday 25 September 2014** from **10am** in **the C J Bond Room, Clinical Education Centre, LRI.**			

Helen Stokes
Senior Trust Administrator

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST

MINUTES OF A MEETING OF THE TRUST BOARD, HELD ON THURSDAY 31 JULY AT 9.45AM IN GLOUCESTER HOUSE, AGE UK, 3 NORMAN WAY, MELTON MOWBRAY LE13 1LE

Present:
Mr R Kilner – Acting Trust Chairman
Mr J Adler – Chief Executive
Col. (Ret'd) I Crowe – Non-Executive Director
Dr S Dauncey – Non-Executive Director
Dr K Harris – Medical Director (up to and including Minute 209/14/2, and for Minute 217/14/4)
Mr R Mitchell – Chief Operating Officer
Ms R Overfield – Chief Nurse
Mr P Panchal – Non-Executive Director
Mr S Sheppard – Acting Director of Finance
Professor D Wynford-Thomas – Non-Executive Director

In attendance:
Dr T Bentley – Leicester City CCG (from Minute 204/14)
Ms K Bradley – Director of Human Resources
Mr D Henson – LLR Healthwatch Representative (from Minute 204/14)
Professor M Lakhani – Chair, West Leicestershire CCG (for Minute 209/14/1)
Mr P Shanahan – Ernst Young (for Minute 197/14)
Ms K Shields – Director of Strategy
Ms H Stokes – Senior Trust Administrator
Mr S Ward – Director of Corporate and Legal Affairs
Mr M Wightman – Director of Marketing and Communications (up to and including Minute 209/14/2)

ACTION

191/14 EXCLUSION OF THE PRESS AND PUBLIC

Resolved – that, pursuant to the Public Bodies (Admission to Meetings) Act 1960, the press and members of the public be excluded during consideration of the following items of business (Minutes 191/14 – 203/14), having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest.

192/14 APOLOGIES AND WELCOME

Apologies for absence were received from Ms J Wilson, Non-Executive Director. The Acting Trust Chairman welcomed Mr S Sheppard to the meeting in his new capacity as Acting Director of Finance.

193/14 DECLARATIONS OF INTERESTS IN THE CONFIDENTIAL BUSINESS

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

194/14 ACTING CHAIRMAN'S AND CHIEF EXECUTIVE'S OPENING COMMENTS

The Acting Trust Chairman noted that a decision on UHL's substantive Chair appointment was expected from the NTDA in the new few weeks.

Resolved – that the position be noted.

195/14 CONFIDENTIAL MINUTES

Resolved – that the confidential Minutes of 26 June 2014 be confirmed as a correct **CHAIR**

record and signed accordingly by the Acting Trust Chairman.

196/14 CONFIDENTIAL MATTERS ARISING REPORT

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

197/14 REPORT BY THE DIRECTOR OF STRATEGY

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

198/14 REPORT BY THE ACTING DIRECTOR OF FINANCE

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

199/14 REPORTS BY THE CHIEF NURSE

Resolved – that this Minute be classed as confidential and taken in private accordingly, on the grounds of commercial interests and on the grounds of personal information.

200/14 JOINT REPORT BY THE ACTING CHAIRMAN AND THE DIRECTOR OF CORPORATE AND LEGAL AFFAIRS

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

201/14 REPORT BY THE DIRECTOR OF CORPORATE AND LEGAL AFFAIRS

Resolved – that this Minute be classed as confidential and taken in private accordingly, on the grounds of personal information.

202/14 REPORTS FROM BOARD COMMITTEES

202/14/1 Finance and Performance Committee

Resolved – that the confidential Minutes of the 25 June 2014 Finance and Performance Committee be received, and the recommendations and decisions therein endorsed and noted respectively.

202/14/2 Quality Assurance Committee (QAC)

Resolved – that the confidential Minutes of the 25 June 2014 QAC be received, and the recommendations and decisions therein endorsed and noted respectively.

202/14/3 Remuneration Committee

Resolved – that the confidential Minutes of the 26 June 2014 Remuneration Committee be received, and the recommendations and decisions therein endorsed and noted respectively.

203/14 CORPORATE TRUSTEE BUSINESS

203/14/1 Charitable Funds Committee

All items from the 9 June 2014 Charitable Funds Committee were presented as recommendations and required Trust Board approval as Corporate Trustee, in light of that meeting's inquorate nature. Approval was given accordingly. **TB**

Resolved – that all recommended items within the inquorate 9 June 2014 Charitable Funds Committee minutes be approved by the Trust Board as Corporate Trustee. **TB**

204/14 DECLARATIONS OF INTERESTS IN THE PUBLIC BUSINESS

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

205/14 ACTING CHAIRMAN'S OPENING COMMENTS

The Acting Chairman drew members' attention to the following issues:-

(a) his thanks to Age UK for hosting this UHL Trust Board meeting (part of UHL's programme of holding more such meetings out in the community);
(b) his welcome to Mr D Henson, LLR Healthwatch representative, Mr S Sheppard Acting Director of Finance, and Professor M Lakhani, Chair of West Leicestershire Clinical Commissioning Group (CCG), and
(c) the key discussions on the LLR "Learning Lessons to Improve Care" quality review (featured in Minute 209/14/1 below and discussed immediately after this introduction from the Acting Trust Chairman). This unique review had involved a proactive audit of the quality of LLR patient care (therefore covering the patient journey across both primary and secondary care), the aims of which had included ensuring ongoing improvements and addressing concerns over fragmentation of care. In 2013 therefore, the case notes had been reviewed of 381 patients admitted as an emergency to the Leicester Royal Infirmary and who had subsequently died either in hospital or in the community in 2012/13. The review had specifically looked to identify any issues, which could now be addressed across the LLR healthcare community on an open and transparent basis, and the Acting Trust Chairman thanked the report's authors for their work.

Resolved – that the position be noted.

206/14 MINUTES

Resolved – that the Minutes of the 26 June 2014 Trust Board be confirmed as a correct record and signed by the Acting Trust Chairman accordingly. **CHAIR**

207/14 MATTERS ARISING FROM THE MINUTES

Paper M detailed the status of previous matters arising, particularly noting those without a specific timescale for resolution. In discussion on the matters arising report, the Board received updated information in respect of the following items:-

(a) **item 7** (Minute 181/14/1 of 26 June 2014) – it was requested that specific dates be identified for the Executive Quality Board and the Quality Assurance Committee to receive updates on the work of the Learning Disability Service; **CN**
(b) **item 12** (Minute 183/14/1 of 26 June 2014) – contact with the National Trust Development Authority (NTDA) regarding monitoring national media storylines had been actioned and could now be removed from the log; **STA**
(c) **item 12a** (Minute 183/14/1 of 26 June 2014) – it was requested that a date be identified for QAC consideration of the issue of TTO prescription error rates; **MD**
(d) item 12b (Minute 183/14/1 of 26 June 2014) – the anticipated date for delivering the 95% **CHAIR/**

appraisal target would be pursued with the Director of Human Resources outside the meeting and could therefore be removed from the action log. **DHR**

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

208/14 REPORT BY THE CHIEF EXECUTIVE – MONTHLY UPDATE REPORT (JULY 2014)

The Chief Executive advised that most of the key issues within his monthly report at paper N were covered on this Trust Board agenda, particularly the LLR Learning Lessons to Improve Care quality review. With regard to other itemised issues, UHL's system resilience plans had been submitted to the NTDA, and performance against the emergency care target appeared to be improving. The Chief Executive also advised the Trust Board of progress on the potential 'mutualisation' agenda for the acute care sector, noting the launch of a Department of Health/Cabinet Office £1m fund to explore pursuing this for interested organisations (fund to be split between 10 organisations). Bids were required by the NTDA by 4 September 2014, and the Chief Executive confirmed that if UHL was to lodge a bid he would report it accordingly to the August 2014 Trust Board. **CE**

The Chief Executive then raised a further additional item regarding the national congenital cardiac surgery review, with specific regard to the provision of paediatric congenital heart surgery at UHL. The Chief Executive drew the Trust Board's particular attention to 2 of the draft national compliance standards relating to:-

(i) the minimum number of procedures required per centre – Trust Board support was now requested for the Director of Strategy to continue discussions with Birmingham Children's Hospital regarding a potential network arrangement, and

(ii) the requirement for co-location of children's services – as this was not currently the case at UHL, the Trust Board was now asked to support an urgent assessment of the potential to alter the Trust's current reconfiguration plan to achieve co-location (including timelines and costs).

The Chief Executive also sought support for (iii) an immediate communication to UHL staff explaining the approach being taken on this issue, and (iv) a further report to be submitted accordingly to a future Trust Board on the implications of meeting the standards and the future strategy for the paediatric congenital cardiac surgery service. These actions (and those in (i) and (ii) above) were supported accordingly by the Trust Board. **CE/DS/ DMC**

<u>Resolved</u> – that (A) an update on any UHL bid for national mutualisation monies be presented to the August 2014 Trust Board prior to submission, and **CE**

(B) Trust Board approval to be given to actions (i) – (iv) above regarding paediatric congenital heart surgery at UHL. **CE/DS/ DMC**

209/14 CLINICAL QUALITY AND SAFETY

209/14/1 <u>LLR "Learning Lessons to Improve Care" Quality Review</u>

Immediately following the Chairman's opening comments in Minute 205/14 above, the Trust Board discussed the key issue of the LLR "Learning Lessons to Improve Care" Quality Review. Noting the Acting Trust Chairman's comments on the unique, proactive and exhaustive nature of the review, the UHL Medical Director began the presentation of its key findings including the fact that 89 of the 381 cases reviewed (23%) had identified care below an acceptable standard. The findings of the review would also be presented to the other participating LLR organisations' Boards, and had been covered in local media. The Medical Director clarified that 'unacceptable' care related to the presence of an error in the delivery of that care, and had no automatic relationship to the eventual outcome. The Medical

Director also commented on the decision to contact the families of all patients involved and offer them a variety of further action including additional investigations and/or meetings with Trust staff if so desired. A helpline was currently in place to respond to queries.

Both the UHL Medical Director and the Chair of West Leicestershire CCG noted the collective apologies of all organisations involved for the unacceptable care identified in the review. Professor M Lakhani, Chair of West Leicestershire CCG then continued the joint presentation of the review's findings, noting in particular:-

(i) the welcomed opportunity to improve care across the LLR system, taking the issues highlighted in the report as a starting point;
(ii) his reiteration that the sample involved was small (in the context of the 1million+ patients treated in UHL each year) and had deliberately focused on a patient group likely to have complex problems. This did not detract from the seriousness with which all parties were viewing the findings, however;
(iii) the recognised need for more 'joined up' care across LLR, and of a more consistently high quality;
(iv) the top 3 themes identified by the review's thematic analysis, including failure to notify the hospital of 'do not attempt resuscitation' (DNAR) orders in place for patients; failings in clinical reasoning, and palliative care issues, and
(v) the reviewers' recommendations and the subsequent development of a 5-point LLR action plan by all involved parties (in which clinical leadership was key, appropriately supported by management input).

Following the joint presentation, the UHL Chief Executive emphasised the aim of the review as having been to identify issues and learn lessons to drive improvement accordingly, with actions both for individual organisations and for the LLR system as a whole. He also confirmed that the full report and recommendations were currently available on the Trust's public website **http://www.leicestershospitals.nhs.uk/**

The Chief Executive also advised that UHL's individual actions resulting from the review would be taken forward through the Trust's extended Quality Commitment and its framework for Delivering Caring at its Best. In discussion on the Learning Lessons to Improve Care review, the Trust Board noted:-

(a) comments from Professor D Wynford-Thomas, Non-Executive Director and Dean of the University of Leicester Medical School that the lessons from the review were also being shared with medical students. He queried whether this was being extended within UHL to post-graduate students, and the Medical Director confirmed that the review's lessons would now be shared with FY1 doctors;
(b) comments from Dr A Bentley, CCG representative, that much individual and cross-LLR organisational improvement had taken place since the time that the audit had been conducted. He also reiterated LLR's commitment to cross-organisational working, as evidenced by his presence at UHL Trust Board meetings, and
(c) that it would be helpful for all involved organisations to receive an update in 3 months' time, re: progress on the LLR cross-cutting actions. **MD**

At this point, the Acting Trust Chairman invited any comments or questions from members of the public present at the meeting – no points were raised.

Resolved – that (A) the findings of, and proposed actions resulting from the LLR Learning Lessons to Improve Care quality review, be noted and endorsed, and

(B) the Boards of all involved organisations receive a further update on the LLR cross-cutting actions, in 3 months' time. **MD**

209/14/2 Medical Revalidation and Appraisal Annual Report 2013-14

Paper P provided assurance that UHL was satisfactorily discharging its statutory duties in its role as a Designated Body (specifically re: medical revalidation and appraisal in this report) for the majority of its medical employees. Once accepted by the Trust Board, the 2013-14 annual medical revalidation and appraisal report would be shared with the higher level Responsible Officer as appropriate. Trust Board approval was also sought for the 'statement of compliance' appended to paper P, confirming that UHL (as a designated body) was in compliance with the Medical Profession (Responsible Officers) Regulations 2010 (as amended in 2013).

The Medical Director advised that there was only a very small number of doctors now not engaging fully with the medical revalidation and appraisal process. He also drew the Trust Board's attention to changes to the external oversight of UHL's appraisal and revalidation processes, which had recently been taken over by NHS England. Independent external review was also being strongly recommended – whilst welcomed by the Trust, this had potential resource implications. In discussion on the report and whilst recognising the reduction from previous years, the Trust Board voiced some concern over the number of doctors not completing appraisals in 2013-14 (62 out of 678), and sought assurance that this would be reduced further in future years. In response to a further query from Col. (Ret'd) I Crowe Non-Executive Director, the Medical Director also outlined the measures in place to ensure the quality of medical appraisals. In response to a query from Dr S Dauncey Non-Executive Director, the Medical Director also confirmed that the relevant triangulation process and 360 degree feedback was taking place as required.

Resolved – that (A) the 2013-14 Medical Revalidation and Appraisal Annual Report be supported, and the statement of compliance appended to the report be endorsed (for onwards submission as required), and **MD**

(B) support be given to amend the Trust's Medical Appraisal and Revalidation Policy to clarify the process in the event of missed appraisals. **MD**

209/14/3 Health and Safety Annual Report 2013-14

The Chief Nurse presented the 2013-14 Health and Safety Annual Report (paper Q) for Trust Board approval, noting that in future the Trust Board version would comprise an executive summary only. She particularly noted improvements in health and safety training compliance, a fall in RIDDOR-reportable incidents, and significant work on equipment for (and training in dealing with) bariatric patients. Conflict resolution training to deal with incidents of violence and aggression was also a key issue. In discussion on the Annual Report, Mr I Crowe Non-Executive Director commented that:-

(i) it would be more meaningful to see 5-year trend data, including resulting actions, and
(ii) more granular detail on violence and aggression incidents needed to be provided to the Trust's Security Committee, in order to equip that group to develop appropriate actions. **CN**

Resolved – that (A) the 2013-14 Health and Safety Annual Report be approved, and

(B) an appropriate level of detail on incidents of violence and aggression be provided to the UHL Security Committee. **CN**

209/14/4 "Sign up to Safety" Campaign

Additional paper 1 from the Chief Nurse advised the Trust Board of the national 'Sign up to Safety' campaign and outlined the organisational actions/improvements therefore required. Although many of the elements were already covered through UHL's Quality Commitment,

this would serve also to bring in safety culture aspects. Although supporting the Trust's involvement in the campaign, the Acting Trust Chairman noted the need for clarity on which existing workstreams could be used and to avoid unnecessary duplication. Dr S Dauncey Non-Executive Director advised that UHL's Quality Assurance Committee had received assurance on this point on 30 July 2014.

Resolved – that (A) the required organisational improvements/actions be supported as detailed in additional paper 1, and **CN**

(B) the Executive Quality Board and Quality Assurance Committee be kept updated of progress on the Sign up to Safety campaign, via the regular patient safety reports. **CN**

210/14 STRATEGY, FORWARD PLANNING AND RISK

210/14/1 Vascular Services Outline Business Case (OBC)

Paper R from the Director of Strategy sought Trust Board approval to submit the vascular services OBC to the National Trust Development Authority, noting that the business case now also incorporated amendments requested by UHL's Capital Monitoring and Investment Committee on 27 June 2014. Members noted that the OBC incorporated the transfer of vascular and supporting services from the LRI to the Glenfield Hospital site (including an inpatient ward and surgical admissions area, vascular studies unit, angiography and the provision of a new hybrid theatre). The project was identified within UHL's capital programme as requiring external loans for the main scheme (£11.9m assuming VAT reclamation at circa £450k).

In his capacity as Finance and Performance Committee Chair, the Acting Trust Chairman confirmed that in supporting the OBC on 30 July 2014, the Finance and Performance Committee had noted the need for the Full Business Case (FBC) to include assurances on its impact on mortality, funding requirements, and operational efficiencies (eg 7-day working). In response to a query from Professor D Wynford-Thomas, Non-Executive Director, it was confirmed that the Finance and Performance Committee has also been made aware of linked research activities at the Glenfield Hospital.

Resolved – that (A) submission of the vascular services OBC to the NTDA be approved as detailed in paper R, and

(B) all associated recommendations within paper R also be approved (including the release of ward 24 at the Glenfield Hospital as an enabler to the vascular project), and the timescale for delivery of the OBC and subsequent FBC at risk (subject to addressing the recommendations listed in paper R) be accepted. **DS**

210/14/2 Capital Funding for the Reprovision of Clinical Space/Modular Wards

Paper S updated the Trust Board on the replacement support accommodation needed at the LRI including the requirement for a new modular ward to support additional bed capacity, and on the financial support required from the NTDA via Public Dividend Capital (PDC) funding for those projects (£8m). The report also outlined the current position of UHL's business case for the redevelopment of its emergency floor, the Full Business Case for which would be submitted to the NTDA in November 2014. The Acting Director of Finance clarified that although the 3 capital schemes within paper S had already received Trust Board approval as part of the 2014-15 capital programme, Trust Board support was now required for the £8m PDC application to the NTDA as the UHL capital programme was over committed. The Trust Board supported the recommendation in paper S, noting that the outcome of the application was expected in November 2014. **ADF**

Resolved – that (A) the application for Public Dividend Capital funding via the NTDA **ADF**

be approved and actioned, recognising the overcommitment of UHL's capital programme, and

(B) a further update on measures to mitigate the over-commitment of the capital programme be provided to the August 2014 Finance and Performance Committee. **ADF**

210/14/3 Managed Print – LRI Business Case

Paper T comprised the business case to extend the Glenfield Hospital managed print solution to the LRI site, which had also been discussed at the 30 July 2014 Finance and Performance Committee (where a further update in 6 months had been requested, to check progress on the delivery of the anticipated quality and financial benefits). The business case was now approved by the Trust Board as presented. **CE**

Resolved – that the business case to extend the managed print solution to the LRI be approved and actioned, for work to commence in August 2014 accordingly. **CE**

210/14/4 Orthopaedic Trauma CMF Implants and Associated Products Framework

Paper U sought Trust Board approval for the orthopaedic trauma CMF implants and associated products framework, which would allow UHL to call-off future contracts following mini-competitions without the requirement for further Trust Board approval. If approved, the framework would be live as of 8 weeks from 31 July 2014 for a period of 3 years. In approving the framework, the Trust Board commented on the number of suppliers involved, and sought confirmation (outside the meeting) of how many had not been shortlisted. **ADF**

Resolved – that (A) the framework contract for Orthopaedic Trauma CMF Implants and Associated Products be approved, and authority delegated to an Executive Director to award contracts within the framework following a mini-competition (without the requirement for further Trust Board approvals), and **ADF**

(B) the number of suppliers not shortlisted for he framework be confirmed to members outside the meeting. **ADF**

210/14/5 (Draft) Strategic Forward Business Planning Programme for Trust Board

Further to discussions at the 17 July 2014 Trust Board development session, paper V from the Director of Strategy outlined the development of a UHL strategic planning function for 2014-15 and beyond (draft calendar as appended). Discussions had also begun with UHL's Clinical Management Groups (CMGs) to improve the planning process for 2015-16. In endorsing the business planning programme approach, the Trust Board:-

(a) noted (in response to a query) that broader engagement with the public and stakeholders would be discussed further with the Director of Marketing and Communications. Dr A Bentley CCG representative queried whether this engagement would be extended to internal clinical staff; **DS/ DMC**
(b) suggested that the strategic planning calendar should also cross-reference appropriately with other organisational strategies, noting that this would be amended in a further iteration of the calendar;
(c) noted a query from Mr D Henson LLR Healthwatch representative, as to whether the 'business rules' being presented to the September 2014 Trust Board also include monitoring aspects (in order to ensure appropriate CMG consistency). Mr Henson also queried whether the risks of the business planning process would also be appropriately articulated, and **ADF**
(d) noted the view of the 30 July 2014 Finance and Performance Committee that any business case not involving a move to 7-day services needed explicitly to articulate the reasons for that position.

Resolved – that (A) arrangements for broader engagement with the public and stakeholders be agreed with the Director of Marketing and Communications, and **DMC/ DS**

(B) the draft business rules framework for the September 2014 Trust Board include appropriate monitoring aspects, to ensure CMG consistency of approach. **ADF**

210/14/6 Medical Workforce Strategy

The Director of Human Resources presented the proposed medical workforce strategy to support UHL's 5-year workforce plan (paper W), describing 4 aspects to support the Trust's medical workforce and address future shortages in supply (particularly re: junior medical staff). The strategy would also link appropriately to national reviews of the Consultant contract and ways of training and working. In discussion, the Trust Board noted:-

(a) comments from Dr A Bentley CCG representative, on the need to reflect moves towards more generalist Consultants (as previously articulated by UHL's Associate Medical Director (Clinical Education)); **DHR**

(b) that progress in addressing gaps in medical trainee numbers would be monitored through UHL's Executive Workforce Board – it was vital to obtain appropriate specialty-level granularity on this issue. Given its importance, it was agreed to review this issue further in 4 months' time at the Trust Board, and **DHR**

(c) a suggestion from Mr P Panchal Non-Executive Director that it might be helpful to take a longer-term view, to assess the wider picture in terms of future medical workforce needs and availability. This would also involve an assessment of medical trainees' reasons for not selecting Leicester as a first-choice employer.

Resolved – that (A) subject to appropriate reflection of point (a) above, the medical workforce strategy be endorsed, and **DHR**

(B) a further report on the future supply of medical trainees (and associated issues) be submitted to the Trust Board in 4 months' time (November 2014). **DHR**

210/14/7 Risk Management Policy

Paper X sought Trust Board approval (as required) for the updated UHL Risk Management Policy (changes as detailed in the report) – this was approved accordingly. **CN**

Resolved – that the updated Risk Management Policy be approved and placed on UHL's intranet accordingly. **CN/STA**

210/14/8 New Format Board Assurance Framework (BAF)

The Chief Nurse presented the new format BAF (paper Y), further updated since discussion at the 17 July 2014 Trust Board development session and now aligned to UHL's strategic objectives. In response to a query from the Acting Trust Chairman, the Chief Executive clarified that the reduced risk scores reflected a change in the scoring mechanism rather than any downgrading of risks. The risk descriptors had also changed. At the request of the Acting Trust Chairman, it was agreed that the monthly review of 3 specific risks (focusing on the highest risks) would start again from the August 2014 Trust Board. In discussion on the new format BAF (which was also scheduled for review at the September 2014 Audit Committee), the Trust Board:- **CN**

(a) queried the new risk on same sex accommodation breaches – in response the Chief Nurse outlined certain privacy and dignity issues arising from a quality and safety audit, and

(b) noted the need to populate the 'gaps' sections in risks 12, 13 and 14, and the scoring of risk 6. The Chief Nurse acknowledged that this information remained outstanding and agreed to include it in the next iteration of the BAF. **CN**

<u>Resolved</u> – that (A) any outstanding information be included in the next iteration of the new format BAF, for submission to the August 2014 Trust Board, and **CN**

(B) monthly Trust Board consideration of 3 specific BAF risks restart in August 2014. **CN**

211/14 QUALITY AND PERFORMANCE

211/14/1 <u>Month 3 Quality and Performance Report</u>

The month 3 quality and performance report (paper Z - month ending 30 June 2014) advised of red/amber/green (RAG) performance ratings for the Trust, and set out performance exception reports in the accompanying appendices. Noting his intention to change the Trust Board approach to considering the monthly quality and performance report from this meeting onwards, the Acting Trust Chairman now invited the QAC and Finance and Performance Committee Non-Executive Director Chairs to provide verbal reports from their most recent meetings, following which he would invite the Chief Executive to highlight the top 3-4 issues for the Trust Board to consider from the month 3 report. Each month a different Executive/Non-Executive Director colleague would also then be asked to comment on their key issues.

In terms of the 30 July 2014 QAC meeting and in the absence of Ms J Wilson Non-Executive Director QAC Chair, Dr S Dauncey Non-Executive Director highlighted the following issues:-

(i) QAC's consideration of the renal transplant action plan and its reassurance that UHL was operating a safe service. Slight slippage on the action plan timescales would be reviewed further in September 2014;
(ii) detailed discussion on worsened fractured neck of femur performance, and
(iii) a suggested future Trust Board development session discussion on medical workforce staffing issues.

Mr P Panchal Non-Executive Director added that the QAC had also discussed NHS preparedness for an ebola virus outbreak (through the infection prevention report) and had received assurance that appropriate local systems were in place.

The Acting Trust Chairman and Finance and Performance Committee Chair then outlined key operational issues discussed by the 30 July 2014 Finance and Performance Committee, namely:-
(a) performance against cancer targets;
(b) improving the number of delayed transfers of care, and
(c) UHL's capital plan – the Finance and Performance Committee considered that detailed consideration was needed and had recommended further review at the August 2014 Trust Board development session and formal Trust Board. **ADF/DS**

The Chief Executive then highlighted his 4 key month 3 issues for Trust Board consideration (noting that financial performance was discussed separately in Minute 211/14/2 below), as follows:-

(1) broadly good progress on compliance with operational targets;
(2) progress on the 18-week referral to treatment target in respect of non-admitted patients, with the target achieved in month 3 (thus ahead of the end August 2014 timeline). The RTT position regarding admitted patients was more challenging however, with UHL currently behind on the November 2014 compliance trajectory. The Chief Executive reiterated the crucial need to achieve that timescale, and the Chief Operating Officer noted his confidence in meeting that target;

(3) continued concerns over cancer performance. The Chief Operating Officer outlined a number of reasons affecting performance, including a significant rise in referrals and changes in internal practices. He had reviewed remedial action plans from each tumour site and considered that performance would become compliant in September 2014 (CCGs and the NTDA had been advised accordingly). In response to a query from Mr D Henson LLR Healthwatch representative, the Chief Operating Officer confirmed that the impact of the referral rise on diagnostic services featured within the tumour sites' action plans, and

(4) emergency care performance (covered in Minute 211/14/3 below).

In discussion on the issues highlighted above and on the month 3 quality and performance report generally, the Trust Board:-

(I) noted that this was the final month for the existing format of the report;

(II) noted a suggestion from Dr A Bentley, CCG representative on the usefulness of auditing the rise in breast cancer referrals, to assess whether it led to a rise in detection of actual cancer cases (this was already intended). It would also be helpful to understand referral patterns for the other tumour sites;

(III) noted comments from Dr A Bentley CCG representative, on the welcomed reduction in UHL's hospital standardised mortality ratio, particularly in light of the earlier item on the LLR Learning Lessons to Improve Care quality review – he considered that the position had therefore already improved since 2013;

(IV) queried how the current position re: nursing vacancies compared to the original recruitment trajectory. The Chief Nurse advised that additional posts had been added since the original plan and confirmed that she would report further on this issue to the August 2014 Trust Board (including the additional investment and the number of posts added); **CN**

(V) queried the position re: ambulance turnaround times, in light of the patient impact and financial penalties involved. The Chief Operating Officer noted the challenging nature of this target and confirmed that an action plan was in place with partners, and

(VI) noted a query from Mr P Panchal Non-Executive Director on whether the Trust monitored the demographic impact of not meeting targets. Although this could potentially be done, it was not monitored at present.

<u>Resolved</u> – that (A) a possible further detailed review of the 2014-15 capital plan be discussed at the August 2014 Trust Board development session and the formal August 2014 Trust Board, and **ADF**

(B) the nursing vacancies trajectory be updated to reflect incremental investments, and reported to the August 2014 Trust Board. **CN**

211/14/2 <u>Month 3 Financial Position</u>

Paper AA advised members of UHL's financial position as at month 3 (month ending 30 June 2014), noting a year-to-date adverse variance to plan of £0.6m. This variance was due largely to a £0.4m shortfall on cost improvement programme delivery. Patient care income was also under-performing. The Trust was still forecasting to deliver its forecast year-end £40.7m deficit, however, and cost improvement programme schemes had now been identified in excess of the original £45m target. Paper AA also set out the current potential risks to delivery of the year end plan. In discussion on the month 3 financial position, the Trust Board:-

(a) queried the reasons for the apparent adverse variance in year-to-date ED activity, and requested that these be further clarified to the August 2014 Finance and Performance Committee. Mr D Henson, LLR Healthwatch representative also noted a need for greater understanding of this variance to the forecast position. The Trust Board noted comments from Executive Directors on the national trend for increased ED attendances and **COO**

admissions, and on the relative performance of Commissioners' ED admission avoidance schemes – in further discussion on this latter aspect, Dr A Bentley CCG representative suggested it would be useful to know whether the acuity of ED patients had changed, and

(b) sought assurance on the adequacy of the Trust's financial contingency – in response the Acting Director of Finance considered that improved planning meant that the contingency was sufficient, and he advised that the contingency was intact as at the end of quarter 1 of 2014-15.

Resolved – that the August 2014 Finance and Performance Committee review the reasons for the year-to-date variance in forecast ED activity. **COO**

211/14/3 Emergency Care Performance and Recovery Plan

Paper BB provided an overview of ED performance, noting improved performance against the target in month 3 (91.2%). Although encouraging, this improvement was still recognised to be below the 95% target. It was also noted that ED admissions remained high compared to 2013 levels. UHL's ED action plan appended to paper BB focused heavily on clinical leadership, and the Chief Operating Officer outlined the key elements of that recovery plan including the use of 4 principal working groups to drive the necessary changes on a day to day basis. A 'rapid cycle testing' approach had also been adopted to assess the impact of new ideas. The Chief Operating Officer also reiterated the Trust's commitment (as stated to the NTDA) to achieve compliance with the ED target by 31 August 2014. In discussion on the ED performance report and recovery plan, the Trust Board:-

(a) sought assurance that performance improvements would be sustained. In response, the Chief Operating Officer was confident of maintaining the momentum – he noted the ongoing work by Dr I Sturgess, External Consultant to deliver change and also advised that there was now a clearer understanding of the various different factors involved. Professor D Wynford-Thomas, Non-Executive Director, suggested a focus on flow issues and noted the need to know which elements of the recovery plan were working well. The Chief Operating Officer also noted the development of key performance indicators for ED, which could be shared at the August 2014 Trust Board, and **COO**

(b) queried whether a change in the acuity of ED attendances was the cause of the rise in admissions compared to 2013. Dr A Bentley CCG representative commented on the impact of care pathway changes and the Chief Operating Officer noted cross-LLR work to understand the reasons for the rise in admissions. A shared understanding of (and partnership approach to) improvement was vital.

Resolved – that KPIs and data on which elements of the emergency care improvement plan were having the most impact, be shared with the August 2014 Trust Board. **COO**

212/14 GOVERNANCE

212/14/1 NHS Trust Over-Sight Self Certifications

The Director of Corporate and Legal Affairs introduced UHL's self certification returns for June 2014 (paper CC). Following due consideration, and taking appropriate account of any further information needing to be included from today's discussions, the self certification against Monitor Licensing Requirements (appendix A), and Trust Board Statements (appendix B) were endorsed for signature accordingly by the Chief Executive and submission to the NTDA. **DCLA/ CE**

Resolved – that the NHS Trust Over-Sight Self Certification returns for June 2014 be approved for signature by the Chief Executive, and submitted to the NTDA. **DCLA/ CE**

212/14/2 Board Effectiveness Review – Proposed Changes

Paper DD detailed the draft Board effectiveness action plan prepared following the Foresight Partnership's review of UHL Board effectiveness. The action plan set out recommendations in respect of the 3 key roles of the Trust Board namely (i) formulating strategy; (ii) ensuring accountability, and (iii) shaping culture, and the Acting Trust Chairman advised that work to take forward those recommendations would be led by UHL's Vice-Chair (Ms J Wilson Non-Executive Director). In response to a query from Mr P Panchal Non-Executive Director on this specific point, the Acting Trust Chairman noted his view that this decision reflected Ms Wilson's particular skillset – he also noted her role as Senior Independent Director. In further discussion on the action plan, the Trust Board:-

(a) noted (in response to a query from Mr P Panchal Non-Executive Director) that the costs of appointing a Board 'coach' were not yet known, as the work required was currently at the scoping stage;
(b) requested that the action plan also include work to reduce the current level of duplication between the corporate Committees, and **DCLA**
(c) noted the need for any 'key' items to be featured at the start of future Trust Board agendas. **CHAIR**

Resolved – that the Board effectiveness review action plan be endorsed, subject to inclusion of actions to:- DCLA /CHAIR
(A) reduce duplicated business between Committees, and
(B) review the order of Trust Board agendas to take the most important items early.

212/14/3 UHL Annual Report 2013-14

Members considered the UHL annual report for 2013-14 (paper EE), noting that the opening statements from the Acting Trust Chairman and the Chief Executive would be circulated once available. **DMC** The Annual Report was endorsed subject to the inclusion of the following additional information:-
(a) Non-Executive Directors' Committee chairing and membership commitments;
(b) a brief explanation of the role of a Non-Executive Director, and
(c) reference to both the CCG and Healthwatch representatives on the Trust Board.

Resolved – that (A) the 2013-14 UHL Annual Report section on the Executive and Non-Executive Director Trust Board members be amended to include:- DMC
(1) CCG and Healthwatch representatives;
(2) Non-Executive Directors'Committee Chairing and membership commitments;
(3) a brief explanation of the role of Non-Executive Directors, and

(B) the opening statements to the Annual Report be circulated once available. DMC

213/14 REPORTS FROM BOARD COMMITTEES

213/14/1 Finance and Performance Committee

Resolved – that the 25 June 2014 Finance and Performance Committee Minutes be received, and the recommendations and decisions therein be endorsed and noted.

213/14/3 Quality Assurance Committee (QAC)

Resolved – that the 25 June 2014 QAC Minutes be received, and the recommendations and decisions therein be endorsed and noted respectively.

214/14 TRUST BOARD BULLETIN

Resolved – that the quarterly update on Trust sealings, and the report on quarter 1 progress against the 2014-15 annual operational plan, be noted.

215/14 CORPORATE TRUSTEE BUSINESS

215/14/1 Charitable Funds Committee

All items from the 9 June 2014 Charitable Funds Committee were presented as recommendations and required Trust Board approval as Corporate Trustee, in light of that meeting's inquorate nature. Approval was given accordingly, including to the 2 supported bids for charitable funding (applications 5006 - £500 from general purposes fund for 4 wheelchairs for LGH outpatients and 5044 - £11,160 from the Women's and Children's equipment fund for the provision of a colposcope for gynaecology services). **ADF**

Resolved – that all recommended items within the inquorate 9 June 2014 Charitable Funds Committee minutes be approved by the Trust Board as Corporate Trustee. **ADF**

216/14 QUESTIONS AND COMMENTS FROM THE PUBLIC RELATING TO BUSINESS TRANSACTED AT THIS MEETING

The Director of Corporate and Legal Affairs agreed to provide a response outside the meeting, to a question tabled earlier by a member of the public who had had to leave before the end of the meeting. **DCLA**

Resolved – that a response be provided outside the meeting to the question tabled by a member of the public. **DCLA**

217/14 ANY OTHER BUSINESS

217/14/1 Query from Mr I Crowe, Non-Executive Director

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

217/14/2 Item from the Dean of the University of Leicester Medical School

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

217/14/3 Report from the Director of Human Resources

Resolved – that this item be classed as confidential and taken in private accordingly on the grounds of personal information.

217/14/4 Report from the Medical Director

Resolved – that this item be classed as confidential and taken in private accordingly on the grounds of personal information.

218/14 **CHAIR'S BULLETIN**

The Acting Trust Chairman invited members to identify key messages from the meeting today, which would then be communicated to staff in the form of a 'Chair's Bulletin'. Following discussion, it was agreed to highlight the following:- **CHAIR/ DMC**

- learning lessons to improve care review;
- medical staffing workforce strategy
- intention to engage more widely on UHL's strategic forward planning business programme;
- clinically-led improvements to emergency care;
- paediatric congenital heart surgery review, and
- engagement with Age UK.

Resolved – that the above issues be communicated immediately to staff through the new 'Chair's Bulletin' as key messages from today's Trust Board. **CHAIR/ DMC**

219/14 DATE OF NEXT MEETING

Resolved – that the next Trust Board meeting be held on Thursday 28 August 2014 at 10am in rooms A & B, Clinical Education Centre, Leicester General Hospital.

The meeting closed at 3.30pm

Helen Stokes - **Senior Trust Administrator**

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

Name	Possible	Actual	% attendance	Name	Possible	Actual	% attendance
R Kilner (Acting Chair from 26.9.13)	5	5	100	R Mitchell	5	4	80
J Adler	5	5	100	R Overfield	5	5	100
T Bentley*	4	4	100	P Panchal	5	5	100
K Bradley*	5	5	100	K Shields*	5	5	100
I Crowe	5	4	80	S Ward*	5	5	100
S Dauncey	5	4	80	M Wightman*	5	5	100
K Harris	5	5	100	J Wilson	5	3	60
D Henson*	1	1	100	D Wynford-Thomas	5	3	60
K Jenkins	4	4	100				

* non-voting members

University Hospitals of Leicester NHS Trust

Progress of actions arising from the Trust Board meeting held on Thursday 31 July 2014

Item No	Minute Ref:	Action	Lead	By When	Progress Update	RAG status*
1.	207/14	***Matters arising*** Specific dates to be scheduled for Executive Quality Board/Quality Assurance Committee updates on the work of UHL's Learning Disability Service.	CN	Dates to be set by 28.8.14	Report to be taken to EQB/QAC in September 2014.	5
1a	207/14	Action 12 (re: contact with NTDA over monitoring national media stories and their likely impact on service demand) to be removed from the log as now complete.	STA	Immediate	Actioned.	5
1b	207/14	Specific date to be scheduled for QAC consideration of TTO prescription error rates (as referred by the Finance and Performance Committee).	CN/MD	Date to be set by 28.8.14	**Verbal confirmation to be provided on 28 August 2014.**	4
1c	207/14	Action 12b (re: anticipated date for delivering the 95% appraisal target) to be pursued with the Director of Human Resources outside the meeting and removed from the action log.	CHAIR/ DHR	Immediate	Actioned.	5
2.	208/14	***Chief Executive's monthly report*** Any intended UHL bid for national mutualisation monies to be presented to the August 2014 Trust Board prior to submission.	CE	TB 28.8.14	To be included in report to August 2014 Trust Board.	4
2a	208/14	Trust Board approval to be given to the following recommendations re: paediatric congenital heart surgery at UHL:- • an urgent assessment to be commissioned of the potential to alter current UHL configuration to achieve co-location (including timelines and costs); • Director of Strategy to be supported in pursuing existing dialogue with Birmingham Children's Hospital with a view to agreeing a network approach as soon as possible; • Submission of a report to a future Trust Board meeting setting out the implications of meeting the emergency standards and also the implications of not meeting them (eg future strategy for the service), and • Issuing of a communication to all staff immediately, explaining the approach being taken and the decision-making timescales.	CE/DS/ DMC	Immediate and for future Trust Board meeting	All actions in progress. All staff communication issued. The Director of Strategy continues discussions with Birmingham Children's Hospital.	4

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

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

3.	209/14/1	***"Learning Lessons to Improve Care" LLR joint quality review*** Boards of all involved organisations to receive a further update on the cross-cutting actions, in 3 months' time.	MD	TB 30.10.14	To be scheduled accordingly for the October 2014 Trust Board.	4
4.	209/14/2	***Medical appraisal and revalidation*** Statement of compliance to be approved as per the Regulations.	MD	Immediate	Actioned.	5
4a	209/14/2	Support to be given for the Executive Team to consider and agree reasonably justified additional funding, to allow UHL to discharge its responsibilities as a designated body.	MD	Ongoing	Timescale to be confirmed outside the meeting.	4
5.	209/14/3	***2013-14 UHL Health and Safety Annual Report*** Security Committee to ensure that it received appropriate detail on incidents of violence and aggression.	CN	Immediate	Actioned – discussed accordingly with the Director of Safety and Risk.	5
6.	209/14/4	***"Sign up to Safety" National Campaign*** Organisational improvements/actions required to be supported as detailed in additional paper 1.	CN	Immediate	Actioned.	5
6a	209/14/4	Executive Quality Board and Quality Assurance Committee to be kept updated of progress on the Sign up to Safety campaign, through the regular patient safety reports.	CN	Monthly updates	In place via Safety Report.	5
7.	210/14/1	***Vascular Services Outline Business Case*** All recommendations to be approved as per paper R, including submission of the OBC to the National Trust Development Authority and release of ward 24 (Glenfield Hospital) as an enabler for the vascular project.	DS	Immediate	Actioned – the vascular OBC was submitted to the NTDA on the 6 August 2014.	5
7a	210/14/1	Full Business Case to include assurance on the impact on mortality, funding requirements, operational efficiencies (as per 30 July 2014 Finance and Performance Committee discussions).	DS	For FBC	A paper is due to go to the 24 September Quality Assurance Committee that includes a service move assessment framework, the paper is to then go to the October ESB.	4
8.	210/14/2	***Capital funding for reprovision of clinical space/modular wards*** Application for Public Dividend Capital funding via the NTDA to be approved and actioned, recognising the overcommitment of UHL's capital programme.	ADF	Immediate	The application will be part of the cash loan submission to the NTDA on 22 August 2014	4
8a	210/14/2	Further update report on measures to mitigate the over-commitment of the capital programme to be provided to the Finance and Performance Committee in August 2014.	ADF	FPC 27.8.14	On track for F&P discussion	4
9.	210/14/3	***Managed Print LRI – business case*** Business case to be approved and actioned, for work to commence in August 2014.	CE	Immediate	Order issued.	5

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

10.	210/14/4	***Orthopaedic trauma CMF implants and associated products framework*** Framework contract to be approved and authority to be delegated to an Executive Director to award contracts within the framework following a mini-competition (without the requirement for further Trust Board approvals).	ADF	Immediate	Actioned	5
10a	210/14/4	Number of suppliers who had not been shortlisted to be confirmed to members outside the meeting.	ADF	By 28.8.14	On track	4
11.	210/14/5	***(draft) strategic forward business planning programme*** Issue of broader engagement with the public and stakeholders to be discussed and arrangements to be agreed with the Director of Marketing and Communications.	DS/DMC	Ongoing	Work in progress.	4
11a	210/14/5	Draft business rules framework for September 2014 Trust Board to include appropriate policing, to ensure CMG consistency of approach.	ADF	TB 25.9.14	Report to be discussed by the Executive Team in September 2014.	4
12.	210/14/6	***Medical workforce strategy*** Future iteration of the strategy to reflect comments from the Associate Medical Director (education and training) re: medical training moving towards more generalist Consultants.	DHR/MD	Next iteration	To be incorporated as appropriate.	4
12a	210/14/6	Future supply of medical trainees (and associated issues) to be reviewed by the Trust Board in 4 months' time.	DHR/MD	TB 27.11.14	To be scheduled accordingly for November 2014 Trust Board.	4
13.	210/14/7	***Risk Management Policy*** Updated Risk Management Policy to be approved and placed on Insite accordingly.	CN/ STA	Immediate	Actioned.	5
14.	210/14/8	***Board Assurance Framework (BAF)*** Trust Board review of 3 key BAF risks to recommence from August 2014 (focusing on the highest risks).	CN	TB 28.8.14	Actioned.	5
14a	210/14/8	BAF to be amended to populate outstanding controls/gaps/risk sores including re: risks 6, 12, 13, and 14.	CN	By TB 28.8.14	Actioned.	5
15.	211/14/1	***Month 3 quality and performance report*** Possible deep dive and further review of the 2014-15 capital plan to be discussed at the August 2014 Trust Board development session and then the formal August 2014 Trust Board.	ADF/ALL	TBDS 14.8.14 & TB 28.8.14	On track	4
15a	211/14/1	Nursing vacancies trajectory to be updated to reflect the incremental investments, and reported to the August 2014 Trust Board.	CN	TB 28.8.14	Report featured on the August 2014 Trust Board agenda accordingly.	5
16.	211/14/2	***2014-15 month 3 financial position*** August 2014 Finance and Performance Committee to review the reasons for the year-to-date variance in forecast ED activity.	COO	FPC 27.8.14	Will be included in report.	5

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

17.	211/14/3	***Emergency Department performance report*** KPIs and data on which elements of the improvement plan were having the most impact, to be shared with the August 2014 Trust Board.	COO	TB 28.8.14	Will be included in report	5
18.	212/14/1	***NHS Trust oversight self-certifications*** Authority to be delegated to the Director of Corporate and Legal Affairs to submit the NHS Trust oversight self certification returns to the NTDA by 31 July 2014 as required (last working day).	DCLA	3.7.14	Actioned.	5
19.	212/14/2	***Board effectiveness review – proposed changes*** Action plan to be amended to include:- • reduction of duplicated business between Committees, and • ordering Trust Board agendas to take the most important items early.	DCLA	Immediate	Actioned.	5
20.	212/14/3	***UHL Annual Report 2013-14*** Depiction of the Executive and Non-Executive Director Trust Board members to be amended to include:- • CCG and Healthwatch representatives; • Committee Chairing and membership commitments of the Non-Executive Directors, and • a brief explanation of the role of Non-Executive Directors.	DMC	By 28.8.14	Actioned.	5
20b	212/14/3	Annual Report opening statements to be circulated to all members for information, once available.	DMC	Once available	Actioned.	5
21.	215/14	***Corporate Trustee Business (inquorate Charitable Funds Committee meeting of 9 June 2014)*** all recommended items to be approved by the Trust Board as Corporate Trustee, and actioned as appropriate.	ADF	Immediate	Actioned.	5
22.	218/14	***Chair's Bulletin*** Key messages from the 31 July 2014 Trust Board meeting to be communicated to staff, focusing on:- • learning lessons to improve care review; • medical staffing workforce strategy • intention to engage more widely on UHL's strategic forward planning business programme; • clinically-led improvements to emergency care; • paediatric congenital heart surgery review; • engagement with Age UK.	Chair/ DMC	Immediate	**Verbal update to be provided on 28 August 2014.**	4

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

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

Matters arising from previous Trust Board meetings

Item No	Minute Ref:	Action	Lead	By When	Progress Update	RAG status*
26 June 2014						
23.	180/14/1	Finalised LLR 5-year health and social care plan to be presented to the September 2014 Trust Board.	DS	TB 25.9.14	Scheduled accordingly.	4
24.	180/14/2	***Draft UHL 5-year plan – executive summary*** Final versions of the UHL (and LLR) 5-year plan to be presented to the Trust Board for formal approval in September 2014.	DS/CE	TB Sept/Oct 2014	Being worked through and on track to be presented to the Trust Board in September 2014.	4
25	180/14/2	Monitoring of progress against the 5-year plan to be included in the detailed Delivering Caring at its Best update being provided to the October 2014 Trust Board.	CE	TB Oct 2014	Scheduled accordingly for report to 30 October 2014 Board meeting.	4

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

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

Trust Board Paper I

To:	**Trust Board**
From:	Kate Shields – Director of Strategy
Date:	**28 August 2014**
CQC regulation:	As applicable

Title:	Meeting the new Cardiac Review standards

Author/Responsible Director: Kate Shields – Director of Strategy

Purpose of the Report:

- To confirm the latest iteration of the Cardiac Review standards expected to be released for public consultation in September 2014
- To highlight the financial and clinical implications/ opportunities of supporting the changes for the delivery of Paediatric Congenital Heart Surgery and Paediatric ECMO services at University Hospitals of Leicester (UHL)
- Identify the implications of not having Paediatric Congenital Cardiac Services in Leicester
- To note the Trust Board to support a clear strategic direction

The Report is provided to the Board for:

Decision	x	Discussion	X
Assurance		Endorsement	

Summary / Key Points:

Recommendations:

The Trust Board is asked to:

- support the retention of congenital heart services at UHL

The Trust Board is further asked to support the following actions being taken forward:

- a service review of current and future requirements
- Support a service review of current and future requirements
- Full options appraisal
- Production of operational policy, workforce requirements, and schedule of required accommodation
- Feasibility study to provide the estate solutions in line with the Trust 5 year estate strategy and Design Control Plan
- Full financial analysis of costs including transition and the estimated impact of not meeting the specifications
- Production of business case to support the recommendations

Previously considered at another corporate UHL Committee? Executive Strategy Board	
Board Assurance Framework:	**Performance KPIs year to date:**
Resource Implications (eg Financial, HR): Yes	
Assurance Implications: Yes	
Patient and Public Involvement (PPI) Implications: Yes	
Stakeholder Engagement Implications: Yes	
Equality Impact:	
Information exempt from Disclosure:	
Requirement for further review?	

Meeting the new Cardiac Review standards

Background

1. In June 2013, following on from the 'Safe and Sustainable' review of Children's Cardiac surgery, the Secretary of State for Health announced that he accepted the advice of the Independent Reconfiguration Panel, that "the [Safe and Sustainable] proposals cannot go ahead in their current form".

2. He instructed NHS England to develop a new process to improve services for children and adults with congenital heart disease within a year, addressing the concerns raised by the Independent Reconfiguration Panel and others.

3. The 'New Cardiac Review' has adopted strict governance, engaged in an open and transparent manner, and included input from clinicians, provider trusts, patients and patient charities. UHL has been represented in all these groups.

4. Rather than determining how many Cardiac units there should be in England and Wales, the Review has produced draft standards highlighting key requirements expected of Specialist Surgical Centres within the Congenital Heart Network. The draft standards are expected to be released for consultation in September. Appendix A summarises the impact of these standards on the delivery of Paediatric congenital heart services.

5. Whilst some of the standards are different to what was expected, they have widespread support within the consultation group and it is not expected that the standards agreed following consultation will be appreciably different from the proposals. Our focus now is on how UHL can implement the recommendations.

Key points that impact UHL

6. The latest iteration has highlighted two key points that impact UHL;

7. Surgical teams require a minimum of 4 surgeons each delivering a minimum of 125 cases and a total of 500 cases per annum. We expected this standard to be included.

    a. Current Cardiac surgery case load is 273 and predictions in activity growth from demographic and network expansion shows that 375 cases can be achieved within a 3 year period

    b. The predictions for reaching 500 cases in the East Midlands show this will be more challenging requiring a minimum of 12 years to achieve

    c. The review committee have indicated that there is some latitude in reaching the 500 caseload. This is very helpful for UHL. They are not adverse to network partnerships which may allow centres to grow across a network. Early discussions with Birmingham indicate an appetite for UHL working with BCH. There may also be potential for derogation in the timescales required for achieving this.

8. All Paediatric services need to be co-located on one site and not as previously indicated within 30 minutes contact time. This is a material challenge for UHL.

    a. The current provision of Paediatric Congenital Cardiac services at Glenfield Hospital will not meet this standard. The review committee have made it clear that there is no latitude for derogation on this requirement

    b. The Congenital Cardiac team have recognised that co-location of services is critical to meeting the standards and are supportive of which ever location is deemed the most appropriate.

9. It should be noted that there remains a number of specifications that need to be achieved which currently are not met at UHL; these will not change as a result of the shift in the requirement for co-location and are also subject to the current service development for Children's services that will not change. These changes would need to be assessed in a business case.

10. By bringing Children's services together on one site, co-located, there will be an opportunity to minimise the additional resources required and maximise the benefits of investment for the whole of the Children's Hospital. This is an important feature as we are currently not compliant with other aspects of local and specialised paediatric care.

11. The options for consideration:

    1. The UHL Board supports the delivery of Paediatric Congenital Cardiac Surgery at UHL, recognising that co-location is imperative, and will identify the implications and opportunities of doing so both clinically and financially.

    2. The UHL Board does not support the commissioning of Paediatric Congenital Cardiac Surgery at UHL and will identify the implications and opportunities of not doing so both clinically and financially.

High level summary of a SWOT analysis of the two options

Option 1

12. This option provides UHL the opportunity to achieve its vision of co-located Children's and relevant Adult services, whilst benefitting from the economies of scale created from more efficient use of staff, lack of duplication, and a single, larger PICU. Co-location of all Paediatric services enables UHL to remain as a Specialist Cardiac Surgical Centre and provides the opportunity for better Cardiac and Paediatric Intensive Care support to other areas of the Children's Hospital and Paediatric ED.

13. It offers the opportunity for a specific Women's and Children's service to be offered at UHL raising the profile of the Leicester Children's Hospital , and potentially offers the opportunity for the commissioning of further National Specialised services such as Severe Tracheal Stenosis, or Paediatric Cardiac Transplant.

14. It is however important that the cost of colocation is assessed and robust clinical pathways and service development are prepared to ensure this opportunity is used to enhance patient outcomes as efficiently as possible.

15. There is a requirement for protection and creation of efficient pathways for Adult Congenital Cardiac services which currently offers a unique service due to its co-location with Paediatric Congenital Cardiac services, which will be lost through this option; and Adult and Mobile ECMO to mitigate the potential risk caused by separation of Adult and Paediatric ECMO, to what is an Internationally recognised and profitable service. This would need to be done in partnership with (RRC) CMG and offers an opportunity to really shape cardiothoracic vascular services

Option 2

16. This option will result in UHL losing its status of a Specialised Cardiac Surgery Centre, which will result in a significant loss of income for the Trust, but also loss of Paediatric ECMO, Paediatric Renal replacement therapy and loss of critical mass for Paediatric Critical Care provision. Adult ECMO would be at risk as would Adult Congenital Heart services.

17. Staff recruitment and retention is likely to worsen especially in respect to junior doctors and nurses to UHL Paediatrics, due to the lack of specialised services and training opportunities.

18. There may be an opportunity to achieve the standards for Specialist Children's Cardiology Service (level 2) but this is not a significantly profitable service and will still require co-location with other Paediatric services which is not without additional cost to achieve. It should be noted that the level 2 service may not be sustainable over time.

19. UHL and East Midlands Congenital Heart Centre has received significant stakeholder support in its quest to retain the service for the children of Leicester and the East Midlands, and this option will mean their efforts and financial investment will have been wasted.

Risks associated with the loss of Congenital Cardiac Surgery on associated clinical services

20. The risk associated with the loss of Congenital Cardiac Surgery on associated clinical services can be summarised as follows;

21. **Immediate:**
    - Children's Cardiac surgery and Interventional Cardiology
    - Infant and Paediatric ECMO
    - Mobile ECMO
    - A large proportion of Children's Cardiology activity
    - A large proportion of Children's ICU activity

22. **Services that will be threatened:**
    - Children's ICU (risk of being downgraded)

- Paediatric Respiratory medicine
- Plans for the development of other specialist Paediatric services

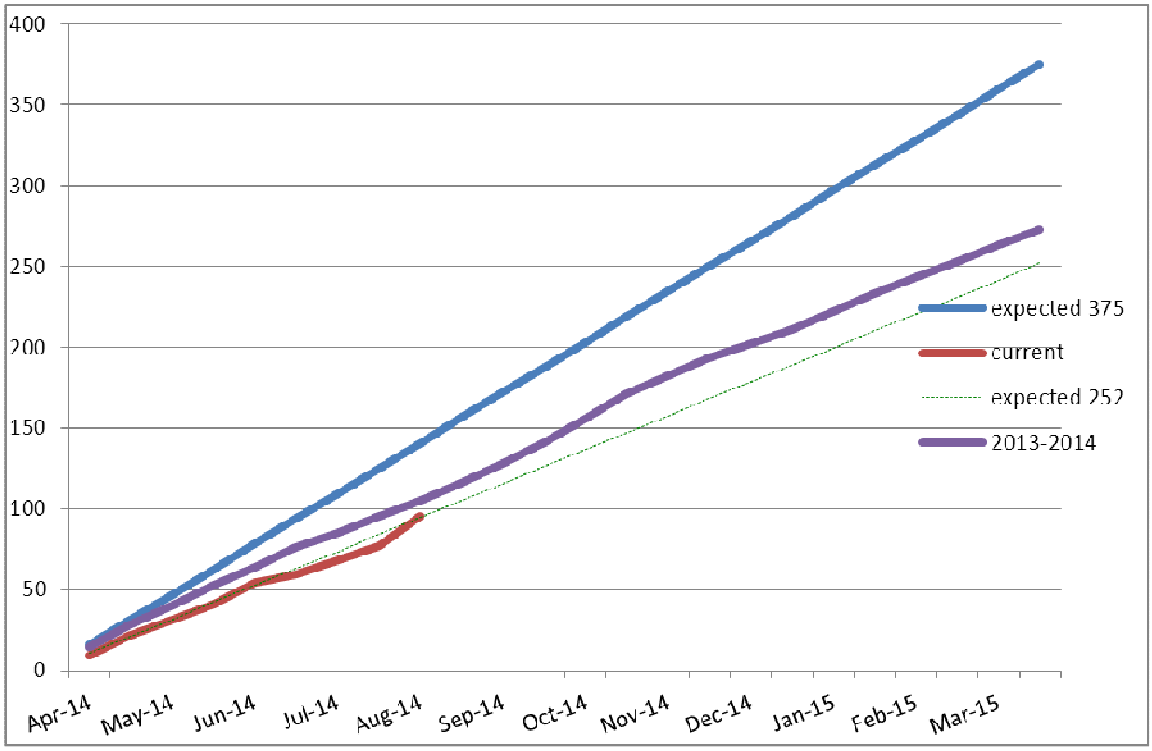
23. **If Children's ICU is downgraded, the following services/activities are threatened:**
    - Paediatric ED training
    - Sleep medicine
    - Long term ventilation
    - Paediatric oncology
    - All other acute specialist paediatric activity.

24. Retaining Leicester as a provider of specialist Paediatric services depends on having a critical mass of these sub specialties. Leicester has very few and therefore cannot afford to lose Congenital Cardiac services without potentially affecting other services.

25. A Children's service that only provides general Paediatric care to the local population will be very different from a regional centre that provides specialist Paediatric care in terms of income, reputation, and ability to attract staff.

Current situation

26. The current projection of caseload vs. expectation is below previous year's activity, as illustrated in the chart below. The proposed service review will address the reasons for this and provide a strategy for bringing the numbers in line with expectation.



Communications

28. A communication was released by the Chief Exec on the 4th August 2014 summarising the situation and the immediate next steps. Once agreed the decisions, actions and associated timeline for the project must be shared with all stakeholders to reduce concern and speculation with regard to the future of the service.

29. This impacts significantly on staff retention and recruitment and the ability of the service to attract clinical activity and stakeholder support

The preferred option for all stakeholders is;

30. The UHL Board supports the retention of Paediatric Congenital Cardiac Surgery at UHL, recognising that co-location is imperative. Co-location will have clinical and financial implications.

31. The opportunity to bring all Paediatric services on to one site affords a significant step forward in achieving the Trusts vision and clinical strategy for Women's and Children's Services. It is important to identify, and wherever possible quantify: the clinical benefits; the improvements to patients experience and perception; the economies of scale of co-location; and the business opportunities. This will all make a significant contribution to UHL's strategic positioning as one of the major specialist centre in England.

Next Steps

32. Subject to the Trust Board supporting the proposal to retain paediatric congenital heart services at UHL, an action plan, described in Appendix B will be developed and taken forward.

The options for consideration

33. The UHL Board supports the commissioning of Paediatric Congenital Cardiac Surgery at UHL, recognising that co-location is imperative, and will identify the implications and opportunities of doing so both clinically and financially.

34. The UHL Board does not support the commissioning of Paediatric Congenital Cardiac Surgery at UHL and will identify the implications and opportunities of not doing so both clinically and financially.

Summary

35. Congenital heart services are an important component of UHLs future strategy

36. In order to stay in this market immediate and long term actions are required Clinical colleagues and key stakeholder are very supportive and working together to achieve the new standards and to ensure East Midlands Congenital Heart Services thrive and develop in line with commissioner expectations

Recommendations:

37. The Trust Board is asked to:

- support the retention of congenital heart services at UHL

38. The Trust Board is further asked to support the following actions being taken forward:

- a service review of current and future requirements
- Support a service review of current and future requirements
- Full options appraisal
- Production of operational policy, workforce requirements, and schedule of required accommodation
- Feasibility study to provide the estate solutions in line with the Trust 5 year estate strategy and Design Control Plan
- Full financial analysis of costs including transition and the estimated impact of not meeting the specifications
- Production of business case to support the recommendations

Appendix A

Review of Proposed Congenital Heart Disease Standards

Following their review of congenital heart services, NHS England has proposed the following standards for such services. In introducing these, they say:

'The standards are based on having three levels of congenital heart disease services for children and adults working as part of networks. These are:

- *specialist children's surgical centres and specialist adult congenital heart disease centres (level 1)*
- *specialist children's cardiology and specialist adult congenital heart disease centres (level 2)*
- *local children's cardiology centres and local adult congenital heart disease centres (level 3)*

The standards set out the different requirements for each level of the service and the way in which they need to work together in a network relationship.'

There are a number of areas where further work is needed by EMCHC and the Trust to comply with the standards whatever the final site of children's congenital heart services. These are RAG rated in detail in an accompanying document (available on request), along with NHS England's proposals for consultation.

The proposed Standards are divided into thirteen sections:

- **Section A: The network approach**
  The standards in this section that we currently do not meet are unaffected by the location of children's congenital heart services in UHL. With or without the single site location we need to address standards relating to a retrieval/transfer service; the development of patient held records; some clinical protocols, including the possibility of a patent ductus arteriosus remote ligation service; and improving our telemedicine facilities

- **Section B: Staffing and skills**
  The standards in this section that we currently do not meet are unaffected by the location of children's congenital heart services in UHL. Our deficiencies relate mainly to the number of surgeons required (4 doing 125 cases per year); the number of Cardiologists in paediatric and adult CHD; and in the numbers of PIC nurses and cardiac liaison nurses.

- **Section C: Facilities**
  The standard affected by a move to the LRI site is the need for a helipad ('centres should ideally have landing facilities for a helicopter'), which we meet at the Glenfield site but not at the LRI. The wording of this standard makes it 'ideal' but not mandatory. Other standards to be addressed whatever the final site include the need for an adolescents and young adults clinical area.

- **Section D: Interdependencies**
  This is the section that describes the requirement for children's congenital heart surgery to be co-located with other specialist children's services. This requirement has been strengthened in the later stages of standard setting, and constitutes one of the biggest challenges to keeping the service in UHL.

The remaining proposed standards include:

- **Section E: Training and education**
- **Section F: Organisation, governance and audit**
- **Section G: Research**
- **Section H: Communication with patients**
- **Section I: Transition**
- **Section J: Pregnancy and contraception**
- **Section K: Fetal diagnosis**
- **Section L: Palliative care and bereavement**
- **Section M: Dental**

  Apart from the need for a strengthened education team and improved facilities for adolescents and young people, EMCHC already complies with these standards or could do so with a moderate amount of additional work. The standards in these sections are not affected by the location of congenital cardiac services.

Action plan - (assuming the UHL Board supports the recommendation in this paper)

1. It is essential that UHL are seen to be actively addressing their ability to comply with the standards, and have a viable plan for communication by the end of the consultation process. As such it is recommended that the following action plan be implemented;

Immediate - (within 6 weeks)

2. Conduct a Service review to address current service requirements to ensure the most efficient and safe delivery of care now with especial reference to:

    a. Waiting times
    b. Meeting demand
    c. Maximising income

3. Scope and cost independent service provision within UHL in conjunction with other relevant CMG's in preparation for co-location with paediatric services, identifying any additional resource requirements.

4. Prepare and approve a Communication strategy for all stakeholders that address concerns regarding the future provision of Congenital Cardiac services at UHL. Communicate and engage all stakeholders the next steps and timeline for delivery of the 'Vision 'for Children (including investigating a charitable campaign)

5. This is essential to ensure that the current staff feel that they fully understand the benefits, have a voice in the process and feel motivated to remain within the service. This degree of clarity will aid the recruitment of any necessary new staff needed to deliver the relocated services.

6. Advance the network development conversations with Birmingham Children's Hospital ensuring an equal partnership and mutual respect.

7. Provide more detailed analysis of the clinical and financial implications of not meeting the standards for the purpose of governance and evidence in the future business case.

Short term - (within 6 months)

8. Identify the clinical model and operational policy for Congenital Cardiac Services and Paediatric and Adult ECMO co-located with Children's services on a single site, that ensures all relevant and inter related service specifications are met – consult and engage with all relevant stakeholders. Identify the schedule of accommodation necessary to meet operational models.

9. Implement the independent service provision at UHL as identified to ensure the service is appropriately prepared for co-location.

10. Produce a brief for a feasibility study into how Paediatric services can be co-located at UHL (using the clinical model, and operational policy as above) in conjunction with the Trust 5 year strategy and Design Control Plan.

11. Appraise and agree the options and timescales required for delivery of Paediatric Congenital Cardiac services with the ability to deliver >500 cases per annum co-located on a single site

Medium term

12. Prepare a business case and seek approval from Trust Board and NTDA

13. Provide interim co-located service on agreed site within derogated time period as directed

14. Agree the plan for sustainable long-term delivery of Children's services at UHL

Trust Board Paper J

To:	**Trust Board**
From:	**Chief Executive**
Date:	**28th August 2014**
CQC regulation:	**All applicable**

Title:	**Activity and Financial Assumptions related to the Emergency Floor (EF) Developed Outline Business Case (OBC)**

Author/Responsible Director:
Nicky Topham – Project Director;
Richard Kinnersley – Technical Projects Director
Kate Shields – Director of Strategy
John Adler – Senior Responsible Officer

Purpose of the Report:
To seek approval to submit the Developed Emergency Floor OBC to the NHS Trust Development Authority (NTDA) in August 2014 and to the Clinical Commissioning Groups (CCG) Boards in September, noting the updated approach being taken to activity and financial assumptions

The Report is provided to the Board for:

Decision	x	Discussion	X
Assurance		Endorsement	

Recommendations:
The Trust Board is asked to:

- Support the submission of the OBC to the NTDA and CCGs
- Support the approval of the case in the knowledge that further activity and financial validation will be the Better Care Together Programme to align planning assumptions. This to include confirmation regarding transitional funding.

Summary / Key Points:

- The original OBC was approved by the Trust Board in November 2013 and then submitted to the NTDA.
- The NTDA responded with a number of queries, which included the need to tie the activity modelling of the business case into the LLR wide activity and capacity plan and to ensure the financial assumptions are aligned to the Trust's LTFM.
- This OBC has therefore been updated in light of this to create a 'Developed OBC".
- The enabling projects have been removed from the capital costs since they are being funded separately. The capital cost for the preferred option is £41.34m.
- Since the NTDA have stipulated that they require an LTFM which aligns with the Better Care Together financial and activity model, we have agreed with the NTDA that this OBC will reflect two scenarios.
- Although this situation is unusual, it is unavoidable due to the state of development of health economy planning assumptions. We have discussed this with the NTDA and it is their suggestion to present two difference sets of assumptions in this OBC. Both scenarios deliver an affordable business case

(subject to transitional funding.

Previously considered at another corporate UHL Committee?

- Finance & Performance Committee - 26 August 2014. This paper has been updated to reflect discussion at F&PC.

Board Assurance Framework:	**Performance KPIs year to date:**
Failure to deliver effective emergency care	4 Hour performance below 95% target.

Resource Implications (eg Financial, HR):
Detailed within the OBC

Assurance Implications:

Patient and Public Involvement (PPI) Implications:
Full patient and public involvement in the design solution has been undertaken

Stakeholder Engagement Implications:
On-going discussion with CCGs and NTDA

Equality Impact:
Due regard considered as part of the design development

Information exempt from Disclosure: None

Requirement for further review?
Trust Board update reports at key milestones

Approval of the key activity assumptions and submission of the Emergency Floor (EF) Developed Outline Business Case (OBC)

Background

1. The original OBC was approved by the Trust Board in November 2013 and then submitted to the NHS Trust Development Authority (NTDA) who responded with a number of queries. These included the need to align the activity and capacity models of the Trust's LTFM and the Better Care Together finance and activity plan the OBC has therefore been updated in light of this to create a 'Developed OBC'.

2. There is mismatch in timing with the LTFM submitted to the NTDA in July 2014 and the Better Care Together five year plan being submitted in September 2014. Therefore, to avoid delay, the NTDA have requested this OBC reflects the two scenarios.

3. The enabling projects have been removed from the capital costs since they are being funded separately. The capital cost for the preferred option is £41.34m.

Activity scenarios

4. In light of the feedback from the NTDA, two scenarios have been modelled based on the following assumptions:

Scenario 1 – Better Care Together assumptions

1. **Activity**
   In Scenario 1 ED attendance activity is projected to reduce by 7.8% over years 1-5, and then in year 6 through to year 20 activity will grow in line with demographic growth. Assessment unit activity is projected to reduce by 3.6% and then in year 6 through to year 20 activity will grow in line with demographic growth. It should be noted that in both scenarios no urgent care activity is included, neither are the operational revenue costs. This is because urgent care activity is currently contracted to George Elliot NHS Trust. Nevertheless, the revenue costs (e.g. capital charges) associated with the capital investment associated with the new Urgent Care Centre are included in the costings as they form an integral part of the Emergency Floor development.

2. **Income**
   In Scenario 1 income is directly linked to activity as above, therefore a reduction in years 1-5 and an increase in years 6-20.

3. **Workforce**
   In both Scenarios the Emergency Floor development generates workforce efficiency gains both within the Emergency Department and within the onward patient journey. At present the changes in workforce costs are the same in both scenarios as the level of service change is unlikely to materially affect the staffing requirement. This will be further reviewed as the final activity model is agreed and further workforce efficiency opportunities may arise at that time.

Scenario 2 – LTFM Assumptions

1. **Activity**
   In Scenario 2 activity is projected to remain constant at 14/15 levels through to year 6 and then increase in line with demographic growth from year 7 through to 20. The same assumptions have been applied to emergency assessment admissions. It should be noted that the first year of these assumptions is the current year and at present both ED attendances and admissions are rising rather than remaining static (or indeed falling). Nevertheless, it is not felt that these trends are likely to fundamentally affect the sizing of the facility. There may be a staffing impact, staffing levels being more readily adjustable than physical capacity. This issue will be further reviewed at FBC stage.

2. **Income**
   In Scenario 2 income is directly linked to activity as above, therefore constant in years 1-6 and an increase in years 7-20.

3. **Workforce**
   In both Scenarios the Emergency Floor development generates workforce efficiency gains both within the Emergency Department and within the onward patient journey.

Financial Models

5. The table below identifies that both scenarios are affordable over a five year time line.

6. Both scenarios show that the increase in costs associated with the move can be supported by savings, although these will need to be greater under the Better Care Together assumptions to offset the reduction in income with Better Care Together assumptions income starts to reduce from 2014/15; efficiencies cannot be made until the emergency floor is opened, transition funding is required. It should be noted that such transitional funding has not yet been agreed through the BCT programme. This is a subset of a wider piece of work related to transitional funding which is being undertaken by the programme team (facilitated by Ernst Young) over the next two months. This issue will therefore have been resolved prior to final approval of this OBC by the NTDA.

Better Care Together

	2014/15	2015/16	2016/17	2017/18	2018/19
Income change	(1,600)	(1,331)	(1,386)	(1,349)	(1,246)
Agency	0	0	738	738	738
Workforce efficiencies	0	0	828	828	828
Other efficiencies	0	0	900	1,600	1,600
Pay and non pay increases from additional activity	0	(40)	(32)	(38)	(53)
Facilities	0	0	(165)	(165)	(165)
Depreciation	0	85	(559)	(774)	(774)
Rate of return	0	45	(957)	(945)	(921)
Transformation funds	1,600	1,250	650	100	0
Total change	**(0)**	**8**	**17**	**(4)**	**8**

LTFM

	2014/15	2015/16	2016/17	2017/18	2018/19
Income change	0	0	0	0	0
Agency	0	0	738	738	738
Workforce efficiencies	0	0	828	828	828
Other efficiencies	0	0	100	350	350
Pay and non pay increases from additional activity	0	0	0	0	0
Facilities	0	0	(165)	(165)	(165)
Depreciation	0	85	(559)	(774)	(774)
Rate of return	0	45	(957)	(945)	(921)
Transformation funds	0	0	0	0	0
Total change	**0**	**130**	**(14)**	**33**	**57**

Key actions required as part of developing the Full Business Case

7. Update the LTFM to reflect the Better Care Together assumptions

8. Agree a single finance and activity model with all stakeholders for inclusion in the FBC

9. Test the impact of any planning assumption on the whole care pathway

Recommendations:

10. The Trust Board is asked to:

- Note that in agreement with the NTDA, two scenarios have been modelled to reflect the Trust's existing LTFM and the projections emerging subsequently from the BCT programme
- Note that the disparity in the scenarios will not materially affect the sizing of the required facility and design planning can therefore continue
- Note that there have been no other material changes to the OBC approved by the Board in November 2013
- Support the submission of the developed OBC to the NTDA and CCGs
- Support the approval of the case in the knowledge a reconciliation process will be undertaken to come to an agreed activity and financial model.

University Hospitals of Leicester NHS
NHS Trust

property and infrastructure | health

Developed Outline Business Case – Executive Summary

Emergency Floor

August 2014

Version **FINAL**

Issue date **August 2014**

In Partnership with CAPITA Interserve

1 | Executive Summary

1.1 Introduction

This Outline Business Case (OBC) is for the redevelopment of the Emergency Department (ED), creating a new Emergency Floor on the Leicester Royal Infirmary site of University Hospitals of Leicester NHS Trust (hereafter referred to as 'UHL' or 'the Trust'). It proposes to develop an Emergency Floor concept that will address the demand challenges faced by both ED and medical assessment services, with the intention of developing a future proofed solution that will flexibly meet future demand over the next 20 years.

The Trust is one of the largest teaching Trusts in the country and operates across three main sites; Leicester Royal Infirmary, Leicester General Hospital and the Glenfield Hospital, and is the only acute Trust serving the diverse local population of Leicester, Leicestershire and Rutland (LLR); equating to approximately 1 million residents.

Glenfield Hospital | Leicester General Hospital | Leicester Royal Infirmary

Figure 1.A University Hospitals of Leicester NHS Trust Sites

Leicester Royal Infirmary provides Leicestershire's only Emergency Department (ED), as well as being the base for the Trust's Children's Hospital and Urgent Care Centre (UCC).

In 2012 the Trust identified a number of services requiring redevelopment/ development across their three sites to ensure ongoing enhancement and maintenance of essential health services to the local community. As a consequence, the Trust has updated its 5 year estates strategy to provide an integrated and strategic approach to developing its estate and infrastructure; aligned to and reflecting the Clinical Strategy and Integrated Business Plan, and is consistent with the LLR system wide strategic plans.

This business case focuses on the Emergency Floor Reconfiguration project; the first of the main reconfiguration projects for the Trust. It highlights that current arrangements do not meet the current activity demands or the projected requirements over the next 20 years.

In line with the national concern about the ability of emergency services to cope with demand, UHL has experienced a rise in attendances to its Emergency Department (ED). This has resulted in many patients waiting for excessive periods and performance being well below the national standard of 95%; this reflects poor quality of care for patients, reduced clinical effectiveness, an unacceptable delay in treatment, increased clinical risk and compromised patient safety.

In partnership with local commissioners, UHL has instigated a number of short term measures to improve performance, such as the addition of adult assessment beds to alleviate current pressures. A full and detailed process review has been carried out and redesign is being undertaken within the existing footprint and built environment, but there is still an issue with the size of the current ED and associated assessment areas in its entirety. It is deemed totally inadequate to cope with demand by the Emergency Care Intensive Support Team (ECIST). Their findings (review undertaken in March 2013) identified that 12,600 patients are seen annually in a 6 bedded resuscitation area where 10 beds is deemed more appropriate, and 52,000 ambulance patients pass through a 16 cubicled majors area. Inadequate space results in patients being lined up in trolleys in the open floor space in majors and doubled up in cubicles. Size and poor adjacencies therefore inhibit the Trust's ability to smoothly move patients through the department to associated floors and assessment areas. In addition, the Medical Assessment Unit (MAU) is currently on the 5th floor of the Balmoral building and there is no access to X-ray or CT services within the ED, all of which further hinders efficiency.

This OBC highlights the urgent need for change to the physical estate to create an Emergency Floor in order to improve patient flows, staff efficiencies, capacity issues and adjacencies.

1.2 Strategic Case

1.2.1 The Strategic Context

The Trust has seven organisational objectives which are:

- Provide safe, high quality, patient-centred healthcare
- Provide joined up emergency care
- To be the provider of choice
- Integrated care closer to home
- Enhanced reputation in research, innovation and clinical education
- To be a professional, passionate and valued workforce
- Sustainable, high performing NHS Foundation Trust

These objectives are underpinned by the following Investment objectives of this project:

- To provide the Trust with increased capacity for emergency services to meet the demands of population growth, changing service models and improved efficiency targets.
- To increase the productivity of emergency care at the LRI.
- To develop a centre of excellence, enhancing the Trust's reputation for training, service delivery and treatment, through the provision of a centralised service in modern accommodation.
- To ensure that the changing needs and expectations of a growing population are met in line with Trust clinical strategy and national guidance standards.

- To provide an Emergency Floor that where practical, is compliant with NHS building guidance standards. Where the design is constrained then any derogation should be approved and signed off by the appropriate project lead.
- To improve the clinical effectiveness and safety of urgent and emergency care service across Leicester.
- To improve the clinical adjacencies of services to optimise clinical safety and reduce clinical risk.
- To facilitate the modernisation of services, including streamlining patient pathways and efficient working practices providing an Emergency Floor that ensures adequate infrastructure and capacity for supporting services that are conducive to the needs of a modern workforce.
- To equip the Emergency Floor to respond effectively to existing and known commissioning requirements, as well as to respond flexibly to future changes in service direction and demand.
- To improve the environment and the experience of users (patients, visitors and staff) of Leicester Royal Infirmary Hospital's Emergency Department.
- To provide a solution that is aligned to the Trust 5 Year Estates Strategy DCP plan and Trust organisation as a whole.
- The development will be delivered on time with minimal disruption to current service delivery.

Each of the project objectives has been formulated based upon the drivers for change and national, regional and local strategic directions, promoting efficiencies in practice and ensuring statutory and national targets are achieved.

National, Regional and Local Strategies, Programmes and Guidance

National and Regional strategies and programmes affecting the provision of Emergency care services at LRI site are set out in Section 2 and include:

National

- Health and Social Care Act 2012
- Quality, Innovation, Productivity and Prevention (QIPP) Programme
- Department of Health Emergency Department Clinical Quality Indicators
- NHS Operating Framework
- Care Quality Commission: Five Domains of Quality
- Transforming Urgent and Emergency Care services in England: Urgent and Emergency Care Review, End of Phase 1 Report, NHS England November 2013
- High Quality Care for all, Now and for Future Generations: Transforming Urgent and Emergency Care Services in England June 2013
- Future Hospital: Caring For Medical Patients, Royal College of Physicians (September 2013)
- HBN 15-01 Planning and Design Guidance: Accident and Emergency Departments (April 2013)
- Royal College of Paediatric and Child Health 'Standards for Children and Young People in Emergency Care Settings' [third edition] 2012[1]

[1] www.rcpch.ac.uk/system/files/protected/page/Intercollegiate%20Emegency%20Standards%202012%20FINAL%20WEB.pdf

- The Silver book – National Guidance 'Quality Care For Older People With Urgent and Emergency Care Needs, June 2012
- Guidance for Commissioning Integrated Urgent and Emergency Care A 'whole system' approach, July 2013[2]

Regional

- CCG Out of Hospital Strategies
- Joint Strategic Needs Assessment (JSNA)
- Emergency Care Network

Local

- Better Care Together: A Blueprint for Health & Social Care in LLR 2014 – 2019
- LLR Health Community Estate
- Trust Clinical Strategy
- Trust 5 Year Integrated Business Plan 2014 - 2019
- Trust 5 Year Estate Strategy 2014 – 2019

1.2.2 The Case for Change

Emergency Medicine is a secondary care specialty which provides immediate care for patients of all ages presenting with illness and injury of all severities[3].

Utilising the Better Care Together Case for Change Framework, the case for change for the Emergency Floor has been summarised in Figure 1B below:

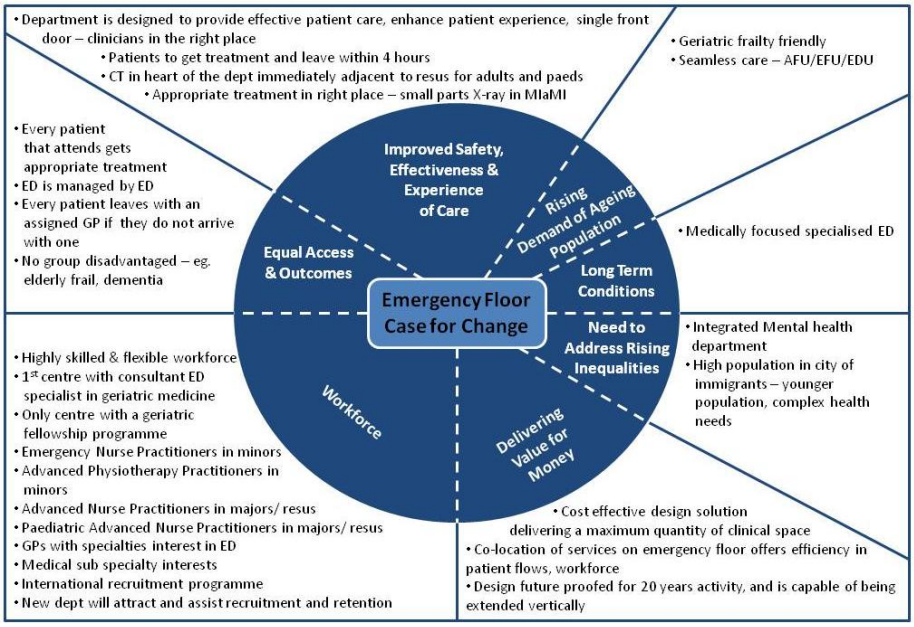


Figure 1.B Emergency Floor Case for Change

2 http://www.rcgp.org.uk/news/2013/july/~/media/Files/Policy/A-Z-policy/Urgent-emergency-care-whole-system-approach.ashx

[3] The College of Emergency (2011, February). What is Emergency Medicine? A guide.

In order to provide the level of high quality emergency care and assessment services that comply with regulatory standards, it is essential that the Trust ensures that its patients can receive treatment and staff can work in a safe environment, and that patient treatment is efficient and timely in its delivery.

The following are key drivers for change:

- The increasing demand for emergency services is greater than the current capacity can provide. Historic trends in growth suggest a 5% annual growth in ED activity and 3.5% annual growth in assessment unit activity
- Requirement for single floor Emergency and Assessment Department that incorporates key adjacencies and presence of diagnostics and assessment unit services on the same floor. This enables implementation of the developed model of care for both adults and children accessing emergency services
- Changes in the local and national demographics combined with the Trust's plan to remain an Emergency Care Centre for Leicester is impacting on increased emergency care demand
- The Trust requires additional capacity to reflect NHS national guidance. The Emergency Floor project reduces the risk of compromising compliance of other standards of care such as quality, infection control, emergency and urgent care standards and commissioning standards
- The Trust needs to be in a position to be named as a 'Major Emergency Centre' as outlined in the Urgent and Emergency Care Review November 2013 – End of Phase 1 Report (Keogh)
- The requirement to address the 4 hour target and ambulance to trolley transfer times will have a significant impact on Trust financial performance if capacity issues are not resolved
- Redevelopment and increased capacity will provide opportunities for the Trust to fulfil its strategic redevelopment programme

1.2.3 Capacity and Demand

Activity

Feedback on the original Outline Business Case (OBC) from the NTDA, included the need to tie the activity modelling into the LLR wide activity and capacity plan as progressed through the Better Care Together Programme, and to ensure the financial assumptions were aligned to the trust's Long Term Financial Model (LTFM).

The BCT activity modelling is at a high level e.g. the 7.8% reduction in ED attendances over the next 5 years is applied to every category of the department – i.e. resus, majors and minors. This will need clinical validation and further discussion with the BCT programme for the Full Business case (FBC).

The Trust's LTFM was submitted to the NTDA in July 2014 before the BCT planning assumptions were available. Thus at this point in time, the BCT activity model and the LTFM are not synchronised.

Since the NTDA have stipulated that they require an LTFM compliant model, and the CCGs require that the case ties into the BCT assumptions, we have agreed with the NTDA that this OBC will reflect 2 scenarios.

Scenario 1 – BCT assumptions

- Uses the current forecast outturn for 14/15 as the baseline. This is a deficit position of £12,248k. Each year is measured compared to this and the deficit should get no worse with the EF
- This assumes a decrease in income and activity (average reduction of 7.8% over 5 years) as per the BCT assumptions. Years 6 to 20 reflect a growth based on demographic growth
- This shows reductions in agency costs, and workforce efficiencies due to the EF and wider efficiencies outside the EF to make affordable upon opening. (It is assumed that the workforce efficiencies will be met across the whole emergency pathway and not just in the EF)
- These efficiencies cannot be made until the floor opens, therefore, if BCT the assumptions come to fruition, the finances are worse in 15/16 than now. Arguably, this would be a problem anyway even without the floor.
- Once the floor is open, efficiencies can be made to make the project affordable.

Scenario 2 – LTFM Assumptions

- Our LTFM assumed that activity and income would remain at 2014/15 planned levels over the next 5 +1 years. Any increases would be managed through the CCG Quality Innovation Productivity & Prevention (QIPP). Years 7-20 reflect a demographic growth.
- There is an assumption in the LTFM that ambulatory care sensitive conditions will reduce activity, income and beds across UHL.
- For the purposes of the OBC, it is assumed that any changes in income and beds will be outside of the EF, i.e. the whole pathway becomes more efficient and so ward beds are removed not assessment beds. There are the same number of assessment beds in the design as current
- Therefore income has remained level until year 6 (end of our LTFM modelling so far) and then demographic growth from that point
- This assumption needs considerable work for the FBC, and does link to the BCT assumptions.
- Again this requires cost reductions to support the additional capital charges.

Capacity Assessment

Original OBC Assumptions

The development of the brief for the new emergency floor has responded to both changing baseline assumptions and a recognition of the operational constraints associated with emergency care and the physical limitations imposed by a tight, inner-city site being redeveloped partially on a refurbishment basis.

The original briefing exercise underpinning the functional content of the new facilities and its design reflected a number of assumptions:

- 10-year planning horizon;
- activity projections based on an analysis of demographic growth and historic trend growth;
- use of 95th percentile hourly arrivals for ED streams, at 100% occupancy;
- a one-off left shift of activity from the acute site to other settings, impacting on the UCC.

To inform that exercise, an analysis was undertaken of recent emergency activity growth and the following key points were noted:

- in ED, recent trend growth had been on average 5% per annum, whilst demographic growth projected by the ONS for the ED population was approx. 1% (age-adjusted);
- For non-elective emergency admissions these figures were 3.5% and 1.5%.

To chart a mid-point between historic trend growth and ONS projected demographic growth, the following annual growth rates were used for the 10-year planning horizon:

- ED: average 3% per annum
- NEL/assessment: average 2.5% per annum

The above parameters formed what was termed the Medium Scenario in the original business case, and informed the capacity calculations used to scope the functional content of the scheme. Low and High Scenarios were also developed to reflect ONS-only and historic trend growth rates (ie, 1% & 5% for ED activity, 1.5% and 3.5% for assessment activity).
The scheme was subsequently briefed and designed to reflect the functional content generated from the Medium Scenario assumptions, involving widespread consultation with clinical, managerial and support staff within and beyond the Trust, [as well as patient representatives].

Revised Assumptions – Scenario 1

The revised activity assumptions are denoted as the **New BCT Baseline**, and are:

- use of 20-year planning horizon instead of 10-years
- use of Better Care Together growth profile for years 1-5 of the projections
- use of Office of National Statistics (ONS) population growth (1% as before) for years 6-20 of the model
- use of 85th percentile hourly arrivals for ED streams, at 85% occupancy, as per ECIST model

The New BCT Baseline assumptions impose a reduction in activity in the early years of the model due to the Better Care Together programme, and then a shallower, but longer, period of growth (i.e. to year 20, not to year 10). As a result of these two factors, the functional content determined by the new BCT demand & capacity model is marginally smaller than that scoped on the basis of the Medium Scenario parameters in the original business case.

Revised Assumptions – Scenario 2

The revised activity assumptions are denoted as the **New LTFM Baseline**, and are:

- use of 20-year planning horizon instead of 10-years
- use of LTFM nil growth profile for years 1-6 of the projections
- use of Office of National Statistics (ONS) population growth (1% as before) for years 7-20 of the model
- use of 85th percentile hourly arrivals for ED streams, at 85% occupancy, as per ECIST model

The new LTFM Baseline assumptions impose nil growth in activity in the early years of the model due to the QIPP, and then a shallower, but longer, period of growth (i.e. to year 20, not to year 10). As a result of these two factors, the functional content determined by the new LTFM demand & capacity model is still marginally smaller than that scoped on the basis of the Medium Scenario parameters in the original business case.

Impact of Revised Scenarios

- the original functional content of the proposed scheme, based on a 10-year planning horizon, remains sufficient to meet the activity projected at year 20 under the new BCT and LTFM baseline assumptions, with a small amount of spare capacity spread across a number of zones
- the original functional content has sufficient capacity to meet around 2% annual growth from years 6-20, should historic trends continue to be realised above the demographic growth of 1%

This confirms that the originally proposed content and the design developed by the project team remain robust in the light of the New BCT and LTFM Baseline assumptions. The slight capacity surplus in the proposed scheme is distributed across the project and its removal from the project would not warrant the cost, time and risk penalties associated with a full-scale redesign.

However, it is recognised that in the early years of occupation of the new facilities there will be considerable surplus accommodation as the BCT programme assumes a significant reduction of emergency activity at LRI in years 1-5. The scheme has been designed to be as flexible as possible through the employment, wherever practical, of generic clinical spaces. This would enable a range of services to backfill surplus accommodation in order to ensure that maximum utilisation is made of the new estate. Candidates include:

- inclusion of the Surgical Assessment Unit in the emergency floor.

Conversely, if future growth surpasses that modelled in the New BCT and LTFM Baseline (the impact of which might not manifest itself for 10-15 years), there are a number of initiatives that can be implemented in mitigation over time:

- further work to understand and resolve downstream operational issues in the acute bed stock to help improve flow out of the emergency facilities generally;
- the provision of additional critical care capacity would similarly ease pressure on the Acute Care Bay and Resus;
- the development control plan for the LRI site can include the further colonisation of adjacent space on the new emergency floor as alternative models of delivery are implemented for other clinical services;
- the relocation of lower acuity workload (UCC and minors) to alternative location would liberate capacity within the proposed unit for higher acuity workload.

The sensitivity testing of the demand and capacity modelling assumptions, and the strategies for coping with long-term upside and downside activity scenarios, have therefore confirmed the robustness of the original planning assumptions for the project. This provides assurance that the proposed investment offers the flexibility to deal with both changing levels and patterns of workload.

1.3 Economic Case

An economic appraisal of the Emergency Floor redevelopment options has been completed in accordance to the Capital Investment Manual and requirements of Her Majesty's Treasury's (HMT) Green Book (A Guide to Investment Appraisal in the Public Sector).

1.3.1 The Long List

The long list of options is described below in Table 1.1.

Table 1.1 Long List of Options

Option	Description
0	Do Minimum - Ensure critical backlog maintenance is undertaken and review clinical processes & procedures
1A	Balmoral Building – Existing 1st floor refurbishment with some assessment provision elsewhere (inc courtyard infill & extension)
1B	Balmoral Building – Existing 1st floor and ground floor refurbishment hot floor/assessment floor
1C	Balmoral Building – Existing floor refurbishment with displacement of radiology
2A	Jarvis Building – Demolition of Jarvis building and part new build/part refurbishment existing floor
2B	Jarvis Building - Demolition of Jarvis building and new build
2C	Jarvis Building - Demolition of Jarvis building and new build ED and refurbish assessment on single floor

Option	Description
3A	Victoria Building – Demolition of Victoria building and part new build/part refurbish assessment on single floor
3B	Victoria Building - Demolition of Victoria building and new build
4	Sandringham Building – refurbishment of 2 floors Sandringham building and new build extensions
5	Havelock Street Car park – New build 2 storey development on Havelock Street car park
6	Knighton Street Car park - New build 2 storey development on Knighton Street car park
7	Victoria Building Staff Car park - New build 2 storey development on Victoria Street car park

This list has been reviewed in a number of clinical forums, and has also been subjected to a technical appraisal to determine impact relating to site constraints and requirements of the building. Table 1.2 below provides the outcome of these reviews, identifying whether the option was shortlisted for detailed appraisal, or discounted. The key criterion for short listing was based on the extent to which each option met the project objectives.

Table 1.2 Results of Review of Long Listed Options

Option		Current Discounted/Shortlisted Status
0	**Do Minimum - Ensure critical backlog maintenance is undertaken and review clinical processes & procedures**	**Shortlisted** as a baseline comparator
1A	**Balmoral Building – Existing 1st floor refurbishment with some assessment provision elsewhere (inc courtyard infill & extension)**	**Shortlisted**
1B	Balmoral Building – Existing 1st floor and ground floor refurbishment hot floor/assessment floor	*Discounted – This was discounted on the basis that it does not strategically fit to the Trust's critical success factors requirement for a single floor ED*
1C	Balmoral Building – Existing floor refurbishment with displacement of radiology	*Discounted – This option was discounted on the basis of diagnostics needing to be a key adjacency requirement of the ED. This option could not deliver the Trust strategic requirements*

Option		Current Discounted/Shortlisted Status
2A	Jarvis Building – Demolition of Jarvis building and part new build/part refurbishment existing floor	*Discounted – This option does not meet the essential adjacency requirements and ED single floor concept and timing to deliver*
2B	Jarvis Building - Demolition of Jarvis building and new build	*Discounted – This option does not strategically fit with the Trust's DCP plans and timing to deliver. It also does not strategically fit to the Trusts critical success factor regarding the requirement for a single floor emergency and assessment service*
2C	**Jarvis Building - Demolition of Jarvis building and new build ED and refurbish assessment on single floor**	**Shortlisted**
3A	**Victoria Building – Demolition of Victoria building and part new build/part refurbish assessment on single floor**	**Shortlisted**
3B	Victoria Building - Demolition of Victoria building and new build	*Discounted - This option does not strategically fit with the Trust's DCP plans and timing to deliver. It also does not strategically fit to the Trusts critical success factors requirement for a single floor ED*
4	Sandringham Building – refurbishment of 2 floors Sandringham building and new build extensions	*Discounted – This was discounted on the basis that it does not strategically fit to the Trusts critical success factor regarding the requirement for a single floor emergency and assessment service*
5	Havelock Street Car park – New build 2 storey development on Havelock Street car park	*Discounted – This was discounted on the basis that it does not strategically fit to the Trusts critical success factors requirement for a single floor ED*
6	Knighton Street Car park - New build 2 storey development on Knighton Street car park	*Discounted – This was discounted on the basis that it does not strategically fit to the Trusts critical success factor regarding the requirement for a single floor emergency and assessment service*
7	Victoria Building Staff Car park - New build 2 storey development on Victoria Street car park	*Discounted– This was discounted on the basis that it does not strategically fit to the Trusts critical success factor regarding the requirement for a single floor emergency and assessment service*

1.3.2 The Short List

The shortlisted options taken forward into this OBC are therefore as follows:

- Option 0: Do Minimum - Ensure critical backlog maintenance is undertaken and review clinical processes & procedures
- Option 1A: Existing 1st floor refurbishment with some assessment provision elsewhere, (inc courtyard infill & extension)
- Option 2C: Demolition of Jarvis building & new build ED & refurbish assessment on single floor
- Option 3A: Demolition of Victoria building and part new build/part refurbish assessment on single floor

1.3.3 Qualitative Benefits – Identifying the Preferred Option

The shortlisted options were appraised against benefit criteria to establish a preferred option. The benefit criteria that would be delivered by the Emergency Floor redevelopment and their raw scores are detailed in table 1.3 below.

Table 1.3 Raw Scores

Criteria	Option			
	0	1A	2C	3A
1. To implement a design solution that provides a safe emergency care service that ensures capacity and known flexibility for current and known future demands of patients requiring emergency care	1.00	7.00	5.00	7.50
2. Improve patient pathway management reducing the clinical risk and discomfort through the emergency care pathway.	1.00	7.50	5.00	7.00
3. Support and consolidate provision of emergency floor concept at LRI	1.00	7.50	7.00	7.50
4. Ensures that the service model of care is delivered in line with National, Trust and local health economy KPIs	1.00	7.50	6.00	7.50
5. Patient safety is enhanced, and clinical risk is reduced.	1.00	6.50	7.50	7.50
6. Where possible ensures that the service is developed in line with NHS Guidance in terms of HBN, HTM, national and Trust policy and local health economy policy in terms of capacity provision	1.00	6.00	8.00	8.00
7. Quality of care is enhanced, in terms of the model of care, and seamless pathways of care and patient flows.	1.00	8.00	6.00	7.50
8. The built environment enhances clinical practice that support clinical effectiveness, improved patient outcomes and patient safety	1.00	8.00	6.00	8.00
9. Provides enhanced departmental relationships and clinical adjacencies that support clinical effectiveness and improved patient outcomes	1.00	8.00	6.00	8.00
10. Ensures facilities are future proofed and adaptable to the changing needs of the health economy	1.00	6.00	7.00	8.00
11. Improved Privacy and dignity provisions for all patients	1.00	6.00	8.00	8.00

Criteria	Option			
	0	1A	2C	3A
12. Consolidates existing services & provides clinical expertise whilst realising the Emergency Floor concept	1.00	8.00	6.00	7.50
13. Improved patient access through a single front door process	2.00	9.00	9.00	9.00
14. Enhances patient, visitor and staff safety through the built environment	1.00	7.50	8.00	8.00
15. The design solution minimises the impact of the construction process on the site and therefore delivery of the Trust core services	7.18	4.64	3.54	4.91
16. Option enables future proofing of the physical ED environment aligned to DCP future expansion needs	1.00	4.00	6.00	8.00
17. The enabling moves will facilitate the Emergency Floor programme whilst minimising delay to delivery	10.00	4.00	7.50	7.00
18. Reduces complexity and sequence dependency of enabling moves	10.00	4.00	7.50	7.00
19. Maintains blue light access throughout whole build process	8.00	6.00	5.00	7.50
Total	51.18	131.74	129.64	148.71
Rank	**4**	**2**	**3**	**1**

Agreed weightings were then applied to each benefit criteria which resulted in the final weighted rankings being the same as the raw rankings i.e.

- Rank 1 Preferred Option: 3A Victoria
- Rank 2: 1A Balmoral
- Rank 3: 2C Jarvis
- Rank 4: Do Nothing

1.3.4 Key Findings of the Economic Appraisal

The overall financial summaries of the three options based on the cash flows input to the Generic Economic Model (GEM) are as follows in Table 1.4:

Table 1.4 Key Results of Economic Appraisals

Option	Appraisal period	NPC £ 000	Risk Adjusted £ 000	Risk Adjusted NPC £ 000
Do Minimum	60 years	1,288,319.22	109	1,289,526.22
Option 1A Balmoral	60 years	1,252,500.35	1,207.00	1,253,707.35
Option 2C Jarvis	60 years	1,249,557.22	2,412.00	1,251,969.22
Option 3A Victoria	60 years	1,252,643.70	2,412.00	1,255,055.70

1.3.5 Economic Appraisal Conclusion

The option which offers the best value for money is the one with the lowest NPC and EAC. This is the preferred option from a purely financial perspective.

Option 2C has the lowest and is therefore the preferred option. However the difference between this and options 1A and 3A is marginal, and therefore not material to the appraisal process.

1.3.6 Overall Findings Preferred Option

As identified above the preferred option from a non financial perspective is option 3A Victoria, whilst from a financial perspective it is option 2C.

By combining the quantitative and qualitative scoring, a NPC per benefit point can be calculated. The preferred option is the one which has the lowest NPC per benefit point as this is the most effective solution based on both the financial and the non financial review.

As can be seen from Table 1.5 below the preferred option from an overall perspective is option 3A Victoria.

Analysis shows that the costs of the preferred option would need to increase by 12% before the second placed option 1A becomes the preferred option.

Table 1.5 Summary of Economic and Value for Money Appraisal

Criteria	Option			
	0	1A	2C	3A
Raw scores	51.18	131.74	129.64	148.71
Weighted Scores	2.27	6.74	6.27	7.54
Rank (non-financial)	4	2	3	1
Net present cost (NPC) (£k)	1,289,526	1,253,707	1,251,969	1,255,056
NPC per point score (£k)	568,073	186,010	199,676	166,453
Rank (VFM)	4	2	3	1
Rank	**4**	**2**	**3**	**1**

1.4 Commercial Case

1.4.1 Procurement Strategy

The scheme will be procured through UHL's framework partnership with Interserve.

Under the bespoke framework, Interserve is appointed as prime contractor for the delivery of projects; commercial arrangements and contracts are pre-agreed to cover commissioning of the business case through to final delivery of the asset using an NEC3 Option C Form of Contract (Target Contract with Activity Schedule). Cost savings and overspends are split between the Trust and the Client based on previously agreed percentages which will engender a spirit of partnering and collaboration within the Project Team. The risk of cost overrun is transferred to Interserve once the GMP has been agreed and construction stage commenced.

Project risk is dealt with openly from the outset of the project and the client; Interserve and the Design Team are encouraged to take an active role in identifying, mitigating and apportioning risk to the party best suited to deal with it. This should be a proactive process throughout the delivery of the project.

Key external advisors and construction services are as follows in Table 1.6:

Table 1.6 Supply Chain for Professional and Construction Services

Role	Organisation
Pre-construction	
Business case preparation	Capita
Mechanical and electrical consultants	Capita
Architects	Capita
Structural engineers	Capita
Cost Consultants	Capita
Project Management/ Cost Advice	RLB
GMP development	Interserve Construction
Construction	
Building contractor	Interserve Construction
Mechanical and electrical contractor	Interserve Construction

Under the framework, Interserve has:

- Taken single point responsibility to manage the design and construction process from completion of OBC through to project completion.
- Assembled a dedicated team from its supply chain of experienced health planners, designers and specialists, to successfully deliver facilities that will benefit patients and staff alike.
- Provided benefits of experience of long term partnering arrangements that will continue throughout the life of the project.

- Committed to identifying construction solutions that will assist in the implementation of improved service delivery, best practice and delivering best value.

Interserve and UHL will work together through the full business case (FBC) stage in the coming months to develop and agree a guaranteed maximum price for delivery of the scheme. This will reflect:

- Fees for professional advice such as design and cost management
- Market tested packages for construction works on an open book basis

The GMP will be assessed for overall value for money by cost consultants acting for both Interserve and UHL (Rider Levett Bucknall). This will take into account elements such as:

- Prevailing rates for similar works nationally and locally
- Published cost indices
- Knowledge of the cost of work in the hospital from other recent schemes
- Prime contractor and client retained risks as identified in the joint risk register

It is intended that the development of the GMP will be run in parallel with the development of the Works Information and this will be undertaken in a fully open book/ collaborative environment such that a minimum of three quotations will be obtained for all Works Packages making up at least 80% of the GMP.

Package responses will be assessed by Interserve Construction Ltd in conjunction with the Trust's advisors Rider Levett Bucknall (RLB) to ensure the 'Best Value' tender is included in the GMP. The assessment will not only be based on price but also programme, design/ technical proposals and likely risk. Interserve and RLB will agree a formal assessment proposal for each package. Tenders will be benchmarked appropriately.

It is the intention that key supply chain members, (e.g. demolition, mechanical, electrical) are engaged early in the process in order that they can contribute to the design process in terms of programme and buildability/ innovation.

Should the scheme not proceed, the Trust will own the design at point of termination but will be liable for Interserve costs up to that point, in line with contractual commitments made during commissioning of the project.

1.4.2 Potential for Risk Transfer

The LLR Framework has a single comprehensive risk management process, which the Trust will be using. The Emergency Floor Project Senior Responsible Officer (SRO) and IFM act as joint owners of the joint project Risk Register for this scheme, responsibility for risks identified in it are then to be allocated and identified on the associated risk register. The risk of cost overrun is transferred to IFM once the GMP has been agreed and construction stage commenced.

1.5 Financial Case

The Financial Case sets out the financial implications for the Trust in terms of capital expenditure and cash flow, income and expenditure account and borrowing.

1.5.1 Capital Costs

The capital costs have been determined by the Design Team technical advisors and are summarised below in Table 1.7.

Table 1.7 Summary of Capital Costs

Capital Costs	Option 3A Victoria (£)
Construction	30,233,828
Fees	6,781,406
Equipment	1,692,000
Decant	
Planning Contingency	2,894,644
Sub Total	41,601,878
Optimism Bias	0
Inflation	389,840
Total	41,991,719
VAT Recovery	-649,792
Grand Total	**41,341,927**

The capital expenditure profile is set out below in Table 1.8:

Table 1.8 Summary of Capital Expenditure

	2013/14 £	2014/15 £	2015/16 £	2016/17 £	2017/18 £	TOTAL £
Capital Expenditure	3,125,760	7,515,326	24,853,587	5,499,544	347,710	**41,341,927**

1.5.2 Revenue Costs

These are described in detail in the Financial Case (Section 5) but broadly comprise the pay and non-pay costs and other allocated direct costs.

Two models have been developed to identify the financial consequences of two scenarios. Scenario 1, BCT assumes reductions in line with those developed by the Better Care Together programme. These are early indications and work is ongoing

within the health economy to identify how these reductions will deliver. This could be considered a worst case scenario for the EF activity.

Scenario 2 is activity and income modelled in line with UHLs LTFM, submitted in June and assumes level income to 2019/20 then growth in line with demographics. In this model any growth is assumed to be managed by commissioner QIPP. These assumptions will be developed along with BCT programme over the coming weeks to aid development of the FBC and one likely case scenario.

Assumptions regarding changes to income are detailed in Table 1.9 with the I&E for 20 years for both scenarios following in Table 1.10 and 1.11.

Table 1.9 Activity Assumptions

	2014/15	2015/16	2016/17	2017/18	2018/19	2019/20 - 2033/34
Better Care Together						
ED	-8.3%	1.6%	-0.2%	0.0%	0.3%	1.0%
AMUs	-3.1%	-5.4%	-6.6%	-2.1%	-1.0%	1.5%
Clinic Activity	0.0%	1.0%	1.0%	1.0%	1.0%	1.0%
LTFM						
ED	0.0%	0.0%	0.0%	0.0%	0.0%	1.0%
AMUs	0.0%	0.0%	0.0%	0.0%	0.0%	1.5%
Clinic Activity	0.0%	0.0%	0.0%	0.0%	0.0%	1.0%

Table 1.10 Scenario 1 - Better Care Together Assumptions Income & Expenditure

	2013/14	2014/15	2014/15	2015/16	2016/17	2017/18	2018/19	2019/20	2020/21	2021/22	2022/23	2023/24	2024/25	2025/26	2026/27	2027/28	2028/29	2029/30	2030/31	2031/32	2032/33	2033/34
	Out-turn	Forecast - Baseline	Forecast BCT assumptions	Forecast	Forecast	Forecast	Forecast	Forecast	Forecast	Forecast	Forecast	Forecast	Forecast	Forecast	Forecast	Forecast	Forecast	Forecast	Forecast	Forecast	Forecast	Forecast
	£K	£K	£K	£K	£K	£K	£K	£K	£K	£K	£K	£K	£K	£K	£K	£K	£K	£K	£K	£K	£K	£K
Income																						
ED Tariff	16,717	16,001	14,673	14,907	14,877	14,877	14,922	15,071	15,222	15,374	15,528	15,683	15,840	15,999	16,158	16,320	16,483	16,648	16,815	16,983	17,153	17,324
Medical Assessment Unit	12,713	13,183	12,911	12,945	12,920	12,957	13,016	13,124	13,233	13,343	13,454	13,566	13,679	13,793	13,908	14,024	14,142	14,260	14,379	14,500	14,621	14,744
Other Income (RTA, Teaching etc)	4,402	4,402	4,402	4,402	4,402	4,402	4,402	4,402	4,402	4,402	4,402	4,402	4,402	4,402	4,402	4,402	4,402	4,402	4,402	4,402	4,402	4,402
Total	**33,832**	**33,585**	**31,985**	**32,254**	**32,199**	**32,236**	**32,340**	**32,597**	**32,857**	**33,119**	**33,384**	**33,651**	**33,921**	**34,194**	**34,469**	**34,746**	**35,027**	**35,310**	**35,596**	**35,884**	**36,176**	**36,470**
Expenditure																						
Pay																						
Nursing	12,966	13,517	13,517	13,517	13,517	13,517	13,517	13,517	13,517	13,517	13,517	13,517	13,517	13,517	13,517	13,517	13,517	13,517	13,517	13,517	13,517	13,517
Nursing Agency	3,828	1,307	1,307	1,307	1,307	1,307	1,307	1,307	1,307	1,307	1,307	1,307	1,307	1,307	1,307	1,307	1,307	1,307	1,307	1,307	1,307	1,307
Medical Staff	14,396	13,287	13,287	13,287	13,287	13,287	13,287	13,287	13,287	13,287	13,287	13,287	13,287	13,287	13,287	13,287	13,287	13,287	13,287	13,287	13,287	13,287
Medical Locums	224	169	169	169	169	169	169	169	169	169	169	169	169	169	169	169	169	169	169	169	169	169
A&C	1,133	1,068	1,068	1,068	1,068	1,068	1,068	1,068	1,068	1,068	1,068	1,068	1,068	1,068	1,068	1,068	1,068	1,068	1,068	1,068	1,068	1,068
Healthcare Assistants	709	791	791	791	791	791	791	791	791	791	791	791	791	791	791	791	791	791	791	791	791	791
Agency reduction					(738)	(738)	(738)	(738)	(738)	(738)	(738)	(738)	(738)	(738)	(738)	(738)	(738)	(738)	(738)	(738)	(738)	(738)
Workforce Efficiencies					(828)	(828)	(828)	(828)	(828)	(828)	(828)	(828)	(828)	(828)	(828)	(828)	(828)	(828)	(828)	(828)	(828)	(828)
Additional staff costs due to activity growth	0	0	0	0	0	0	0	0	578	578	578	578	1,155	1,155	1,155	1,155	1,155	1,155	1,700	1,700	1,700	1,700
Total	**33,256**	**30,139**	**30,139**	**30,139**	**28,573**	**28,573**	**28,573**	**28,573**	**29,151**	**29,151**	**29,151**	**29,151**	**29,728**	**29,728**	**29,728**	**29,728**	**29,728**	**29,728**	**30,273**	**30,273**	**30,273**	**30,273**
Non pay																						
Clinical Supplies	1,363	1,306	1,306	1,306	1,306	1,306	1,306	1,306	1,306	1,306	1,306	1,306	1,306	1,306	1,306	1,306	1,306	1,306	1,306	1,306	1,306	1,306
Drugs	891	808	808	808	808	808	808	808	808	808	808	808	808	808	808	808	808	808	808	808	808	808
Pathology and Blood	2,041	2,058	2,058	2,058	2,058	2,058	2,058	2,058	2,058	2,058	2,058	2,058	2,058	2,058	2,058	2,058	2,058	2,058	2,058	2,058	2,058	2,058
Other	673	915	915	915	915	915	915	915	915	915	915	915	915	915	915	915	915	915	915	915	915	915
Changes to Non Pay costs due to activity		0	0	40	32	38	53	92	131	170	210	250	290	331	373	414	456	499	542	585	629	673
Total	**4,968**	**5,087**	**5,087**	**5,127**	**5,119**	**5,125**	**5,140**	**5,179**	**5,218**	**5,257**	**5,297**	**5,337**	**5,377**	**5,418**	**5,460**	**5,501**	**5,543**	**5,586**	**5,629**	**5,672**	**5,716**	**5,760**
Total Direct Costs	**38,224**	**35,226**	**35,226**	**35,266**	**33,692**	**33,698**	**33,713**	**33,752**	**34,369**	**34,408**	**34,448**	**34,488**	**35,105**	**35,146**	**35,188**	**35,229**	**35,271**	**35,314**	**35,902**	**35,945**	**35,989**	**36,033**

FM Costs	471	471	471	471	636	636	636	636	636	636	636	636	636	636	636	636	636	636	636	636	636	636
Support Service Costs	3,647	3,647	3,647	3,647	3,647	3,647	3,647	3,647	3,647	3,647	3,647	3,647	3,647	3,647	3,647	3,647	3,647	3,647	3,647	3,647	3,647	3,647
Overheads	6,619	6,619	6,619	6,619	6,619	6,619	6,619	6,619	6,619	6,619	6,619	6,619	6,619	6,619	6,619	6,619	6,619	6,619	6,619	6,619	6,619	6,619
Changes to Support costs due to activity		0	0	0	0	0	0	0	0	0	0	0	67	122	177	232	288	345	402	460	518	577
Transformation funding assumed			(1,600)	(1,250)	(650)	(100)																
Reduction to costs in the emergency pathway		0	0	0	(900)	(1,600)	(1,600)	(1,600)	(1,600)	(1,600)	(1,600)	(1,600)	(1,600)	(1,600)	(1,600)	(1,600)	(1,600)	(1,600)	(1,600)	(1,600)	(1,600)	(1,600)
Change in depreciation		(85)	(85)	(170)	474	689	689	689	689	689	689	689	689	689	689	689	689	689	689	689	689	689
Change in Rate of return		(45)	(45)	(89)	912	900	876	852	828	804	780	756	732	708	684	660	636	612	588	564	540	516
Total costs (baseline)	**48,961**	**45,833**	**44,233**	**44,494**	**44,430**	**44,488**	**44,580**	**44,594**	**45,187**	**45,202**	**45,218**	**45,234**	**45,894**	**45,966**	**46,038**	**46,111**	**46,185**	**46,261**	**46,882**	**46,959**	**47,037**	**47,116**
Net (deficit)	**(15,129)**	**(12,248)**	**(12,248)**	**(12,240)**	**(12,231)**	**(12,252)**	**(12,240)**	**(11,997)**	**(12,330)**	**(12,083)**	**(11,834)**	**(11,583)**	**(11,973)**	**(11,772)**	**(11,569)**	**(11,365)**	**(11,159)**	**(10,951)**	**(11,286)**	**(11,074)**	**(10,861)**	**(10,646)**

Table 1.11 Scenario 2 - Long Term Financial Model Assumptions - Income & Expenditure

	2013/14	2014/15	2014/15	2015/16	2016/17	2017/18	2018/19	2019/20	2020/21	2021/22	2022/23	2023/24	2024/25	2025/26	2026/27	2027/28	2028/29	2029/30	2030/31	2031/32	2032/33	2033/34
	Out-turn	Forecast - Baseline	Forecast BCT assumptions	Forecast	Forecast	Forecast	Forecast	Forecast	Forecast	Forecast	Forecast	Forecast	Forecast	Forecast	Forecast	Forecast	Forecast	Forecast	Forecast	Forecast	Forecast	Forecast
	£K	£K	£K	£K	£K	£K	£K	£K	£K	£K	£K	£K	£K	£K	£K	£K	£K	£K	£K	£K	£K	£K
Income																						
ED Tariff	16,717	16,001	16,001	16,001	16,001	16,001	16,001	16,161	16,322	16,485	16,650	16,817	16,985	17,155	17,326	17,500	17,675	17,851	18,030	18,210	18,392	16,717
Medical Assessment Unit	12,713	13,183	13,183	13,183	13,183	13,183	13,183	13,291	13,401	13,511	13,623	13,735	13,849	13,963	14,079	14,195	14,313	14,432	14,551	14,672	14,794	12,713
Other Income (RTA, Teaching etc)	4,402	4,402	4,402	4,402	4,402	4,402	4,402	4,402	4,402	4,402	4,402	4,402	4,402	4,402	4,402	4,402	4,402	4,402	4,402	4,402	4,402	4,402
Total	**33,832**	**33,585**	**33,585**	**33,585**	**33,585**	**33,585**	**33,585**	**33,854**	**34,125**	**34,399**	**34,675**	**34,954**	**35,236**	**35,520**	**35,807**	**36,097**	**36,389**	**36,685**	**36,983**	**37,284**	**37,588**	**33,832**
Expenditure																						
Pay																						
Nursing	12,966	13,517	13,517	13,517	13,517	13,517	13,517	13,517	13,517	13,517	13,517	13,517	13,517	13,517	13,517	13,517	13,517	13,517	13,517	13,517	13,517	12,966
Nursing Agency	3,828	1,307	1,307	1,307	1,307	1,307	1,307	1,307	1,307	1,307	1,307	1,307	1,307	1,307	1,307	1,307	1,307	1,307	1,307	1,307	1,307	3,828
Medical Staff	14,396	13,287	13,287	13,287	13,287	13,287	13,287	13,287	13,287	13,287	13,287	13,287	13,287	13,287	13,287	13,287	13,287	13,287	13,287	13,287	13,287	14,396

Medical Locums	224	169	169	169	169	169	169	169	169	169	169	169	169	169	169	169	169	169	169	169	169	224
A&C	1,133	1,068	1,068	1,068	1,068	1,068	1,068	1,068	1,068	1,068	1,068	1,068	1,068	1,068	1,068	1,068	1,068	1,068	1,068	1,068	1,068	1,133
Healthcare Assistants	709	791	791	791	791	791	791	791	791	791	791	791	791	791	791	791	791	791	791	791	791	709
Agency reduction				(738)	(738)	(738)	(738)	(738)	(738)	(738)	(738)	(738)	(738)	(738)	(738)	(738)	(738)	(738)	(738)	(738)	(738)	
Workforce Efficiencies				(828)	(828)	(828)	(828)	(828)	(828)	(828)	(828)	(828)	(828)	(828)	(828)	(828)	(828)	(828)	(828)	(828)	(828)	
Additional staff costs due to activity growth	0	0	0	0	0	0	0	0	578	578	578	1,155	1,155	1,155	1,155	1,155	1,155	1,700	1,700	1,700	1,700	0
Total	**33,256**	**30,139**	**30,139**	**28,573**	**28,573**	**28,573**	**28,573**	**28,573**	**29,151**	**29,151**	**29,151**	**29,728**	**29,728**	**29,728**	**29,728**	**29,728**	**29,728**	**30,273**	**30,273**	**30,273**	**30,273**	**33,256**
Non pay																						
Clinical Supplies	1,363	1,306	1,306	1,306	1,306	1,306	1,306	1,306	1,306	1,306	1,306	1,306	1,306	1,306	1,306	1,306	1,306	1,306	1,306	1,306	1,306	1,363
Drugs	891	808	808	808	808	808	808	808	808	808	808	808	808	808	808	808	808	808	808	808	808	891
Pathology and Blood	2,041	2,058	2,058	2,058	2,058	2,058	2,058	2,058	2,058	2,058	2,058	2,058	2,058	2,058	2,058	2,058	2,058	2,058	2,058	2,058	2,058	2,041
Other	673	915	915	915	915	915	915	915	915	915	915	915	915	915	915	915	915	915	915	915	915	673
Changes to Non Pay costs due to activity			0	0	0	0	0	40	81	122	163	205	248	290	333	377	421	465	510	555	600	
Total	**4,968**	**5,087**	**5,087**	**5,087**	**5,087**	**5,087**	**5,087**	**5,127**	**5,168**	**5,209**	**5,250**	**5,292**	**5,335**	**5,377**	**5,420**	**5,464**	**5,508**	**5,552**	**5,597**	**5,642**	**5,687**	**4,968**
Total Direct Costs	**38,224**	**35,226**	**35,226**	**33,660**	**33,660**	**33,660**	**33,660**	**33,700**	**34,319**	**34,360**	**34,401**	**35,020**	**35,063**	**35,105**	**35,148**	**35,192**	**35,236**	**35,825**	**35,870**	**35,915**	**35,960**	**38,224**
FM Costs	471	471	471	636	636	636	636	636	636	636	636	636	636	636	636	636	636	636	636	636	636	471
Support Service Costs	3,647	3,647	3,647	3,647	3,647	3,647	3,647	3,647	3,647	3,647	3,647	3,647	3,647	3,647	3,647	3,647	3,647	3,647	3,647	3,647	3,647	3,647
Overheads	6,619	6,619	6,619	6,619	6,619	6,619	6,619	6,619	6,619	6,619	6,619	6,619	6,619	6,619	6,619	6,619	6,619	6,619	6,619	6,619	6,619	6,619
Other efficiencies in support services				(100)	(350)	(350)	(350)	(350)	(350)	(350)	(350)	(350)	(350)	(350)	(350)	(350)	(350)	(350)	(350)	(350)	(350)	
Changes to support costs due to activity									108	163	218	274	330	387	391	394	398	402	406	410	414	
Change in depreciation		(85)	(170)	474	689	689	689	689	689	689	689	689	689	689	689	689	689	689	689	689	689	
Change in Rate of return		(45)	(89)	912	900	876	852	828	804	780	756	732	708	684	660	636	612	588	564	540	516	
Total costs (baseline)	**48,961**	**45,833**	**45,704**	**45,848**	**45,800**	**45,776**	**45,752**	**45,768**	**46,471**	**46,543**	**46,615**	**47,266**	**47,340**	**47,416**	**47,439**	**47,462**	**47,486**	**48,055**	**48,079**	**48,105**	**48,130**	**48,961**
Net (deficit)	**(48,961)**	**(12,248)**	**(12,118)**	**(12,262)**	**(12,215)**	**(12,191)**	**(12,167)**	**(11,914)**	**(12,346)**	**(12,144)**	**(11,940)**	**(12,312)**	**(12,105)**	**(11,896)**	**(11,632)**	**(11,365)**	**(11,096)**	**(11,370)**	**(11,096)**	**(10,820)**	**(10,542)**	**(48,961)**

1.5.3 Financial Summary of Scenarios

Over the life of the project the two scenarios presented vary marginally in their overall average annual benefit to UHL:

- The BCT scenario means a reduction to income in the first five years relative to the current baseline, although an overall increase over 20 years. This reduction takes place prior to the opening of the EF. Once opened savings from within the EF workforce and the wider emergency pathway will offset the additional costs relating mainly to capital charges.
- The LTFM scenario assumes level income until 19/20, when growth is then modelled as demographics. This model gives a larger average income change over the life of the project, and therefore a reduction to the required efficiencies to support the additional costs.

Revised activity modelling has enabled the project team to understand the sensitivity of the functional content in relation to the revised assumptions that underpin the scheme, which has given comfort that the designed capacity is acceptable.

A summary of the two scenarios presented for the next 5 years can be seen in Tables 1.12 and 1.13 below. Both scenarios show that the increase in costs associated with the move can be supported by savings, although these will need to be greater under BCT assumptions than LTFM assumptions to offset the reduction in income. BCT assumptions are for a reduction to income from 2014/15, however efficiencies cannot be made until the Emergency Floor is opened. As such, transformational support funding will be needed in the interim years.

Table 1.12 5 Year Financial Summary - Better Care Together Scenario

	2014/15	2015/16	2016/17	2017/18	2018/19
Income change	(1,600)	(1,331)	(1,386)	(1,349)	(1,246)
Agency	0	0	738	738	738
Workforce efficiencies	0	0	828	828	828
Other efficiencies	0	0	900	1,600	1,600
Pay and non pay increases from additional activity	0	(40)	(32)	(38)	(53)
Facilities	0	0	(165)	(165)	(165)
Depreciation	0	85	(559)	(774)	(774)
Rate of return	0	45	(957)	(945)	(921)
Transformation funds	1,600	1,250	650	100	0
Total change	**(0)**	**8**	**17**	**(4)**	**8**

Table 1.13 5 Year Financial Summary - Long Term Financial Model Scenario

	2014/15	2015/16	2016/17	2017/18	2018/19
Income change	0	0	0	0	0
Agency	0	0	738	738	738
Workforce efficiencies	0	0	828	828	828
Other efficiencies	0	0	100	350	350
Pay and non pay increases from additional activity	0	0	0	0	0
Facilities	0	0	(165)	(165)	(165)
Depreciation	0	85	(559)	(774)	(774)
Rate of return	0	45	(957)	(945)	(921)
Transformation funds	0	0	0	0	0
Total change	**0**	**130**	**(14)**	**33**	**57**

1.5.4 Financing

The Trust will be undertaking several capital projects in the next few years and it is anticipated that the capital expenditure for this scheme will be as follows in Table 1.14:

Table 1.14 Sources and Applications of Funds

	2013/14 £	2014/15 £	2015/16 £	2016/17 £	2017/18 £	TOTAL £
Capital Expenditure	3,125,760	7,515,326	24,853,587	5,499,544	347,710	41,341,927
Funded By						
PDC/Public Loan		7,515,326	24,853,587	5,499,544	347,710	38,216,167
Trust Resources	3,125,760					3,125,760
Total Funding	3,125,760	7,515,326	24,853,587	5,499,544	347,710	**41,341,927**

1.5.5 Impact on the Balance Sheet

The proposed expenditure will have the impact on the Trust balance sheet as shown in Table 1.15 below.

Table 1.15 Impact on Trust Balance Sheet

	2013 /14	2014 /15	2015 /16	2016 /17	2017 /18
Assets Under Construction	3,125,760	7,515,326	24,853,587	5,499,544	347,710
Impairments on new building coming into use (DV likely revaluation)				-11,911,822	
Impairment on partial demolition of Victoria based m^2		-2,472,646			
Depreciation				-474,227	-688,993
Change to Fixed Assets		-2,472,646		28,608,168	28,266,885

1.6 Management Case

1.6.1 Project Management Arrangements

The project will be managed reflecting national guidance[4] and the Trust's own Capital Governance Framework, as shown in Figure 1C below:

[4] Capital Investment Manual 'Managing Capital Projects' (Department of Health); PRINCE2 (Office of Government Commerce); Managing Successful Programmes (Office of Government Commerce/ Efficiency & Reform Group)

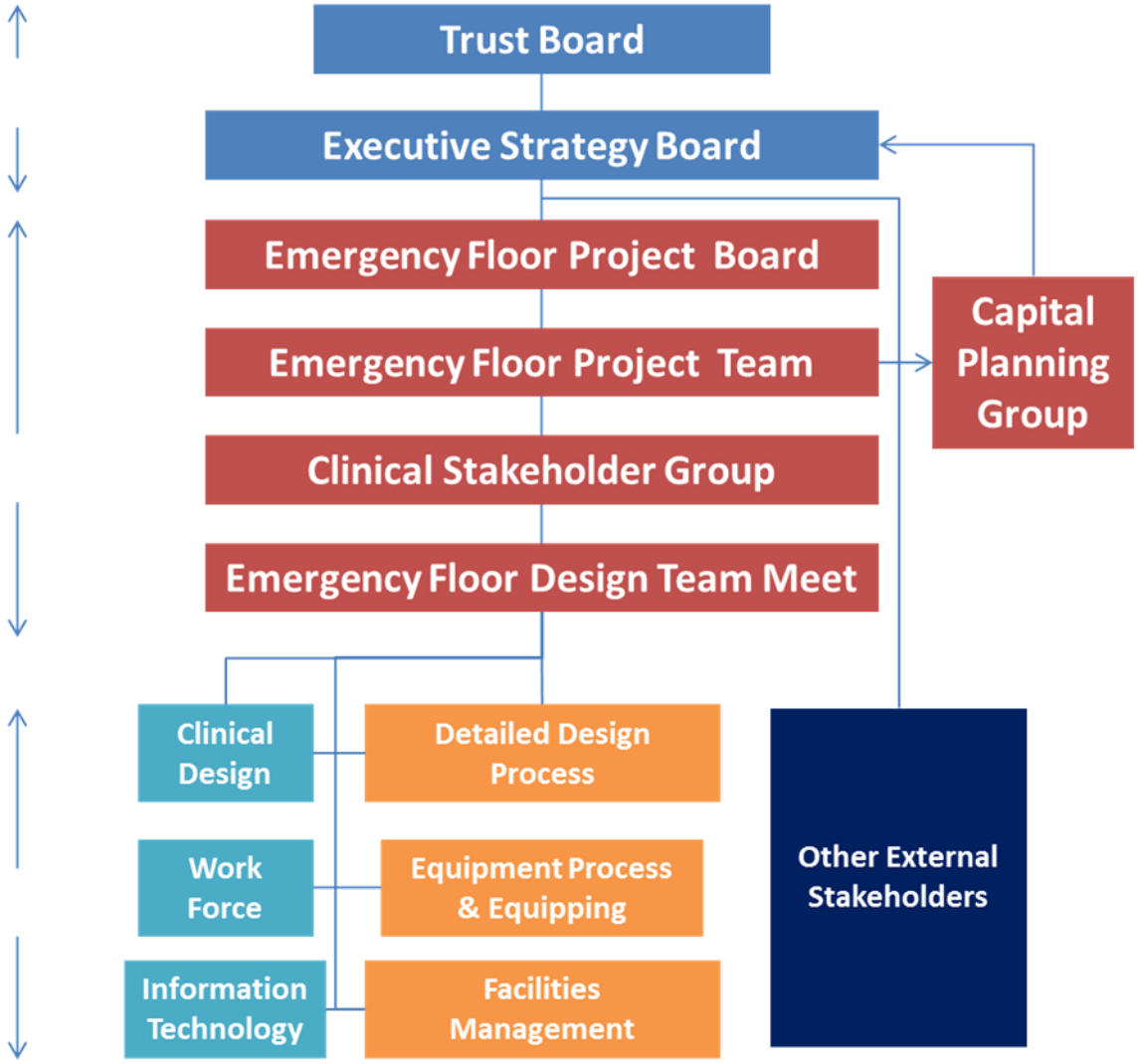


Figure 1.C UHL Capital Governance Framework

Working groups have also been set up in support of the project:

- Equipping Group
- Security and Major Incident Planning
- Hard and Soft Facilities Management
- Information Management & Technology
- Communications
- Technical and Operational Commissioning
- Site Progress

1.6.2 Project Plan

The Project Programme is established to deliver in two phases:

- Phase 1: ED – July 2016

- Phase 2: Assessment area – December 2016

The Project Programme is identified in Table 1.16 below, and is predicated on meeting key submission and approval dates to both the Trust Board and NTDA.

Table 1.16 Project Milestones

Milestone	Date
Outline Business Case presented to Trust Board Development Session	21st Nov 2013
Outline Business Case presented for Trust Board approval	28th Nov 2013
Outline Business Case sent to the NTDA	Dec 2013
Outline Business Case presented to CCGs & UCB	Dec 2013
Commence Detailed Design & Full Business Case	Feb 2014
Submission of Planning Application	2nd Jun 2014
Trust commit to place order for early procurement items	2nd Jun 2014
Trust approval of Developed Outline Business Case	28th August 2014
Trust commit to place order for early works (isolation, diversion)	5th Sept 2014
LCC Planning Committee	24th Sept 2014
Trust commit to place order for demolition works	25th Sept 2014
Commence demolition works	6th Oct 2014
NTDA approval of Developed Outline Business Case	20th Nov 2014
Trust Board approval of Full Business Case	27th Nov 2014
NTDA submission of the Full Business Case	28th Nov 2014
Demolition complete	20th Feb 2015
NTDA approval of the Full Business Case	2nd March 2015
Commence construction (Phase 1 – ED)	9th March 2015
Complete construction (Phase 1 – ED)	13th May 2016
Commence construction (Phase 2 – Assessment)	21st Jun 2016
Complete construction (Phase 2 – Assessment)	13th Dec 2016

1.6.3 Use of Special Advisors

Special advisers have been used in a timely and cost-effective manner in accordance with the Treasury Guidance, as shown in Table 1.17.

Table 1.17 External Advisors

Emergency Floor Development		
1	Interserve Construction Ltd	Building/ Construction Supervisors
2	Rider Levett Bucknall	Project Management
3	Capita	Architects
4	Capita	Cost Consultants
5	Capita	Business case / Finance analysis
6	Capita	Structural Engineers
7	Capita	Mechanical and Electrical Engineers
8	Capita	CDM

1.6.4 Outline Arrangements for Change & Contract Management

The Change Control procedures will be undertaken in accordance with the flow charts identified within the NEC3 procurement framework.

Change management associated with the project will be managed through the Project Board and executive forums that preside over it, under the chairmanship of the Senior Responsible Owner (SRO) and Trust Board respectively. Day to day change management issues will be discussed at the Emergency Floor Project Team Meeting and any resultant contract and/ or cost changes will need to be approved by the Project Board.

1.6.5 Outline Arrangements for Benefits Realisation

The delivery of benefits will be managed through the Emergency Floor Project Board. The benefits realisation plan can be found in Section 2.17 and will be expanded for the FBC submission. This articulates how the following benefits will be realised:

- To implement a design solution that provides a safe emergency care service that ensures capacity and known flexibility for current and known future demands of patients requiring emergency care
- Improve patient pathway management reducing the clinical risk and discomfort through the emergency care pathway
- Support and consolidate the provision of emergency floor concept at LRI
- Ensures that the service model of care is delivered in line with National, Trust and local health economy KPI's
- Patient safety is enhanced, and clinical risk is reduced.
- Where possible ensures that the service is developed in line with NHS Guidance in terms of HBN, HTM, national and Trust policy and local health economy policy in terms of capacity provision
- Quality of care is enhanced, in terms of the model of care, and seamless pathways of care and patient flows.

- The built environment enhances clinical practice that support clinical effectiveness, improved patient outcomes and patient safety
- Provides enhanced departmental relationships and clinical adjacencies that support clinical effectiveness and improved patient outcomes
- Ensures facilities are future proofed and adaptable to the changing needs of the health economy
- Improved Privacy and dignity provisions for all patients
- Consolidates existing services & provides clinical expertise whilst realising the Emergency Floor concept
- Improved patient access through a single front door process
- Enhances patient, visitor and staff safety through the built environment
- The design solution minimises the impact of the construction process on the site and therefore delivery of the Trust core services
- Option enables future proofing of the physical Emergency Department environment aligned to DCP future expansion needs
- The enabling moves will facilitate the Emergency Floor programme whilst minimising delay to delivery
- Reduces complexity and sequence dependency of enabling moves
- Maintains blue light access throughout whole build process

Work is ongoing within the Trust to identify and quantify the clinical benefits resulting from this project. These will include:

- Improved patient experience
- Reduced patient complaints
- Increased compliments
- Reduced institutionalisation of long term care from hospital
- Improved staff morale
- Recommendation that people work here
- Increased recruitment and retention
- Reduced staff sickness rates

1.6.6 Outline Arrangements for Risk Management

All projects are subject to risk and uncertainty. Successful project management should ensure that major foreseeable risks are identified, their effects considered and actions taken to remove, or mitigate the risks concerned.

Risks will be classified as:

- Client – these will be the responsibility of the Project Board to manage and monitor
- Contractor – a project specific risk register will be set up for the Project. These will be the responsibility of the Contractor to monitor and will form part of the GMP

The qualification of the costs of identified risks will enable the calculation of a realistic client contingency.

A pro-active risk management regime will be employed throughout the project. It is essential on any project (in particular one of this size and complexity) that the risk management process involves all key members of the project team including:

- Trust Estates
- Trust FM
- Project Consultant Team
- Contractor
- Designers

1.6.7 Post Project Evaluation Arrangements

The outline arrangements for post Project Evaluation (PPE) have been established in accordance with best practice. The Trust will ensure that a thorough post-project evaluation is undertaken at key stages in the process to ensure that positive lessons can be learnt from the project. These will be of benefit to:

- The Trust – in using this knowledge for future capital schemes
- Other key local stakeholders – to inform their approaches to future projects
- The NHS more widely – to test whether the policies and procedures used in this procurement have been used effectively
- Contractors – to understand the healthcare environment better

Formal post project evaluation reports will be compiled by project staff, and reported to the Board to ensure compliance to stated objectives.

1.6.8 Gateway Review Arrangements

Gateway reviews provide a valuable perspective on the issues facing the internal project team, and an external challenge to the robustness of plans and processes. The Gateway process provides support to SROs by helping them to ensure the following:

- The best available skills and experience are deployed on the programme or project
- All the stakeholders covered by the programme or project fully understand the current status and the issues involved
- The programme or project can progress more confidently to the next stage of development, implementation or realisation
- Achievement of more realistic time and cost targets for the programme or project

The Gateway Project Review Process looks at a project or programme at six key stages in the life of the project and considers the readiness to progress to the next phase.

The six stages or Gates are:

- Gate 0 - Strategic Assessment
- Gate 1 - Business Justification
- Gate 2 - Delivery Strategy
- Gate 3 - Investment Decision
- Gate 4 - Readiness For Service
- Gate 5 - Operations Review and Benefits Evaluation

A Health Gateway Review 2: Delivery Strategy was undertaken and associated report issued to the Project SRO on the 18th June 2014. A Delivery Confidence Assessment of AMBER was issued by the review team along with recommendations for consideration/ implementation.

The next Health Gateway Review, Gateway 3 Investment Decision is recommended once GMP is received and the Full Business Case is complete and ready for Trust Board and other approvals. The current programme indicates this will be November 2014.

1.7 Recommendation

The Trust Board is recommended to approve this business case for submission to the NTDA.

Signed: .....

Senior Responsible Owner

Date:.....

Senior Responsible Owner
Project Team

Trust Board paper K

To:	**Trust Board**
From:	Rachel Overfield, Chief Nurse
Date:	**28 August 2014**
CQC regulation:	

Title:	Nursing Workforce Report

Author/Responsible Director:
Maria McAuley, Head of Nursing
Rachel Overfield, Chief Nurse

Purpose of the Report:
To assure the Trust Board that matters relating to nursing workforce are being managed and risk wherever possible is mitigated.

The Report is provided to the Board for:

Decision		Discussion	
Assurance	x	Endorsement	

Summary / Key Points:
The report provides the Trust Board with the latest staffing in post figures; the current recruitment position and the mitigation of workforce gaps.

Recommendations:
The Trust Board are asked to note the contents and support ongoing recruitment initiatives.

Previously considered at another corporate UHL Committee?
Executive Quality Board

Strategic Risk Register: Yes	**Performance KPIs year to date:** No

Resource Implications (eg Financial, HR):
Yes, cost of international recruitment; impact of premium pay.

Assurance Implications:
To note that whilst everything possible is done to close gaps, there remain shifts not appropriately staffed.

Patient and Public Involvement (PPI) Implications:
No

Stakeholder Engagement Implications:
The Clinical Quality Review Group receives the same report. The TDA/NHSE receive Hard Truths data.

Equality Impact:
No.

Information exempt from Disclosure:
No.

Requirement for further review?
Report is produced monthly.

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST

MEETING: **Trust Board**

DATE: **28 August 2014**

REPORT BY: **Maria McAuley, Head of Nursing**

SUBJECT: **Nursing Workforce Report**

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1. Background

This paper sets out the current nursing workforce position within UHL for July 2014 including

- Hard Truths
- Real Time Staffing
- Vacancy levels and Nurse to bed Ratio's
- Premium Pay.
- Recruitment Activity
- Recommendations.

2. Hard Truths

In the national strategy for nursing and midwifery (DH and NHSCB, 2012) clear expectations of Chief Nurses and Directors of Nursing are set out around presentation and discussion of nursing metrics at Board meetings held in public at least twice a year. The National Quality Board (NQB, 2013) identified 10 key expectations in their guidance on staffing levels which have been followed more recently by further guidance from the Care Quality Commission (CQC, 2014) for organisations to deliver the commitments the Government made in 'Hard truths: the journey to putting patients first' to make staffing information more publically available.

UHL's real time staffing summary will support UHL's reporting in relation to NHS England's, 'Hard Truths Commitments Regarding the Publishing of Staffing Data'. The July return has been submitted and is attached as Appendix 1. This information is also available on our internet at http://www.leicestershospitals.nhs.uk/patients/patient-welfare/safer-staffing/

The return details the planned and actual staffing in hours on a daily basis, per ward area. NHS England have not advised Trusts in relation to ratings/parameters however the rationale is that the data will contribute to improved care for patients by ensuring that effective staffing levels are continually presented, challenged, owned and discussed at Board. NHS Trusts will be advised of the ratings/parameters prior to publication on the NHS Choices website.

The Board will be advised about wards where staffing falls below the requirements, once we have been informed what these are. However the Board will see that some areas appear to have very low % fill rates. These are predominantly in paediatrics and critical care areas where beds are flexed to adjust the staffing levels. It is not possible to reflect this in the return.

3. Real Time Staffing

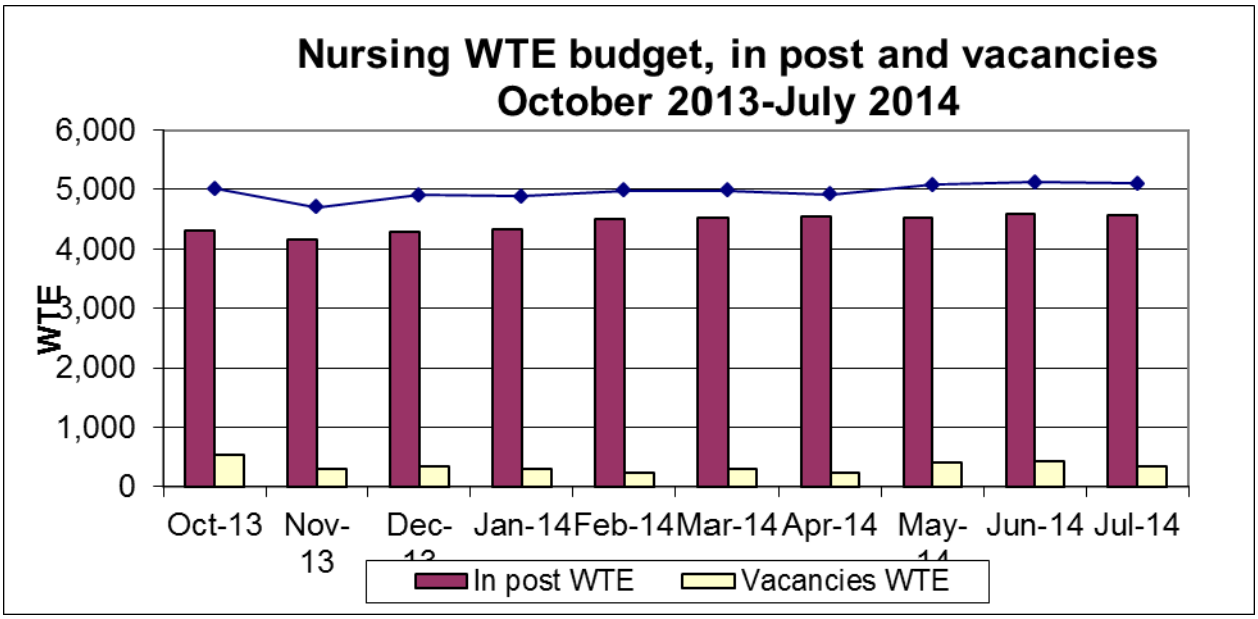
Attached as Appendix 2 is the real time staffing summary for July 2014. This report is at high level and details how many times in month CMG's declared unmanageable staffing levels. The electronic version of the report drills down into the detail per ward area for Heads of Nursing and Deputy Heads to review.

In the 40 cases where CMGs were unable to manage their staffing issues, Corporate Nursing became involved and a number of actions take place, eg moving staff across CMG boundaries, using corporate non ward bases nurses etc. It should be noted that in these cases any action that can be taken is taken, it is not always possible to fully mitigate the risk of staffing gaps. We continue to be concerned at the absence of safety statements in many cases and are working hard with the Heads of Nursing to resolve.

4. Vacancies and Nurse to Bed Ratio

July Statistics

The sum of budgeted wtes for July 2014 is reported as	**5106wtes**
The sum of nurses in post for July 2014 is reported as	**4565wtes**
The sum of nurses waiting to start in July is reported as	**320wte**
The sum of nurses waiting to leave in July is reported as	**120wte**
Therefore the sum of total reported vacancies for July is	**341wte**



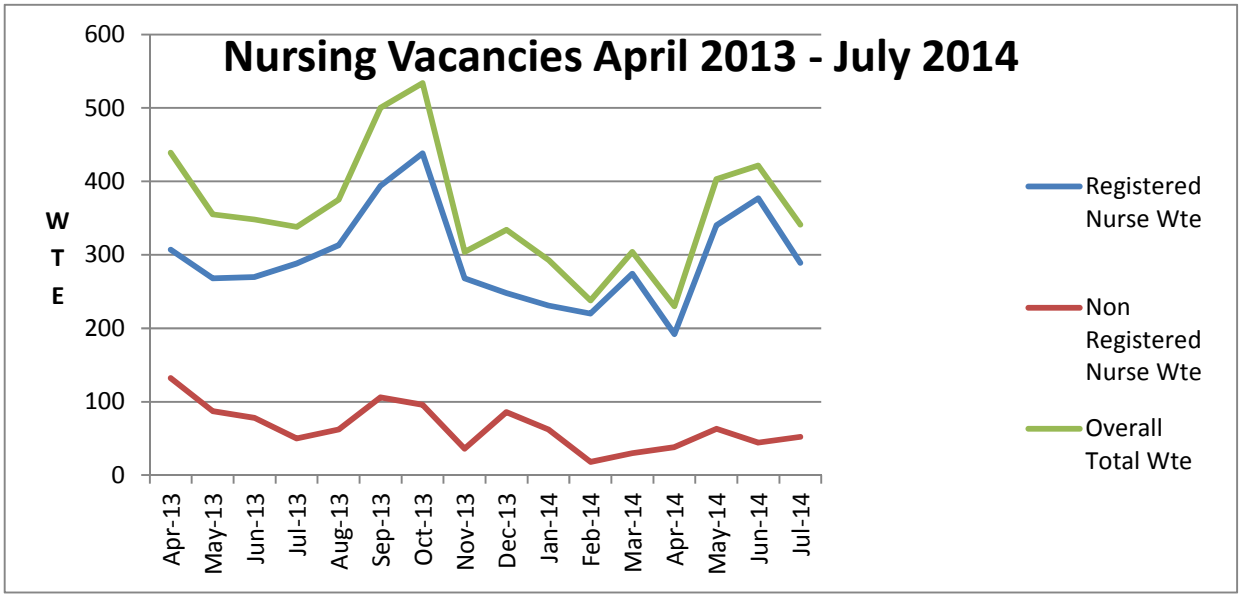
Graph 1

Graph 1 details the Nursing wte Budget, in post and Vacancies to date

Reported vacancies for July are at 34wte.

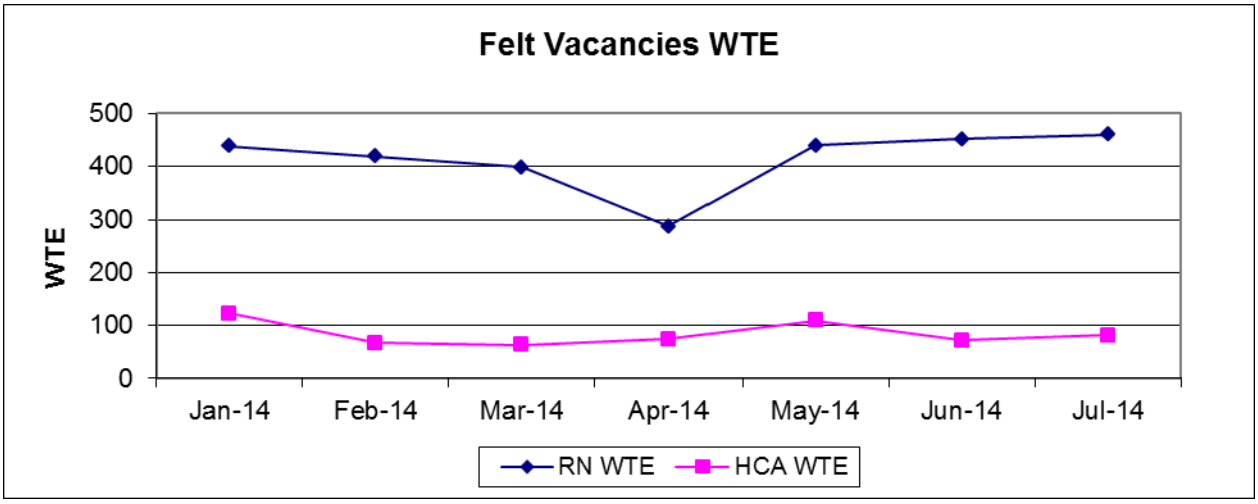
There has been increased funding in areas (ITAPS) to open extra ITU beds, the same within women's and children's. The establishments and month 3 budget reports have been reviewed and agreed by all CMG Heads.

Graph 2 details the Nursing Vacancies for UHL since April 2013 to date.



Graph 2

Graph 3 details the 'felt' vacancies from Jan 2014 to July 2014



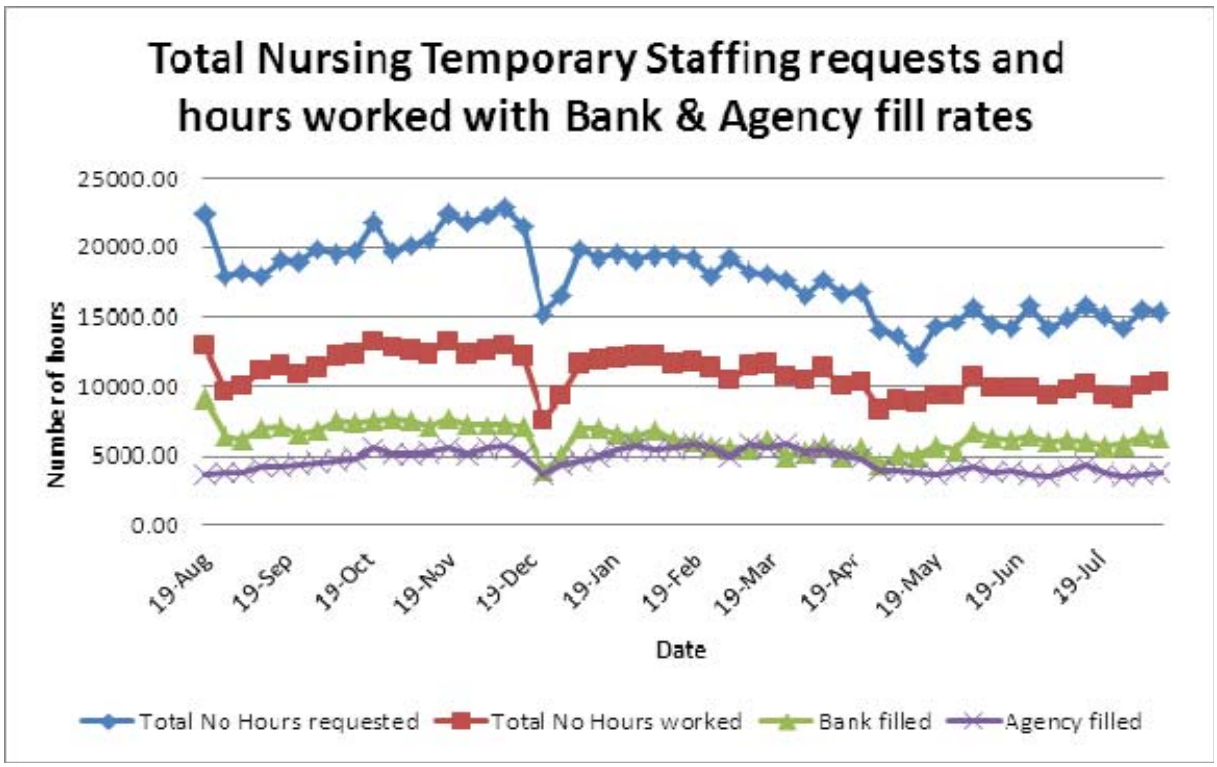
Graph 3

5. Premium Pay

- The percentage of bank fill versus agency has increased in favour of bank fill compared to July 2013
- Every attempt is being made to fill the gap more across the organisation.
- As a senior nursing team we have agreed that non-framework agencies will not be used unless the request is made from the Head of Nursing for the CMG.

For the month of July the average figures are

Requests	14788 hours-this equals 394wte
Fill rate	64%
Bank filled	5886 hours
Agency filled	3796 hours



Graph 4

6. Recruitment

International Recruitment

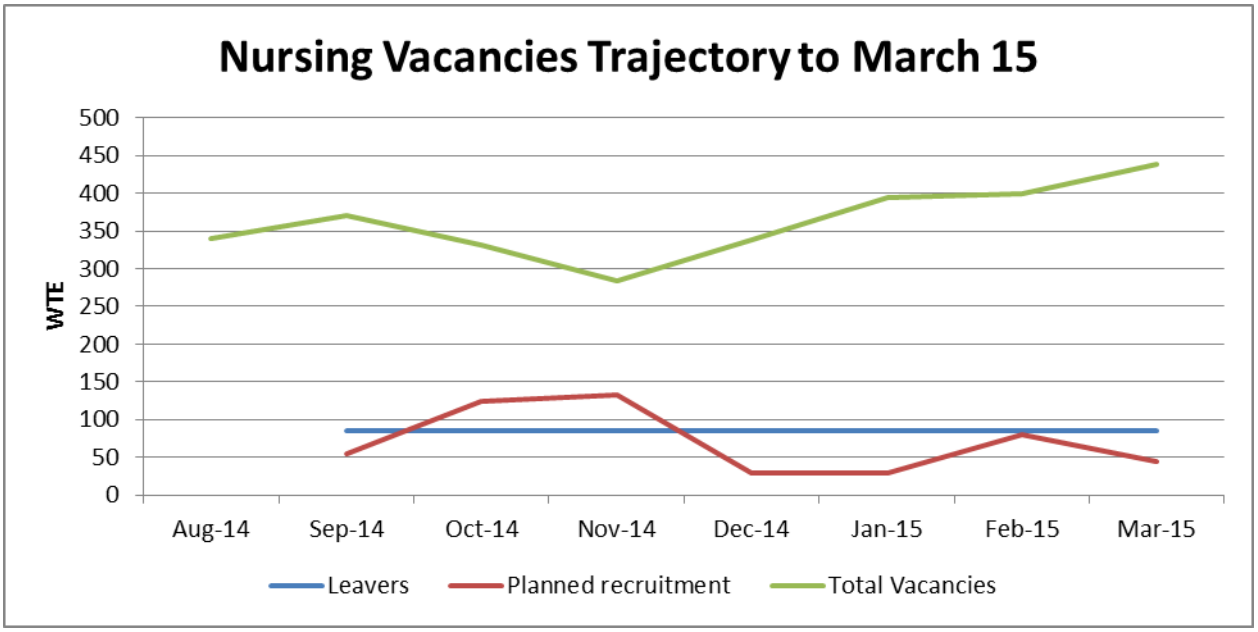
To date 161 international nurses have joined the Trust, and have undertaken a very detailed and comprehensive induction programme. Further recruitment is planned with a further 50 international recruits planned to join the Trust on September 11th. Current plans are for a further 50 international to join the Trust in November 2014. The plan for 2015 and our international recruitment is for 5 cohorts of up to 30 nurses recruited throughout 2015. This number can be increased in line with availability of training facilities. The schedule is attached as Appendix 3.

Local Recruitment

Our local recruitment continues, with monthly adverts for Registered Nurses and bi-monthly adverts for Health Care Assistants, to further support this we proactively attend all RCN recruitment fairs across the country. We continuously recruit form our local university twice a year, we have recruited 82 newly qualified Adult nurses, 25 children's nurses and 25 midwives the timeline for these nurses joining the Trust is November 2014.

Recruitment Trajectory

The recruitment trajectory detailed below in Graph 5. This is conservative and assumes leavers will remain stagnant at 85, which is the average amount of leavers per month over the last year. This includes our international recruitment plan, alongside our monthly recruitment programme for local staff, the monthly programme is estimated, with clearing house numbers confirmed. It is clear from the below that we must ensure focus is maintained on nursing recruitment.



Graph 5

Key Facts
Nursing recruitment from 1st April 2013 to date
161 International nurses
405 clearing house nurses and local RNs, Jobs Fair
379 Nursing Assistants
Total 945 RNs and HCAs recruited since April 2013

7. Recommendations

Reporting
Information on nursing workforce is reported to the following committees, in the following order:

- Nursing Executive Team
- Executive Quality Board
- Executive Workforce Board
- Quality Assurance Committee
- Clinical Quality Review Group

It will also be copied for information to the Finance and Performance Committee. This will mean for some committee's data will be less real time than other.

Actions
Trust Board are asked to support ongoing international recruitment based on the trajectory included in this plan and until local recruitment catches up with need.

University Hospitals of Leicester NHS Trust
Ward Fill Rate Indicator
Staffing: Nursing, midwifery and care staff
July 2014

				Day				Night				Day		Night	
		Main 2 Specialties on each ward		Registered		Care Staff		Registered		Care Staff					
Hospital Site name	Ward name	Specialty 1	Specialty 2	Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours	Average fill rate - registered nurses/midwives (%)	Average fill rate - care staff (%)	Average fill rate - registered nurses/midwives (%)	Average fill rate - care staff (%)
Glenfield Hospital - RWEAE	GH WD 15	340 - RESPIRATORY MEDICINE		2498	1860	1860	1733	1070	1035	713	725	74.5%	93.2%	96.7%	101.7%
Glenfield Hospital - RWEAE	GH WD 16 Respiratory Unit	340 - RESPIRATORY MEDICINE		2325	2040	1395	1403	1070	1024	713	656	87.7%	100.6%	95.7%	92.0%
Glenfield Hospital - RWEAE	GH WD 17	340 - RESPIRATORY MEDICINE		2670	2565	1395	1275	1783	1576	357	391	96.1%	91.4%	88.4%	109.5%
Glenfield Hospital - RWEAE	GH WD Clinical Decisions Unit	340 - RESPIRATORY MEDICINE		4883	4260	2325	2070	3922	3398	1783	1426	87.2%	89.0%	86.6%	80.0%
Glenfield Hospital - RWEAE	GH WD 24	320 - CARDIOLOGY		1860	1725	1395	1230	1070	1081	713	633	92.7%	88.2%	101.0%	88.8%
Glenfield Hospital - RWEAE	GH WD 26	170 - CARDIOTHORACIC SURGERY		2265	2100	930	773	1024	989	357	357	92.7%	83.1%	96.6%	100.0%
Glenfield Hospital - RWEAE	GH WD 27	320 - CARDIOLOGY	300 - GENERAL MEDICINE	1800	1613	1163	1148	1070	932	357	483	89.6%	98.7%	87.1%	135.3%
Glenfield Hospital - RWEAE	GH WD 28	320 - CARDIOLOGY		2070	1725	1305	1088	1001	1012	667	667	83.3%	83.4%	101.1%	100.0%
Glenfield Hospital - RWEAE	GH WD 29 EXT 3656	340 - RESPIRATORY MEDICINE		510	450	383	338	276	219	92	81	88.2%	88.3%	79.3%	88.0%
Glenfield Hospital - RWEAE	GH WD 30	321 - PAEDIATRIC CARDIOLOGY	170 - CARDIOTHORACIC SURGERY	1395	1155	465	270	1070	725	0	127	82.8%	58.1%	67.8%	#DIV/0!
Glenfield Hospital - RWEAE	GH WD 31	170 - CARDIOTHORACIC SURGERY		3135	2805	1350	1245	1783	1760	575	391	89.5%	92.2%	98.7%	68.0%
Glenfield Hospital - RWEAE	GH WD 32	320 - CARDIOLOGY	340 - RESPIRATORY MEDICINE	1380	1335	345	360	173	161	173	161	96.7%	104.3%	93.1%	93.1%
Glenfield Hospital - RWEAE	GH WD 33	320 - CARDIOLOGY		2325	2025	930	1065	1070	1070	713	564	87.1%	114.5%	100.0%	79.1%
Glenfield Hospital - RWEAE	GH WD 33A Card Procedures	320 - CARDIOLOGY		1860	1748	930	720	713	690	713	713	94.0%	77.4%	96.8%	100.0%
Glenfield Hospital - RWEAE	GH WD Coronary Care Unit	320 - CARDIOLOGY	300 - GENERAL MEDICINE	3720	3023	1163	1020	2139	2151	713	644	81.3%	87.7%	100.6%	90.3%
Glenfield Hospital - RWEAE	GH WD GICU Gen Intensive	340 - RESPIRATORY MEDICINE	320 - CARDIOLOGY	8655	7890	1335	945	6636	5566	357	345	91.2%	70.8%	83.9%	96.6%
Glenfield Hospital - RWEAE	GH WD Paed ITU	170 - CARDIOTHORACIC SURGERY	321 - PAEDIATRIC CARDIOLOGY	3720	2925	345	23	2852	2289	0	0	78.6%	6.7%	80.3%	#DIV/0!
Leicester General Hospital - RW	LGH WD 10	361 - NEPHROLOGY		1800	1568	930	1088	713	713	713	794	87.1%	117.0%	100.0%	111.4%
Leicester General Hospital - RW	LGH WD 14	110 - TRAUMA & ORTHOPAEDICS		2130	1830	1065	960	874	840	437	437	85.9%	90.1%	96.1%	100.0%
Leicester General Hospital - RW	LGH WD 15A HDU Neph	361 - NEPHROLOGY		1860	1725	465	450	1070	1024	357	357	92.7%	96.8%	95.7%	100.0%
Leicester General Hospital - RW	LGH WD 15N Nephrology	361 - NEPHROLOGY		1770	1755	930	780	713	725	713	713	99.2%	83.9%	101.7%	100.0%
Leicester General Hospital - RW	LGH WD 16	110 - TRAUMA & ORTHOPAEDICS		1635	1823	1140	878	874	874	437	437	111.5%	77.0%	100.0%	100.0%
Leicester General Hospital - RW	LGH WD 17 Transplant	361 - NEPHROLOGY	100 - GENERAL SURGERY	1305	1208	495	495	713	702	357	357	92.6%	100.0%	98.5%	100.0%
Leicester General Hospital - RW	LGH WD 18	110 - TRAUMA & ORTHOPAEDICS		1635	1575	1140	1275	874	840	437	460	96.3%	111.8%	96.1%	105.3%
Leicester General Hospital - RW	LGH WD 2	430 - GERIATRIC MEDICINE	300 - GENERAL MEDICINE	1860	1695	930	1275	713	713	713	713	91.1%	137.1%	100.0%	100.0%
Leicester General Hospital - RW	LGH WD 22	100 - GENERAL SURGERY		1568	1358	930	848	713	702	713	713	86.6%	91.2%	98.5%	100.0%
Leicester General Hospital - RW	LGH WD 23	100 - GENERAL SURGERY		923	908	720	563	529	529	265	253	98.4%	78.2%	100.0%	95.5%
Leicester General Hospital - RW	LGH WD 26 SAU	101 - UROLOGY		1740	1463	930	915	713	702	713	667	84.1%	98.4%	98.5%	93.5%
Leicester General Hospital - RW	LGH WD 27	100 - GENERAL SURGERY		1395	1283	930	930	713	713	713	679	92.0%	100.0%	100.0%	95.2%
Leicester General Hospital - RW	LGH WD 28 Urology	100 - GENERAL SURGERY		1928	1635	1395	1058	1070	989	713	713	84.8%	75.8%	92.4%	100.0%
Leicester General Hospital - RW	LGH WD 29 EMU Urology	100 - GENERAL SURGERY	101 - UROLOGY	2025	1650	1568	1200	1070	897	713	702	81.5%	76.5%	83.8%	98.5%
Leicester General Hospital - RW	LGH WD 3	328-STROKE MEDICINE		1395	1275	930	1193	713	679	713	679	91.4%	128.3%	95.2%	95.2%

University Hospitals of Leicester NHS Trust
Ward Fill Rate Indicator
Staffing: Nursing, midwifery and care staff
July 2014

				Day				Night				Day		Night	
		Main 2 Specialties on each ward		Registered		Care Staff		Registered		Care Staff					
Hospital Site name	Ward name	Specialty 1	Specialty 2	Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours	Average fill rate - registered nurses/midwives (%)	Average fill rate - care staff (%)	Average fill rate - registered nurses/midwives (%)	Average fill rate - care staff (%)
Leicester General Hospital - RW	LGH WD 30	501 - OBSTETRICS		1395	1388	930	990	1070	943	713	587	99.5%	106.5%	88.1%	82.3%
Leicester General Hospital - RW	LGH WD 31	502 - GYNAECOLOGY		2025	1958	1275	1238	713	725	311	311	96.7%	97.1%	101.7%	100.0%
Leicester General Hospital - RW	LGH WD Brain Injury Unit	400 - NEUROLOGY		1395	998	930	938	713	679	713	518	71.5%	100.9%	95.2%	72.7%
Leicester General Hospital - RW	LGH WD Labour Ward	501 - OBSTETRICS		5115	4275	930	930	3922	3117	713	713	83.6%	100.0%	79.5%	100.0%
Leicester General Hospital - RW	LGH WD Crit Care Med	100 - GENERAL SURGERY	101 - UROLOGY	4650	4065	930	668	3209	3048	0	23	87.4%	71.8%	95.0%	#DIV/0!
Leicester General Hospital - RW	LGH WD Spec Care Babies	422- NEONATOLOGY		1740	1485	1163	1148	1070	1012	713	702	85.3%	98.7%	94.6%	98.5%
Leicester General Hospital - RW	LGH WD Surg Acute Care	100 - GENERAL SURGERY		930	930	465	390	713	656	357	345	100.0%	83.9%	92.0%	96.6%
Leicester General Hospital - RW	LGH WD Young Disabled	400 - NEUROLOGY		930	968	1860	788	713	690	713	529	104.1%	42.4%	96.8%	74.2%
Leicester Royal Infirmary - RWI	LRI WD 10 Bal L4	171 - PAEDIATRIC SURGERY		2025	1313	1335	615	713	713	357	345	64.8%	46.1%	100.0%	96.6%
Leicester Royal Infirmary - RWI	LRI WD 11 Bal L4	110 - TRAUMA & ORTHOPAEDICS	420 - PAEDIATRICS	1980	1635	1155	915	713	725	357	357	82.6%	79.2%	101.7%	100.0%
Leicester Royal Infirmary - RWI	LRI WD 12 Bal L4	420 - PAEDIATRICS		2033	1553	465	465	1426	1150	357	357	76.4%	100.0%	80.6%	100.0%
Leicester Royal Infirmary - RWI	LRI WD 14 Bal L4	420 - PAEDIATRICS	421 - PAEDIATRIC NEUROLOGY	1740	1403	930	615	1070	1081	357	334	80.6%	66.1%	101.0%	93.6%
Leicester Royal Infirmary - RWI	LRI WD 17 Bal L5	110 - TRAUMA & ORTHOPAEDICS		2325	2025	1860	1695	1070	1058	1070	725	87.1%	91.1%	98.9%	67.8%
Leicester Royal Infirmary - RWI	LRI WD 18 Bal L5	110 - TRAUMA & ORTHOPAEDICS		2093	1800	1860	1770	1070	1047	713	713	86.0%	95.2%	97.9%	100.0%
Leicester Royal Infirmary - RWI	LRI WD 19 Bal L6	300 - GENERAL MEDICINE		2798	2325	1860	1740	1070	909	713	667	83.1%	93.5%	85.0%	93.5%
Leicester Royal Infirmary - RWI	LRI WD 21 Bal L6	100 - GENERAL SURGERY		1628	1598	1395	1328	1070	1035	575	587	98.2%	95.2%	96.7%	102.1%
Leicester Royal Infirmary - RWI	LRI WD 22 Bal 6	100 - GENERAL SURGERY		2318	1860	1103	1058	1070	989	713	702	80.2%	95.9%	92.4%	98.5%
Leicester Royal Infirmary - RWI	LRI WD 23 Win L3	300 - GENERAL MEDICINE		2325	2145	1628	1598	1070	920	713	702	92.3%	98.2%	86.0%	98.5%
Leicester Royal Infirmary - RWI	LRI WD 24 Win L3	300 - GENERAL MEDICINE	400 - NEUROLOGY	2325	1988	1568	1800	1070	886	713	771	85.5%	114.8%	82.8%	108.1%
Leicester Royal Infirmary - RWI	LRI-Stroke Unit Wards 25 & 26	328-STROKE MEDICINE		3720	4230	2325	2820	1426	1622	1426	1783	113.7%	121.3%	113.7%	125.0%
Leicester Royal Infirmary - RWI	LRI WD 27 Win L4	420 - PAEDIATRICS	303 - CLINICAL HAEMATOLOGY	2340	1523	780	495	1070	909	357	357	65.1%	63.5%	85.0%	100.0%
Leicester Royal Infirmary - RWI	LRI WD 28 Windsor Level 4	420 - PAEDIATRICS		930	915	930	810	713	679	357	357	98.4%	87.1%	95.2%	100.0%
Leicester Royal Infirmary - RWI	LRI WD 29 Win L4	301 - GASTROENTEROLOGY	300 - GENERAL MEDICINE	2205	1808	1163	1110	978	932	713	702	82.0%	95.4%	95.3%	98.5%
Leicester Royal Infirmary - RWI	LRI WD 30 Win L4	301 - GASTROENTEROLOGY		2033	1733	1860	1628	1070	943	713	690	85.2%	87.5%	88.1%	96.8%
Leicester Royal Infirmary - RWI	LRI WD 31 Win L5	300 - GENERAL MEDICINE		2805	2295	1860	1785	1070	840	713	656	81.8%	96.0%	78.5%	92.0%
Leicester Royal Infirmary - RWI	LRI WD 32 Win L5	110 - TRAUMA & ORTHOPAEDICS		2093	1785	1628	1808	1070	966	1070	1185	85.3%	111.1%	90.3%	110.7%
Leicester Royal Infirmary - RWI	LRI WD 33 Win L5	300 - GENERAL MEDICINE		2325	2243	1860	2018	1783	1725	1426	1357	96.5%	108.5%	96.7%	95.2%
Leicester Royal Infirmary - RWI	LRI WD 34 Windsor Level 5	300 - GENERAL MEDICINE		2325	2093	1860	1695	1426	1254	1070	1058	90.0%	91.1%	87.9%	98.9%
Leicester Royal Infirmary - RWI	LRI WD 36 Win L6	300 - GENERAL MEDICINE	430 - GERIATRIC MEDICINE	2325	2115	1740	1695	1070	1081	713	713	91.0%	97.4%	101.0%	100.0%
Leicester Royal Infirmary - RWI	LRI WD 37 Win L6	300 - GENERAL MEDICINE		2498	1718	930	1328	713	598	1070	966	68.8%	142.8%	83.9%	90.3%
Leicester Royal Infirmary - RWI	LRI WD 38 Win L6	300 - GENERAL MEDICINE		2205	2010	1395	1320	1070	1070	713	725	91.2%	94.6%	100.0%	101.7%
Leicester Royal Infirmary - RWI	LRI WD 39 Osb L1	800 - CLINICAL ONCOLOGY	303 - CLINICAL HAEMATOLOGY	1395	1118	930	930	713	610	357	368	80.1%	100.0%	85.6%	103.1%
Leicester Royal Infirmary - RWI	LRI WD 40 Osb L1	800 - CLINICAL ONCOLOGY		1395	1260	930	833	713	667	357	357	90.3%	89.6%	93.5%	100.0%
Leicester Royal Infirmary - RWI	LRI WD 41 Osb L2	303 - CLINICAL HAEMATOLOGY		1860	1718	930	885	1070	909	357	357	92.4%	95.2%	85.0%	100.0%

University Hospitals of Leicester NHS Trust
Ward Fill Rate Indicator
Staffing: Nursing, midwifery and care staff
July 2014

				Day				Night				Day		Night	
		Main 2 Specialties on each ward		Registered		Care Staff		Registered		Care Staff					
Hospital Site name	Ward name	Specialty 1	Specialty 2	Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours	Average fill rate - registered nurses/midwives (%)	Average fill rate - care staff (%)	Average fill rate - registered nurses/midwives (%)	Average fill rate - care staff (%)
Leicester Royal Infirmary - RWI	LRI WD 5 Ken L3	501 - OBSTETRICS		1860	1785	1395	1395	713	736	713	713	96.0%	100.0%	103.2%	100.0%
Leicester Royal Infirmary - RWI	LRI WD 6 Ken L3	501 - OBSTETRICS		1860	1763	1395	1395	713	713	713	713	94.8%	100.0%	100.0%	100.0%
Leicester Royal Infirmary - RWI	LRI WD 7 Bal L3	100 - GENERAL SURGERY	160 - PLASTIC SURGERY	1568	1508	1335	1245	1070	1024	713	713	96.2%	93.3%	95.7%	100.0%
Leicester Royal Infirmary - RWI	LRI WD 8 SAU Bal L3	100 - GENERAL SURGERY		2265	1823	1740	1493	1472	1150	1070	1139	80.5%	85.8%	78.1%	106.4%
Leicester Royal Infirmary - RWI	LRI WD Bone Marrow	303 - CLINICAL HAEMATOLOGY		930	930	0	0	713	713	0	0	100.0%	#DIV/0!	100.0%	#DIV/0!
Leicester Royal Infirmary - RWI	LRI WD Paed ITU	420 - PAEDIATRICS		2325	2168	465	465	1783	1714	0	0	93.2%	100.0%	96.1%	#DIV/0!
Leicester Royal Infirmary - RWI	LRI Delivery Suite, Ward 1 and MAU	501 - OBSTETRICS		6510	6645	2790	2790	4991	4548	1426	1426	102.1%	100.0%	91.1%	100.0%
Leicester Royal Infirmary - RWI	LRI WD Fielding John Vic L1	300 - GENERAL MEDICINE		1860	1898	1395	1560	713	690	713	828	102.0%	111.8%	96.8%	116.1%
Leicester Royal Infirmary - RWI	LRI WD IDU Infectious Diseases	350 - INFECTIOUS DISEASES	300 - GENERAL MEDICINE	1395	1200	1365	1208	713	679	357	414	86.0%	88.5%	95.2%	116.0%
Leicester Royal Infirmary - RWI	LRI WD ITU Bal L2	100 - GENERAL SURGERY	192 - CRITICAL CARE MEDICINE	8370	6848	930	615	6417	6084	357	322	81.8%	66.1%	94.8%	90.2%
Leicester Royal Infirmary - RWI	LRI WD Kinmonth Unit Bal L3	100 - GENERAL SURGERY	120 - ENT	1470	1320	728	720	713	690	713	690	89.8%	98.9%	96.8%	96.8%
Leicester Royal Infirmary - RWI	LRI WD Spec Care Baby Ken L5	422- NEONATOLOGY		6975	4853	930	908	5348	3657	713	874	69.6%	97.6%	68.4%	122.6%
	Total			**183652**	**161012**	**92743**	**86257**	**105636**	**95906**	**47474**	**46489**				

Safety Statements July 2014

Week (All)

Row Labels	Ward staffed to establishment	Ward has manageable shortfall in staffing and is being managed across the CMGs	Ward has unmanageble shortfall in staffing and Director support required	No Safety Statement given
CHUGS	145	0	6	235
Emergency & Specialty medicine	185	0	26	369
ITAPS	9	11	0	37
MSK & Specialist Surgery	110	0	3	103
RRC	152	63	0	196
Women's & Childrens	105	29	5	273
Grand Total	706	103	40	1213

International recruitment plan-updated 020714

Month/YR	Arrival Date & Welcome event	Induction Date	Numbers in cohort		Recruitment Trip	Travel Date	Interview Date	Return Travel date	Interview team complete
May-14	Thursday May 8th 2014	Monday May 12th 2014	44		Portugal (Lisbon)	Monday 26th May 2014	27th & 28th May	Wednesday 26th - pm	Confirmed
Jun-14	Thursday 26th June 2014	Monday 30th June 2014	16		Madrid	Tuesday 24th June	25th & 26th June	Thursday 26th June-pm	Confirmed
Sep-14	Thursday 11th September 2014	Monday 15th September 2014	48		Scotland	Monday 28th July	29th July	Tuesday 29th July	Confirmed
Nov-14	Thursday 27th November 2014	Monday 1st December 2014	50		Belfast	Monday 18th August	Tuesday 19th August	Tuesday 19th August	Confirmed
Feb-15	TBC	TBC	50		Portugal (Lisbon)	Tuesday 9th September	10th &11th September	Thursday 11th September	
Apr-15	TBC	TBC	30						
Jun-15	TBC	TBC	30						
Aug-15	TBC	TBC	30						
Oct-15	TBC	TBC	30						

Trust Board paper L

To:	**Trust Board**
From:	**Kate Bradley, Director of Human Resources**
Date:	**28 August 2014**
CQC regulation: 1&16	**Respecting and involving people who use services** **Assessing and monitoring the quality of service provision**

Title:	**Equality Update report**

Author/Responsible Director:
Kate Bradley, Director of Human Resources
Deb Baker, Service Equality Manager

Purpose of the Report:
This is the first of the biannual 2014 Equality update reports for the Trust Board. The report was discussed at the Executive Quality Board on 6 August 2014 before presentation to Trust Board today.

This report will:

(a) Provide an update on the revised governance and reporting arrangements for Equality.

(b) Present the 2013 Equality annual report that demonstrates compliance with the Public Sector Equality Duty which is to:

- eliminate unlawful discrimination, harassment and victimisation
- advance equality of opportunity between different groups
- foster good relations between different groups

Please note due to the limitations of file size the attached Equality Annual Report at Appendix 1 is best suitable for web viewing in terms of the graphics quality. A printable version of the report containing higher resolution images will be used for any printed document that is sent out from the Trust. There will be some copies available at the Trust Board.

The Report is provided to the Board for:

Decision		Discussion√	
Assurance√		Endorsement√	

Recommendations:

- The Board is asked to note and discuss the content;
- Support further internal analysis being undertaken of the two critical incidents that have occurred;
- Conduct a Learning Disability Patient Outcome Review and;
- Agree the 2014/2015 Equality Programme of Work at Appendix 2

Previously considered at another corporate UHL Committee? **Yes** Executive Quality Board August 6th 2014	
Board Assurance Framework: **Risk** Principal risks 1 and 14	**Performance KPIs year to date:** Quality Schedule for Equality PE6.
Assurance Implications: The equality programme is assessed for compliance with the Public Sector Duty annually via our web site.	
Patient and Public Involvement (PPI) Implications: Equality and Patient and Public involvement is now aligned. The Due Regard proforma has been changed to now incorporate Patient Experience and Patient Involvement.	
Stakeholder Engagement Implications: The Equality Advisory Group is an active partner in monitoring delivery of the annual Equality Work Programme.	
Information exempt from Disclosure: None.	
Requirement for further review? • A Learning Disability report to be presented to the Executive Quality Board in September 2014. • A Workforce Equality Update report to be presented to the Executive Workforce Board (EWB) in December 2014. • The second of the biannual equality updates will be presented to the Trust Board in December 2014.	

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST

REPORT TO: **TRUST BOARD**

DATE: **28 August 2014**

REPORT BY: **Deb Baker, Service Equality Manager**
Kate Bradley, Director of Human Resources

SUBJECT: **EQUALITY UPDATE**

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1. INTRODUCTION

This is the first of the biannual 2014 Equality update reports for the Trust Board. The report was discussed at the Executive Quality Board on 6 August 2014 before presentation to the Trust Board.

2. PURPOSE

2.1 This report will:

2.1.1 Provide an update on the revised governance and reporting arrangements for Equality.

2.1.2 Present the 2013 Equality annual report that demonstrates compliance with the Public Sector Equality Duty which is to:

- Eliminate unlawful discrimination, harassment and victimisation;
- Advance equality of opportunity between different groups and
- Foster good relations between different groups.

2.1.3 Outline the Equality priorities for this year.

3. EQUALITY COMPLIANCE 2013 - 2014

3.1 UHL is required to publish on the web site by the 31st January each year an equality dashboard that demonstrates our compliance with the Public Sector Duty. The current dashboard includes the annual workforce monitoring report and more recently patient access and experience data.

3.2 The reported position is based upon delivery of the annual equality action plan for 2013 - 2014. The monitoring arrangements for this are through the Patient Involvement, Patient Experience, Equality Assurance Committee (PIPEEAC), The Executive Quality Board (EQB) and Trust Board. The Equality Advisory Panel also has an invaluable role in terms of providing some independent scrutiny of our plans.

4. QUALITY SCHEDULE

4.1 The Quality Schedule requires us to demonstrate compliance with the Equality Act 2010 and the Equality Delivery System (EDS) implementation demonstrated through the:

- Production of a biannual progress report to include detailed workforce information across the 9 protected characteristics and

- Service specific KPI data analysis by protected characteristics (age, gender, ethnicity) as a minimum and working towards increasing the number of protected groups that can be reported on by January 2015 to identify specific areas where targeted improvements need to be achieved.

4.2 The information should include how many staff and patients are declaring their protected characteristics.

4.3 Patient data collection by protected characteristic remains a challenge as there is no national mandate to do so despite it being recognised as best practice. Most organisations routinely collect age, gender and ethnicity as we do. UHL has agreed to expand our data collection to include disability and work has commenced to initiate this. We plan to pilot this first before rolling out across the Trust if successful. The more contentious issue for us will be to expand further and monitor sexual orientation.

5. STRATEGIC DIRECTION

5.1 The general direction of travel for Equality last year was to ensure ownership at Clinical Management Group level. There has been early success with the implementation of the Patient Experience, Patient Involvement and Equality assurance template.

5.2 The 'ownership' theme will continue for this year as the CMG five year plans are developed in line with the Better Care Together (BCT) programme. With so many different partners involved it is essential that the agreed approach for equality is consistent, robust but straightforward and is applied early on in the service development cycle.

5.3 The principles of alignment need also to apply to any internal strategies that we have or are developing such as the recently published Age Strategy to avoid any duplication.

5.4 The Equality lead recently attended an LLR Better Care Together Equality Workshop to determine the:

- Proposed Leicester, Leicestershire and Rutland approach to Equality and Diversity in respect of Due Regard/Equality Impact Assessments;
- Supporting documentation and
- Proposed support arrangements for the delivery of the approach.

5.5 The recommendations from the workshop to be agreed by the BCT Partnership Board were that:

- Senior Responsible Officers (SROs) for each work stream would be responsible for ensuring that all business cases have a Due Regard/ Impact Assessment completed;
- Equality Leads within each organisation to provide support to managers drafting impact assessment for business case(s);
- Equality Leads to become a (virtual) reference group, and source for best practice and

- Equality leads to be members of a review panel chaired by a member of the Partnership Board to provide assurance of Equality and Diversity impact on decisions proposed and subsequently made.

6. THE EQUALITY ANNUAL REPORT 2013-2014

6.1 The full annual report is attached at appendix 1 and details the various work streams that have been undertaken by the Equality Team in addition to the day to day operational management of the service. Particular areas of additional focus have been:

- End of life care for people with learning disabilities;
- Learning from the experience of patients with a learning disability;
- Improved engagement with the Lesbian Gay, Bisexual and Transgender community;
- Embedding equality within CMG's;
- Further development of training resources;
- Interpreting and translation service monitoring;
- Representation of the workforce and
- Patient data collection.

6.2 Our equality ambitions based upon the Equality Delivery Framework are to improve health outcomes, patient access and experience for all of our patients, visitors, carers and staff. In essence we need to ensure that in all of our service provision:

- Our processes and procedures are non- discriminatory;
- We identify areas for change and
- We make sure that equality is at the heart of all that we do.

6.3 Our spotlight for this year has been to further embed equality within the CMG structures. In order to achieve this we have successfully aligned Equality with Patient Experience and Patient and Public Involvement with an identified Lead within each of the Clinical Management Groups. Whist this model is in its infancy we are already seeing improved engagement and less duplication by aligning the agendas. Feedback from the CMG Leads has also been positive.

6.4 PIPEEAC meets bi-monthly and submits a quarterly assurance report to Executive Quality Board. The equality elements of the assurance template that CMG's are required to evidence are:

- The completion of Due Regard analysis on any service development/change;
- That communication needs are identified and addressed to ensure access to services is equitable and
- That patient journeys/pathways are flexible enough to accommodate the needs of all of our patients.

7. PROGRESS WITHIN THE CMGs

7.1 From an equality point of view overall the RAG rating has improved from the baseline measurement assessed in March 2014. It is anticipated that this will continue to improve through focussed work with the PIPEE Leads.

7.1.1 Due Regard

There is evidence that due regard is being considered and in some instances formally documented, however some inconsistency remains which is due in part to:

- Local service development plans not having been finalised;
- The experience / confidence of staff completing them;
- The PIPEE CMG lead is not necessarily fully informed of all of the forthcoming changes and
- The principle of impact assessment or Due Regard isn't as well embedded within the service improvement/development cycle as other concepts such as Risk Assessment are.

7.1.2 Communication Needs

Similarly on an individual patient basis communication requirements and the need for reasonable adjustments are being assessed and actioned, however this is yet to be firmly embedded and in some areas is less well organised.

8. SPECIFIC EQUALITY MANAGED SERVICES

8.1 Interpreting Service

- Within the past six months 4055 bookings have been made within the Trust with a total cost of £216,265.
- The top five language requests are for Gujarati (30%); Polish (11%); Punjabi (11%); Slovak (6%); Bengali (4%) and
- Of the requests made 92% were for face to face interpreting sessions and 8% via Telephone.

In order to assist the CMGs to proactively manage their interpreter usage they now receive a three monthly breakdown of usage for their areas. Alongside this we have been working closely with Maternity, Physiotherapy and the Quality Mark wards looking at their particular needs, assisting them to work smarter with the resources available whilst maintaining the quality of care for patients.

The current contract is being retendered with a new contract commencing April 2015.

8.2 Translation

A total number of 59 translations requests were made to the Equality team during the past six month period made up of a mixture of patient letters, patient information and patient feedback. A total of £1597 was spent on new translations but many requests for patient information can be provided from those already held. This element of the service however remains fragmented as there are few single points of access for patient information within CMGs.

8.3 The Acute Liaison Nurse Service (ALNS)

The ALNS provide additional specialised support for patients with Learning Disabilities. The team have seen 574 people an increase of 165 more than last year. The main admitting diagnoses are:

- Respiratory (chest/breathing) which includes aspiration pneumonia; asthma; pneumonia; chest infections;
- Epilepsy;
- Urine/kidney infections;
- Cellulitis (infection of the skin and the tissue under the skin);
- Fractures and hip replacements;
- Ophthalmology (Eye) Appointments;
- Diarrhoea;
- E.C.G; CT Scans; MRI Scans;
- Catheter changes – planned and not Planned and
- Sickness and vomiting.

The service specific method of feedback for this group of patients is via the patient diaries. Diaries are given to every patient/carer on discharge. Very few are returned. From those that are, the diary feedback is positive however, general improvement themes are:

- The provision of better information of ward routines, treatment plans, tests procedures and discharge plans;
- Notifying the ALNS that a patient with a learning disability is in hospital;
- UHL staff using information brought in by the patient (grab sheet and traffic light assessment) to aid assessment and treatment plans;
- Better access to specialised equipment.

There have been several formal complaints received from carers of patients with learning disabilities. The Equality Lead is alerted when a complaint is received from any patient where their protected group appears as a feature of the complaint. Whilst this has been really useful in helping to inform the development of the LD service a more formal monitoring arrangement of complaints for this group is required to ensure any trends are identified, fed back and addressed.

The themes raised via this route are:

- Perceived/actual delays in accessing diagnostics whilst an inpatient;
- A lack of planning in terms of the additional considerations that are required for a patient with a learning disability i.e. the need for a general anaethstetic for a routine procedure such as CAT scan;
- A lack of awareness/ understanding of health staff of the particular needs of people with a learning disability.

In addition two patients with Downs Syndrome have been the subjects of a serious incident investigation one of which is just commencing. The inquest date is scheduled for December 2014. The Equality Lead will undertake an analysis of the complaints and the two incidents and include any findings in a specific report scheduled for presentation at EQB in September. A review of all admissions for this patient group for the last twelve months will be completed in conjunction with the Audit and Effectiveness Team

8.4 **Learning Disability (LD) – Strategic Direction**

LD has been identified as a specific work stream of the Better Care Together programme. UHL already contribute to the joint Health and Social Care LLR Self Assessment Framework that was last submitted to NHS England by the Local Authorities in December 2013. This is the replacement framework for 6 Lives which again UHL actively contributed too. A high level national report is available and locally NHS England is commissioning a piece of work looking at the Regional response. What this will look like and exact timeframes are yet to be announced. This will inevitably generate further work as the current assessment framework (if it continues) will need to be adapted to take account of the five year strategic plan for LD Services. A more detailed report on the current position and the implications for UHL going forward will be submitted to the September 2014 EQB and included in the December Trust Board update.

9. THE EQUALITY PROGRAMME FOR 2014 - 2015

9.1 The Equality programme of work attached is at Appendix 2; the priorities are summarised below and are to:

- Successfully re tender the interpreting and translation service;
- Undertake a communication campaign specifically around the needs of deaf and hard of hearing patients;
- Undertake key patient pathway reviews within the CMG's to inform future service development plans;
- Improve the reporting of patient feedback by protected group;
- Expand Patient data collection by additional protected groups;
- Agree the Better Care Together LLR Due Regard process;
- Agree the strategic direction for the LD service as part of the Better Care Together Programme and
- To develop a robust approach to address under representation at senior levels.

10. FUTURE DIRECTION

10.1 We anticipate increased scrutiny as a result of the NHS Equality and Diversity Council's recent announcement (31st July 2014):-

''that more action was required to ensure that employees from black and ethnic minority (BME) backgrounds have equal access to career opportunities and fair treatment in the workplace. Recent reports have highlighted disparities in the number of BME people in senior leadership positions across the NHS, as well as lower levels of wellbeing amongst the BME population''.

10.2 There is likely to be a new robust set of workforce indicators to address the low levels of BME Board representation across the NHS. The EDS may also become mandatory for all health organisations. We already use the framework to help define and support our Equalities Work Programme.

11. SUMMARY

11.1 UHL continues to declare legal compliance with the Public Sector Equality Duty and has a range of activities and processes to evidence our position. In addition

we are meeting all of our external requirements via the Quality Schedule and the Learning Disability Self Assessment Framework.

11.2 There is no doubt that the principles of equality are well understood by many staff in the Trust, although there is still some way to go before a consistent standard across all services is achieved. The newly established PIPEEAC is already improving the interface for the equality agenda at CMG level both operationally and strategically.

11.3 Early involvement of Equality in the BCT programme and the inclusion of LD as a separate work stream are welcomed and should aid the embedding process both corporately and within the CMG's.

12. RECOMMENDATIONS

12.1 The Board is asked to note and discuss the content;

12.2 Support further internal analysis being undertaken of the two critical incidents that have occurred;

12.3 Conduct a Learning Disability Patient Outcome Review and;

12.4 Agree the 2014/2015 Equality Programme of Work at Appendix 2.

University Hospitals of Leicester NHS

NHS Trust

Caring at its best

Equality

Annual Report 2013-2014

Introduction

Welcome to the 2014 Equality Annual report.

The refreshed Equality Delivery System 2 (EDS) was relaunched in November 2013. The EDS is a toolkit and framework for assessing how NHS organisations including UHL are performing with regard to equality, diversity and human rights; how we can improve; and gives a focus to how we get to where we want to be.

Like all hospitals we have an annual equality plan that details our activities for the year. The purpose of which is to ensure that:

- Our processes and procedures are non-discriminatory
- We identify areas for change
- We make sure that equality is at the heart of all that we do

Our focus for this year has been to better embed equality in all our activity. In order to achieve this we have aligned Equality with Patient Experience and Patient and Public Involvement with an identified lead within the Clinical Management Groups.

UHL continues to declare legal compliance with the Public Sector Equality Duty and has a range of activities to evidence our position. Highlights include the hosting of a conference for staff on health issues for people who are Gay, Lesbian, Bisexual and Transgender; increased usage of the interpreting service; improved access for patients with a learning disability to our specialist nursing service; the development of an e-learning hate crime training package for staff working in emergency areas. We have also seen continued success of the Leicester Works programme, an increase in equality education available for staff and the development of guidelines to support staff with disabilities whilst at work.

We would also like to thank the Equality Advisory Panel for their continued commitment to equality within UHL.

The population we serve

The demographic make-up of Leicester, Leicestershire and Rutland (LLR) is diverse and ever changing.

The 2011 census estimated the regions population at just over one million people showing a 17% increase since the last census. It is important that the Trust understands the characteristics of the population to ensure that its services are equipped to meet those it serves.

What did the census tell us about our Leicester, Leicestershire and Rutland population?

32% are under 24yrs and **15.7%** are over 65yrs

51% are women and **49%** men

25% are from a Black Minority Ethnic (BME) background

16.5% have a disability which limits their day to day activities.

10.4% act as unpaid carers

49% of over 16yr olds are married or in a civil partnership

52% are Christian and **26%** have no religion

12% do not speak English

**Patients sexual orientation was omitted from the census.

Our patient data tells us that on average;

33% of patients are over 65 years

55% of our patients are female

23% of our patients are from a BME background

60% of our patients are Christian and 11% have no religion. Other faiths which many of our patients follow include Hindu, Muslim, Sikh and Jewish.

Over the coming twelve months we will be looking at how we can better capture patient information around other 'protected characteristics' such as disability and sexual orientation.

The census information gives us more detail about who our potential service users and communities are. More detailed engagement with service users from across all the counties diverse communities will also help to establish what their needs are. By monitoring our service users, it allows us to see if we are reaching all the people that may require services. We are also able to assess how effective our services are, and how satisfied or otherwise the different communities are with them. All of this information helps to inform and improve our provision.

1 Better outcomes for all

Better health day

The better health day brings services users, professional staff from health and social care and carers together to discuss how people think health and social care services are doing in relation to caring for peoples needs who have a learning disability. The events are always well attended.

The ideas that are generated are drawn on to a poster. These ideas are then worked on by people involved with the services. On the whole most attendees had received a good service from UHL. There were some comments on waiting time and staff attitude not always being as positive as they would have liked. We are going to use some of the patient stories we have in next years training.

Better Health day ideas posters

Hate crime figures

Hate crime incidents are reported in Leicester every year and sadly the numbers are rising.

Many victims access health services at this time and have ongoing health issues as a result of the event. Darren Goddard, hate crime officer with Leicestershire Police, said: "We know that some victims of hate crimes prefer to speak to a healthcare professional first, rather than the police.

"Therefore, it's important that our healthcare colleagues have awareness and understanding of hate crimes and the impact they can have."

Last year we committed to developing an e-learning programme aimed at raising awareness amongst staff in emergency areas of the hospital as well as ambulance staff who are often the first on the scene. This is a collaborative piece of work with Leicestershire police, EMAS and LPT.

7 years ago Sylvia Lancaster received the devastating news that her daughter had been murdered. Sophie simply dressed differently and as a result she and her boyfriend were beaten up. Sophie died of the injuries she sustained in the attack. Sylvia, Sophie's mum has campaigned ever since to raise awareness of hate crime and she kindly contributed to our e-learning package for which we are very grateful.

The programme is completed and will be launched imminently so watch this space.

Sophie's wristband

End of life care for those with a learning disability

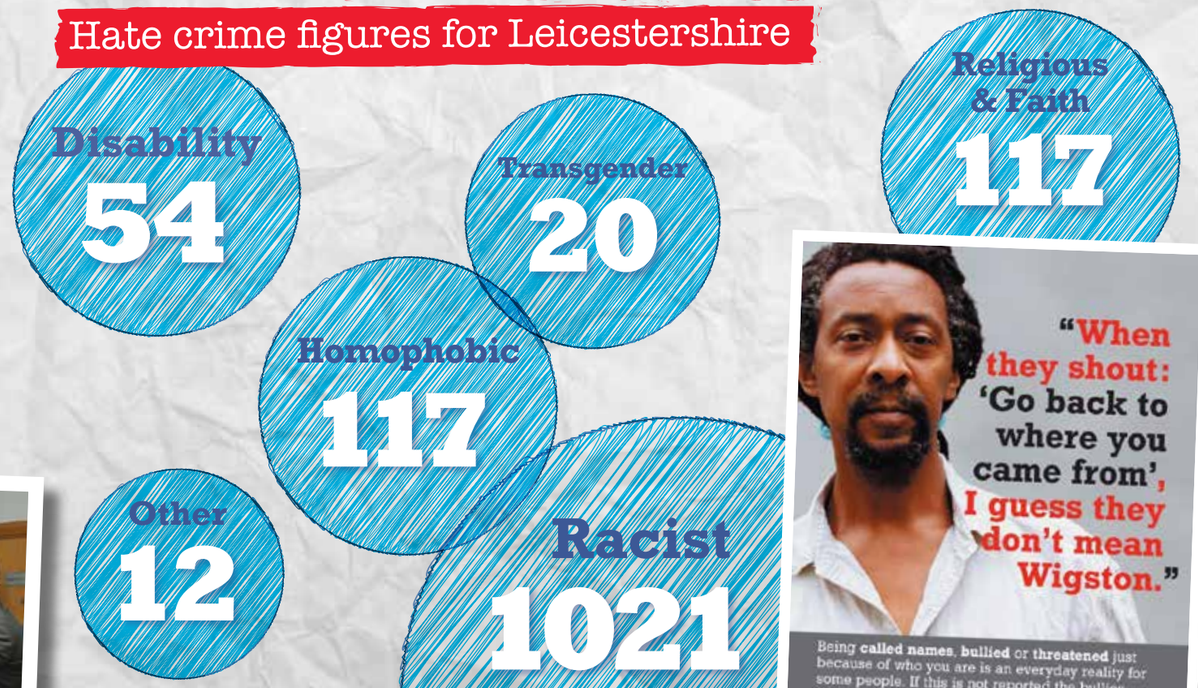
An end of life conference for people with a learning disability was held in 2012, which was well attended by staff and service users.

Following on from this the primary and acute care liaison team have continued to work together to look at supporting people with a learning disability to be able to make informed choices about their wishes at end of life.

There is on going work by the team to raise awareness and encourage the use of a pain assessment tool known as DISDAT. The tool identifies pain/discomfort in patients who are unable to communicate their pain.

Along with the Palliative Care Team they are continuing to support and promote the use of "Advance Care Plans" as well as patients own documentation which include their wishes and views. In support of the discussions and ideas highlighted in this years national conference a local group focusing on Palliative Care for People with Learning Disabilities has now been developed to implement some of the national initiatives locally.

Hate crime figures for Leicestershire



More information around hate crime in Leicester, Leicestershire and Rutland can be found on the Stamp it Out website **www.stamp-it-out.co.uk**

2 Improved patient access and experience

Embedding Equality

The Clinical Management Groups (CMG) Review

Mainstreaming equality remains one of our main challenges. Each clinical area has responsibility for providing fair, accessible and individualised care to all of their patients. This year we met with all key managers to review equality work and to discuss how embedded equality principles were in everyday practice.

There were three lines of enquiry that the interviews were based around which were to:

1. Understand how CMG services operate for all of our patients.

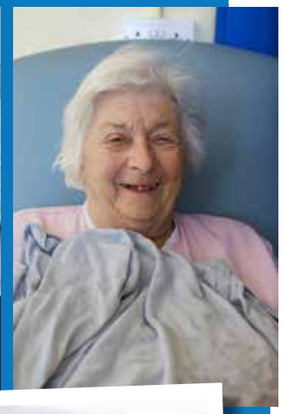
Across all CMG's there was genuine commitment to the principles of fairness and equality of access for patients, carers and visitors. Understanding what this looked like in terms of patient outcomes was less well understood. An example being that patient feedback is generally assessed across the whole patient population. Rarely is there information that looks at satisfaction between groups, making targeted improvement difficult.

2. Demonstrate how the CMG's 'reasonably adjust' their services to accommodate the needs of everyone.

The aim of 'reasonable adjustment' is to ensure that every effort is made to reasonably accommodate the differing needs of patients. On a case by case basis it appears this is done well, with good evidence that the Learning Disability liaison nurses are well utilised across the Trust. For other protected groups it is often less well organised. 'Due Regard' assessments are often only used for larger scale changes rather than as a routine element of care pathway development. This can result in some patients needs being overlooked. The test of any care pathway is "if we get it right for the most vulnerable of our patient groups we are likely to get it right for everyone".

3. Explain how equality and inclusion issues are addressed within the CMG's.

There is clearly an ambition to 'get things right for patients' however equality issues tended to be addressed when they arose. There were some examples where services had adapted to take account of a particular patient group.



For instance Musculo-skeletal had developed 'learning cards' for the patients who had fractured their hips and had dementia or had English as their second language enabling the patients to participate in their treatment plan. Maternity run a specialised clinic for pregnant women who have undergone genital mutilation.

The good news is that there was no evidence to suggest that access is directly denied on unreasonable grounds for any protected group. That said we do have some issues of consistency in relation to how far a service may or may not go to make the patient journey smoother for our more vulnerable/complex patients. Factors such as bed pressures, staffing levels and attitude all contribute to how well services meet the differing and or additional needs of patients.

We have developed an access checklist for use when planning; designing or renewing services. This will be available on INsite soon so look out for it.

Patient Experience

Patient metrics

Over the last year we have extended the number of areas of the Trust's key performance data we are monitoring, by age, sex and ethnicity to check both access and treatment equity. The data continues to show that there are only minimal differences in measured outcomes for ethnicity and sex. There are some differences noted within the age profiles of patients which will require further investigation.

- As demonstrated last year in the emergency department data, the older you are the less likely you are to meet the 4hour waiting target. 96% of those aged below 17yrs whilst only 36% of those aged 85 yrs or older did so.
- When looking at our in patient referral to treatment times, those from the younger and older age profiles are slightly more likely to experience a delay in accessing services. For outpatient services however all age group's access services equally.
- Re-admission rates demonstrate that if you are over 65 yrs you are twice as likely to come back into hospital within 30 days compared with those less than 65yrs.

2 Improved patient access and experience

Patient survey questions

Patient surveys provide feedback on the quality of the care patients receive, giving the Trust a better understanding of their needs and enabling improvements.

In order to ensure we are getting it right for all groups we have analyzed some key questions from our Patient surveys and the new national Family and Friends test by age ethnicity and sex.

The questions we looked at

1) Overall, did you feel you were treated with dignity and respect whilst you were on this ward?

2) Overall, how would you rate the care you received on this ward?

3) Over all were you treated in a way that respects cultural and religious preferences?

The good news is that we have seen improved scores across all three questions with the set target or above being achieved in nearly all groups. The exceptions were in question 2 where those who's ethnicity was recorded as white or 'other' and for those aged over 85 years fell below set targets. We continue to work with the patient experience team to understand why this is and how we can address it going forward.

The friends and family test

The Friends and Family Test asks "How likely are you to recommend our (service) to friends and family if they needed similar care or treatment?"

Our results from in-patients shows that targets are being met except again those whose ethnicity was recorded as white or 'other' fell below set targets. This clearly demonstrates a parallel from the patient survey results. As this is the first analysis of this question we will need to continue to monitor to see if this is seen in further results as it continues to be rolled out to all areas in the Trust over the next year.

To try to ensure that we gain feedback from a representative sample of our community many of our patient surveys have now been translated into the three most common foreign languages spoken by patients coming to our Trust - Gujarati, Punjabi and Polish.

Feedback from Patients with Learning Disabilities

In the past year the service had contact with 500 patients with a Learning disability, which is an increase on the previous year.

We need to make sure that this patient group and their families have an opportunity to feedback their experiences. This information is obtained by the patient and/or their carers filling in a patient's diary during their stay. Generally feedback is good.

"Learning Disability Acute Liaison Nurse came before the appointment and brought papers... All nursing staff read and used their hospital information"

"I liked the paper flower made by the doctor for me at Leicester"

"We are appreciative of the support you have given to them on both occasions they were at the LRI"

"I thanked the hospital staff for the help they gave to me when I arrived in the hospital because I was feeling very bad but they gave me all the help I needed to recover from my illness"

"We were very grateful to have the Learning Disability Acute Liaison Nurse involved"

"All nursing staff read and used their hospital information very well and had regular contact with the home staff team. The whole ward was very good in every way to them"

"During their stay in hospital the ward staff were very helpful; liaising with the home to provide them with person centred individualised care. Regular updates from the ward helped us to prepare for their return and each person had a friendly and helpful attitude"

Less positive feedback includes issues around:

- Communication between disciplines leading to delays in treatment
- Lack of awareness of staff of caring for someone with a disability
- Over reliance on home carers when in hospital

Top tips towards getting it right

All patients with a learning disability should have the Emergency Grabsheet, the Hospital Information Booklet and the pain assessment tool when they come into hospital. This will help the hospital staff understand the patient's individual needs.

Inform the Learning Disability Acute Liaison Nurse of the patient's admission on extension 4382.

Orientate the patient to the ward and explain the ward's routine to reduce any anxieties.

Ensure mental capacity assessments are undertaken and results documented.

If the patient does not have capacity, hospital staff should involve family or carers whilst the patient is in hospital when decisions need to be made.

Being Lesbian, Gay, Bisexual or Transgender

Why is sexual orientation important when in hospital?

Whilst in many ways society has become far more open to people regardless of their sexual orientation issues still persist. Lesbian, Gay, Bisexual and Transgender (LGBT) people can experience discrimination and harassment because of perception and prejudice.

Some Health Facts

- National research suggests that this particular harassment may lead to poor mental health.
- Around half of lesbians (47%), four in 10 gay men (42%) and a quarter (24%) of bisexual women and men reported that they had suffered stress in their lifetime as a result of prejudice and discrimination linked to their sexual orientation.
- 9% of gay men and 14% of bisexual men in the survey reported a mental health condition as did 16% of lesbians and a substantial 26% of bisexual women.
- Substance Misuse - LGBT people are more likely to be affected by substance misuse, and lead unhealthy lifestyles.

What people at Pride told us... Top tips for providing care to LGB&T Patients

UHL Partnered with Leicestershire Partnership Trust and attended the Leicestershire Pride event and invited people to comment on their health experiences. Thankfully many had had very positive experiences some less so.

- Lack of confidence about disclosure to health professionals
- Too much focus on mental health and not treating the physical problems;
- "People not referring to my reassigned gender"
- "Good experience in hospital"
- "Need to treat partners of LGB&T patients the same as you would 'heterosexual' partners"

We also asked what key things would make their experiences more positive...

- Respect the individual for who they are
- Don't pre-judge
- Listen
- Provide effective LGBT training and development for health professional to improve awareness
- Treat same sex partners with equal respect.

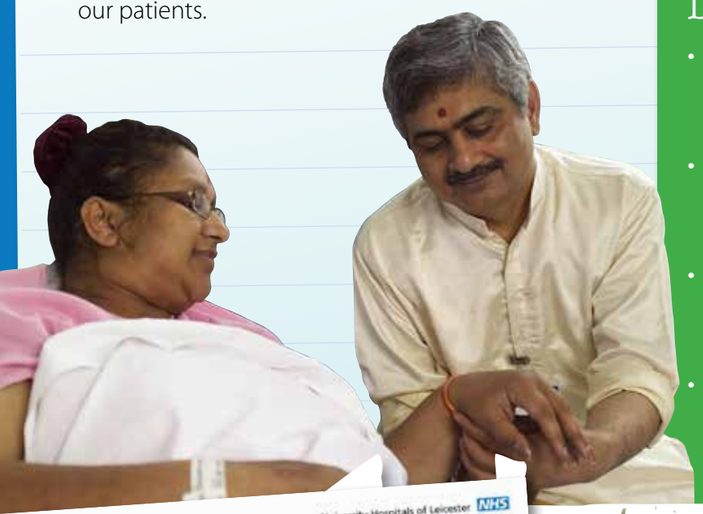
2 Improved patient access and experience

Religion and Belief

Chaplaincy forms an integral part of the holistic care provided by Leicester's hospitals.

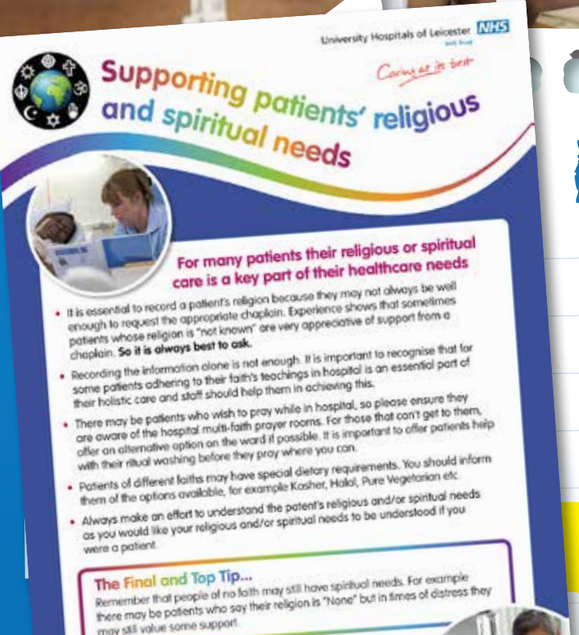
As part of the wider hospital team Chaplains draw upon their training and experience to offer religious, spiritual and pastoral support to patients, visitors and staff members of all faiths or no faith.

We know from feedback in the patient survey that the average score received for the question 'Overall, Did you feel you were treated in a way that respects cultural and religious preferences' is 95. This suggests that we are getting it right for a high proportion of our patients.



Did you know?

- The chaplaincy team includes Bahai, Buddhist, Christian, Hindu, Humanist, Jewish, Muslim and Sikh members.
- Chaplains and Chaplaincy volunteers made 14,500 visits to inpatients through the past year.
- Regular Christian, Hindu and Muslim prayers are organised on each site for patients, staff and visitors.
- Approx 250 calls for religious/spiritual support or advice were made out of hours in the last year.


University Hospitals of Leicester NHS

Caring at its best

Supporting patients' religious and spiritual needs

For many patients their religious or spiritual care is a key part of their healthcare needs

- It is essential to record a patient's religion because they may not always be well enough to request the appropriate chaplain. Experience shows that sometimes patients whose religion is "not known" are very appreciative of support from a chaplain. **So it is always best to ask.**
- Recording the information alone is not enough. It is important to recognise that for some patients adhering to their faith's teachings in hospital is an essential part of their holistic care and staff should help them in achieving this.
- There may be patients who wish to pray while in hospital, so please ensure they are aware of the hospital multi-faith prayer rooms. For those that can't get to them, offer an alternative option on the ward if possible. It is important to offer patients help with their ritual washing before they pray where you can.
- Patients of different faiths may have special dietary requirements. You should inform them of the options available, for example Kosher, Halal, Pure Vegetarian etc.
- Always make an effort to understand the patient's religious and/or spiritual needs as you would like your religious and/or spiritual needs to be understood if you were a patient.

The Final and Top Tip...

Remember that people of no faith may still have spiritual needs. For example there may be patients who say their religion is "None" but in times of distress they may still value some support.

Why did we decide to do Top Tips?

At the Trust Annual Public meeting and through discussions with patients while in hospital the Equality team provided the opportunity for patients to say what was important to them with regards to Faith whilst in hospital'. From replies we are developing an information poster summarizing the key finding to be used as an easy guide for staff.

Look out for copies of the poster coming to your ward soon!!

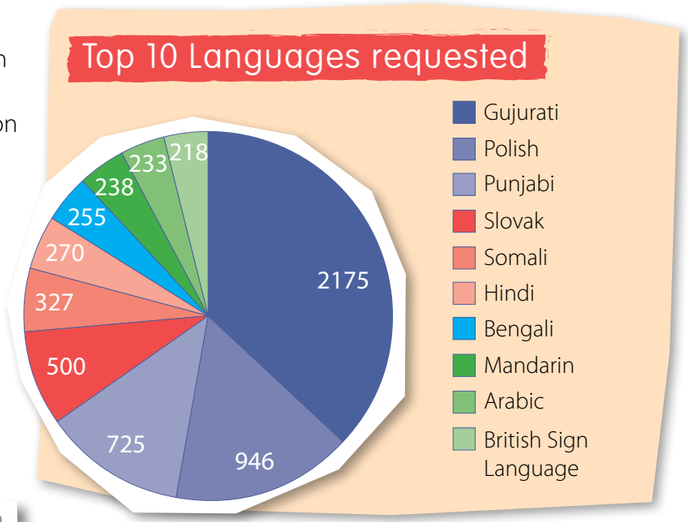
Interpreting and Translation

Ensuring good communication between healthcare staff and those we care for is essential if we are to maintain patient safety and increase levels of patient satisfaction.

At all times patients and those who care for them should be involved in discussions and decisions about their healthcare, and to be given information to enable them to do this.

In order to achieve this some of our patients will need an interpreter or translation of information into a format they can understand. The Trust has been working with Pearl Linguistics for several years to provide these services for our patients.

In the past year we have seen a 14% increase in the use of interpreters demonstrating that staff understand the need for independent communication support for patients.



This years top ten language requests shows a change to the previous year with Polish now becoming the second most requested language; Bengali and Arabic now fall within in the top 10 and Russian and Kurdish now falling just outside.

In addition to the top ten languages a further 1621 requests comprising 48 other languages were also made. This demonstrates the multi-cultural society Leicester is well known for.

In the last year there were over 100 requests to the Equality Team for information in an alternate format including large print, foreign language and easy read. We now hold a large amount of alternate formatted literature so these can often be provided to the patient or service users immediately.

One of our goals is to increase the use of telephones for foreign language interpreting this will help ensure good communication in urgent situations and for short conversations. Many areas have been benefiting from the use of new portable dual handsets phones. The distinctive phones will allow conversations between two individuals and the interpreter or in a larger setting using the loud speaker facility to allow a group discussion.

For staff needing more information about accessing interpreting services for patients go to http://insite.xuhl-tr.nhs.uk/homepage/corporate/equality-and-diversity/accessing-interpreters

3 Empowered, engaged and included staff

Workforce Report

Each year in order to comply with the public sector equality duty and make sure we are a fair and diverse organisation we produce a workforce monitoring report.

The report provides an overview analysis of the Equality protected characteristics against our workforce composition, looking at who is starting in and who is leaving the Trust, application of disciplinary procedures and access to training and development.

Headlines

The overall number of staff working at the Trust remained stable. We did see some changes within our staff groups with an increase in front line staff while some support staff transferred to outside providers. Despite these changes our overall profile remains unchanged.

What was new in this years report?

- A higher than expected representation of staff involved in the disciplinary process who either have declared a disability, identify as LGB or are aged 41-50 yrs.
- A reduction in the 'unknown' status in areas of disability, sexual orientation and religion and belief.
- The continued challenge of representation at senior level.
- That our representation across the protected characteristics is good compared to other Trusts similar to ours.

How have we progressed with last years top five priorities?

✓ **To establish benchmarks with similar acute Trusts so we can consider our performance in line with others and where possible work jointly to resolve issues.**

An initial benchmarking of workforce data was carried out. The results indicate that our declaration rates are greater than neighbouring Trusts and our overall representation is favourable.

✓ **To understand why a higher proportion of males and individuals from a BME background are employed on fixed term contracts.**

Looking at a sample of posts both fixed term and permanent has indicated that although a higher percentage of individuals from a BME background apply for fixed term posts, at the point of shortlisting there is no difference.

We now need to complete further analysis on those appointed into positions and look at a sample of posts to verify the reason for the fixed term contract.

✓ **To develop guidance for staff on 'reasonable adjustment'.**

The guidance was developed and is now available to staff and managers on our internal website.

✓ **To audit Band 6 staff to identify any perceived / real blocks to career progression for BME staff.**

The findings suggest that there is no indication of direct discrimination evident between men and women, ethnic groups or differing age groups which are acting as barriers to career progression.

✓ **To ensure equality data is consistently embedded in all data recording across the Trust, with clear explanation and reassurance given on how the data will be utilised.**

The data in this year's report demonstrates improvements in some reporting areas.
Next year we will review all data recording activity to identify where we are unable to generate accurate equality reports.

Top Priorities for the Coming Year...

- To conduct some further analysis of staff appointed into Band 7 positions.
- To review our data recording activity to identify where we are unable to generate accurate equality reports.
- Establish an agreed data set for benchmarking with East Midlands colleagues.
- To understand why there is a higher representation of disabled and LGB staff involved in disciplinaries.

A copy of the full 2013 report can be found at:
http://www.leicestershospitals.nhs.uk/aboutus/equality-and-diversity/reports-and-data

Staff Disability Advisory Service

In September 2012 the Disability Advisory Service was established. Its aim is to provide an additional support service for disabled staff and managers, providing confidential advice and support around working or supporting team members with a disability.

Individuals can contact the service and receive support via email, telephone or meet with an advisor.

What are you contacting the service about?

- Accessing appropriate supportive equipment
- Alteration to working hours
- Changes to working areas
- Parking issues
- Absence related to disability

Key theme in calls and what we have done

Reasonable adjustments

This has lead to the service developing "a guide to making reasonable adjustments". It is hoped this will encourage a pro-active attitude to making reasonable adjustments where needed and ensure a standardised approach throughout the Trust.

Learning differences

To support staff that may benefit from some guidance around managing their learning differences, ten key members of staff have recently attended 'Hidden Disability Training' with dyslexia action. The training will enable them to assist staff identify potential strategies that will aid them to utilise their strengths and if required make reasonable adjustments in the workplace.

"Thank you so much for all this information, you have given me the most reassurance from everyone I have spoken to. Thank you so much."
Deputy Sister

"Thank you for your time & help today, it's very much appreciated."
Support worker

For more information about the service visit
http://insite.xuhl-tr.nhs.uk/homepage/corporate/equality-and-diversity/disability-advice

3 Empowered, engaged and included staff

Update on Leicester Works

We work jointly with Remploy and Leicester College to provide a "getting ready for work programme" for young people who have a learning disability.

This is the fourth year of the programme with fourteen students to date having secured permanent employment in and outside of the Trust. This is an average of over 3 students per cohort of ten or 35% against a national employment average for people with a learning disability of 7%.

Joseph a student on the Leicester Works programme is working within the Volunteer Service meeting and greeting visitors, assisting with the library and helping the buggy drivers.

Alison Reynolds the Volunteer Services Manager said that it had been a pleasure having Joseph, seeing him develop and build his confidence. She also added that he had become a popular and well liked member of the Volunteer Team.

If you would be interested in supporting a student in the future on a three month work placement please contact: Shaheen.mulla@uhl-tr.nhs.uk or ext 4382. We would love to hear from you.

When asked about what was different about coming to work and going to college, Joseph says:

"I have to make sure I get up early so I am not late to work"

"I need to wear special clothes"

"I have made lots of new friends"

"I speak to lots of different people"

When asked what he liked least he responded:

"I love everything"

Employment Average for People with a Learning Disability

Equality & Diversity Training compliance

Equality Training

The Equality team provides training in a variety of ways. This year we have again seen the number of staff receiving Equality and Diversity training increase by another 40% with 6520 staff receiving training in the last twelve months. This means 75% of staff working for the Trust are up to date with their Equality and Diversity training which is above the national average of 60% seen in similar Trusts.

New E-Learning Programme

This year the equality team have developed a new streamlined e-learning programme to ensure that our Equality and Diversity training remains current and relevant to our staff. As well as providing key information around how we should apply the principles of Equality, the module gives staff the opportunity to test out their knowledge and reflect on what they have learned by relating it to their own experiences.

Learning Disability Training

In the last year 1100 staff viewed **'Freddie's Story'** a training film about people with learning disabilities for everyone working in healthcare. The film addresses many different aspects of the hospital environment based on real experiences with a focus on improving communication and inspiring everyone to respect and value people with a learning disability.

"It was a rewarding course; it helped to refresh my existing knowledge and also gave me new information."
HCA - Orthopaedics

"I found the course very interesting. I liked the mix between theory and practice. I found the practical sessions very beneficial."
HCA - Medicine

Specialist Training for our Healthcare Assistants

This year the Acute Learning Disability Nurses along with the Development Lead for Planned Care developed an in-house training programme called "Health Care Assistants – Extended Skills to Manage Potential Workplace Challenges".

The training focused on increasing awareness of aspects of care that affect patients with learning disabilities and patients with dementia. We know in many circumstances these groups still experience unsatisfactory care, and face unacceptable inequalities.

The three training days were delivered by the team alongside some of the Trusts specialist nurses including Patient Experience Sister, Nurse for Adult Safeguarding and the Alcohol Liaison Service.

The programme was specifically aimed at Health Care Assistants because they are at the front line of delivering patient care. So far fifty seven Health Care Assistants have attended the training, their feedback about the programme was positive and also highlighted the potential and enthusiasm that exists within the HCAs that work for the Trust.

3 Empowered, engaged and included staff

Lesbian, Gay, Bisexual and Transgender

At this year's Equality conference held in July the focus was around the experiences and specific health needs affecting the Lesbian, Gay, Bisexual and Transgender (LGBT) community.

The presentations were delivered by a mix of speakers covering national and local initiatives, LGBT Health Research, local support services available from the Leicester LGBT centre and very personal stories from individuals who were willing to share their experiences. The common aim for all was to ensure we get it right for both our patients and our colleagues.

50 members of staff from across the organisation attended the event with all the evaluations stating that the day was informative and had enhanced their knowledge & awareness of issues that maybe experienced by this group.

Responses

Examples of responses to:
"What information individuals found valuable?"

- Not a single or irrelevant speaker **brilliant.** Information on Transgender awareness to cascade to colleagues.
- As a doctor I learnt the do's and don'ts with LGBT patients.
- How often someone "out" would have to keep "coming out".
- Every presentation had valuable and interesting topics and personal stories.

Comments

Final comments from some of the attendees…

- I am glad I attended this conference. I have learnt so much and will do my utmost to be the champion expected of me.
- **Excellent day.** I was gripped! UHL should be very proud of their involvement and commitment.
- The variety of speakers was excellent. Signposting to services. Challenging assumption. Increase visual images in all areas of practice / patients. How to engage within ward / clinical area.
- Another great conference by the equality team well done. Great speakers, covering lots of different topics. Jacob was great.
- Superb conference with good balance of content – patient / staff and theory and real life experiences.

4 Inclusive leadership at all levels

Representation at Senior Level

Previous workforce reports had highlighted decreased representation of female and black, minority and ethnic (BME) staff in senior positions in the Trust.

In order to explore this further a sample of Band 6 staff were approached to share their opinions and experiences. The aim was to investigate their career aspirations and discover if there were any perceived barriers unique to particular groups that were preventing career progression.

One hundred and thirty one staff working in a variety of Band 6 job rolls responded to the questionnaire.

The findings suggest that there is no indication of direct discrimination evident between men and women, ethnic groups or differing age groups which are acting as barriers to career progression.

Key Findings

- More men than women and more BME staff than white want to progress to a higher band.
- For all genders, ethnicity and age groups lack of promotional opportunities is the most significant reason for lack of career progression.
- The reasons given by those that do not wish to progress differ dependent on gender, ethnicity and age.
- A higher number of men and white staff had previously applied for a senior position, with the majority being within the Trust.
- The number of those that had previously applied increases with age.
- The main reason as to why individuals felt they were not given the senior post was due to other candidates on the day.
- The majority of respondents wanted further training in all areas of leadership and management including some who did not wish to progress to a higher grade.

Contacting the Team

Please do contact the team if you would like to discuss anything within the report or any other Equality issue or ideas you may have.

We always love to hear from people.

Deb Baker
Equality Manager
deb.baker@uhl-tr.nhs.uk
or 0116 258 4382

Nicola Trainer
Assistant Equality Manager
nicola.trainer@uhl-tr.nhs.uk
or 0116 250 2959

Shaheen Mulla
Equality Advisor
Shaheen.mulla@uhl-tr.nhs.uk
or 0116 258 4382

Katrina Dickens
Learning Disability Acute Liaison Lead Nurse
Katrina.dickens@uhl-tr.nhs.uk
or 0116 258 4382

Louise Hammond
Learning disability Acute Liaison Nurse
Louise.hammond@uhl-tr.nhs.uk
or 0116 250 2435

Or you can send us a message to:
equality@uhl-tr.nhs.uk

Further information around equality can be found at the following webpages:

External: www.leicestershospitals.nhs.uk/aboutus/equality-and-diversity
Internal: insite.xuhl-tr.nhs.uk/homepage/corporate/equality-and-diversity

Appendix 2

Equality Action Plan – 2014-2015

Please note
Each CMG has a Patient Involvement, Patient Experience and Equality Lead responsible for leading on the joint work streams identified within this work programme are referred to as the CMG Leads.

University Hospitals of Leicester NHS
NHS Trust
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EDS OUTCOME	ACTION	LEAD	BY WHEN	PROGRESS- July 2014	RAG
1.Better health outcomes for all Services are commissioned, procured, designed and delivered to meet the health needs of local communities.	Embed equality processes within the CMG's to ensure newly designed / refurbished services incorporate the needs of all patients	CMG Leads	Quarterly	An assurance template has been developed for the CMG leads that will be responsible for completing and reporting Due Regard analysis on each service /care pathway development. This will be reported quarterly to the Executive Quality Board via the newly established joint assurance committee for Patient Involvement, Patient Experience and Equality (PIPEEAC).	4
	Output **All new developments will have a completed Due Regard proforma.**	CMG Leads	July, October, March 2015	The due regard proforma has been updated to include patient experience and will support the development of the CMG 5 year plans This will be reported in the Quarterly Executive Quality Board report.	

	Implement the PIPEEC work programme **Output** **Demonstrable progress for CMG'S against the standards developed.**	HL,KM,DB	Monitored monthly	Work plan developed.	4
Individual people's health needs are assessed and met in appropriate and effective ways.	Successfully re tender the Interpreting and translation contract by March 2015 **Output** **A new interpreting and translation contract**	Procurement & Equality	March 2015	Currently developing the service specification	4
	To focus upon communication of people with specific needs i.e. deaf and hard of hearing, non English speaking and patients with learning needs as a work stream for the CMG Leads. Activities to include: - Implementing the hearing loss tool (recently developed by the RCN) - Increase telephone interpreting usage to maximise efficiency and access to the service - Regular awareness raising via the use of the promo boxes, leaflets etc - Develop and implement the 'Coming into Hospital' easy read information for patients with learning disabilities and	CMG and Equality Team	March 2015	This is a new piece of work driven by feedback from patients in the previous year. The communication campaign will be launched in April 2014. Quarterly interpreting reports are provided for each CMG.	4
				A joint proposal between LPT, UHL and the City CCG has been submitted to the Innovation fund to improve the first contact response form Heath services for BSL users.	5

	their families **Output** **-Implementation of the RCN toolkit** **-Easy read material for patients coming in to hospital who have a learning disability** **- an increase in telephone interpreting usage for the 8 Quality Mark wards**				
Transitions from one service to another, for people on care pathways, are made smoothly with everyone well-informed	To review the current end of life pathway for LD patients to ensure equity of access to services, information and ensure alignment with the generic pathway **Output** **Case review of an LD patient at end of life to identify any learning**	Acute Liaison Nurse Team	July 2014	This is a collaborative piece of work with UHL and Primary Care to ensure adequate end of life provision is available and delivered in a timely way for patients with learning disabilities	4
	The CMG's to review their key care pathways to ensure adequate reasonable adjustments are made to accommodate the needs of patients in the protected characteristic groups **Output** **Evidence from the CMG's that reasonable adjustments are been made to the standard key pathways**	CMG leads	August 2014	Meetings will be held quarterly with the CMG PIPEE leads to progress this	4
2. Improved access and experience People, carers and communities can readily access hospital, community health or primary care	**Quality Schedule indicator.* To identify specific areas where targeted improvements need to be made as a result of the data collected on protected groups	Equality Lead and Informatics	April 2014 (1/4ly reports to Commissioners)	Currently collect patient data on ethnicity, age and gender. No patient metrics are reported on at present. An action plan will be developed detailing the 'how' this will be achieved once feasibility has been identified by	4

services and should not be denied access on unreasonable grounds				informatics (End of March 2014) Changes forwarded to Informatics lead for Outpatients data collection	
People are informed and supported to be as involved as they wish to be in decisions about their care	Review the current (written) translation arrangements and agree with CMG's a standardised approach to managing requests **Output** **A more consistent process for written translation**	ED PIPEE and Leads	September 2014	There is some inconsistency across the Trust as to how patients access written information about their care	1
	To implement phase 2 of the hate crime project **Output** **Completed DVD**	Equality Lead and ED staff	June 2014	The e learning training for emergency department staff is in the final stages of its development	4
	To conduct a bi annual audit of the number of documented Mental Capacity Assessments for patients with Learning disability as part of the Consent process **Output** **Identified practice gaps**	Acute liasion Nurse Service	March& Oct 2014	Previous audits have identified incomplete documentation. Audit results to be reported to the Consent Committee	4
3. A representative and supported workforce					
Fair NHS recruitment and selection processes lead to a more representative workforce at all levels	Our workforce report identified several areas that warrant further investigation: Undertake a further detailed review of recruitment data to understand why BME staff are disproportionately represented at senior levels	Equality Team & HR Recruitment Lead	July 2014	This has been carried over from the previous action plan due to a change in personnel	1

	Output **Completed analysis and recommendations to be included in this years annual report**				
	To investigate further the representation of LGB and disabled staff within the disciplinary process **Output** **Completed analysis and recommendations to be included in this years annual report**	Equality Team & HR Recruitment Lead	July 2014	The numbers within the overall figures remain small. A case review will be undertaken to identify whether the issue is related to the protected group the individual identifies with	1
	Maintain the Leicester Works programme and secure permanent positions for as many students as possible **Output** **Job outcomes for some students**	Equality team, Leicester college and Remploy	March 2015	Numbers of placements available continues to rise. Interserve is now offering placements which have increased the range available to the students. The 2014 recruitment process commences in April 2014 for commencement in September	4
The NHS is committed to equal pay for work of equal value and expects employers to use equal pay audits to help fulfil their legal obligations	Monitoring the new pay and progression reward strategy to ensure no adverse impact on any particular group **Output** **The provision of evidence to ensure process equity**	HR Workforce Lead	December 2014	A full Due regard analysis has been undertaken. The number of staff receiving and not receiving pay awards will be monitored by protected group and reported annually in the workforce report	5

Training and development opportunities are taken up and positively evaluated by all staff	To improve the processes for managing and supporting staff with dyslexia and dyscalculia by developing clear guidelines. To improve access to mandatory training for staff unable to complete by e-learning. **Output** **An established process for improving the level of support for staff with Dyslexia** **Raised staff awareness of how to manage and support staff with dyslexia** **Establishment of a clear pathway for staff with a disability to undertake mandatory training.** **A revised Statutory and Mandatory Training policy**	Nurse Education, Equality and Training Teams	March 2014	This work has been delayed until the training has been completed. Several relevant members of staff are undertaking dyslexia screening in March 2014 to enable earlier intervention. Subject leads to provide training in a different way. To be agreed at the TED Group in July 2014.	3
When at work, staff are free from abuse, harassment, bullying and violence from any source	To implement the recommendations from the last anti bullying report produced in January 2014 To devise and deliver a 'managing difficult working relationships' training session for HR staff and Managers **Output** **Provide earlier intervention to**	HR and Equality Lead	June 2014	Meeting arranged with Amica. Outline programme agreed. To deliver 3 sessions per year for 1-2 hours.	4

	reduce the number of formal Dignity @Work cases				
	Revise the Dignity @Work policy **Output** **Revised policy that aligns to Trust Values**	HR and Equality Lead	October 2014		4
	Revise the spreadsheet to enable the recording of informal interventions **Output** **Improved reporting data**	HR and Equality Lead	April 2014	Completed	5
	To promote the anti bullying service within the well being induction slide and staff handbook **Output** **Improved understanding of expected behaviours**	Well being and Equality Lead	April 2014	Completed	5
Flexible working options are available to all staff consistent with the needs of the service and the way people led their lives	To conduct a 'deep dive' into the use of flexible working options for Medical staff. To include analysis of working hours by protected characteristic within this years workforce report. **Output** **To ensure that flexible working policies are accessed by staff from all groups to remove any potential barriers to career progression**	Equality Team & Workforce	August 2014		1

Staff report positive experiences of their membership of the workforce	To analyse the national Friends and Family test for staff by all protected characteristics. To undertake a staff survey with an Equality focus analysed by all protected characteristics. **Output** **To ensure all areas of staff concern relating to staff belonging to the Protected groups are adequately understood and addressed.**	LIA Lead	Quarterly	The first assessment will be carried out in May 2014.	4
	Adopt best practice data collection and analysis through benchmarking with East Midlands colleagues **Output** **To assess our position in relation to others and adopt and share best practice**	Regional Equality Leads.	Annually		4
	To develop a women's informal network at UHL looking at for example: -career progression -access to flexible working -representation in awards -personal safety -using social media -adopt the Athena Swann model **Output** **To positively promote and celebrate Women in the workforce** **Encourage Women who want to progress in their careers**	Equality Team, Director of HR &Kath Higgins	May 2014	Several interested individuals identified this as and area they would like to see developed further. Medical Womens forum to be established and led by Kath Higgins. Suggested areas of interest to be included in this years workforce analysis.	4

	Ensure fair representation of women in all areas of the Trust				
Papers that come before the Board and other major Committees identify equality-related impacts including risks, and say how these risks are to be managed	To further embed equality into the core activities of the Trust review he equality impact of all Board papers monthly and recommend appropriate action if a potential negative impact is identified **Output** **Less reliance on corporate equality compliance**	Equality Lead	Monthly	To review the equality impact of all Board papers monthly and recommend appropriate action if a potential negative impact Equality impact is recorded.	1

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

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