Trust Board Paper M

To:	**Trust Board**
From:	Richard Mitchell, Chief Operating Officer
Date:	**28 August 2014**
CQC regulation:	Regulation 9 (Regulated activities) Outcomes 4 Regulation 24 (Regulated activities) Outcome 6

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

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

NHS England is currently reviewing the position of all Acute Trusts in relation to the core standards.

The Report is provided to the Board for:

Decision		Discussion	
Assurance		Endorsement	X

Summary / Key Points:
The Trust continues to be largely compliant with the requirements of the core standards, 71.4% fully compliant, 22.0% partially compliant and 6.6% not compliant. The majority of improvements required are relating Chemical, Biological, Radiological and Nuclear (CBRN) incidents for which the national response plan has changed requiring updates to local procedures.

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

Previously considered at another corporate UHL Committee?
Trust Executive

Board Assurance Framework: 11 – Loss of Business Continuity	**Performance KPIs year to date:** Against the old core standards 40% increase in green ratings and 70% reduction in Amber and Red ratings. This however can't be quantified against the new standards.

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

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

Patient and Public Involvement (PPI) Implications:
None

Stakeholder Engagement Implications: Will support our requirements to engage with external partners i.e. other emergency services. It will ensure that appropriate arrangements are in place
Equality Impact: None
Information exempt from Disclosure: None
Requirement for further review? Annually – will form part of the annual plan and reporting Executive Team will review progress in January 2015

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

Aaron Vogel

Emergency Planning Officer

August 2014

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1 Introduction

1.1 In October 2013 NHS England undertook its first annual assurance review of providers of NHS funded care against the national Emergency Preparedness, Resilience and Response (EPRR) core standards. NHS England is now undertaking the assurance review for 2014.

1.2 In summary this report identifies that the Trust continues largely compliant with the requirements of the core standards, 71.4% fully compliant, 22.0% partially compliant and 6.6% not compliant. The majority of improvements required are relating Chemical, Biological, Radiological and Nuclear (CBRN) incidents for which the national response plan has changed requiring updates to local procedures.

2 Overview

2.1 The core standards were reviewed and updated nationally and as such it is not possible to compare the current level of compliance to position in October 2013, however many of the themes still remain in the new standards. The largest change was the inclusion of new specific CBRN standards in to the assurance process.

2.2 Table 1 below shows the current position of the Trust against the new core standards. It shows that of the standards the Trust is compliant with 71.4% of the standards, 22.0% partially compliant and only 6.6% not compliant. One of the non-compliant standard is due to the inclusion of a new standard not previously included in this review which is with regards to personal development of senior managers and directors. The others relate to specific pieces of CBRN equipment now required due to changes in national response plan.

Table 1 UHL Core Standards Review 2014

	All Standards		EPRR Standards Only		CBRN Standards Only		CBRN Equipment Standards	
	Total	**%**	Total	%	Total	%	Total	%
GREEN = Fully compliant with core standard.	**65**	**71.4**	36	76.6	7	50	23	74.2
AMBER = Not compliant but evidence of progress and in the EPRR work plan for the next 12 months.	**20**	**22.0**	10	21.3	7	50.0	3	9.7
RED = Not compliant with core standard and not in the EPRR work plan within the next 12 months.	**6**	**6.6**	1	2.1	0	0.0	5	16.1

2.3 The majority of the partially compliant standards are due to arrangements, processes or plans that are current but require a review and update or require updating due to specific requirements of the core standards. Themes include evacuation, mass countermeasures, access to specialist advice, management of mass fatalities and CBRN updates.

2.4 The table 2 and figure 1 show the position of compliance and improvement against the previous Core Standards since October 2013. It shows that there was continual improvement since October 2013 and reflects the current strong position that the Trust is in on the August 2014 review.

Table 2 Position against the old core standards (May 2014)

	May 2014		October 2013	
	Total	Percentage	Total	Percentage
GREEN - arrangements in place now, compliant with core standards	106	89.1%	76	63.9%
AMBER - draft or scheduled on action plan for completion by Dec 2013	8	6.7%	27	22.7%
RED - arrangements not in place or scheduled for completion after Jan 2014	5	4.2%	16	13.4%
Total	119	100	119	100

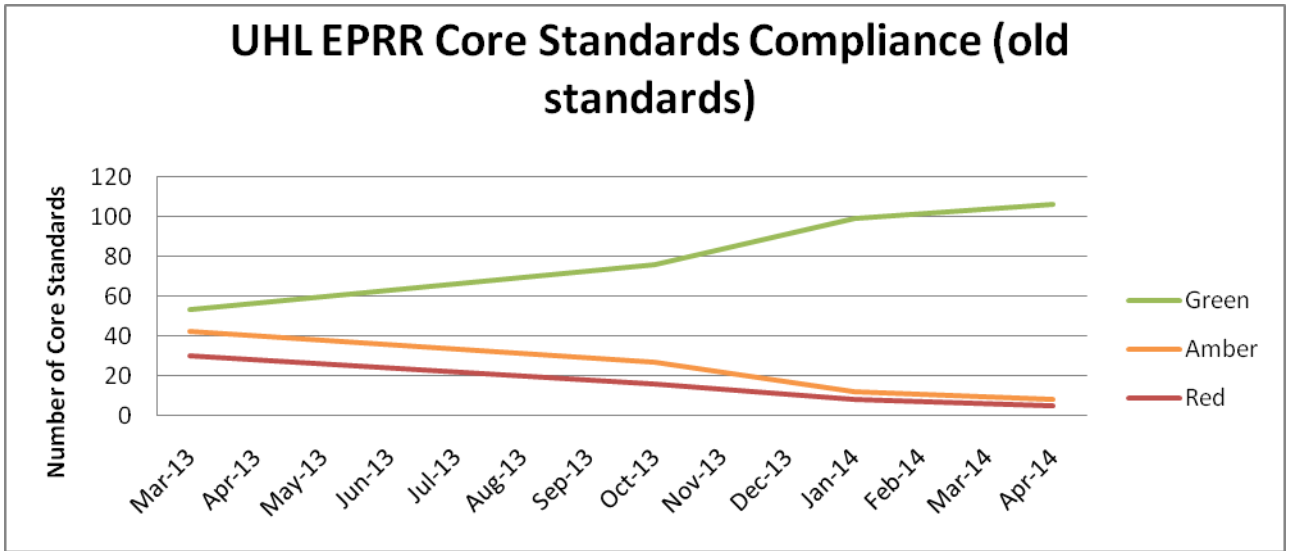

Figure 1 Trend against the old core standards

3 Action Plan

3.1 Each core standard assessed as amber or red has been given an action and deadline date to resolve. It is anticipated that many of the outstanding issues will be resolved by the development of the new Trust CBRN Plan, scheduled for completion

in October 2014 and other areas of work currently being undertaken. The Emergency Planning and Business Continuity Committee will monitor the progress of the action plan and provide regular updates and assurances to the Executive Team.

4 Conclusion

4.1 There are a number of areas that still require addressing however they should not impede the ability of the Trust to respond. Plans and procedures that are in place have been developed and tested over the last year and should provide for an appropriate response. The Emergency Planning Annual report which is due to Audit Committee provides further details of the progress made in the last year. The Trust Executive is asked to accept this report and endorse the programme of work with support from relevant staff and service areas within the Trust.

NHS England Core Standards for Emergency preparedness, resilience and response
v2.0

The attached EPRR Core Standards spreadsheet has 3 tabs:

EPRR Core Standards tab - with core standards nos 1 - 37.

HAZMAT/ CBRN core standards tab: with core standards 38- 51. Please note this is designed as a stand alone tab.

HAZMAT/ CBRN equipment checklist: designed to support acute and ambulance service providers in core standard 43.

Red = Not compliant with core standard and not in the EPRR work plan within the next 12 months.
Amber = Not compliant but evidence of progress and in the EPRR work plan for the next 12 months.
Green = fully compliant with core standard.

	Core standard	Clarifying information	Evidence of assurance	Self assessment RAG	Action to be taken	Lead	Timescale
Governance							
1	Organisations have a director level accountable emergency officer who is responsible for EPRR (including business continuity management)		• Ensuring accountaable emergency officer's commitment to the plans and giving a member of the executive management board and/or governing body overall responsibility for the Emergeny Preparedness Resilience and Response, and Business Continuity Management agendas • Having a documented process for capturing and taking forward the lessons identified from exercises and emergencies, including who is responsible. • Appointing an emergency preparedness, resilience and response (EPRR) professional(s) who can demonstrate an understanding of EPRR principles. • Appointing a business continuity management (BCM) professional(s) who can demonstrate an understanding of BCM principles. • Being able to provide evidence of a documented and agreed corporate policy or framework for building resilience across the organisation so that EPRR and Business continuity issues are mainstreamed in processes, strategies and action plans across the organisation. • That there is an approporiate budget and staff resources in place to enable the organisation to meet the requirements of these core standards. This budget and resource should be proportionate to the size and scope of the organisation.	GREEN			
2	Organisations have an annual work programme to mitigate against identified risks and incorporate the lessons identified relating to EPRR (including details of training and exercises and past incidents) and improve response.	Lessons identified from your organisation and other partner organisations. NHS organisations and providers of NHS funded care treat EPRR (including business continuity) as a systematic and continuous process and have procedures and processes in place for updating and maintaining plans to ensure that they reflect: - the undertaking of risk assessments and any changes in that risk assessment(s) - lessons identified from exercises, emergencies and business continuity incidents - restructuring and changes in the organisations - changes in key personnel - changes in guidance and policy		GREEN			
3	Organisations have an overarching framework or policy which sets out expectations of emergency preparedness, resilience and response.	Arrangements are put in place for emergency preparedness, resilience and response which: • Have a change control process and version control • Take account of changing business objectives and processes • Take account of any changes in the organisations functions and/ or organisational and structural and staff changes • Take account of change in key suppliers and contractual arrangements • Take account of any updates to risk assessment(s) • Have a review schedule • Use consistent unambiguous terminology, • Identify who is responsible for making sure the policies and arrangements are updated, distributed and regularly tested; • Key staff must know where to find policies and plans on the intranet or shared drive. • Have an expectation that a lessons identified report should be produced following exercises, emergencies and /or business continuity incidents and share for each exercise or incident and a corrective action plan put in place. • Include references to other sources of information and supporting documentation		GREEN			
4	The accountable emergency officer will ensure that the Board and/or Governing Body will receive as appropriate reports, no less frequently than annually, regarding EPRR, including reports on exercises undertaken by the organisation, significant incidents, and that adequate resources are made available to enable the organisation to meet the requirements of these core standards.	After every significant incident a report should go to the Board/ Governing Body (or appropriate delegated governing group) . Must include information about the organisation's position in relation to the NHS England EPRR core standards self assessment.		GREEN			
Duty to assess risk							
5	Assess the risk, no less frequently than annually, of emergencies or business continuity incidents occurring which affect or may affect the ability of the organisation to deliver it's functions.	Risk assessments should take into account community risk registers and at the very least include reasonable worst-case scenarios for: • severe weather (including snow, heatwave, prolonged periods of cold weather and flooding); • staff absence (including industrial action); • the working environment, buildings and equipment (including denial of access); • fuel shortages; • surges and escalation of activity; • IT and communications; • utilities failure; • response a major incident / mass casualty event • supply chain failure; and • associated risks in the surrounding area (e.g. COMAH and iconic sites) There is a process to consider if there are any internal risks that could threaten the performance of the organisation's functions in an emergency as well as external risks eg. Flooding, COMAH sites etc.	• Being able to provide documentary evidence of a regular process for monitoring, reviewing and updating and approving risk assessments • Version control • Consulting widely with relevant internal and external stakeholders during risk evaluation and analysis stages • Assurances from suppliers which could include, statements of commitment to BC, accreditation, business continuity plans. • Sharing appropriately once risk assessment(s) completed	GREEN			
6	There is a process to ensure that the risk assessment(s) is in line with the organisational, Local Health Resilience Partnership, other relevant parties, community (Local Resilience Forum/ Borough Resilience Forum), and national risk registers.			GREEN			
7	There is a process to ensure that the risk assessment(s) is informed by, and consulted and shared with your organisation and relevant partners.	Other relevant parties could include COMAH site partners, PHE etc.		GREEN			
Duty to maintain plans – emergency plans and business continuity plans							
	Effective arrangements are in place to respond to the risks the organisation is exposed to, appropriate to the role, size and scope of the organisation, and there is a process to ensure the likely extent to which particular types of emergencies will place demands on your resources and capacity. Have arrangements for (but not necessarily have a separate plan for) some or all of the following (organisation dependent) (NB, this list is not exhaustive):	Incidents and emergencies (Incident Response Plan (IRP) (Major Incident Plan))	Relevant plans: • demonstrate appropriate and sufficient equipment (inc. vehicles if relevant) to deliver the required responses • identify locations which patients can be transferred to if there is an incident that requires an evacuation; • outline how, when required (for mental health services), Ministry of Justice approval will be gained for an evacuation; • take into account how vulnerable adults and children can be managed to avoid admissions, and include appropriate focus on providing healthcare to displaced populations in rest centres:	GREEN			
		corporate and service level Business Continuity (aligned to current nationally recognised BC standards)		AMBER	Corporate level BC plan to be developed. Local BC plans to be finalised	**A.Vogel**	Jun-15
		HAZMAT/ CBRN - see separate checklist on tab overleaf		GREEN			
		Severe Weather (heatwave, flooding, snow and cold weather)		GREEN			

	Core standard	Clarifying information	Evidence of assurance	Self assessment RAG	Action to be taken	Lead	Timescale
8		Pandemic Influenza	• include arrangements to co-ordinate and provide mental health support to patients and relatives, in collaboration with Social Care if necessary, during and after an incident as required; • make sure the mental health needs of patients involved in a significant incident or emergency are met and that they are discharged home with suitable support • ensure that the needs of self-presenters from a hazardous materials or chemical, biological, nuclear or radiation incident are met. • for each of the types of emergency listed evidence can be either within existing response plans or as stand alone arrangements, as appropriate.	GREEN			
		Mass Countermeasures (eg mass prophylaxis, or mass vaccination)		AMBER	Review current arrangements and update plans	**A.Vogel**	Apr-15
		Mass Casualties		GREEN			
		Fuel Disruption		AMBER	Current plan requires reviewing and updating	**A.Vogel**	Feb-15
		Surge and Escalation Management (inc. links to appropriate clinical networks e.g. Burns, Trauma and Critical Care)		GREEN			
		Infectious Disease Outbreak		GREEN			
		Evacuation		AMBER	Current plan requires reviewing and updating to include off site evacuation	**A.Vogel**	May-15
		Lockdown		GREEN			
		Utilities, IT and Telecommunications Failure		AMBER	Incorporated as part of the local and corporate BC plans	**A.Vogel**	Dec-14
		Excess Deaths/ Mass Fatalities		AMBER	Currently reviewing with the Local Authorities and LRF	**A.Vogel**	Dec-14
9	Ensure that plans are prepared in line with current guidance and good practice which includes:	• Aim of the plan, including links with plans of other responders • Information about the specific hazard or contingency or site for which the plan has been prepared and realistic assumptions • Trigger for activation of the plan, including alert and standby procedures • Activation procedures • Identification, roles and actions (including action cards) of incident response team • Identification, roles and actions (including action cards) of support staff including communications • Location of incident co-ordination centre (ICC) from which emergency or business continuity incident will be managed • Generic roles of all parts of the organisation in relation to responding to emergencies or business continuity incidents • Complementary generic arrangements of other responders (including acknowledgement of multi-agency working) • Stand-down procedures, including debriefing and the process of recovery and returning to (new) normal processes • Contact details of key personnel and relevant partner agencies • Plan maintenance procedures (Based on Cabinet Office publication Emergency Preparedness, Emergency Planning, Annexes 5B and 5C (2006))	• Being able to provide documentary evidence that plans are regularly monitored, reviewed and systematically updated, based on sound assumptions: • Being able to provide evidence of an approval process for EPRR plans and documents • Asking peers to review and comment on your plans via consultation • Using identified good practice examples to develop emergency plans • Adopting plans which are flexible, allowing for the unexpected and can be scaled up or down • Version control and change process controls • List of contributors • References and list of sources • Explain how to support patients, staff and relatives before, during and after an incident (including counselling and mental health services).	GREEN			
10	Arrangements include a procedure for determining whether an emergency or business continuity incident has occurred. And if an emergency or business continuity incident has occurred, whether this requires changing the deployment of resources or acquiring additional resources.	Enable an identified person to determine whether an emergency has occurred - Specify the procedure that person should adopt in making the decision - Specify who should be consulted before making the decision - Specify who should be informed once the decision has been made (including clinical staff)	• Oncall Standards and expectations are set out • Include 24-hour arrangements for alerting managers and other key staff.	GREEN			
11	Arrangements include how to continue your organisation's prioritised activities (critical activities) in the event of an emergency or business continuity incident insofar as is practical.	Decide: - Which activities and functions are critical - What is an acceptable level of service in the event of different types of emergency for all your services - Identifying in your risk assessments in what way emergencies and business continuity incidents threaten the performance of your organisation's functions, especially critical activities		AMBER	to be incoporated as part of the corporate BC plan.	**A.Vogel**	Dec-15
12	Arrangements explain how VIP and/or high profile patients will be managed.	This refers to both clinical (including HAZMAT incidents) management and media / communications management of VIPs and / or high profile management		GREEN			
13	Preparedness is undertaken with the full engagement and co-operation of interested parties and key stakeholders (internal and external) who have a role in the plan and securing agreement to its content		• Specifiy who has been consulted on the relevant documents/ plans etc.	GREEN			
14	Arrangements include a debrief process so as to identify learning and inform future arrangements	Explain the de-briefing process (hot, local and multi-agency, cold)at the end of an incident.		GREEN			
Command and Control (C2)							
15	Arrangements demonstrate that there is a resilient single point of contact within the organisation, capable of receiving notification at all times of an emergency or business continuity incident; and with an ability to respond or escalate this notification to strategic and/or executive level, as necessary.	Organisation to have a 24/7 on call rota in place with access to strategic and/or executive level personnel	Explain how the emergency on-call rota will be set up and managed over the short and longer term.	GREEN			
16	Those on-call must meet identified competencies and key knowledge and skills for staff.	NHS England publised competencies are based upon National Occupation Standards .	Training is delivered at the level for which the individual is expected to operate (ie operational/ bronze, tactical/ silver and strategic/gold). for example strategic/gold level leadership is delivered via the 'Strategic Leadership in a Crisis' course and other similar courses.	AMBER	Training is developed against a self assessment of the NOS. No formal accreditation is provided. Staff should be provided with access to accredited training	**A.Vogel**	May-15

	Core standard	Clarifying information	Evidence of assurance	Self assessment RAG	Action to be taken	Lead	Timescale
17	Documents identify where and how the emergency or business continuity incident will be managed from, ie the Incident Co-ordination Centre (ICC), how the ICC will operate (including information management) and the key roles required within it, including the role of the loggist .	This should be proportionate to the size and scope of the organisation.	Arrangements detail operating procedures to help manage the ICC (for example, set-up, contact lists etc.), contact details for all key stakeholders and flexible IT and staff arrangements so that they can operate more than one control/co0ordination centre and manage any events required.	GREEN			
18	Arrangements ensure that decisions are recorded and meetings are minuted during an emergency or business continuity incident.			GREEN			
19	Arrangements detail the process for completing, authorising and submitting situation reports (SITREPs) and/or commonly recognised information pictures (CRIP) / common operating picture (COP) during the emergency or business continuity incident response.			GREEN			
20	Arrangements to have access to 24-hour specialist adviser available for incidents involving firearms or chemical, biological, radiological, nuclear, explosive or hazardous materials, and support strategic/gold and tactical/silver command in managing these events.	Both acute and ambulance providers are expected to have in place arrangements for accessing specialist advice in the event of incidents chemical, biological, radiological, nuclear, explosive or hazardous materials		AMBER	nothing on site but access to specialist via telephone. To review arrangements and update plan	**A.Vogel**	Oct-14
21	Arrangements to have access to 24-hour radiation protection supervisor available in line with local and national mutual aid arrangements;	Both acute and ambulance providers are expected to have arrangements in place for accessing specialist advice in the event of a radiation incident		AMBER	To review current arrangements and update plans	**A.Vogel**	Oct-14
Duty to communicate with the public							
22	Arrangements demonstrate warning and informing processes for emergencies and business continuity incidents.	Arrangements include a process to inform and advise the public by providing relevant timely information about the nature of the unfolding event and about: - Any immediate actions to be taken by responders - Actions the public can take - How further information can be obtained - The end of an emergency and the return to normal arrangements Communications arrangements/ protocols: - have regard to managing the media (including both on and off site implications) - include the process of communication with internal staff - consider what should be published on intranet/internet sites - have regard for the warning and informing arrangements of other Category 1 and 2 responders and other organisations.	• Have emergency communications response arrangements in place • Be able to demonstrate that you have considered which target audience you are aiming at or addressing in publishing materials (including staff, public and other agencies) • Communicating with the public to encourage and empower the community to help themselves in an emergency in a way which compliments the response of responders • Using lessons identified from previous information campaigns to inform the development of future campaigns • Setting up protocols with the media for warning and informing • Having an agreed media strategy which identifies and trains key staff in dealing with the media including nominating spokespeople and 'talking heads'. • Having a systematic process for tracking information flows and logging information requests and being able to deal with multiple requests for information as part of normal business processes. • Being able to demonstrate that publication of plans and assessments is part of a joined-up communications strategy and part of your organisation's warning and informing work.	GREEN			

	Core standard	Clarifying information	Evidence of assurance	Self assessment RAG	Action to be taken	Lead	Timescale
23	Arrangements ensure the ability to communicate internally and externally during communication equipment failures		• Have arrangements in place for resilient communications, as far as reasonably practicable, based on risk.	GREEN			
Information Sharing – mandatory requirements							
24	Arrangements contain information sharing protocols to ensure appropriate communication with partners.	These must take into account and inclue DH (2007) Data Protection and Sharing – Guidance for Emergency Planners and Responders or any guidance which supercedes this, the FOI Act 2000, the Data Protection Act 1998 and the CCA 2004 'duty to communicate with the public', or subsequent / additional legislation and/or guidance.	• Where possible channelling formal information requests through as small as possible a number of known routes. • Sharing information via the Local Resilience Forum(s) / Borough Resilience Forum(s) and other groups. • Collectively developing an information sharing protocol with the Local Resilience Forum(s) / Borough Resilience Forum(s). • Social networking tools may be of use here.	GREEN			
Co-operation							
25	Organisations actively participate in or are represented at the Local Resilience Forum (or Borough Resilience Forum in London if appropriate)		• Attendance at or receipt of minutes from relevant Local Resilience Forum(s) / Borough Resilience Forum(s) meetings, that meetings take place and memebership is quorat. • Treating the Local Resilience Forum(s) / Borough Resilience Forum(s) and the Local Health Resilience Partnership as strategic level groups • Taking lessons learned from all resilience activities • Using the Local Resilience Forum(s) / Borough Resilience Forum(s) and the Local Health Resilience Partnership to consider policy initiatives • Establish mutual aid agreements • Identifying useful lessons from your own practice and those learned from collaboration with other responders and strategic thinking and using the Local Resilience Forum(s) / Borough Resilience Forum(s) and the Local Health Resilience Partnership to share them with colleagues • Having a list of contacts among both Cat. 1 and Cat 2. responders with in the Local Resilience Forum(s) / Borough Resilience Forum(s) area	GREEN			
26	Demonstrate active engagement and co-operation with other category 1 and 2 responders in accordance with the CCA			GREEN			
27	Arrangements include how mutual aid agreements will be requested, co-ordinated and maintained.	NB: mutual aid agreements are wider than staff and should include equipment, services and supplies.		GREEN			
#REF!	Arrangements demonstrate how organisations support NHS England locally in discharging its EPRR functions and duties	Examples include completing of SITREPs, cascading of information, supporting mutual aid discussions, prioritising activities and/or services etc.		GREEN			
#REF!	Arrangements are in place to ensure attendance at all Local Health Resilience Partnership meetings at a director level			GREEN			
Training And Exercising							
34	Arrangements include a training plan with a training needs analysis and ongoing training of staff required to deliver the response to emergencies and business continuity incidents	• Staff are clear about their roles in a plan • Training is linked to the National Occupational Standards and is relevant and proportionate to the organisation type. • Training is linked to Joint Emergency Response Interoperability Programme (JESIP) where appropriate • Arrangements demonstrate the provision to train an appropriate number of staff and anyone else for whom training would be appropriate for the purpose of ensuring that the plan(s) is effective • Arrangements include providing training to an appropriate number of staff to ensure that warning and informing arrangements are effective	• Taking lessons from all resilience activities and using the Local Resilience Forum(s) / Borough Resilience Forum(s) and the Local Health Resilience Partnership and network meetings to share good practice • Being able to demonstrate that people responsible for carrying out function in the plan are aware of their roles • Through direct and bilateral collaboration, requesting that other Cat 1. and Cat 2 responders take part in your exercises • Refer to the NHS England guidance and National Occupational Standards For Civil Contingencies when identifying training needs. • Developing and documenting a training and briefing programme for staff and key stakeholders • Being able to demonstrate lessons identified in exercises and emergencies and business continuity incidentshave been taken forward • Programme and schedule for future updates of training and exercising (with links to multi-agency exercising where appropriate) • Communications exercise every 6 months, table top exercise annually and live exercise at least every three years	GREEN			
35	Arrangements include an ongoing exercising programme that includes an exercising needs analysis and informs future work.	• Exercises consider the need to validate plans and capabilities • Arrangements must identify exercises which are relevant to local risks and meet the needs of the organisation type and of other interested parties. • Arrangements are in line with NHS England requirements which include a six-monthly communications test, annual table-top exercise and live exercise at least once every three years. • If possible, these exercises should involve relevant interested parties. • Lessons identified must be acted on as part of continuous improvement. • Arrangements include provision for carrying out exercises for the purpose of ensuring warning and informing arrangements are effective		GREEN			
36	Demonstrate organisation wide (including oncall personnel) appropriate participation in multi-agency exercises			GREEN			
37	Preparedness ensures all incident commanders (oncall directors and managers) maintain a continuous personal development portfolio demonstrating training and/or incident /exercise participation.			RED	SMOC and OCD should maintain records and details of their personal experiences and developments for future reflections	R.Mitchell	May-15
CBRN/HAZMAT							
	Preparedness						
38	There is an organisation specific HAZMAT/ CBRN plan (or dedicated annex)	Arrangements include: • command and control interfaces • tried and tested process for activating the staff and equipment (inc. Step 1-2-3 Plus) • pre-determined decontamination locations and access to facilities • management and decontamination processes for contaminated patients and fatalities in line with the latest guidance • communications planning for public and other agencies • interoperability with other relevant agencies • access to national reserves / Pods • plan to maintain a cordon / access control • emergency / contingency arrangements for staff contamination • plans for the management of hazardous waste • stand-down procedures, including debriefing and the process of recovery and returning to (new) normal processes	• Being able to provide documentary evidence of a regular process for monitoring, reviewing and updating and approving arrangements • Version control	AMBER	To be reviewed and updated	**A.Vogel**	Dec-14
39	Staff are able to access the organisation HAZMAT/ CBRN management plans.	Decontamination trained staff can access the plan	• Site inspection • IT system screen dump	GREEN			
40	HAZMAT/ CBRN decontamination risk assessments are in place which are appropriate to the organisation.	• Documented systems of work • List of required competencies • Impact assessment of CBRN decontamination on other key facilities • Arrangements for the management of hazardous waste	• Appropriate HAZMAT/ CBRN risk assessments are incorporated into EPRR risk assessments (see core standards 5-7)	AMBER	Risk assessments to be reviewed	**A.Vogel**	Dec-14
41	Rotas are planned to ensure that there is adequate and appropriate decontamination capability available 24/7.		• Resource provision / % staff trained and available • Rota / rostering arrangements	GREEN			
42	Staff on-duty know who to contact to obtain specialist advice in relation to a HAZMAT/ CBRN incident and this specialist advice is available 24/7.	• For example PHE, emergency services.	• Provision documented in plan / procedures • Staff awareness	AMBER	To be reviewed and updated	**A.Vogel**	Dec-14
	Decontamination Equipment						

	Core standard	Clarifying information	Evidence of assurance	Self assessment RAG	Action to be taken	Lead	Timescale
43	There is an accurate inventory of equipment required for decontaminating patients in place and the organisation holds appropriate equipment to ensure safe decontamination of patients and protection of staff.	• Acute and Ambulance service providers - see Equipment checklist overleaf on separate tab • Community, Mental Health and Specialist service providers - see Response Box in 'Preparation for Incidents Involving Hazardous Materials - Guidance for Primary and Community Care Facilities' (NHS London, 2011) (found at: http://www.londonccn.nhs.uk/_store/documents/hazardous-material-incident-guidance-for-primary-and-community-care.pdf) • Initial Operating Response (IOR) DVD and other material: http://www.jesip.org.uk/what-will-jesip-do/training/	• completed inventory list (see overleaf) or Response Box (see Preparation for Incidents Involving Hazardous Materials - Guidance for Primary and Community Care Facilities (NHS London, 2011))	GREEN			
44	The organisation has the expected number of PRPS suits (sealed and in date) available for immediate deployment should they be required (NHS England published guidance (May 2014) or subsequent later guidance when applicable)	There is a plan and finance in place to revalidate (extend) or replace suits that are reaching the end of shelf life until full capability of the current model is reached in 2017		AMBER	Additional suits to be purchased and recertified	**A.Vogel**	Dec-14
45	There are routine checks carried out on the decontamination equipment including: A) Suits B) Tents C) Pump D) RAM GENE (radiation monitor) E) Other decontamination equipment	There is a named role responsible for ensuring these checks take place		GREEN			
46	There is a preventative programme of maintenance (PPM) in place for the maintenance, repair, calibration and replacement of out of date Decontamination equipment for: A) Suits B) Tents C) Pump D) RAM GENE (radiation monitor) E) Other equipment			GREEN			
47	There are effective disposal arrangements in place for PPE no longer required.	(NHS England published guidance (May 2014) or subsequent later guidance when applicable)		AMBER	To be reviewed and updated	**A.Vogel**	Dec-14
	Training						
48	The current HAZMAT/ CBRN Decontamination training lead is appropirately trained to deliver HAZMAT/ CBRN training			GREEN			
49	Internal training is based upon current good practice and uses material that has been supplied as appropriate.	• Documented training programme • Primary Care HAZMAT/ CBRN guidance • Lead identified for training • Established system for refresher training so that staff that are HAZMAT/ CBRN decontamination trained receive refresher training within a reasonable time frame (annually). • A range of staff roles are trained in decontamination techniques • Include HAZMAT/ CBRN command and control training • Include ongoing fit testing programme in place for FFP3 masks to provide a 24/7 capacity and capability when caring for patients with a suspected or confirmed infectious respiratory virus • Including, where appropriate, Initial Operating Response (IOR) and other material: http://www.jesip.org.uk/what-will-jesip-do/training/	• Show evidence that achievement records are kept of staff trained and refresher training attended • Incorporation of HAZMAT/ CBRN issues into exercising programme	AMBER	Training materials to be refressed to include new procedures	**A.Vogel**	Dec-14
50	The organisation has sufficient number of trained decontamination trainers to fully support it's staff HAZMAT/ CBRN training programme.			GREEN			
51	Staff that are most likely to come into first contact with a patient requiring decontamination understand the requirement to isolate the patient to stop the spread of the contaminant.	• Including, where appropriate, Initial Operating Response (IOR) and other material: http://www.jesip.org.uk/what-will-jesip-do/training/ • Community, Mental Health and Specialist service providers - see Response Box in 'Preparation for Incidents Involving Hazardous Materials - Guidance for Primary and Community Care Facilities' (NHS London, 2011) (found at: http://www.londonccn.nhs.uk/_store/documents/hazardous-material-incident-guidance-for-primary-and-community-care.pdf)		AMBER	Training to reflect updated national guidance	**A.Vogel**	Dec-14

Totals	91	%
GREEN	65	71.4
AMBER	20	22.0
RED	6	6.6
EPRR CORE STANDARDS	46	%
GREEN	35	76.1
AMBER	10	21.7
RED	1	2.2
HAZMAT STANDARDS	14	%
GREEN	7	50
AMBER	7	50.0
RED	0	0.0
HAZMAT EQUIPMENT - Separate Spreadsheet	31	%
GREEN	23	74.2
AMBER	3	9.7
RED	5	16.1

HAZMAT CBRN equipment list - for use by Acute and Ambulance service providers in relation to Core Standard 43.

No	Equipment	Equipment model/ generation/ details etc.	Self assessment RAG Red = Not in place and not in the EPRR work plan to be in place within the next 12 months. Amber = Not in place and in the EPRR work plan to be in place within the next 12 months. Green = In place.	Action to be taken	Lead	Timescale
	EITHER: Inflatable mobile structure					
E1	Inflatable frame					
E1.1	Liner					
E1.2	Air inflator pump					
E1.3	Repair kit					
E1.2	Tethering equipment					
	OR: Rigid/ cantilever structure					
E2	Tent shell	PPS Radpid Pro 2 Line 7	GREEN			
	OR: Built structure					
E3	Decontamination unit or room					
	AND:					
E4	Lights (or way of illuminating decontamination area if dark)	Slam Tube Lighting - provided with decon tent	GREEN			
E5	Shower heads	2x Showers 2x brushes - provided with decon tent	GREEN			
E6	Hose connectors and shower heads	standard equipment provided with decon tent and additional extentions	GREEN			
E7	Flooring appropriate to tent in use (with decontamination basin if needed)	floor tiles as provided with the decon tent	GREEN			
E8	Waste water pump and pipe	Compact water pump	GREEN			
E9	Waste water bladder	oil drums x4	GREEN			
	PPE for chemical, and biological incidents					
E10	The organisation (acute and ambulance providers only) has the expected number of PRPS suits (sealed and in date) available for immediate deployment should they be required. (NHS England published guidance (May 2014) or subsequent later guidance when applicable).	15x currently in service 4x require recertification 5x additional to be purchased	AMBER	4 suits are to be recertified 5 to be purchased	Aaron Vogel	Nov 2014 Dec 2014
E11	Providers to ensure that they hold enough training suits in order to facilitate their local training programme	x10	GREEN			
	Ancillary					
E12	A facility to provide privacy and dignity to patients	Derobe and rerobe areas built into the decon tent	GREEN			
E13	Buckets, sponges, cloths and blue roll		GREEN			
E14	Decontamination liquid (COSHH compliant)		AMBER	To be checked as part of the equipment review in line with new national requirements	Aaron Vogel	Oct-14
E15	Entry control board (including clock)	To be included in the revised	AMBER	To be checked as part of the equipment review in line with new national requirements	Aaron Vogel	Oct-14
E16	A means to prevent contamination of the water supply		RED	Capture tanks are in place but need to review how we address spillages	Aaron Vogel	Oct-14
E17	Poly boom (if required by local Fire and Rescue Service)	Arrangements in place with the Fire Service none held locally	GREEN			
E18	Minimum of 20 x Disrobe packs or suitable equivalent (combination of sizes)		GREEN			
E19	Minimum of 20 x re-robe packs or suitable alternative (combination of sizes - to match disrobe packs)		GREEN			
E20	Waste bins		GREEN			
	Disposable gloves		GREEN			
E21	Scissors - for removing patient clothes but of sufficient calibre to execute an emergency PRPS suit disrobe		GREEN			
E22	FFP3 masks		GREEN			
E23	Cordon tape		GREEN			
E24	Loud Hailer		GREEN			
E25	Signage		GREEN			
E26	Tabbards identifying members of the decontamination team		GREEN			
E27	Chemical Equipment Assessement Kits (ChEAKs) (via PHE) (replaced Toxboxes in 2010)		RED	Requirements to be identified	Aaron Vogel	Oct-14
	Radiation					
E28	RAM GENE monitors (x 2 per Emergency Department and/or HART team)		GREEN			
E29	Hooded paper suits		RED	To check requirements and levels of PPE with the Radiation Protection Officer	Aaron Vogel	Oct-14
E30	Goggles		RED		Aaron Vogel	Oct-14
E31	FFP3 Masks - for HART personnel only		GREEN			
E32	Overshoes & Gloves		RED	To check requirements and levels of PPE with the Radiation Protection Officer	Aaron Vogel	Oct-14

Totals	
RED	5
AMBER	3
GREEN	23

Emergency Planning Year Plan 2013/2014

	Item	Aug-14				Sep-14					Oct-14					Nov-14					Dec-14					Jan-15					Feb-15				Mar-15					Apr-15				May-15					Jun-15					Jul-15			
		4	11	18	25	1	8	15	22	29	6	13	20	27	3	10	17	24	1	8	15	22	29	5	12	19	26	2	9	16	23	2	9	16	23	30	6	13	20	27	4	11	18	25	1	8	15	22	29	6	13	20	27
0	**Admin Functions**																																																						
0.1	Emergency Planning and Business Continuity Committee Meetings								23													23																																	
0.2	Financial/Budget Planning																																																					
1	**Risk Management**																																																				
1.1	EP Risk assessments																																																				
1.3	Review CRR and align EP risk assessments																																																				
2	**BCM**																																																				
2.1	Service Area Action Cards																																																				
2.2	Review BIAs																																																				
3	**EP Activity**																																																				
3.1	Core Standards Review																			ET																				ET															
3.2	Major Incident Plan																																																				
3.2.1	Major Incident Call Out System																																																				
3.3	CBRN Plan																																																				
3.4	Internal Incident/Corporate Business Continuity Plan																																																				
3.5	Heatwave Plan																																																				
3.6	Road Fuel Shortage Plan																																																				
3.7	Evacuation Plan																																																				
3.8	Pandemic Flu Plan																																																				
3.9	Friends and Relative's Reception Centre Plan																																																				
3.10	Staff Capacity Response Plan																																																				
3.11	Lockdown Plan																																																				
3.12	Flood Plan																																																				
3.13	Control Rooms Audits																																																				
3.14	Cold Weather Plan/Severe Weather Response Plan																																																				
3.15	Mass Countermeasures/Mass Vaccination Plan																																																				
3.16	Excess Deaths/Mass Fatalities																																																				
3.17	Review arrangements for access to 24/7 specialist advisers																																																				
3.18	Bank Holiday Plans																																																				
3.19	Christmas Activity Plan																																																				
4	**Training and Exercises**																																																				
4.1	Major Incident Call Out Test (every six months)																																																				
4.2	SMOC Training																																																				
4.3	DOC Training																																																				
4.4	BCM Training																																																				
4.5	Police Documentation Team Exercise																																																				
4.6	Major Incident Exercises																																																				
4.7	Loggist Training																																																				
5	**LRF Traininng**																																																				
5.1	Training						11																																														
5.2	Operational Training Days					4											20			12							29					5																					
5.3	SCG												15			12																																						
6	**LRF Exercises**									2									5								22		12				12																					

Trust Board paper O

To:	**Trust Board**
From:	**CHIEF EXECUTIVE**
Date:	**28 AUGUST 2014**
CQC regulation:	N/A

Title:	**MONTHLY UPDATE REPORT – AUGUST 2014**

Author/Responsible Director: Director of Corporate and Legal Affairs

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

The Report is provided to the Committee for:

Decision		Discussion	√
Assurance	√	Endorsement	

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

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

Previously considered at another corporate UHL Committee? No

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

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

Assurance Implications: N/A

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

Stakeholder Engagement Implications: N/A

Equality Impact: N/A

Information exempt from Disclosure: None

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

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST

REPORT TO: **TRUST BOARD**

DATE: **28 AUGUST 2014**

REPORT BY: **CHIEF EXECUTIVE**

SUBJECT: **MONTHLY UPDATE REPORT – AUGUST 2014**

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

2. For this meeting, the key issues which the Chief Executive has identified and upon which he will report further, orally, at the Board meeting are as follows:-

(a) emergency care;

(b) the Trust's financial position as at month 4 2014/15.

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

John Adler
Chief Executive

15th August 2014

University Hospitals of Leicester NHS
NHS Trust

Trust Board Paper P

To:	**Trust Board**
From:	Chief Executive
Date:	**28 August 2014**
CQC regulation:	Not applicable to this paper

Title:	**Blood Transfusion Laboratory Information System (BT-LIMS)**

Author/Responsible Director: Chief Executive

Purpose of the Report: To seek approval for the procurement of an MHRA compliant Blood Transfusion laboratory computer system.

The Report is provided to the Board for:

Decision	√	Discussion	
Assurance		Endorsement	

Summary / Key Points: The existing blood transfusion laboratory computer system is outdated and non-compliant with the MHRA regulatory requirements. This paper outlines the case of need for a replacement laboratory information system and presents a summary of option appraisal.

Recommendations: To procure the Clinisys Winpath laboratory information system for blood transfusion service at UHL.

Previously considered at another corporate UHL Committee?
The business case was approved by the UHL Capital Group on 27th June 2014.

Board Assurance Framework: The business case has had the initial approval from the director of finance and the recommended option and procurement route satisfies the requirements of procurement governance.	**Performance KPIs year to date:** All applicable KPI's will be specified within the service contract with the supplier.

Resource Implications (eg Financial, HR): The project does not require a capital investment. The revenue cost of £1.6 M (approx.) for a 5-year contract will be offset against the full cost of empath IT procurement plan subject to final approval of the empath business case. There are no HR implications.

Assurance Implications: The recommended system, Clinisys-Winpath, is fully compliant with the MHRA regulatory requirements.

Patient and Public Involvement (PPI) Implications:
None. The system is clinically and technically evaluated.

Stakeholder Engagement Implications: All stakeholders including emPath board, emPath executive team and IT procurement team, CSI CMG, UHL IM&T / IBM, UHL procurement team and UHL capital group have been fully involved.

Equality Impact:
Not applicable to this paper.

Information exempt from Disclosure:
No exemption.

Requirement for further review?
None

1. Project Background

Blood Transfusion Services in the UK must comply with Blood Safety and Quality Regulations 2005 *(BSQR 2005, Statutory Instrument 50).* In the UK, the Medicines and Healthcare products Regulatory Agency (MHRA) enforce full compliance with this legislation through regular inspections. The MHRA have the authority, under *articles 11,14,18 and 19 of BSQR 2005, SI 50*, to prosecute individuals responsible for failure to comply, as well as serve hospitals / blood transfusion services with legal enforcement notices, including an eventual 'cease and desist' notice.

At their last inspection of UHL blood transfusion service in February 2014, the MHRA highlighted a number of non-conformities, including the current blood transfusion laboratory system being non-compliant with regulatory requirements.

Following the inspection, a comprehensive action plan was drawn up, including the procurement of a fully compliant Blood Transfusion Laboratory Information system (BT-LIMS).

2. Project outline

The project will require a maximum revenue expenditure of approximately £1.6m over 5 years, as detailed below.

	Year 1	Year 2	Year 3	Year 4	Year 5	Total
Total Cost	240,921,83	333,477.17	333,624.88	333,780.35	333,947.82	1,575,752.04

No capital is requested and there is no impact on estates. IM&T support would be required to implement the hosted service and to maintain desktop support as currently provided. Implementation support will be required from empath (Nottingham University Hospital and University Hospitals of Leicester Pathology IT teams).

The revenue will purchase a stand-alone, hosted, LIMS service for Blood Transfusion. The supplier of this solution will be emPath's preferred supplier for a definitive pan-pathology LIMS solution. The strategic Outline Business Case (OBC) for the pan-pathology solution has already been approved by the Trust and the Full Business Case (FBC) is scheduled to go through the approvals process shortly. In the event of the FBC being approved by October 2014, the full cost of this stand-alone BT solution will be offset by the main contract. The additional cost (over and above the strategic solution) and financial risk is therefore very likely to be only that arising from an extended period of double running of systems rather than any substantial additional committed expenditure.

In the unlikely event of Full Business Case approval for the strategic solution not being achieved, then a compliant LIMS would still be required by the Trust and similar expenditure would still incur.

3. Summary of Option Appraisal	The option appraisal involved full consideration of six possible options, as it is not possible to "do nothing" and continue to operate as a licensed blood establishment. The options are: 1) Present MHRA with a plan to carry on with present manual checking solution. 2) Revert to Serological matching for all patients. 3) Modification of Existing BAPEX system for compliance. 4) Roll out v5 of the preferred LIMS from Nottingham University Hospital 5) Introduce a stand-alone BT solution 6) Proceed with the original plan of early roll out of blood transfusion component of the empath pan-pathology IT solution. Options 1 to 5 are discounted as inappropriate, not cost effective or not deliverable. Option 6 is being presented as the preferred solution, which would be fully compliant with the MHRA, and in line with the overall emPath IT strategy.
4. Recommendation & Benefits of Decision	*4.1: Preferred Option (No 6).* Option 6 offers an MHRA compliant solution that could be procured and implemented in the required timeframe. However, the contract period would only make it financially viable if the procurement of a stand-alone system could be linked to the strategic direction i.e., bringing forward components of full emPath IT programme, with reuse of the resource such that much of the cost of initial implementation would be offset when full emPath IT solution is subsequently implemented. *4.2: Recommendation:* Based on the above, on behalf of the project steering group, I make the following recommendations to the board: • *Proceed with the procurement of Clinisys-Winpath LIMS for blood transfusion service at UHL.* *4.2: Benefits of Decision:* • The preferred solution will achieve compliance with the MHRA regulations (BSQR 2005). • This solution is deliverable within the tight timeframe required by the MHRA. • Since this option essentially brings forward a component of the preferred empath IT solution, the initial revenue cost will be subsequently offset against the cost of full emPath IT project.

Trust Board paper Q

To:	**Trust Board**
From:	John Adler, Chief Executive Kate Bradley, Director of Human Resources
Date:	28 August 2014
CQC Regulations:	Outcomes 12 to 14
Title:	**Mutuals in Health: Pathfinder Programme**

Author/Responsible Director:
John Adler Chief Executive, Kate Bradley Director of Human Resources and Bina Kotecha Assistant Director of Learning and Organisational Development.

Purpose of the Report: This report and the corresponding prospectus (as attached) sets out details of the 'Mutuals in Health: Pathfinder Programme' designed to explore the benefits of mutualisation in the NHS.

The Report is provided to the Board for:

Decision		Discussion	X
Assurance		Endorsement	X

Summary / Key Points:

Introduction

The Chief Executive presented a report, in exploring some of the principals of mutualisation, at the April Trust Board Development Session (10 April 2014) and highlighted that if we are to overcome the challenges facing us we have to find ways to deliver differently. The mutual model, with its focus on improving the engagement and empowerment of staff, is set to play a central role.

This paper updates specifically on the 'Mutuals in Health: Pathfinder Programme'. This programme is a joint Department of Health and Cabinet Office initiative, and forms the cornerstone of the Government's response to 'Improving NHS care by engaging staff and developing decision making – report of the review of Staff Engagement and Empowerment in the NHS'. This review was led by Professor Chris Ham, Chief Executive of Kings Fund, supported by an expert panel with UHL's Chief Executive representative on the panel (members met four times to discuss the findings and recommendations).

The Pathfinder Programme is designed to support the NHS with exploring the potential benefits of mutualisation for all or part of their services. Critical to this programme is the objective of developing the business case for mutuals in the NHS, exploring how the mutual model can further increase staff engagement as well as ensure patients have access to effective and high quality health provision.

Public Service Mutuals

Over the last four years, the Government has broadened approaches to the delivery of healthcare, including through public service mutuals: a model which is revolutionising frontline provision and bringing benefits to staff, local commissioners, and service users. Over 45 mutuals are already delivering community healthcare across the country, transforming the quality of patient care through a more engaged and empowered workforce.

Chris Ham's review recognises these achievements and sets out a strong case for using the mutual model to increase levels of staff engagement right across the NHS. As the review makes clear, "this is particularly important in relation to acute hospital services where there is currently much less diversity of ownership models than in other sectors of care."

Support for Pathfinder Trusts

The Pathfinder Programme has been established to help NHS Trusts, Foundation Trusts and Government take

the first steps. All NHS Trusts and Foundation Trusts are eligible to apply. Using a £1m fund, the programme will provide around 10 Pathfinder Trusts with up to £100,000 worth of support. Designed to help Trusts to consider the potential advantages of the mutual model, it will enable the pathfinders to understand what mutualisation could mean for them and to identify solutions to practical barriers.

Output of the Pathfinder Programme

For UHL the output of the Pathfinder Programme will be a bespoke review, setting out the business case for becoming a mutual for all or parts of our services. The review will include an analysis of potential benefits, the steps required to release them, barriers to their implementation and potential solutions.

The outcomes from this work will feed into the Government's broader programme of work in 2015/16 to enable a range of new options for providers of NHS care. In addition, the findings from this programme will be brought together next year and used to set out clear actions Government could take to address any practical barriers that exist.

Pathfinder Programme: Indicative Timetable

The programme will be of a fixed duration, running to spring 2015. An indicative timetable is shown below:

1. Applications Open — August (closing date 4th September 2014)
   The first draft of our 'Expression of Interest (EoI)' is included in the attached prospectus (pages 8-20)
2. Short listing and Interviews — September
3. Developing support packages — October
4. Procurement process — November – December
5. Support contracts in place — January

Recommendations:

The Trust Board is asked to confirm support in exploring the business case for mutualisation as a 'Pathfinder Trust'. In summary, successful application (comprising of EoI and interview), will enable UHL to benefit from:-

- Up to £100,000 worth of bespoke technical, legal and consultancy support - procured centrally on our behalf (as necessary to develop our business case);
- Access to an expert panel to provide advice on specific issues; and
- Networking events and opportunities.

Previously considered at another corporate UHL Committee? N/A

2013-2015 Strategic Risk Register	**Performance KPIs**
Risk 3	National Staff Survey, Listening into Action Pulse Check Survey and Staff Friends and Family Test.

Resource Implications (e.g. Financial, HR): The Chief Executive will act as the Senior Responsible Owner (SRO) throughout the support package exploring the business case for a mutual supported by the Director of Human Resources (Project Lead). Internal dedicated resource will be identified (senior representatives of the LiA and OD Team) and will work closely with the appointed consultancy throughout the duration of the Pathfinder Programme review.

Assurance Implications: Chris Ham's Review of Staff Engagement and Empowerment confirmed the growing acceptance that higher levels of staff engagement and empowerment through a staff-led mutual model leads to a happier staff group which in turn can result in better outcomes for service users (and the evidence base is growing).

Patient and Public Involvement (PPI): We will systematically plan engagement activity commencing with stakeholder mapping. On an essential basis will ensure that UHL staff and patient representatives play an active role in the development of the mutual business case; placing staff and service users at the heart of decisions about how to make services effective throughout. The mutual model will build on 'Listening into Action' in working with the frontline and service users to identify and suggest improvements to services.

Stakeholder Engagement Implications: All identified stakeholders including UHL Staff Side colleagues, patient representatives, commissioners and the Trust Development Authority will be fully involved and engaged in all elements of the option appraisal and business planning process as part of the Pathfinder Programme.

Equality Impact: Considered with no impact against the nine protected characteristics

Information exempt from Disclosure: None

Requirement for further review? A further update will be provided at the September Trust Board. As part of

the pathfinder application process, during September we will proceed to the ‘Interview Stage’. The interview will be conducted by representatives from the two government departments and the expert panel.

Cabinet Office | Department of Health

MUTUALS IN HEALTH: PATHFINDER PROGRAMME

SUPPORTING HEALTH AND CARE ORGANISATIONS EXPLORE THE BENEFITS OF MUTUALISATION

CONTENTS

MUTUALS IN HEALTH: PATHFINDER PROGRAMME

SETTING THE SCENE

The *Mutuals in Health: Pathfinder Programme* is a joint Department of Health and Cabinet Office initiative, and is designed to support health and care organisations to explore the potential benefit of mutualisation for their services. The programme is open to all Foundation Trusts and NHS Trusts.

The Mutuals Programme has been part of the Cabinet Office since 2010. This agenda is driven by an explicit commitment in the Coalition's Programme for Government to support the creation and expansion of mutuals, helping public sector staff take control of the services they deliver. Cabinet Office has engaged around 200 emerging and established public service mutuals across multiple sectors, ranging from social care and integrated health to libraries and youth services.

The Review of Staff Engagement and Empowerment in the NHS, led by Chris Ham, set out a strong case for increasing levels of staff engagement across the NHS. This *Pathfinder Programme*, which builds on learning from previous work to establish mutuals within the health sector, forms the cornerstone of the Government's response to one of the core recommendations made by the Review, namely that Government should support NHS organisations in testing the mutual model, where they have an interest in doing so.

Using a £1m fund, the programme will provide around 10 *Pathfinder* Trusts (and their partners) with up to £100,000 worth of bespoke technical, legal and consultancy support. Designed to help Trusts to consider the potential advantages of the public service mutual ('mutual') model, it will enable *Pathfinders* to understand what mutualisation means for them, the potential benefits, including increasing staff engagement across their organisations, and identifying solutions to practical barriers regarding implementation. Government will work in partnership with the successful *Pathfinders* to design a bespoke package of expert support that meets their needs and will then run the procurement process on their behalf (with *Pathfinders* actively involved in choosing their support provider).

The full package of support is as follows:

Up to £100k of support to explore the business case for mutualisation

Access to an expert panel to provide advice on specific issues

Networking events and opportunities

Further details on the support available have been included in this pack. The application process will consist of two stages:

Stage one: An Expression of Interest (EOI) and;

Stage two: An interview with representatives from the two Government departments and the expert panel

If you wish to participate in the *Mutuals in Heath: Pathfinder Programme*, you must complete an EOI by **Thursday 4 September 2014.** EOIs should be sent to mutualsinhealth@cabinet-office.gsi.gov.uk with the Trust(s) name in the subject title.

To find out more, potential applicants are invited to an initial exploratory event on *Mutuals in Health: Pathfinder Programme,* which will be held in London on **Monday 11 August** in partnership with Cabinet Office Mutuals Ambassadors. Please register for this event via info@mutualventures.co.uk.

This event will provide further discussion on the Review of Staff Engagement and Empowerment in the NHS, information on mutual models with presentations from live health mutuals, details on the *Pathfinder Programme*, and an opportunity for interested applicants to ask any questions.

CAN I APPLY?

Potential applicants should consider the following minimum requirements before applying:

What is in scope?

The programme is open to applications from all Foundation Trusts or NHS Trusts interested in exploring the benefits of a mutual model either alone or in partnership (including those that are interested in bringing together services from more than one provider through an integrated care model).

Trusts must be able to demonstrate that there is commitment to exploring the mutual model to address strategic challenges as well as increasing staff engagement across the organisation in order to improve services to patients.

Senior support

Applicants must show they have the support of a senior sponsor (e.g. Chief Executive) who will act as the senior responsible owner (SRO) throughout the support package exploring the business case for a mutual.

For NHS Trusts, applicants should discuss their proposals with the Trust Development Authority (TDA) before submitting an application. The TDA have been invited to sit on the expert panel and will be closely involved in the sifting of applications from NHS Trusts.

Dedicated resource

Applicants must identify what dedicated resource they will allocate to the project. Any internal resource identified should be able to commit to working with the appointed consultancy and Government throughout the duration of the review to ensure continuity.

Commitment to sharing knowledge across the health sector and with Government

Applicants must demonstrate how they will learn from the process and apply this learning to benefit other health and care organisations.

Of equal importance, applicants must clearly show a commitment to capturing and sharing lessons learnt in the programme with Government so these can be shared with the wider health and care sector.

Application Process

EOIs must be completed by **Thursday 4 September 2014.** EOIs should be sent to mutualsinhealth@cabinet-office.gsi.gov.uk with the Trust(s) name in the subject title.

Applicants will only proceed to the interview stage if their Expression of Interest meets the required threshold.

If you are interested in applying and would like to discuss the programme further or have any questions, please contact mutualsinhealth@cabinet-office.gsi.gov.uk.

WHAT WILL MAKE A STRONG APPLICATION?

Critical to this programme is the objective of developing the business case for mutuals in new areas of the health sector, exploring how the mutual model can further increase staff engagement as well as be able to ensure citizens have access to effective and high quality health provision.

When considering outcomes for staff and citizens, applicants should consider how these will be enhanced through partnership working, engaging and empowering staff as well as other stakeholders across the health and care system, and through commitment to innovation. These characteristics are explained below.

Characteristic	Explanation
Focus on outcomes and impact measurement	We welcome applications that have considered the potential benefits of a fully independent mutual model and how outcomes will be identified and measured, both in terms of the wider strategic objectives of the organisation and on improving services for patients.
Staff engagement	We welcome applications from Trusts that have considered opportunities for staff engagement throughout the *Pathfinder Programme*, including providing opportunities for employees to play an active role in the development of the mutual business case; placing staff at the heart of decisions about how to make services effective throughout. We particularly welcome applications from Trusts where staff are supportive of the Trust exploring the potential benefits of the mutual model.
Integration and stakeholder management	We welcome applications that demonstrate strategic leadership from the Trust and demonstrate how they recognise the value that different organisations can play in the development of the mutual model and improving service provision; including, where appropriate, direct involvement in the governance structure. We recognise that this collaboration will vary according to local conditions, but the benefits of creating strong networks and partnerships with local organisations should remain a key consideration. These local networks are likely to include local authorities – in particular social care services; the voluntary, community and social enterprise sector, GPs, businesses and other agencies. We also particularly welcome applications that consider bringing together services from more than one provider through an integrated care model, where relevant.
Appetite for and experience of innovation	We welcome applications from organisations that can demonstrate a keen appetite for new and innovative ways of delivering services, and particularly welcome practical experience of this.

FREQUENTLY ASKED QUESTIONS

Mutual Models

1. *What do you mean by a public service mutual?*

The Government definition of a public service mutual refers to an organisation that:

- Has spun out of the public sector
- Continues to deliver public services
- Involves a high degree of employee control

This employee control can take the form of ownership, but can also manifest itself through enhanced governance arrangements, including employee councils and elected board members. This should go beyond existing Foundation Trust arrangements.

The public service mutual model encompasses a broad range of employee-led structures, including (but not limited to) charities, social enterprises, community interest companies, partnerships, and joint ventures.

Application Process

2. *Can we team up with partners and submit a joint Expression of Interest?*

We will accept joint bids across Trusts or other public bodies where there is a clear rationale for combining service provision and a clear commitment from all parties to exploring a mutual model.

3. *What if we only want to explore mutual models for parts of our service?*

We will consider applications from Foundation Trusts and NHS Trusts that are interested in a mutual model for parts of their services, although applications should consider how this learning will be spread to the wider organisation.

For Foundation Trusts interested in exploring mutual models for specific services, staff groups should access the wider Mutuals Support Programme. This support includes access to a four day course which will support staff to develop their business plan and explore mutual governance in more detail. The course will also act as a gateway to further spin out support for the implementation phase.

4. *When is the application deadline?*

You can submit an Expression of Interest form as of 28 July 2014 and the window will close on Thursday 4 September 2014. EOIs should be sent to mutualsinhealth@cabinet-office.gsi.gov.uk with the Trust(s) name in the subject title.

We encourage Trusts to submit their applications as soon as possible, provided that they are confident that that they have explained clearly and in sufficient detail the benefits they hope to realise and their commitment to the programme.

Support Package

5. How long will the Pathfinder Programme last?

The programme will be of a fixed duration, running to spring 2015. An indicative timetable has been included below.

Applications Open	*July*
Short listing and Interviews	*September*
Developing support packages	*October*
Procurement process	*November – December*
Support contracts in place	*January*

6. Is this Programme open to all Trusts, including in Scotland and Wales?

Mutuals in Health: Pathfinder Programme is open to all Foundation Trusts and NHS Trusts and their partners in England. However, the guidance materials produced by the programme will be made available, and will be of use to all health and care organisations.

7. Will we be given the £100,000 to buy support ourselves?

We will work in partnership with you to design and develop a package of bespoke technical, legal and consultancy support and will then run the procurement process on your behalf. We will work closely with you throughout the process and you will be invited to sit on the evaluation panel that selects the successful support provider.

8. Will we be provided with support to implement the model and implementation plan?

The support provided will cover all technical and advisory support necessary to develop the business case for mutuals. For individual projects, the output will be bespoke reviews, setting out the business case for becoming a mutual. The review will include an analysis of potential benefits, the steps required to realise them, barriers to their implementation, and potential solutions or further recommendations.

The outcomes of this mutual *Pathfinder Programme* and Sir David Dalton's Review will be brought together into a single programme of work in 2015/16 to consider new provider options. Following these reviews, should you wish to go ahead with implementing the mutual model, we will signpost you to the most appropriate avenue to receive additional support if required.

Please email any further questions to mutualsinhealth@cabinet-office.gsi.gov.uk.

EXPRESSION OF INTEREST FORM AND GUIDANCE

The Expression of Interest Form asks seven core questions, covering the benefits you hope to realise as a result of the *Pathfinder Programme*, the resource you would commit, and the stakeholders you would involve in the process.

We expect applicants to make clear in the Expression of Interest both their commitment to exploring the option of a mutual model, improving services to patients and spreading learning to other health and care organisations and Government.

APPLICANT DETAILS

NHS Trust/Foundation Trust	University Hospitals of Leicester NHS Trust
Name of project lead	Kate Bradley
Title	Director of Human Resources
Address	University Hospitals of Leicester NHS Trust, Leicester Royal Infirmary, Infirmary Square, Leicester. LE1 5WW
Email	Kate.bradley@uhl-tr.nhs.uk
Phone	0116 258 8903

SENIOR SPONSOR DETAILS

Name	John Adler
Title	Chief Executive
Email	John.adler@uhl-tr.nhs.uk
Phone	0116 258 8940

1. WHAT IS YOUR UNDERSTANDING OF THE MAIN STRATEGIC CHALLENGES FACING YOUR ORGANISATION(S) AND HOW HAVE YOU ADDRESSED THESE TO DATE?

Word Limit: 500

The response should include an overview of the key strategic challenges facing the Trust(s) including both national and local issues
As part of the response, it would be useful to include details of work that has been undertaken to date to address these key challenges, including any existing innovative or transformative programmes or projects, their purpose, intended results and any outcomes, particularly in terms of improving services for patients

Introduction to the Trust

University Hospitals Leicester NHS Trust (UHL) is one of the largest and busiest Teaching Hospitals in the country, providing a full range of acute services to a million local people across Leicester, Leicestershire and Rutland (LLR), and a range of specialist services to a further two to three million people regionally and, in some cases, nationally. The Trust was formed in 2000 as the result of a merger between Leicester Royal Infirmary (LRI), Leicester General Hospital (LGH) and Glenfield Hospital, the three primary sites across which it still operates, and currently has over 10,000 staff and an annual turnover in excess of £750m.

UHL has an excellent reputation for its research and development activity, hosts the NIHR East Midlands Clinical Research Network and three Biomedical Research Units, respectively for cardiovascular disease, respiratory disease and nutrition, diet and lifestyle. The Trust is a leading centre for cancer research, focusing particularly on prevention and the development of new treatments. This activity both attracts substantial levels of research funding, but also helps attract and retain staff of the highest quality.

Leadership and Structure

The Trust has seen a number of changes to the Senior Leadership Team including the appointment of the Trust's Chief Executive, John Adler, in January 2013.

The Trust has simplified the management structure (from September 2013) to provide four key benefits:-

- A simpler structure with fewer layers to support improved working between the Executive Team and service provision;
- Increase management visibility and clinical engagement with quicker and more effective decision making;
- Smaller management units, in terms of income, expenditure and staff numbers which support improved operational 'grip' and clearer management accountability; and
- Improved parity between the comparative size of the units – referred to as 'Clinical Management Groups' in the revised structure.

Performance

Operational performance at UHL has until recently been largely good and green rated for most areas, but like many Acute Trusts, UHL has been finding it hard to sustainably meet the four hour A&E target, with emergency care across LLR being placed under extreme pressure for sustained periods in the last two years and performance against the 18 week standard has also been poor. The Trust is devoting significant resource and energy to resolving these operational challenges and is adopting a 'whole system' approach, working with partners in the local Emergency Care Network. Much has been achieved and the Trust is now focused on embedding the many system changes they have

made to improve resilience. The concerns around our ability to meet the RTT targets are a more recent occurrence and the Trust has developed a recovery plan which has been agreed with commissioners.

Finance

The Trust, it must be admitted, is currently extremely challenged in regards to its financial position with a forecast deficit for 2014/15 of £40m. What has become clear is that this deficit, plus the Trust's pre-existing CIP target of £45m pa, presents a complex and difficult challenge that is unlikely to be resolved easily by the Trust on its own and requires significant involvement from all stakeholders, internally and externally, to carefully map a pathway through and achieve financial sustainability. The Trust Development Authority has worked closely with the Trust to create an improvement plan and a whole health economy 5 year 'Better Care Together (BCT) Strategy' has been developed, within which UHL has positioned its own strategy.

Strategic Direction

The Trust's Strategic Direction was launched in November 2012 and has been refined and updated to take account of the changes within the organisation and the wider health economy. Central to the Strategic Direction is the Delivery of 'Caring at its Best', which describes the Trust's core purpose.

2014/15 Objectives

Whilst the Strategic Direction describes the journey for the Trust over the next 5 years, the Trust has also set out objectives for 2014-15. Foremost amongst those is the task which befalls the whole health economy; to improve the effectiveness of urgent and emergency care.

Listening into Action (LiA)

Under the leadership of the Chief Executive, the Trust has developed excellent experience of leading large scale innovative programmes through adopting the Listening into Action approach based on the LiA Optimal Framework (commenced March 2013). This framework focuses on three key dimensions of change:-
1) quality and safety;
2) the patient experience; and
3) working together.

2. WHAT DO YOU SEE AS THE MAIN BENEFITS OF THE MUTUAL MODEL IN ADDRESSING THE STRATEGIC CHALLENGES INDENTIFIED AT (1) ABOVE AND ON IMPROVING SERVICES TO PATIENTS?

Word Limit: 500

Please provide detail of any current thinking on the mutual model and its relevance to your organisation and to improving services to patients and the community

Responses should include how the model might apply to your organisation and the benefits you are hoping to achieve to address the strategic challenges and meet organisational aims e.g. sustainability, innovation, commercial potential, community involvement. There are separate questions below considering any challenges in relation to staff engagement, and how the mutual model might benefit these

It would be useful if responses also gave consideration to any barriers to implementing changes currently

Growing Body of Evidence

Chris Ham's Department of Health Report into staff engagement (Improving NHS Care by Engaging Staff and Devolving Decision-Making) draws heavily on the growing body of evidence that independent staff-led mutuals are a delivery model worth exploring hence we are very keen and interested in participating in the Pathfinder Programme and leading the way for other Acute Trusts.

Research shows that the mutual approach embeds shared accountability and responsibility across an entire organisation if the principles are truly embraced and implemented in the right way. This empowerment of front-line staff, who are ready to take responsibility, is surely the golden thread that should run through UHL in achieving our purpose of delivering 'Caring at its Best'.

We understand that the first phase of mutualisation was initiated under the 'Right to Request' Programme and supported trailblazer groups of staff who wanted to seize the opportunity to set up as social enterprises and staff-led mutuals. Through attendance at the recent Pathfinder Programme Workshop we recognise that organisations such as Social adVentures and Navigo have experienced significant benefits of what can be achieved if staff are given more freedom and trusted to use their professional judgment. We also appreciate that these organisations deliver a huge range of services including early intervention public health services, specialist mental health provision and nurse-led therapy units.

Chris Ham's Review Panel, which also included UHL's Chief Executive, confirmed the growing acceptance that higher levels of staff engagement and empowerment through a staff-led mutual model leads to a happier staff group which in turn can result in better outcomes for service users (and the evidence base is growing).

This feels like exactly the right moment to challenge the accepted delivery norms within UHL. Even if it means disruption and challenge to business as usual. The evidence clearly points to the need for new delivery models with staff leadership at their core.

Meeting Future Needs of our Local People

At UHL we have a forward-thinking Senior Leadership Team who are willing to step forward, grasp the opportunities that the Pathfinder Programme presents and lead the way. We are very keen to

spin out of the public sector, continue to deliver public services and involve a high degree of employee control. Initially this employee control will manifest itself though enhanced governance arrangements as set out in question 4.

The mutual model is highly relevant to improving our services to our patients and our community. The 5 year strategy 'Better Care Together' is about ensuring that health and social care services in Leicester, Leicestershire and Rutland are capable of meeting the future needs of local people. Services face increased and more complex demands because of the ageing population. At the same time, there are major financial pressures, with the funding gap predicted to reach £400m in 5 years' time (2018/19). This means that big changes are needed to the way health and social care are delivered. Overall the Trust will become smaller and more specialised and more able to support the drive to deliver non urgent care in the community.

We do not under-estimate the significance of the fact that we now have 5 year plans both for ourselves and for the wider health and social care system. The mutual model will provide UHL a platform for taking forward the key changes that are needed in order to improve the quality of care that we provide and to ensure that our services are both clinically and financially sustainable over the coming years.

Factors to Explore Through Participation in the Pathfinder Programme

We have a keen appetite for new and innovative ways of delivering services and have practical experience of this through adopting the Listening into Action approach. There would appear to be a number of key factors to work though as part of the Pathfinder Programme:

- Acute trusts tend to be monopolies or near-monopolies in their local area. Therefore patients have limited choice. As a result, any mutual structure needs to include patients and the public as part of that model.

- Acute Trusts own a range of high value assets (which it is presumed would need to stay in state ownership) and require access to significant capital.

- The issue of employment status would need to be resolved. It may be possible to create most (possibly all) the features and benefits of mutualisation without transferring staff out of the NHS, but the pros and cons of the options need further consideration.

- We will need to work though options relating to 'ownership and governance' in defining our organisation as part of the business planning process. They are mutually reinforcing so it is important that both are considered together.

3. WHAT IS YOUR UNDERSTANDING OF THE LEVELS OF STAFF ENGAGEMENT IN YOUR ORGANISATION(S) AND THE MAIN CHALLENGES YOU CURRENTLY FACE TO IMPROVING THIS?

Word Limit: 500

The response should provide a benchmark of current staff engagement levels, including details of recent staff surveys and overall impact on improving services for patients

As part of the response, it would be useful to include details on work has been undertaken to date to engage staff in decision making and some of the main challenges to improving staff engagement levels

In recent years, UHL has suffered from poor staff engagement, as evidenced through both the staff and patient surveys and a number of external reviews. In 2012, the Trust developed a fresh Strategic Direction and Quality Commitment, which saw an improvement in staff survey results, and in 2013 the Trust embarked on the Listening into Action programme, which has driven further improvement in levels of engagement. LiA is the Trust's main vehicle for improving engagement and is used in the following five ways:

- **Classic LiA:** To improve day-to-day working in individual teams or across pathways addressing the things that matter the most to staff and patients;
- **Enabling LiA:** To tackle Trust-wide issues (e.g. equipment, recruitment processes);
- **Management of Change LiA:** As a precursor to proposed major service or structural changes;
- **Thematic LiA:** On a thematic basis (e.g. improvements to emergency flow); and
- **Nursing into Action:** Supporting all Wards, Departments or Units to implement local changes to improve patient experience.

The Trust will be using the LiA approach on an indefinite basis so as to embed an engaged style of leadership and a strong voice for front line staff.

To facilitate the required level of organisational change, we have set out an ambitious Organisational Development plan (as shown below). Earlier this year the plan was audited by PWC (final report published in February 2014) and findings confirm that the Trust has implemented a strong OD Plan with clear alignment to the Strategic Direction of the Trust.

We collect staff views and experiences of working at the Trust through the annual National Staff Survey, LiA Pulse Check and the Staff Friends and Family Test to help improve the working lives of staff and the quality of care we provide. Analysis of results helps to identify if we are making sustainable change and to identify areas for improvement.

National Staff Survey Results

The National Staff Survey was open to all UHL staff between October and December 2013 and in total 3988 staff completed the survey giving an organisational response rate of 39%. Overall National Staff Survey Key Findings indicate no change from the previous year with the exception of an increase in the number of staff having Equality and Diversity Training in 2013. We also note that change has not been sustained at the same pace as comparable organisations resulting in a downward trend in relation to overall rankings. A core theme within the full comparison report is the measurement of the 'Staff Engagement' score. The Trust's overall 2013 score for Staff Engagement is 3.68 (rated as below average ranking compared to average last year) and has increased from 3.66 in 2012. The 2013 national average score for Acute Trusts is 3.74.

Findings based on the 'UHL specific local questions' provide reassurance in relation to senior manager communication and consistent demonstration of Trust values by immediate line managers and colleagues. Results show that the majority of respondents reported positively on receiving regular team briefings including the Chief Executive briefing and are positive about organisational communication about priorities and goals.

Listening into Action Pulse Check Survey Results

UHL has completed 2 LiA Pulse Check surveys since introducing Listening into Action (LiA) in March 2013. The first survey was undertaken in April 2013 at the start of the programme and the second survey was undertaken in January 2014. Survey Two responses are significantly more positive in 8 of 9 questions. It is worth noting that UHL has not only improved between surveys but is also reporting more positive scores in the majority of questions when compared to the average scores of other NHS LiA organisations.

Staff Friends and Family Test

We recently introduced the Staff Friends and Family Test (FFT) with 1107 responses. The primary purpose of the FFT for staff is to support local service improvement work through staff engagement. NHS England's vision for staff FFT is that staff can feedback their views and opinions to their organisation to help promote a big cultural shift in the NHS, empowering staff to have the confidence

to speak up and their views heard.

The results of the staff FFT will be published nationally in September 2014. The raw data (at the end of first quarter) shows that:

- 68% of respondents are likely to recommend this organisation to friends and family if they needed care or treatment.
- 53% of respondents are likely to recommend this organisation to friends and family as a place to work.

4. PLEASE DESCRIBE YOUR CURRENT THINKING ON HOW YOU WOULD USE THE MUTUAL MODEL TO IMPROVE STAFF ENGAGEMENT, INCLUDING ITS RELEVANCE TO ANY EXISTING STAFF ENGAGEMENT PROGRAMMES.

Word Limit: 500

The response should consider any current thinking on mutual models including the role of staff in governance and/or ownership,

The response should make links to existing programmes or projects to engage staff and how the Pathfinder Programme could build on these

The response should also detail the extent to which staff have been involved in the application to the Pathfinder Programme and the extent to which they are supportive

In order to progress this agenda, UHL has been working on a number of potential scenarios, with the aim of developing over time towards full mutualisation. The ideas which follow are not yet fully worked up but hopefully they can form the basis for further discussion and evaluation as part of the Pathfinder Programme.

Autonomous, Incentivised Teams

There are a number of teams in the Trust who have expressed an interest in piloting operating in an autonomous, incentivised model, with high levels of staff engagement and a "mutualised" ethos. The basic building blocks of such a model would be:

- The team would operate on as autonomous a basis as possible, with ring-fenced budgets once Trust-wide efficiency gain requirements were met
- The team would have control over recruitment and other key business processes
- The team would be free to develop (within appropriate ground rules) incentives of varying kinds, including team and individual financial incentives
- The team would have a management board which would have a significant number of elected

front line staff on it, so as to give those staff a strong say in the direction of the team

- The team would have straightforward trading relationships with other teams/services with which it interacted

The purpose here is to create the sense of a self-governed team, suitably incentivised, so that this mirrors as far as possible the ethos and drive that we have seen created in small social enterprises. The key issue here is of course that teams are rarely free-standing and this tensions will inevitable arise. Nevertheless, we feel that considerable benefits could be derived from this model, noting that in general, NHS staff identify most closely with their team.

Integrated Working Across Boundaries

UHL has recently entered into a partnership with Leicestershire Partnership NHS Trust (also a LiA site) and the Leicestershire GP Provider Company. The Alliance, thought to be the first of its kind, has been awarded a contract worth circa £25m p.a. to provide elective care services from community hospitals across the county, starting on 1st April 2014. It is the intention of the Alliance and its commissioners that the model will help facilitate more effective use of community facilities, assist in the shift of care from traditional acute settings and drive greater integration across primary, community and secondary care. The initial contract is viewed as the basis for further development in the future.

The proposition here is that we could give the staff in the Alliance similar autonomy and incentives to those described for teams in the previous section. We feel that this would maximise the potential of this novel approach and also chime well with the model that GP practices have used for many years. Loughborough Hospital, a high quality, relatively large scale, facility, would be a suitable physical focus for this initiative.

Embedding Staff Engagement and a Sense of "Ownership"

UHL will continue to use Listening into Action to develop exemplary levels of staff engagement. In order to take this further, we intend to embed the voice of front-line staff in the structure of the organisation. Specifically:

We have already established a Clinical Senate within the Trust, with all its members directly elected by the consultant body. None of the members are involved in clinical management. The Senate acts a sounding board on major issues and as a critical friend.

We intend to elect staff representatives for all teams using a model similar to that used by the John Lewis Partnership. Those representatives will sit on team management boards and act as advocates for front line staff.

The intention of the above approaches is to "institutionalise" engagement and to add to the sense of ownership and a shared agenda.

Further Development Towards Mutualisation

The intention of the above proposals is that they will, alongside Listening into Action, "lock in" high levels of staff engagement and begin to develop a culture of ownership. These are essential prerequisites to successful operation as a mutual.

The natural next step would be develop the approach towards full mutualisation as part of the Pathfinder Programme. There are a number of different organisational models which could be adopted subject to further exploration; these include:

- A variant on the established Foundation Trust or NHS Trust models
- The community interest company model

5. WHAT IS YOUR EXISTING ENGAGEMENT WITH STAKEHOLDERS AND HOW WOULD YOU DEVELOP THIS FURTHER FOLLOWING SUCCESSFUL APPLICATION? (VCSE GROUPS, PRIVATE SECTOR, GPS AND OTHER PUBLIC SECTOR ORGANISATIONS)?

Word Limit: 500

Please detail any existing partnerships, and list any organisations or groups you believe may be relevant to this project, including why and how you will engage them

The response should consider any current thinking or ambitions to build any of these stakeholders into governance arrangements, including through joint ventures or cooperative models

This section should also include any interest in bringing together services from more than one provider through an integrated care model

On an essential basis, we will ensure that UHL Staff Side colleagues, patient representatives, commissioners and the Trust Development Authority are fully involved and engaged in all elements of the option appraisal and business planning process as part of the Pathfinder Programme.

We recognise the value different organisations can play in the development of the mutual model and improving service provision including direct involvement in the governance structures. Partner involvement through the Better Care Together Programmes, regional partnerships and academic partnerships, as set out below will be fully explored as part of the Pathfinder Programme and option appraisal:

Better Care Together

Better Care Together is a partnership of NHS organisations and local authorities across Leicester, Leicestershire and Rutland. Its importance is reflected in the fact that Chief Executives and other very senior officers sit on the Programme Board. Also on that Board are representatives of Healthwatch as well as elected councillors, in their capacity as chairs of the local Health and Wellbeing Boards. All the NHS organisations involved have their own significant public involvement from board level onwards.

There are compelling reasons why more radical change is now required in Leicester, Leicestershire and Rutland:

Quality: Local services need to reflect the very best practice, providing the right care in the right place at the right time.

Finance: The pressure on public sector budgets is unprecedented. By 2019, the funding gap across local health and social care is expected to be around £400m.

Demand: As elsewhere, the local population is ageing. More people are living longer, with complex long-term needs. This is creating greater demand for services at a time when resources are severely limited.

Sustainability: Highly-skilled professionals are in short supply, particularly in some medical specialties. This will need to be addressed through different ways of working, harnessing the full potential of new technology and developing the existing workforce.

The combined effect of these issues is that maintaining the status quo is not an option. Better Care Together is working to identify what changes should be made, and how.

Regional Partnerships

The April Trust Board supported the underpinning principle of regional partnership working, which is to be a two stage approach for UHL. This work will be led by the Trust Head of Partnership Development (on appointment).

The first stage is to agree a provider collaboration with the South of the East Midlands to come together to establish Leicestershire, Northamptonshire and Rutland partnership for specialised services. There is a population of around two million people across the south of the East Midlands. Traditionally planning populations for many Specialised Services needed to be in the region of one million; this planning assumption is now being challenged by the emerging NHS England Specialised Services Strategy which appears to suggest that units of planning should be around 2 million. NHS England's stated intention is to move from 220 Acute Providers of Specialised Services to between 15–30 providers within a five year time line.

The second stage is to agree with Nottingham University Hospitals provider collaboration across

the whole of the East Midlands.

Academic Partnerships

UHL's Research and Development (R&D) Strategy is driven by the Trust's strategic objective to become internationally recognised for our specialist services, supported by R&D. The Trust relies on productive relationships with academic partners and as a major Teaching Hospital UHL has links with all three local universities, Loughborough, Leicester and De Montfort and a total of c950 trainee doctors working in the Trust at any given time. Recruitment is consistently strong, with the possible exception of the Emergency Department where it can be a little harder to attract trainees.

6. WHAT DEDICATED RESOURCE WOULD THE TRUST COMMIT TO THE PATHFINDER PROGRAMME AND HOW WILL STAFF BE ENGAGED IN THIS WORK?

Word Limit: 300

Please detail what internal resource you would commit to the project, including relevant project specific experience of the proposed team members (e.g. innovative and/or transformative projects)

Please detail how staff will be engaged in the Pathfinder Programme and the role of staff in supporting the development of a mutual business case

(Internal resource identified should be able to commit to working with the appointed consultant and Government throughout the duration of the review to ensure continuity)

Engagement and Marketing Work Stream

Staff and stakeholders will be engaged adopting the LiA approach and this will form part of the Trust's

Communication, Engagement and Marketing work steam led by the Director of Communications. Progress will be monitored through the Trust's Executive Performance Board chaired by the Trust's Chief Executive as set out in the Trust's Delivering Caring at its Best Governance Structure.

We are keen to explore opportunities to improve staff engagement throughout the Pathfinder Programme, including opportunities for staff to play an active role in the development of the Mutual Business Case, placing staff at the heart of decisions about how to make services effective throughout UHL.

Dedicated Resource

We recognise that the progressing the mutual model will require staff dedicated to the project, with a clear role for staff engagement throughout the Pathfinder Programme. Primarily we will be allocating senior members of our LiA and Organisational Development (OD) Team with extensive experience of organisational development and cultural change. Our teams are involved in creating a range of learning and organisational development programmes and interventions that meet organisational, team and individual learning needs in facilitating the development of the Trust into a learning organisation.

Our OD and LiA Team have extensive experience in implementing programmes to empower and engage with all staff and to develop a culture of listening so that strong managerial, clinical and support teams are given permission to appropriately act without seeking permission first. Our teams ensure optimal staff engagement is delivered in the most clinically effective manner and within financial resource allocations, and that they are focused on supporting improvements in the annual National Staff Opinion Survey. Our teams will benefit significantly from working closely with the appointed consultant throughout the Pathfinder Programme.

We are able to demonstrate commitment to the provision of excellent learning and development for all staff through the co-ordination and quality assurance of a large range of learning programmes and interventions. We are working towards achieving the national Skills for Health Quality Mark (new benchmark for Outstanding Health Care Training). In light of recent published reports by Robert Francis, Sir Bruce Keogh and Professor Don Berwick the importance of assuring quality of education delivery against standards in the quality mark is of significant importance in demonstrating the high standard of our training and learning provision.

7. HOW WOULD YOU ENSURE THAT YOUR PARTICIPATION IN THE PROGRAMME HELPS OTHER HEALTH AND CARE ORGANISATIONS EXPLORE THE BENEFITS OF MUTUALISATION?

Word Limit: 250

Please describe how you would spread learning from the review through other health and care organisations and share with local partners and Government

We are representative on a range of local, regional and national groups and will use this as a mechanism to spread learning and experience of participating in the Pathfinder Programme.

Communications, Engagement and Marketing are three separate elements that co-exist and on many occasions work hand in hand to achieve the same goal. As part of our Communication, Engagement and Marketing Plan, over 2014/15 we will focus on the following three areas ensuring clear links are made to the learning from the Pathfinder Programme: -

Improved Internal Communication

We will ensure that more staff are aware of and engaged in:

- Developing the Business Case as part of the Pathfinder Programme;
- Delivering Caring at its Best; and
- Improvements in National Staff Survey, LiA Pulse Check results and Staff FFT results.

Improved External/Stakeholder Communications

Central to our plans is improved relationships with external stakeholders.

The Trust works hard at maintaining good relationships with the local community, in particular being as open and 'up front' as possible with regard to communication. In 2013 the 'Safe and Sustainable' review into the provision of children's cardiac services had been especially prominent and UHL, as one of the eleven Trusts affected nationally, received sizeable support from the local population for its attempts to secure the services for the long term at the Glenfield Hospital site.

Increased Patient/Public Involvement

Engagement and involvement with patients/the public through the development of our 5 year strategy and service changes planned ensuring improved local understanding of our 5-year strategy.

If you wish to participate in the *Mutuals in Heath: Pathfinder Programme,* you must submit this EOI by **Thursday 4 September 2014.**

Completed EOIs should be sent to mutualsinhealth@cabinet-office.gsi.gov.uk with the Trust(s) name in the subject title.

EXPRESSION OF INTEREST: SCORING CRITERIA

The exact threshold for applications progressing to the panel interview will depend on the standard of other applications. However, at a minimum your application is unlikely to proceed if it scores below a 3 and so we strongly encourage you to aim for a 4 on all relevant sections.

Question	Score	Description
Question 1	1	**Limited clarity on the main strategic challenges both locally and nationally**
	2	**Good clarity in part on the strategic challenges facing the Trust(s) locally but limited insights into how these might apply nationally and/or limited experience of leading large-scale transformative or innovative programmes**
	3	**Good clarity on the strategic challenges facing the Trust(s) both locally and nationally, and some experience of leading large-scale transformative or innovative programmes**
	4	**Excellent clarity on the strategic challenges facing the Trust(s) both locally and nationally, as well as wider consideration for the Trusts partners and key stakeholders; and excellent experience of leading large-scale transformative or innovative programmes**
Question 2	1	**Limited understanding of the mutual model and little or no consideration for how the model may address the strategic challenges identified and improve services to patients**
	2	**Good understanding on the potential benefits of the mutual model but less clarity on how the model may address the strategic challenges identified and improve services to patients**
	3	**Good understanding on both the potential benefits of the mutual model and how it might address the strategic challenges identified and improve services to patients, with some explanation of current work being undertaken that may be applicable**
	4	**Excellent understanding of the potential benefits of the mutual model and its application to local circumstances as well as excellent consideration for how these benefits would address the strategic challenges and improve services to patients. The answer may draw on examples of relevant project specific work that is currently being undertaken which would inform the Pathfinder Programme**
Question 3	1	**Limited clarity on the current levels of staff engagement and limited exploration of the challenges to addressing it, and/or, limited understanding of barriers**
	2	**Some clarity on the current levels of staff engagement but limited information about the challenges to addressing it and any barriers**
	3	**Good clarity on the current levels of staff engagement, including recent figures and trends, with some understanding of the challenges to addressing it and barriers to be overcome**
	4	**Excellent clarity on the current levels of staff engagement, including recent figures and trends, with a clear explanation of the challenges to addressing it and details on existing programmes and projects that could support the Pathfinder Programme**
Question 4	1	**Limited understanding of the mutual model and its applicability to addressing the challenges of staff engagement**
	2	**Good understanding of how the mutual model could address the challenges of staff**

		engagement identified but limited details on applicability to existing projects
	3	**Good understanding of how the mutual model could address the challenges of staff engagement identified and some links with existing projects. Staff may have had some role in the application to the Pathfinder Programme**
	4	**Good understanding of how the mutual model could address the challenges of staff engagement identified with a clear view to the benefits that could be achieved, and an understanding of what success looks like. Staff have had some role in the application to the Pathfinder Programme and there may be some evidence of staff support**
Question 5	1	**Limited recognition of other organisations or why there is a need to consider their role in developing a mutual model**
	2	**Good clarity in part about the role of other organisations, but limited information about how they will be engaged**
	3	**Good clarity about the role of other organisations and the need for engagement, with a clear view to the benefits that could be achieved**
	4	**Excellent clarity about the role of other organisations and the opportunities for partnerships, with a clear view to how different stakeholders will be engaged in a mutual model**
Question 6	Fail	**Suitability of individual(s) dedicated to the project unclear/or unclear role for staff engagement throughout the Pathfinder Programme**
	Pass	**Highly suitable individual(s) dedicated to the project, and a clear role for staff engagement throughout the Pathfinder Programme**
Question 7	Fail	**No clear approach to knowledge capture or knowledge sharing**
	Pass	**Sound approach to knowledge capture and knowledge sharing**

MUTUALS IN HEALTH: PATHFINDER PROGRAMME - WORKSHOP

Two of the Cabinet Office Mutual Ambassadors will host a workshop providing the opportunity to discuss the Review of Staff Engagement and Empowerment in the NHS and its recommendations. Colleagues from the Cabinet Office, Department of Health, specialist advisors and colleagues from the NHS will be attending.

Why this is of interest to NHS leaders?

A chance to learn about the public service mutual model and the potential benefits and challenges

An opportunity to hear first-hand from someone who has successfully led an NHS team on the journey to setting up a public service mutual

You will hear about the *Pathfinder Programme* and the support available to those interested in exploring this model

LOGISTICS

Date	Monday 11 August
Time	1000 to 1300 (*with lunch @ 1230*)
Venue	Mutual Ventures, **@Waterloo** Offices, 2-6 Boundary Row, London, SE1 8HP

AGENDA

Each of the sessions will be followed by a Q&A

1000 Welcome and objectives for the day
Andrew Laird *Director, Mutual Ventures and Mutuals Ambassador*

1010 Review of Staff Engagement and Empowerment in the NHS
Speaker (TBC)

1040 Overview of the mutual model including benefits and challenges
Andrew Laird *Director, Mutual Ventures and Mutuals Ambassador*

- Coffee Break -

1115 Mutual Case study: Social adVentures
Scott Darraugh *Chief Executive, Social adVentures and Mutuals Ambassador*
Mutual Case study: NAVIGO CIC
Kevin Bond *Chief Executive, NAVIGO*

1200 Pathfinder Programme: An Overview
Tim Decamp *Deputy Director, Cabinet Office*
Hari Rentala *Head of Mutuals Support Programme, Cabinet Office*

1215 Final Q&A

- Lunch -

REGISTRATION

If you or a colleague from your Trust would like to attend the workshop, please RSVP to info@mutualventures.co.uk detailing the name, job title and contact details of the delegate. With 30 spaces available, attendance is limited to one delegate per Trust.

To:	**Trust Board**
From:	**Rachel Overfield - Chief Nurse**
Date:	**28th August 2014**
CQC regulation:	Outcome 16 – Assessing and Monitoring the Quality of Service Provision

Title:	**UHL RISK REPORT INCORPORATING THE BOARD ASSURANCE FRAMEWORK (BAF) 2014-15**

Author/Responsible Director: Chief Nurse

Purpose of the Report:

This report provides the Trust Board (TB) with:-

a) A copy of the UHL BAF and action tracker as of 31st July 2014.

b) Notification of any new extreme or high risks opened during July 2014

The Report is provided to the Board for:

Decision		Discussion	
Assurance	**X**	Endorsement	

Summary :

- In relation to the 2014/15 BAF the TB is asked to note the following:

  The 'controls' element of the BAF now reflects the processes and plans in place to secure the delivery of each objective.

  The 'current risk scores' for risks 11, 12 and 14 have been reduced to the target scores as no gaps in control or assurance have been noted..

  Completion dates are under discussion and are yet to be agreed in relation to actions 8.3 and 21.2,

  Previous action 9.2 has been removed following further review of the BAF content by the Director of Strategy.

- Three new high risks have opened on the UHL organisational risk register during July 2014

Recommendations:

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

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

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

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

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

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

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

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST

REPORT TO: **UHL TRUST BOARD**

DATE: **28th AUGUST 2014**

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

SUBJECT: **UHL BOARD ASSURANCE FRAMEWORK 2014/15**

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1 INTRODUCTION

1.1 This report provides the Trust Board (TB) with:-

a) A copy of the revised UHL BAF as of 31st July 2014.
b) Notification of any new extreme or high risks opened during July 2014.
c) Notification of all extreme and high risks that are on the UHL risk register as of 31st July 2014.

2. 2014/15 BAF AS OF 31st JULY 2014

2.1 Following the endorsement of the 2014/15 BAF at the July TB meeting all actions associated with each BAF entry have been recorded on the 2014/15 'action tracker' and respective directors have updated the action tracker to show progress up to and including 31st July 2014.

2.2 A copy of the 2014/15 BAF is attached at appendix 1 with changes since the previous version highlighted in red text. A copy of the action tracker is attached at appendix 2.

2.3 All risks from the 2013/14 BAF have been subsumed into the 2014/15 version with the exception of risks around business continuity and in this instance the risks will be transferred to the organisational risk register under the ownership of the *'Operations'* directorate.

2.4 In relation to the 2014/15 BAF the TB is asked to note the following points:

a. The 'controls' element of the BAF now reflects the processes and plans in place to secure the delivery of each objective.

b. The 'current risk scores' for risks 11, 12 and 14 have been reduced to the target scores as no gaps in control or assurance have been noted.

c. Completion dates are under discussion and are yet to be agreed in relation to actions 8.3 and 21.2,

d. Previous action 9.2 has been removed following further review of the BAF content by the DS.

e. As previously agreed the TB will continue to review 3 BAF risks at each meeting. The sequencing of this will be in numerical order of the risks and therefore the following risks will be presented:

- Risk 1 – Lack of progress in implementing the Quality Commitment. (Chief Nurse)
- Risk 2 - Failure to implement LLR emergency care improvement plan. (Chief Operating Officer)

- Risk 3 - Failure to effectively implement UHL Emergency Care quality programme. (Chief Operating Officer).

3. EXTREME AND HIGH RISK REPORT.

3.1 Three new high risks have opened on the UHL organisational risk register during July 2014 as described below. The details of these risks are included at appendix 3 for information.

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Risk ID	Risk Title	Risk	CMG/Corporate Directorate
2398	There is a risk of patient cancellations due to the limited number of Cardiac Scrub Nurses with competence to perform the task	20	ITAPS
2399	Risk of not being able to deliver enough theatre additional sessions to meet the RTT Target for the Trust	16	ITAPS
2400	Ward 23 has significantly reduced nursing staffing levels increasing a risk of harm and quality of patient delivery	16	Emergency & Specialist Medicine

4. RECOMMENDATIONS

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

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

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

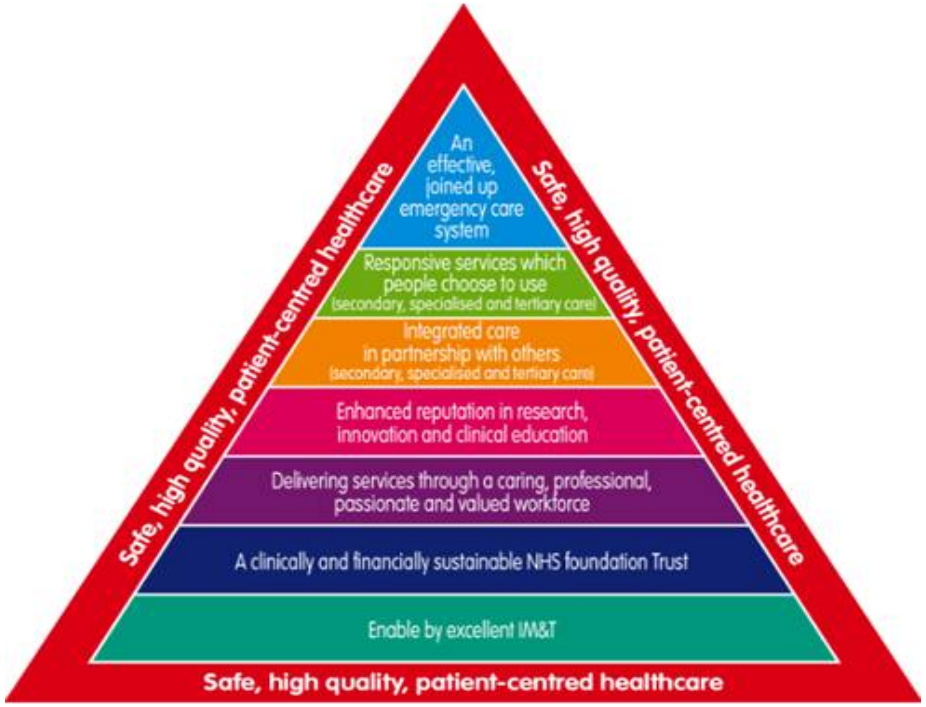
(c) identify any areas which it feels that the Trust's controls are inadequate and do not, therefore, effectively manage the principal risks to the organisation achieving its objectives;

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

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

Peter Cleaver
Risk and Assurance Manager
20th August 2014

UHL BOARD ASSURANCE FRAMEWORK 2014/15



UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST – BOARD ASSURANCE FRAMEWORK

STRATEGIC OBJECTIVES

Objective	Description	Objective Owner(s)
a	Safe, high quality, patient centred healthcare	Chief Nurse
b	An effective, joined up emergency care system	Chief Operating Officer
c	Responsive services which people choose to use (secondary, specialised and tertiary care)	Director of Strategy / Chief Operating Officer/ Director of Marketing & Communications
d	Integrated care in partnership with others(secondary, specialised and tertiary care)	Director of Strategy
e	Enhanced reputation in research, innovation and clinical education	Medical Director
f	Delivering services through a caring, professional, passionate and valued workforce	Director of Human Resources
g	A clinically and financially sustainable NHS Foundation Trust	Director of Finance
h	Enabled by excellent IM&T	Chief Executive / Chief Information Officer

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST – BOARD ASSURANCE FRAMEWORK

PERIOD: JULY 2014

Risk No.	Link to objective	Description	Risk owner	Current Score C x L	Target Score C x L
1.	Safe, high quality, patient centred healthcare	Lack of progress in implementing UHL Quality Commitment.	CN	12	8
2.	An effective joined up emergency care system	Failure to implement LLR emergency care improvement plan.	COO	12	6
3.		Failure to effectively implement UHL Emergency Care quality programme	COO	12	6
4.		Delay in the approval of the Emergency Floor Business Case.	MD	9	6
5.	Responsive services which people choose to use (secondary, specialised and tertiary care)	Failure to deliver RTT improvement plan.	COO	9	6
6.		Failure to achieve effective patient and public involvement	DMC	12	8
7.		Failure to effectively implement Better Care together (BCT) strategy.	DS	12	8
8.		Failure to respond appropriately to specialised service specification.	DS	15	8
	Integrated care in partnership with others (secondary, specialised and tertiary care)	Failure to effectively implement Better Care together (BCT) strategy.**(See 7 above)**	DS		
9.		Failure to implement network arrangements with partners.	DS	8	6
10.		Failure to develop effective partnership with primary care and LPT.	DS	12	8
11.	Enhanced reputation in research, innovation and clinical education	Failure to meet NIHR performance targets.	MD	6	6
12.		Failure to retain BRU status.	MD	6	6
13.		Failure to provide consistently high standards of medical education.	MD	9	4
14.		Lack of effective partnerships with universities.	MD	6	6
15.	Delivering services through a caring, professional, passionate and valued workforce	Failure to adequately plan workforce needs of the Trust.	DHR	12	8
16.		Inability to recruit and retain staff with appropriate skills.	DHR	12	8
17.		Failure to improve levels of staff engagement.	DHR	9	6
18	A clinically and	Lack of effective leadership capacity and capability	DHR	9	6

19.	financially sustainable NHS Foundation Trust	Failure to deliver the financial strategy (including CIP).	DF	15	10
20		Failure to deliver internal efficiency and productivity improvements.	COO	16	6
21.		Failure to maintain effective relationships with key stakeholders	DMC	15	10
22.		Failure to deliver service and site reconfiguration programme and maintain the estate effectively.	DS	10	5
23.	Enabled by excellent IM&T	Failure to effectively implement EPR programme.	CIO	15	9
24.		Failure to implement the IM&T strategy and key projects effectively	CIO	15	9

Consequence and Likelihood Descriptors:

Impact/Consequence			**Likelihood**	
5	Extreme	Catastrophic effect upon the objective, making it unachievable	5	Almost Certain (81%+)
4	Major	Significant effect upon the objective, thus making it extremely difficult/ costly to achieve	4	Likely (61% - 80%)
3	Moderate	Evident and material effect upon the objective, thus making it achievable only with some moderate difficulty/cost.	3	Possible (41% - 60%)
2	Minor	Small, but noticeable effect upon the objective, thus making it achievable with some minor difficulty/ cost.	2	Unlikely (20% - 40%)
1	Insignificant	Negligible effect upon the achievement of the objective.	1	Rare (Less than 20%)

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST – BOARD ASSURANCE FRAMEWORK

Principal risk 1	Lack of progress in implementing UHL Quality Commitment.	**Overall level of risk to the achievement of the objective**	**Current score 4 x 3 = 12**	**Target score 4 x 2 = 8**
Executive Risk Lead(s)	Chief Nurse			
Link to strategic objectives	Provide safe, high quality, patient centred healthcare			

Key Controls(What control measures or systems are in place to assist secure delivery of the objective)	**Assurance Source** (Provide examples of recent reports considered by Board or committee where delivery of the objectives is discussed and where the board can gain evidence that controls are effective).	**Gaps in Assurance (a)/ Control (c)** (i.e. What are we not doing - What gaps in systems, controls and assurance have been identified)	**Actions to Address Gaps**	**Timescale/ Action Owner**
Corporate leads agreed for all component parts of the Quality Commitment.	Q&P Report. Reports to EQB and QAC.	(c) Quality Commitment not fully embedded within organisation	Corporate leads to embed QC into organisation (1.1)	September 2014 Chief Nurse
Objectives agreed for all parts of the Quality Commitment.	Reports to EQB and QAC based on key outcome/KPIs.	(a) KPIs for QC not fully developed	Corporate leads to develop KPIs (1.2)	September 2014 Chief Nurse
Clear action plans agreed for all parts of the Quality Commitment.	Action plans reviewed regularly at EQB and annually reported to QAC. Annual reports produced.	(c) Some action plans remain outstanding.	Corporate leads to complete action plans (1.3)	September 2014 Chief Nurse
Committee structure is in place to ensure delivery of key work streams – led by appropriate senior individuals with appropriate support.	Regular committee reports. Annual reports. Achievement of KPIs.	No gaps identified		

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST – BOARD ASSURANCE FRAMEWORK

Principal risk 2	Failure to implement LLR emergency care improvement plan.	**Overall level of risk to the achievement of the objective**	**Current score 4 x 3 = 12**	**Target score 3 x 2 = 6**
Executive Risk Lead(s)	Chief Operating Officer			
Link to strategic objectives	An effective joined up emergency care system			

Key Controls(What control measures or systems are in place to assist secure delivery of the objective)	**Assurance Source** (Provide examples of recent reports considered by Board or committee where delivery of the objectives is discussed and where the board can gain evidence that controls are effective).	**Gaps in Assurance (a)/ Control (c)** (i.e. What are we not doing - What gaps in systems, controls and assurance have been identified)	**Actions to Address Gaps**	**Timescale/ Action Owner**
Establishment of emergency care delivery and improvement group with named sub groups	Meetings are minuted with actions circulated each week. Trust Board emergency care report references the LLR steering group actions.			
Appointment of Dr Ian Sturgess to work across the health economy	Weekly meetings between Dr Sturgess, UHL CEO and UHL COO. Dr Sturgess attends Trust Board.	(c) Dr Sturgess is contracted to finish work here in mid-November 2014.	CEO and Dr Sturgess to agree plans to ensure his legacy is sustainable(2.2)	Aug 2014 CE
Allocation of winter monies	Allocation of winter monies is regularly discussed in the LLR steering group			

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST – BOARD ASSURANCE FRAMEWORK

Principal risk 3	Failure to effectively implement UHL Emergency Care quality programme.	**Overall level of risk to the achievement of the objective**	**Current score 4 x 3 = 12**	**Target score 3 x 2 = 6**
Executive Risk Lead(s)	Chief Operating Officer			
Link to strategic objectives	An effective joined up emergency care system			

Key Controls(What control measures or systems are in place to assist secure delivery of the objective)	**Assurance Source** (Provide examples of recent reports considered by Board or committee where delivery of the objectives is discussed and where the board can gain evidence that controls are effective).	**Gaps in Assurance (a)/ Control (c)** (i.e. What are we not doing - What gaps in systems, controls and assurance have been identified)	**Actions to Address Gaps**	**Timescale/ Action Owner**
Emergency care action team meeting has been remodelled as the 'emergency quality steering group' (EQSG) chaired by CEO and significant clinical presence in the group. Four sub groups are chaired by three senior consultants and chief nurse.	Trust Board are sighted on actions and plans coming out of the EQSG meeting.	(C) Progress has been made with actions outside of ED and we now need to see the same level of progress inside it	Subgroup to focus on the front end of the pathway to ensure progress within ED (3.1)	Sep 2014 COO
Reworked emergency plans are focussing on the new dashboard with clear KPIs which indicates which actions are working and which aren't	Dashboard goes to EQSG and Trust Board	(C) ED performance against national standards	As above	Sep 2014 COO

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST – BOARD ASSURANCE FRAMEWORK

Principal risk 4	Delay in the approval of the Emergency Floor Business Case.	**Overall level of risk to the achievement of the objective**	**Current score 3 x 3 = 9**	**Target score 3 x 2 = 6**
Executive Risk Lead(s)	Medical Director			
Link to strategic objectives	An effective joined up emergency care system			

Key Controls(What control measures or systems are in place to assist secure delivery of the objective)	**Assurance Source** (Provide examples of recent reports considered by Board or committee where delivery of the objectives is discussed and where the board can gain evidence that controls are effective).	**Gaps in Assurance (a)/ Control (c)** (i.e. What are we not doing - What gaps in systems, controls and assurance have been identified)	**Actions to Address Gaps**	**Timescale/ Action Owner**
Monthly ED project program board to ensure submission to NTDA as required Gateway review process Engagement with stakeholders	Monthly reports to Executive Team and Trust Board Gateway review	(c) Inability to control NTDA internal approval processes	Regular communication with NTDA (4.1)	Aug 2014 MD

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST – BOARD ASSURANCE FRAMEWORK

Principal risk 5	Failure to deliver RTT improvement plan.	**Overall level of risk to the achievement of the objective**	**Current score 3 x 3 = 9**	**Target score 3 x 2 = 6**
Executive Risk Lead(s)	Chief Operating Officer			
Link to strategic objectives	Responsive services which people choose to use (secondary, specialised and tertiary care)			

Key Controls(What control measures or systems are in place to assist secure delivery of the objective)	**Assurance Source** (Provide examples of recent reports considered by Board or committee where delivery of the objectives is discussed and where the board can gain evidence that controls are effective).	**Gaps in Assurance (a)/ Control (c)** (i.e. What are we not doing - What gaps in systems, controls and assurance have been identified)	**Actions to Address Gaps**	**Timescale/ Action Owner**
Fortnightly RTT meeting with commissioners to monitor overall compliance with plan	Trust Board receives a monthly report detailing performance against plan	(c) UHL is behind trajectory on its admitted RTT plan	Action plans to be developed in key specialities – general surgery and ENT to regain trajectory (5.1)	Sept 2014 COO
Weekly meeting with key specialities to monitor detailed compliance with plan	Trust Board receives a monthly report detailing performance against plan	(c) UHL is behind trajectory on its admitted RTT plan	As above	Sep 2014 COO
Intensive support team back in at UHL (July 2014) to help check plan is correct	IST report including recommendations to be presented to Trust Board	(a) Report has not been seen yet	Await publication of report and act on findings and recommendations (5.2)	Aug 2014 COO

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST – BOARD ASSURANCE FRAMEWORK

Principal risk 6	Failure to achieve effective patient and public involvement	**Overall level of risk to the achievement of the objective**	**Current score 4x3=12**	**Target score 4x2=8**
Executive Risk Lead(s)	Director of Marketing and Communications			
Link to strategic objectives	Responsive services which people choose to use (secondary, specialised and tertiary care)			

Key Controls(What control measures or systems are in place to assist secure delivery of the objective)	**Assurance Source** (Provide examples of recent reports considered by Board or committee where delivery of the objectives is discussed and where the board can gain evidence that controls are effective).	**Gaps in Assurance (a)/ Control (c)** (i.e. What are we not doing - What gaps in systems, controls and assurance have been identified)	**Actions to Address Gaps**	**Timescale/ Action Owner**
1. PPI / stakeholder engagement Strategy Named PPI leads in all CMGs 2. PPI reference group meets regularly to assess progress against CMG PPI plans 3. Patient Advisors appointed to CMGs 4. Patient Advisor Support Group Meetings receive regular updates on PPI activity and advisor involvement 5. Bi-monthly Membership Engagement Forums 6. Health watch representative at UHL Board meeting 7. PPI input into recruitment of Chair / Exec' Directors 8. Quarterly meetings with LLR Health watch organisations, including Q's from public. 9. Quarterly meetings with Leicester Mercury Patient Panel	Emergency floor business case (Chapel PPI activity) PPI Reference group reports to QAC July Board Development session discussion about PPI resource. Health watch updates to the Board Patient Advisor Support Group and Membership Forum minutes to the Board.	PPI/ stakeholder engagement strategy requires revision Time available for CMG leads to devote to PPI activity Incomplete PPI plans in some CMGs PA vacancies (4) Single handed PPI resource corporately	Update the PPI/stakeholder engagement strategy (6.1) Revised PPI plan (6.2) OD team involvement to reenergise the vision and purpose of Patient Advisors (6.3)	Sep 2014 DMC Sept 14 DMC Oct 14 DMC

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST – BOARD ASSURANCE FRAMEWORK

Principal risk 7	Failure to effectively implement Better Care together (BCT) strategy.	**Overall level of risk to the achievement of the objective**	**Current score 4 x 3 = 12**	**Target score 4 x 2 = 8**
Executive Risk Lead(s)	Director of Strategy			
Link to strategic objectives	Responsive services which people choose to use (secondary, specialised and tertiary care) Integrated care in partnership with others (secondary, specialised and tertiary care)			

Key Controls(What control measures or systems are in place to assist secure delivery of the objective)	**Assurance Source** (Provide examples of recent reports considered by Board or committee where delivery of the objectives is discussed and where the board can gain evidence that controls are effective).	**Gaps in Assurance (a)/ Control (c)** (i.e. What are we not doing - What gaps in systems, controls and assurance have been identified)	**Actions to Address Gaps**	**Timescale/ Action Owner**
Better Care Together Strategy: **1)** UHL actively engaged in the Better Care Together governance structure, from an operational to strategic level: • John Adler - the Chair of the Strategy Delivery Group • Kate Shields - member of the LLR Strategy Delivery Group • Peter Hollinshead / Simon Sheppard - members of the finance sub-group **2)** Better Care Together plans co–created in partnership with LLR partners e.g. sub-acute project with LPT	LLR Better Care Together Executive Summary (directional plan): o received and approved at the June 2014 UHL Trust Board meeting	(c) Work plan for June to September 2014 yet to developed	Work plan to be developed by the LLR BCT Strategy Delivery Group to be considered by the BCT Programme (7.1)	Aug 2014 DS
Effective partnerships with primary care and Leicestershire Partnership Trust (LPT): 1) Active engagement and leadership of the LLR Elective Care Alliance 2) LLR Urgent Care and Planned Care work streams in partnership with local GPs 3) A joint project has been established to test the concept of early transfer of sub-acute care to a community hospitals setting or home in partnership with LPT. The impact of this is reflected in UHLs, LPTs the LLR BCT 5 year plans. 4) Mutual accountability for the delivery of shared objectives are reflected in the LLR BCT 5 year directional plan	Minutes of the June public Trust Board meeting: o Trust Board approved the LLR BCT 5 year directional plan and UHLs 5 year directional plan on 16 June, 2014 o urgent care and planned care work streams reflected in both of these plans	(c) respective partnership plans need not yet reconciled or developed in a greater level of detail to support operational delivery.	Work plans to be reconciled and developed by the LLR BCT Strategy Delivery Group to be considered by LLR BCT Programme (7.2)	Aug 2014 DS/ COO

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST – BOARD ASSURANCE FRAMEWORK

Principal risk 8	Failure to respond appropriately to specialised service specification.	**Overall level of risk to the achievement of the objective**	**Current score 5 x 3 = 15**	**Target score 4 x 2 = 8**
Executive Risk Lead(s)	Director of Strategy			
Link to strategic objectives	Responsive services which people choose to use (secondary, specialised and tertiary care) Integrated care in partnership with others (secondary, specialised and tertiary care)			

Key Controls(What control measures or systems are in place to assist secure delivery of the objective)	**Assurance Source** (Provide examples of recent reports considered by Board or committee where delivery of the objectives is discussed and where the board can gain evidence that controls are effective).	**Gaps in Assurance (a)/ Control (c)** (i.e. What are we not doing - What gaps in systems, controls and assurance have been identified)	**Actions to Address Gaps**	**Timescale/ Action Owner**
(i) Regional partnerships: UHL is actively engaging with partners with a view to: • establishing a Leicestershire Northamptonshire and Rutland partnership for the specialised service infrastructure in partnership with Northampton General Hospital and Kettering General Hospital • establishing a provider collaboration across the East Midland's as a whole • Developing an engagement strategy for the delivery of the long term vision for and East Midlands network for both acute and specialised services	Minutes of the April 2014 Trust Board meeting: o Paper presented to the April 2014 UHL Trust Board meeting, setting out the Trust's approach to regional partnerships Project Initiation Document (PID): o Developed as part of UHL's Delivering Care at its Best o Reviewed at the June 2014 Executive Strategy Board (ESB) meeting	(c) No Head of External Partnership Development or administrative support (c) Lack of Programme Plan	Highlight report to be presented at the August 2014 ESB meeting for approval. (8.1) Appoint Head of Partnerships and admin support (8.2) Programme Plan to be developed (8.3)	Aug 2014 DS Dec 2014 DS TBA DS
(ii) Academic and commercial partnerships.		c) Lack of PID for academic and commercial partnerships	PIDs to be developed and overarching highlight report to be presented at the August 2014 ESB for sign off. (8.5)	DR&D Aug 2014
(iii) Local partnerships		(c) Lack of PID for local partnerships		Aug 2014 DMC
Specialised Services specifications: CMGs addressing Specialised Service derogation plans	Plans issued to CMGs in February 2014. Follow up meetings being convened for w/c 14th July 2014to identify progress to date.	(a) Currently no mechanism in place to monitor progress	Contracts Team to develop monthly reporting tool to track progress (8.4)	Sep 2014 DS

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST – BOARD ASSURANCE FRAMEWORK

Principal risk 9	Failure to implement network arrangements with partners.	**Overall level of risk to the achievement of the objective**	**Current score 4 x 2 = 8**	**Target score 3 x 2 = 6**
Executive Risk Lead(s)	Director of Strategy			
Link to strategic objectives	Integrated care in partnership with others (secondary, specialised and tertiary care)			

Key Controls(What control measures or systems are in place to assist secure delivery of the objective)	**Assurance Source** (Provide examples of recent reports considered by Board or committee where delivery of the objectives is discussed and where the board can gain evidence that controls are effective).	**Gaps in Assurance (a)/ Control (c)** (i.e. What are we not doing - What gaps in systems, controls and assurance have been identified)	**Actions to Address Gaps**	**Timescale/ Action Owner**
Directional 5 year Integrated Business Plan (IBP) submitted to the NHS Trust Development Authority (NTDA) defines three principle partnership networks to support the integration of services (Local, regional and academic). These will progress in a structured and methodical way. Clear lines of reporting have been established through the Executive Strategy Board (ESB) Delivering Care at its Best structure. Highlight reports will be presented to monitor progress.	Minutes of the April 2014 Trust Board meeting: o Paper presented to the April 2014 UHL public Trust Board meeting, describing the development of an East Midlands Provider Partnership Project Initiation Document (PID): o Developed as part of UHL's Delivering Care at its Best o Reviewed at the June 2014 ESB meeting			
Regional partnerships: UHL is actively engaging with partners with a view to: • establishing a Leicestershire Northamptonshire and Rutland partnership for the specialised service infrastructure in partnership with Northampton General Hospital and Kettering General Hospital • establishing a provider collaboration across the East Midland's as a whole • Developing an engagement strategy for the delivery of the long term vision for and East Midlands network for both acute and specialised services		(c) No Head of External Partnership Development or administrative support (c) Lack of Programme Plan	See action 8.1 and 8.2 See action 8.3	See action 8.1 and 8.2 See action 8.3
Academic and commercial partnerships		c) Lack of PID for academic and commercial partnerships	See action 8.5	See action 8.5
Local partnerships		(c) Lack of PID for local partnerships		

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST – BOARD ASSURANCE FRAMEWORK

Delivery of Better Care Together: 1) UHL is actively engaged in the Better Care Together governance structure, from an operational to strategic level: • John Adler is the Chair of the Strategy Delivery Group • Kate Shields is a member of the LLR Strategy Delivery Group • DF and DDF are members of the finance sub-group 2) Better Care Together plans are co–created in partnership with LLR partners e.g. sub-acute project with LPT	LLR Better Care Together Executive Summary (directional plan): o received and approved at the June 2014 UHL Trust Board meeting	(C) Lack of detailed delivery plans to be	Work plan developed by the LLR BCT Strategy Delivery Group to be considered by the BCT Programme Board (9.2)	August 2014 DS

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST – BOARD ASSURANCE FRAMEWORK

Principal risk 10	Failure to develop effective partnership with primary care and LPT.	**Overall level of risk to the achievement of the objective**	**Current score 4 x 3 = 12**	**Target score 4 x 2 = 8**
Executive Risk Lead(s)	Director of Strategy			
Link to strategic objectives	Integrated care in partnership with others (secondary, specialised and tertiary care)			

Key Controls(What control measures or systems are in place to assist secure delivery of the objective)	**Assurance Source** (Provide examples of recent reports considered by Board or committee where delivery of the objectives is discussed and where the board can gain evidence that controls are effective).	**Gaps in Assurance (a)/ Control (c)** (i.e. What are we not doing - What gaps in systems, controls and assurance have been identified)	**Actions to Address Gaps**	**Timescale/ Action Owner**
Effective partnerships with LPT: A joint project has been established to test the concept of early transfer of sub-acute care to be delivered in community Hospitals or home in partnership with LPT for specific cohorts of patients e.g. frail older person The impact of this is reflected in UHLs, LPTs the LLR BCT 5 year plans.	Reflected in UHL directional 5 year plan presented to TB June 20 2014	(c) UHLs and LPTs 5 year plans yet to be reconciled and developed in enough detail to support operational delivery.	PID & draft Terms of Reference to be reviewed at the August 2014 ESB meeting. (10.1)	Aug 2014 DS/COO
Effective partnerships with primary care: Elective Care Alliance established with agreed terms of reference for the Leadership Board and other sub groups thereby allowing structured engagement and partnership working with local GPs through the LLR Provider Company LTD. Joint business plan under development.	Minutes of the March 2014 Trust Board meeting: o establishment of the Alliance formally approved by Trust Board in March, 2014 Minutes of ESB meetings: o Progress against plan is reported to the ESB	(c) Alliance Business Plan and our own plans not yet reconciled and developed in enough detail to support operational delivery.	Business plan to be finalised prior to consideration by the ESB and then the Trust (10.2)	Aug 2014 DS
Effective partnerships with primary care and LPT: Active engagement and leadership of the LLR Urgent Care and Planned Care work streams in partnership with local GPs. Mutual accountability for the delivery of shared objectives reflected in the LLR BCT 5 year plan.	Minutes of the June public Trust Board meeting: o Trust Board approved the LLR BCT 5 year directional plan and UHLs 5 year directional plan on 16 June, 2014 o urgent care and planned care work streams reflected in both of these plans	(c) Respective plans not yet reconciled or detailed to support operational delivery.	Work plan developed by the LLR BCT Strategy Delivery Group to be considered by the LLR BCT Programme Board. (10.3)	Aug 2014 DS

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST – BOARD ASSURANCE FRAMEWORK

Principal risk 11	Failure to meet NIHR performance targets.	**Overall level of risk to the achievement of the objective**	**Current score** 3 x 2 = 6	**Target score** 3 x 2= 6
Executive Risk Lead(s)	Medical Director			
Link to strategic objectives	Enhanced reputation in research, innovation and clinical education			

Key Controls(What control measures or systems are in place to assist secure delivery of the objective)	**Assurance Source** (Provide examples of recent reports considered by Board or committee where delivery of the objectives is discussed and where the board can gain evidence that controls are effective).	**Gaps in Assurance (a)/ Control (c)** (i.e. What are we not doing - What gaps in systems, controls and assurance have been identified)	**Actions to Address Gaps**	**Timescale/ Action Owner**
Action Plan developed in response to the introduction of national metrics and potential for financial sanctions	Performance in Initiation & Delivery of Clinical Research (PID) reports from NIHR – to CE and R&D (quarterly) UHL R&D Executive (monthly) R&D Report to Trust Board (quarterly) R&D working with CMG Research Leads to educate and embed understanding of targets across CMGs (regular; as required)	No gaps identified		

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST – BOARD ASSURANCE FRAMEWORK

Principal risk 12	Failure to retain BRU status.	**Overall level of risk to the achievement of the objective**	**Current score** 3 x 2 = 6	**Target score** 3 x 2 = 6
Executive Risk Lead(s)	Medical Director			
Link to strategic objectives	Enhanced reputation in research, innovation and clinical education			

Key Controls(What control measures or systems are in place to assist secure delivery of the objective)	**Assurance Source** (Provide examples of recent reports considered by Board or committee where delivery of the objectives is discussed and where the board can gain evidence that controls are effective).	**Gaps in Assurance (a)/ Control (c)** (i.e. What are we not doing - What gaps in systems, controls and assurance have been identified)	**Actions to Address Gaps**	**Timescale/ Action Owner**
Maintaining relationships with key partners to support joint NIHR/ BRU infrastructure	Joint BRU Board (bimonthly) Annual Report Feedback from NIHR for each BRU (annual) UHL R&D Executive (monthly) R&D Report to Trust Board (quarterly) Athena Swan Silver Status by University of Leicester and Loughborough University. (The Athena Swan charter applies to higher education institutions)	No gaps identified		

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST – BOARD ASSURANCE FRAMEWORK

Principal risk 13	Failure to provide consistently high standards of medical education.	**Overall level of risk to the achievement of the objective**	**Current score 3 x 3 = 9**	**Target score 2 x 2 = 4**
Executive Risk Lead(s)	Medical Director			
Link to strategic objectives	Enhanced reputation in research, innovation and clinical education			

Key Controls(What control measures or systems are in place to assist secure delivery of the objective)	**Assurance Source** (Provide examples of recent reports considered by Board or committee where delivery of the objectives is discussed and where the board can gain evidence that controls are effective).	**Gaps in Assurance (a)/ Control (c)** (i.e. What are we not doing - What gaps in systems, controls and assurance have been identified)	**Actions to Address Gaps**	**Timescale/ Action Owner**
Medical Education Strategy	Department of Clinical Education (DCE) Business Plan and risk register are discussed at regular DCE Team Meetings and information given to the Trust Board quarterly Medical Education issues championed by Trust Chairman Bi-monthly UHL Medical Education Committee meetings (including CMG representation) Oversight by Executive Workforce Board Appointment processes for educational roles established KPI are measured using the: • UHL Education Quality Dashboard • CMG Education Leads and stakeholder meetings • GMC Trainee Survey results • UHL trainee survey • Health Education East Midlands Accreditation visits	(c) Transparent and accountable management of postgraduate medical training tariff is not yet established (c) Transparent and accountable management of SIFT funding not yet identified in CMGs (proposal prepared for EWB) (c) Job Planning for Level 2 (SPA) Educational Roles not written into job descriptions (c) Appraisal not performed for Educational Roles	To work with Finance to address all funding issues (13.1) Ensure appropriate Consultant Job descriptions include job planning (13.2) Develop appraisal methodology for educational roles (13.3) Disseminate agreed	Oct 2014 MD Jan 2015 MD Jan 2015 MD Jan 2015

		Trainee Drs in community – anomalous location in DCE budgets	appraisal methodology to CMG s (13.4) Work to relocate to HR as other Foundation doctor contracts (13.5)	MD Dec 2014 MD
UHL Education Committee	CMG Education Leads sit on Committee. Education Committee delivers to the Workforce Board twice monthly and Prof. Carr presents to the Trust Board Quarterly.	No system of appointing to College Tutor Roles	Develop more robust system of appointment and appraisal of disparate roles by separating College Tutor roles in order to be able to appoint and appraise as College Tutors	Jan 2015 MD

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST – BOARD ASSURANCE FRAMEWORK

Principal risk 14	Lack of effective partnerships with universities.	**Overall level of risk to the achievement of the objective**	**Current score** 3 x 2 = 6	**Target score** 3 x 2= 6
Executive Risk Lead(s)	Medical Director			
Link to strategic objectives	Enhanced reputation in research, innovation and clinical education			

Key Controls(What control measures or systems are in place to assist secure delivery of the objective)	**Assurance Source** (Provide examples of recent reports considered by Board or committee where delivery of the objectives is discussed and where the board can gain evidence that controls are effective).	**Gaps in Assurance (a)/ Control (c)** (i.e. What are we not doing - What gaps in systems, controls and assurance have been identified)	**Actions to Address Gaps**	**Timescale/ Action Owner**
Maintaining relationships with key academic partners	Joint Strategic Meeting (University of Leicester and UHL Trust) Joint BRU Board (quarterly) UHL R&D Executive (monthly)	No gaps identified		

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST – BOARD ASSURANCE FRAMEWORK

Principal risk 15	Failure to adequately plan the workforce needs of the Trust.	**Overall level of risk to the achievement of the objective**	**Current score 4 x 3 = 12**	**Target score 4 x 2 = 8**
Executive Risk Lead(s)	Director of Human Resources			
Link to strategic objectives	Delivering services through a caring, professional, passionate and valued workforce			

Key Controls(What control measures or systems are in place to assist secure delivery of the objective)	**Assurance Source** (Provide examples of recent reports considered by Board or committee where delivery of the objectives is discussed and where the board can gain evidence that controls are effective).	**Gaps in Assurance (a)/ Control (c)** (i.e. What are we not doing - What gaps in systems, controls and assurance have been identified)	**Actions to Address Gaps**	**Timescale/ Action Owner**
UHL Workforce Plan (by staff group)	Reduction in number of 'hotspots' for staff shortages across UHL reported as part of workforce plan update. Executive Workforce Board will consider progress in relation to the overarching workforce plan through highlight report from CMG action plans.	(c) Workforce planning difficult to forecast more than a year ahead as changes are often dependent on transformation activities outside UHL (e.g. social services/ community services and primary care and broad based planning assumptions around demographics and activity).	Develop an integrated approach to workforce planning with LPT in order that we can plan an overall workforce to deliver the right care in right place at the right time. (15.1)	Oct 2014 DHR
			Establish a joint group of strategy, finance and workforce leads to share plans and numbers (15.2)	Oct 2014 DHR
		(c) Difficulty in recruiting to hotspots as frequently reflect a national shortage occupation (e.g. nurses)	Establish Multi-professional new roles group to devise and monitor processes for the creation of new roles (15.3)	Oct 2014 CN

			Develop Innovative approaches to recruitment and retention to address shortages. (15.4)	Mar 2015 DHR
Nursing Recruitment Trajectory and international recruitment plan in place for nursing staff	Overall nursing vacancies are monitored and reported monthly by the Board and NET as part of the Quality and Performance Report NHS Choices will be publishing the planned and actual number of nurses on each shift on every inpatient ward in England			
Development of an Employer Brand and Improved Recruitment Processes	Reports of the LIA recruitment project Reports to Executive Workforce Board regarding innovative approaches to recruitment	(c) Capacity to develop and build employer brand marketing	Delivering our Employer Brand group to share best practice and development social media techniques to promote opportunities at UHL (15.6)	Mar 2015 DHR
		(c) Capacity to build innovative approaches to recruitment of future service/ operational managers	Development of internship model and potential management trainee model supported by robust education programme and education scheme. (15.7)	Nov 2014 DHR
		(c) capacity to build innovative approaches to consultant recruitment	Consultant recruitment review team to develop professional assessment centre approach to	April 2015 DHR

			recruitment utilising outputs to produce a development programme (15.8)	

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST – BOARD ASSURANCE FRAMEWORK

Principal risk 16	Inability to recruit and retain staff with appropriate skills.	**Overall level of risk to the achievement of the objective**	**Current score 4 x 3 = 12**	**Target score 4 x 2 = 8**
Executive Risk Lead(s)	Director of Human Resources			
Link to strategic objectives	Delivering services through a caring, professional, passionate and valued workforce			

Key Controls(What control measures or systems are in place to assist secure delivery of the objective)	**Assurance Source** (Provide examples of recent reports considered by Board or committee where delivery of the objectives is discussed and where the board can gain evidence that controls are effective).	**Gaps in Assurance (a)/ Control (c)** (i.e. What are we not doing - What gaps in systems, controls and assurance have been identified)	**Actions to Address Gaps**	**Timescale/ Action Owner**
Refreshed Organisational Development Plan (2014-16) including five work streams: 'Live our Values' by embedding values in HR processes including values based recruitment, implementing our Reward and Recognition Strategy (2014-16) and continuing to showcase success through Caring at its Best Awards	Quarterly reports to EWB and Trust Board and measured against implementation plan milestones set out in PID	(a) Improvements required in 'measuring how we are doing'	Team Health Dashboard to be developed – mock up to be presented to EWB at September Meeting (16.1)	Sep 2014 DHR
'Improve two-way engagement and empower our people' by implementing the next phase of Listening into Action (see Principal Risk 16), building on medical engagement, experimenting in autonomy incentivisation and shared governance and further developing health and wellbeing and Resilience Programmes.	Quarterly reports to and EWB and measured against Implementation Plan Milestones set out in PID	No gaps identified		
'Strengthen leadership' by implementing the Trust's Leadership into Action Strategy (2014-16) with particular emphasis on 'Trust Board Effectiveness', 'Technical Skills Development' and 'Partnership Working'	Quarterly reports to EWB and bi-monthly reports to UHL LETG. Measured against implementation Plan milestones set out in PID	No gaps identified		
'Enhance workplace learning' by building on training capacity and resources, improvements in medical education and developing new roles	Quarterly report to EQB, EWB and bi-monthly reports to UHL LETG and LLR WDC. Measured against implementation plan milestones set out in PID	(a) eUHL System requires significant improvement in centrally managing all development activity (c) Robust processes required in relation to e-learning development	eUHL system updates required to meet Trust needs (16.2) Robust ELearning policy and procedures to be developed (16.3)	Mar 2015 DHR Oct 2014 DHR
'Quality Improvement and innovation' by implementing quality	Quarterly reports to EQB and EWB and measured	No gaps identified		

improvement education, continuing to develop quality improvement networks and creating a Leicester Improvement and Innovation Centre	against implementation plan milestones set out in PID.			
Appraisal and Objective Setting in line with Strategic Direction	Appraisal rates reported monthly via Quality and Performance Report. Appraisal performance features on CMG/Directorate Board Meetings. Board/CMG Meetings to monitor the implementation of agreed local improvement actions	No gaps identified		

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST – BOARD ASSURANCE FRAMEWORK

Principal risk 17	Failure to improve levels of staff engagement	**Overall level of risk to the achievement of the objective**	**Current score 3 x 3 = 9**	**Target score 3 x 2 = 6**
Executive Risk Lead(s)	Director of Human Resources			
Link to strategic objectives	Delivering services through a caring, professional, passionate and valued workforce			

Key Controls(What control measures or systems are in place to assist secure delivery of the objective)	**Assurance Source** (Provide examples of recent reports considered by Board or committee where delivery of the objectives is discussed and where the board can gain evidence that controls are effective).	**Gaps in Assurance (a)/ Control (c)** (i.e. What are we not doing - What gaps in systems, controls and assurance have been identified)	**Actions to Address Gaps**	**Timescale/ Action Owner**
Year 2 Listening into Action (LiA) Plan (2014 to 2015) including five work streams: Work stream One: **Classic LiA** • Two waves of Pioneering teams to commence (with 12 teams per wave) using LiA to address changes at a ward/department/pathway level	Quarterly reports to Executive Workforce Board (EWB) and Trust Board Updates provided to LiA Sponsor group on success measures per team and reports on Pulse Check improvements Annual Pulse Check Survey conducted (next due in Feb 2015) Update reports provided to JSCNC meetings	(a Lack of triangulation of LiA Pulse Check Survey results with National Staff Opinion Survey and Friends and Family Test for Staff	Team Health Dashboard to be developed – mock up to be presented to EWB at September 2014 meeting (Please see Principal Risk 15) (17.1)	Mar 2015 DHR
Work stream Two: **Thematic LiA** • Supporting senior leaders to host Thematic LiA activities. These activities will respond to emerging priorities within Executive Directors' portfolios. Each Thematic event will be hosted and led by a member of the Executive Team or delegated lead.	Quarterly reports to Executive Workforce Board (EWB) and Trust Board Updates provided to LiA Sponsor group on each thematic activity Update reports provided to JSCNC meetings	No gaps identified		
Work stream Three: **Management of Change LiA** • LiA Engagement Events held as a precursor to change projects associated with service transformation and / or HR Management of Change (MoC) initiatives.	Quarterly reports to Executive Workforce Board (EWB) and Trust Board Updates provided to LiA Sponsor group on each thematic activity Update reports provided to JSCNC meetings	(c Reliant on IBM / HR to notify LiA Team of MoC activity	Ensure IBM aware of requirements. (17.2) HR Senior Team aware of need to include Engagement event prior to formal	Mar 2015 DHR Mar 2015 DHR

			consultation (with MoC impacting on staff – (more than 25 people) (17.3)	
Work stream Four: **Enabling LiA** • Provide support to delivering UHL strategic priorities (Caring At its Best), where employee engagement is required.	Quarterly reports to Executive Workforce Board (EWB) and Trust Board Updates provided to LiA Sponsor group on each thematic activity Update reports provided to JSCNC meetings	(C) Resource requirements in terms of people and physical resources difficult to anticipate from LiA activity linked to Caring at its Best engagement events	Include as regular agenda item on LiA sponsor group identifying activity and anticipated resources required (17.4)	Mar 2015 DHR
Work stream Five: **Nursing into Action (NiA)** • Support all nurse led Wards or Departments to host a listening event aimed at improving quality of care provided to patients and implement any associated actions.	Quarterly reports to Executive Workforce Board (EWB) and Trust Board Updates provided to LiA Sponsor group every 6 months on success measures per set and reports on Pulse Check improvements Update reports provided to JSCNC meetings Monthly updates to Nursing Executive Team (NET) meetings via Heads of Nursing per CMG	No gaps identified		
Annual National Staff Opinion and Attitude Survey	Annual Survey report presented to EWB and Trust Board Analysis of results in comparison to previous year's results and to other similar organisations presented to EWB and Trust Board annually Updates on CMG / Corporate actions taken to address improvements to National Survey presented to EWB Staff sickness levels may also provide an indicator of staff satisfaction and performance and are reported monthly to Board via Quality and Performance report Results of National staff survey and local patient	(a) Lack of triangulation of National Staff Survey results with local Pulse Check Results (Work stream One: Classic LiA / Work stream Five: NiA) and other indicators of staff engagement such as Friends and Family Test for Staff	Please see action 17.1	Mar 2015 DHR

	polling reported to Board on a six monthly basis. Improving staff satisfaction position.			
Friends and Family Test for NHS Staff	Quarterly survey results for Quarter 1, 2 and 4 to be submitted to NHS England for external publication: Submission commencing 28 July 2014 for quarter 1 with NHS England publication commencing September 2014 Local results of response rates to be CQUIN Target for 2014/15 – to conduct survey in Quarter 1 (achieved)	(a) Survey completion criteria variable between NHS organisations per quarter. Survey to include 'NHS Workers' and not restricted to UHL staff therefore creating difficulty in comparisons between organisations as unable to identify % response rates. No guidance available regarding how NHS England will present the data published in September 2014, i.e. same format at FFT for Patients or format for National Staff Opinion and Attitude Survey. Lack of triangulation of Friends and Family Test for Staff results with local Pulse Check Results (Work stream One: Classic LiA / Work stream Five: NiA) and other indicators of staff engagement such as National Staff Survey	National data on UHL workforce numbers to be used by NHS England to get a sense of how many staff completed the survey (Same calculations being used for all other Trusts so variables consistent nationally). (17.5) Develop draft internal reports in development in readiness for possible analysis methodology used by NHS England in September 2014. (17.6) Please see action 17.1	First report published by NHS England Sep 2014 Sep 2014 DHR Mar 2015 DHR

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST – BOARD ASSURANCE FRAMEWORK

Principal risk 18	Lack of effective leadership capacity and capability	**Overall level of risk to the achievement of the objective**	**Current score** 3 x 3 = 9	**Target score** 3 x 2 = 6
Executive Risk Lead(s)	Director of Human Resources			
Link to strategic objectives	A clinically and financially sustainable NHS Foundation Trust			

Key Controls(What control measures or systems are in place to assist secure delivery of the objective)	**Assurance Source** (Provide examples of recent reports considered by Board or committee where delivery of the objectives is discussed and where the board can gain evidence that controls are effective).	**Gaps in Assurance (a)/ Control (c)** (i.e. What are we not doing - What gaps in systems, controls and assurance have been identified)	**Actions to Address Gaps**	**Timescale/ Action Owner**
Leadership into Action Strategy (2014:16) including six work streams: 'Providing Coaching and Mentoring' by developing an internal coaching and mentoring network, with associated framework and guidance which will be piloted in agreed areas (targeting clinicians at phase 1).	Quarterly Reports to Executive Workforce Board (EWB) as part of Organisational Development Plan and Learning, Education and Development Update as set out in Risk 16.	Leadership into Action Strategy not yet approved UHL Coaching and Mentoring Framework requires development	Strategy to be reviewed by EWB (18.1) Improve internal coaching and mentoring training provision in collaboration with HEEM and at phase 1 establish process for assigning coaches and mentors to newly appointed clinicians (18.2)	September 2014 DHR December 2014 DHR
'Shadowing and Buddying' by creating shadowing opportunities and devising a buddy system for new clinicians or those appointed into new roles.	Quarterly Reports to Executive Workforce Board as part of Organisational Development Plan and Learning, Education and Development Update as set out in Risk 16.	Buddying / Shadowing System Requires Development	System being developed in partnership with HEEM and Assistant Medical Director to ensure support provided to newly appointed Consultants at initial phase (18.3)	April 2015 DHR
'Improving local communications and 360 degree feedback' by	Quarterly Reports to Executive Workforce Board as	360 Feedback Tool not	360 System	August

developing and implementing a 360 Degree feedback Tool for all leaders and developing nurse leaders to facilitate Listening Events in all ward and clinical department areas as set out in Risk 17.	part of Organisational Development Plan and Learning, Education and Development Update as set out in Risk 16. Updates provided to LiA Sponsor group every 6 months on success measures Monthly updates to Nursing Executive Team (NET) meetings via Heads of Nursing per CMG	yet developed	Specification to be produced (18.4)	2014 DHR / CIO
'Shared Learning Networks' by creating and supporting learning networks across the Trust, developing action learning sets across disciplines and initiating paired learning.	Quarterly Reports to Executive Workforce Board as part of Organisational Development Plan and Learning, Education and Development Update as set out in Risk 16.	No gaps identified		
'Talent Management and Succession Planning' by developing a talent management and succession planning framework, reporting on talent profile across the senior leadership community, aligning talent activity to pay progression and ensuring succession plans are in place for business critical roles.	Quarterly Reports to Executive Workforce Board as part of Organisational Development Plan and Learning, Education and Development Update as set out in Risk 16.	Talent Management and Succession Planning Framework requires development at regional and national level with alignment to the new NHS Health Care Leadership Model	Support national and regional Talent Management and Succession Planning Projects by National NHS Leadership Academy , EMLA and NHS Employers (18.5)	March 2015 DHR
'Leadership Management and Team Development' by developing leaders in key areas, team building across CMG leadership teams, tailored Trust Board Development and devising a suite of internal eLearning programmes	Quarterly Reports to Executive Workforce Board as part of Organisational Development Plan and Learning, Education and Development Update as set out in Risk 16.	Improvement required in senior leadership style and approach as identified as part of Board Effectiveness Review (2014)	Board Coach (on appointment) to facilitate Board Development Session (18.6) Update of UHL Leadership Qualities and Behaviours to reflect Board Development, UHL 5 Year Plan and new NHS Healthcare Leadership Model (18.7)	October 2014 January 2015 CEO / DHR

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST – BOARD ASSURANCE FRAMEWORK

Principal risk 19	Failure to deliver financial strategy (including CIP).	**Overall level of risk to the achievement of the objective**	**Current score** 5 x 3 = 15	**Target score** 5 x 2 = 10
Executive Risk Lead(s)	Director of Finance			
Link to strategic objectives	A clinically and financially sustainable NHS Foundation Trust			

Key Controls(What control measures or systems are in place to assist secure delivery of the objective)	**Assurance Source** (Provide examples of recent reports considered by Board or committee where delivery of the objectives is discussed and where the board can gain evidence that controls are effective).	**Gaps in Assurance (a)/ Control (c)** (i.e. What are we not doing - What gaps in systems, controls and assurance have been identified)	**Actions to Address Gaps**	**Timescale/ Action Owner**
Delivering recurrent balance via effective management controls including SFIs, SOs and on-going Finance Training Programme Health System External Review has defined the scale of the financial challenge and possible solutions UHL Service & Financial Strategy including Reconfiguration/ SOC	Monthly progress reports to F&P Committee, Executive Board, & Trust Board Development Sessions TDA Monthly Meetings Chief Officers meeting CCGs/Trusts TDA/NHSE meetings Trust Board Monthly Reporting UHL Programme Board, F&P Committee, Executive Board & Trust Board	(C) Lack of supporting service strategies to deliver recurrent balance	Production of a FRP to deliver recurrent balance within six years (19.2)	Aug 2014 DDF
CIP performance management including CIP s as part of integrated performance management	Monthly reports to F&P committee and Trust Board. Formal sign-off documents with CMGs as part of agreement of IBPs	(C) CIP Quality Impact Assessments not yet agreed internally or with CCGs (c) PMO structure not yet in place to ensure continuity of function following departure of Ernst & Young	Expedite agreement (19.5) PMO Arrangements need to be finalised (19.6)	Aug 2014 DDF Aug 2014 DDF
Managing financial performance to deliver recurrent balance via SFI and SOs and utilising overarching financial governance processes	Monthly progress reports to Finance and Performance (F&P) Committee, Executive Board and Trust board.	(c) Finance department having difficulties in recruiting to finance posts leading to temporary staff being	Restructuring of financial management via MoC (19.8)	Review Aug 2014 DDF

		employed.		Jul 2014 DDF
Financially and operationally deliverable by contract signed off by UHL and CCGs and Specialised Commissioning on 30/6/14	Agreed contracts document through the dispute resolution process/arbitration Regular updates to F&P Committee, Executive Board, Escalation meeting between CEOs/CCG Accountable Officers			
Securing capital funding by linking to Strategy, Strategic Outline Case (SOC) and Health Systems Review and Service Strategy	Regular reporting to F&P Committee, Executive Board and Trust Board	(c) Lack of clear strategy for reconfiguration of services.	Production of Business Cases to support Reconfiguration and Service Strategy (19.10)	Review Sep 2014 DDF
Obtaining sufficient cash resources by agreeing short term borrowing requirements with TDA	Monthly reporting of cash flow to F&P Committee and Trust Board	(c) Lack of service strategy to deliver recurrent balance	Agreement of long-term loans as part of June Service and Financial plan (19.11)	Aug 2014 DDF

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST – BOARD ASSURANCE FRAMEWORK

Principal risk 20	Failure to deliver internal efficiency and productivity improvements.	**Overall level of risk to the achievement of the objective**	**Current score 4 x 4 = 16**	**Target score 3 x 2 = 6**
Executive Risk Lead(s)	Chief Operating Officer			
Link to strategic objectives	A clinically and financially sustainable NHS Foundation Trust			

Key Controls(What control measures or systems are in place to assist secure delivery of the objective)	**Assurance Source** (Provide examples of recent reports considered by Board or committee where delivery of the objectives is discussed and where the board can gain evidence that controls are effective).	**Gaps in Assurance (a)/ Control (c)** (i.e. What are we not doing - What gaps in systems, controls and assurance have been identified)	**Actions to Address Gaps**	**Timescale/ Action Owner**
CIP performance management including CIP s as part of integrated performance management	Monthly reports to F&P committee and Trust Board. Formal sign-off documents with CMGs as part of agreement of IBPs	(c) CIP Quality Impact Assessments not yet agreed internally or with CCGs (c) PMO structure not yet in place to ensure continuity of function following departure of Ernst & Young	Please see action 19.5 Please see action 19.6	Aug 2014 DDF Aug 2014 DDF
Cross cutting themes are established.	Executive Lead identified. Monthly reports to F&P committee and Trust Board	(A) Not all cross cutting themes have agreed plans and targets for delivery	Agree plans and targets through the monthly cross cutting theme delivery board (20.1)	August 2014 COO

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST – BOARD ASSURANCE FRAMEWORK

Principal risk 21	Failure to maintain effective relationships with key stakeholders	**Overall level of risk to the achievement of the objective**	**Current score 5x3=15**	**Target score 5x2=10**
Executive Risk Lead(s)	Director of Marketing and Communications			
Link to strategic objectives	A clinically and financially sustainable NHS Foundation Trust			

Key Controls(What control measures or systems are in place to assist secure delivery of the objective)	**Assurance Source** (Provide examples of recent reports considered by Board or committee where delivery of the objectives is discussed and where the board can gain evidence that controls are effective).	**Gaps in Assurance (a)/ Control (c)** (i.e. What are we not doing - What gaps in systems, controls and assurance have been identified)	**Actions to Address Gaps**	**Timescale/ Action Owner**
Stakeholder Engagement Strategy	Annual Stakeholder surveys presented to the Board Feedback from stakeholders in Board 360 as part of Foresight review. BCT strategy and planning Regular meeting with: CCGs and GPs and Health watch(s) Mercury Panel MPs and local politicians TDA / NHSE	(a) Survey is quantative and therefore improvement actions harder to identify (c) No structured key account management approach to commercial relationships (c) Commissioner (clinical) relationships can be too transactional i.e. not creative / transformational.	Qualitative survey by Trust Internal Audit (PWC) (21.1) TBA with DoS / DoF (21.2) Create a platform to launch Clinical Task Group (21.3)	Oct 14 DMC TBA Sept 14 MD

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST – BOARD ASSURANCE FRAMEWORK

Principal risk 22	Failure to deliver service and site reconfiguration programme and maintain the estate effectively.	**Overall level of risk to the achievement of the objective**	**Current score 5 x 2 = 10**	**Target score 5 x 1 = 5**
Executive Risk Lead(s)	Director of Strategy			
Link to strategic objectives	A clinically and financially sustainable NHS Foundation Trust			

Key Controls(What control measures or systems are in place to assist secure delivery of the objective)	**Assurance Source** (Provide examples of recent reports considered by Board or committee where delivery of the objectives is discussed and where the board can gain evidence that controls are effective).	**Gaps in Assurance (a)/ Control (c)** (i.e. What are we not doing - What gaps in controls and assurance have been identified)	**Actions to Address Gaps**	**Timescale/ Action Owner**
Capital Monitoring Investment Committee Chaired by the Director of Finance & Procurement – meets monthly. All capital projects are subject to robust monitoring and control within a structured delivery platform to provide certainty of delivery against time, cost and scope. Project scope is monitored and controlled through an iterative process in the development of the project from briefing, through feasibility and into design, construction, commissioning and Post Project Evaluation. Project budget is developed at feasibility stage to enable informed decisions for investment and monitored and controlled throughout design, procurement and construction delivery. Project timescale is established from the outset with project milestone aspirations developed at feasibility stage. Process to follow: • Business case development • Full business case approvals • TDA approvals • Availability of capital • Planning permission • Public Consultation • Commissioner support	Minutes of the Capital Monitoring Investment Committee meetings. Capital Planning & Delivery Status Reports. Minutes of the March 2014 public Trust Board meeting - Trust Board approved the 2014/15 Capital Programme. Project Initiation Document (PID) (as part of UHL's Delivering Care at its Best) and minutes of the May 2014 Executive Strategy Board (ESB) meeting. Estates Strategy - submitted to the NTDA on 20th June in conjunction with the Trust's 5 year directional plan.	(C) Patient and public engagement strategy	Highlight report to be presented at the August 2014 ESB meeting for sign off. (22.1)	Aug 2014 DS

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST – BOARD ASSURANCE FRAMEWORK

Principal risk 23	Failure to effectively implement EPR programme	**Overall level of risk to the achievement of the objective**	**Current score 5 x 3 = 15**	**Target score 3 x 3 = 9**
Executive Risk Lead(s)	Chief Information Officer			
Link to strategic objectives	Enabled by excellent IM&T			

Key Controls(What control measures or systems are in place to assist secure delivery of the objective)	**Assurance Source** (Provide examples of recent reports considered by Board or committee where delivery of the objectives is discussed and where the board can gain evidence that controls are effective).	**Gaps in Assurance (a)/ Control (c)** (i.e. What are we not doing - What gaps in systems, controls and assurance have been identified)	**Actions to Address Gaps**	**Timescale/ Action Owner**
Governance in place to manage the procurement of the solution	EPR project board with executive and Non-Executive members. Standard boards in place to manage IBM; Commercial board, transformation board and the joint governance board. UHL reports progress to the CCG IM&T Strategy Board	(C) OBC/FBC approval with NTDA	Work closely with finance, procurement and the NTDA to navigate the approvals process to submit OBC (23.1)	Aug 2014 CIO
Clinical acceptability of the final solution	Clinical sign-off of the specification. Clinical representation on the leadership of the project. The creation of a clinically led (Medical Director) EPR Board which oversees the management of the programme. Highlight reports on objective achievement go through to the Joint Governance Board, chaired by the CEO. The main themes and progress are discussed at the IM&T clinical advisory group.	(C) Not all clinicians can be part of the process	Continue to communicate with the wider/non-involved clinicians throughout the procurement process	Oct2014 CIO
Transition from procurement to delivery is a tightly controlled activity	EPR board has a view of the timeline. Trust Board and ESB have had an outline view of the delivery timelines.	(c) No detailed plan is in place for the delivery phase of the project until the vendor is chosen	When the final vendor is chosen we will create and communicate the detail delivery plan and its	Sep 2014 CIO

			dependencies. (23.5)	

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST – BOARD ASSURANCE FRAMEWORK

Principal risk 24	Failure to implement the IM&T strategy and key projects effectively *Note: Projects are defined, in IM&T, as those pieces of work, which require five or more days of IM&T activity.*	**Overall level of risk to the achievement of the objective**	**Current score 5 x 3 = 15**	**Target score 3 x 3 = 9**
Executive Risk Lead(s)	Chief Information Officer			
Link to strategic objectives	Enabled by excellent IM&T			

Key Controls(What control measures or systems are in place to assist secure delivery of the objective)	**Assurance Source** (Provide examples of recent reports considered by Board or committee where delivery of the objectives is discussed and where the board can gain evidence that controls are effective).	**Gaps in Assurance (a)/ Control (c)** (i.e. What are we not doing - What gaps in systems, controls and assurance have been identified)	**Actions to Address Gaps**	**Timescale/ Action Owner**
Project Management to ensure we are only proceeding with appropriate projects	Project portfolio reviewed by the ESB every two months. Agreements in place with finance and procurement to catch projects that are not formally raised to IM&T.	(C) Formal prioritisation matrix	Develop, disseminate and implement the new matrix (24.1)	Aug 2014 CIO
Ensure appropriate governance arrangements around the deliverability of IM&T projects	Projects managed through formal methodologies and have the appropriate structures, to the size of project, in place. KPIs are in place for the managed business partner and are reported to the IM&T service delivery board	(C) Lack of ownership at CMG level for IT projects	All IT projects requested by CMGs to be formally signed off through their governance (24.2)	Aug 2014 CIO
Signed off capital plan for 2014/15 and 2015/16	2 year plan in place and a 5 year technical in place highlighting future requirements - signed off by the capital governance routes	(A) In year requirements which could not be reasonable forecasted cause unsustainable pressure within existing resources	Please see action 24.1	Aug 2014 CIO
Formalised process for assessing a project and its objectives	All projects go through a rigorous process of assessment before being accepted as a proposal	(C) Lack of transparency of the process and unachievable delivery expectations based on the priority of the project	All CMGs to hold formal monthly meeting with IM&T service delivery lead where these issues can be solved	Sep 2014 CIO/CMGs

Appendix two

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST

ACTION TRACKER FOR THE 2014/15 BOARD ASSURANCE FRAMEWORK (BAF)

Monitoring body (Internal and/or External):	Executive Team
Reason for action plan:	Board Assurance Framework
Date of this review	**July 2014**
Frequency of review:	Monthly
Date of last review:	N/A

REF	ACTION	SENIOR LEAD	OPS LEAD	COMPLETION DATE	PROGRESS UPDATE	STATUS
1	**Lack of progress in implementing UHL Quality Commitment.**					
1.1	Corporate leads to embed QC into organisation	CN	DCQ	September 2014	QC included in CEO brief September. QC included in Q&P reporting QC included in CMG reviews.	4
1.2	Corporate leads to develop KPIs	CN	DCQ	September 2014	KPIs in place for most QC work streams/committees. Expect to complete September.	4
1.3	Corporate leads to complete action plans	CN	DCQ	September 2014	On track – systematically being reviewed at EQB as part of EQB work programme.	4
2	**Failure to implement LLR emergency care improvement plan.**					
2.1	Chair of group will confirm membership of LLR meeting and sub group activities	COO	D Briggs	August 2014	**Complete.**	5
2.2	CEO and Dr Sturgess to agree plans to ensure his legacy is sustainable	Chief Executive		August 2014	Discussions commenced. Likely contract for re-visits to ensure momentum is maintained.	4
2.3	Dr Sturgess to chair a group to recommend how the money can be allocated/ used most effectively.	COO	D Briggs	July 2014	**Complete.**	5
3	**Failure to effectively implement UHL Emergency Care quality programme.**					
3.1	Subgroup to focus on the front end of the pathway to ensure progress within ED	COO	M Ardron	September 2014		4
4	**Delay in the approval of the Emergency Floor Business Case.**					
4.1	Regular communication with NTDA	MD		August 2014		4

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

5	**Failure to deliver RTT improvement plan.**					
5.1	Action plans to be developed in key specialities – general surgery and ENT to regain trajectory	COO		September 2014		4
5.2	Await publication of report and act on findings and recommendations	COO		August 2014		4
6	**Failure to achieve effective patient and public involvement**					
6.1	Update the PPI/stakeholder engagement strategy	DMC		September 2014		4
6.2	Revised PPI plan	DMC	PPIMM	September 2014		4
6.3	OD team involvement to reenergise the vision and purpose of Patient Advisors	DMC	PPIMM	October 2014		4
7	**Failure to effectively implement Better Care together (BCT) strategy.**					
7.1	Work plan to be developed by the LLR BCT Strategy Delivery Group to be considered by the BCT Programme	DS		August 2014		4
7.2	Work plans to be reconciled and developed by the LLR BCT Strategy Delivery Group to be considered by LLR BCT Programme	DS/COO		August 2014		4
8	**Failure to respond appropriately to specialised service specification.**					
8.1	Highlight report to be presented at the August 2014 ESB meeting for approval.	DS		August 2014		4
8.2	Appoint Head of External Partnership development and admin support	DS		December 2014		4
8.3	Programme Plan to be developed	DS		TBA		
8.4	Contracts Team to develop monthly reporting tool to track progress	DS		September 2014		4
8.5	PIDs to be developed for academic, commercial and local partnerships and overarching highlight report to be presented at the August 2014 ESB for sign off.	DR&D/ DMC		August 2014		4

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

9	**Failure to implement network arrangements with partners.**					
	Actions 8.1, 8.2, 8.3 and 8.5 also refer to risk 9, therefore refer above for progress					
9.2	*Action removed from BAF / action tracker by DS following further review of content of risk number 9.*	N/A		N/A		N/A
10	**Failure to develop effective partnership with primary care and LPT.**					
10.1	PID & draft Terms of Reference to be reviewed at the August 2014 ESB meeting.	DS/ COO		August 2014		4
10.2	Business plan to be finalised prior to consideration by the ESB and then the Trust (10.2)	DS		August 2014		4
10.3	Work plan developed by the LLR BCT Strategy Delivery Group to be considered by the LLR BCT Programme Board.	DS		August 2014		4
11	**Failure to meet NIHR performance targets.**					
12	**Failure to retain BRU status.**					
13	**Failure to provide consistently high standards of medical education.**					
13.1	To work with Finance to address all funding issues relating to medical training tariff	MD	AMD (CE)	October 2014		4
13.2	Ensure appropriate Consultant Job descriptions include job planning	MD	AMD (CE)	January 2015		4
13.3	Develop appraisal methodology for educational roles	MD	AMD (CE)	January 2015		4
13.4	Disseminate approved appraisal methodology to CMGs.	MD	AMD (CE)	December 2014		4
13.5	Work to relocate anomalous budgets to HR as other Foundation doctor contracts	MD	AMD (CE)	January 2015		4
14	**Lack of effective partnerships with universities.**					
15	**Failure to adequately plan the workforce needs of the Trust.**					

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

15.1	Develop an integrated approach to workforce planning with LPT in order that we can plan an overall workforce to deliver the right care in right place at the right time.	DHR		October 2014	Group has been established to link workforce, strategy and finance. Second meeting 26 August	4
15.2	Establish a joint group of strategy, finance and workforce leads to share plans and numbers	DHR		October 2014	See 15.1	4
15.3	Establish multi-professional new roles group to devise and monitor processes for the creation of new roles	CN		October 2014	Date set for first meeting. Terms of Reference drafted. Discussed with CMGs.	4
15.4	Develop Innovative approaches to recruitment and retention to address shortages.	DHR		March 2015	Medical Workforce Strategy in place which addresses mechanisms to improve recruitment and retention	4
15.5	Continuation of International recruitment plan	CN		On-going action	**Complete.** Plan in place for rolling recruitment for next 12 months.	5
15.6	Delivering our Employer Brand group to share best practice and development social media techniques to promote opportunities at UHL	DHR		March 2015	Webpage review planned for end of August	4
15.7	Development of internship model and potential management trainee model supported by robust education programme and education scheme	DHR		November 2014	Five internships planned to commence in October – advertisement in place. Trainee management proposal to be shared with Executive Workforce Board 16 September	4
15.8	Consultant recruitment review team to develop professional assessment centre approach to recruitment utilising outputs to produce a development programme	DHR		April 2015	Proposal prepared for review by DHR and MD	4
16	**Inability to recruit and retain staff with appropriate skills.**					

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

16.1	Team Health Dashboard to be developed – mock up to be presented to EWB at September Meeting	DHR		September 2014	Team Health Dashboard currently in development. Number of scoping meetings held with key stakeholders to consider potential data inclusion. Meeting with Assistant Director of Information booked to scope dashboard content and to ensure compliance with Trust dashboard format.	4
16.2	eUHL system updates required to meet Trust needs	DHR		March 2015	A eUHL System Replacement Specification will be delivered by the 20 August 2014.	4
16.3	Robust ELearning policy and procedures to be developed to reflect P&GC approach	DHR		October 2014	Draft produced in consultation with Deputy Medical Director, Director of Clinical Quality and relevant Educational Leads. This will form part of the Core Training Policy currently under development.	4
17	**Failure to improve levels of staff engagement**					
17.1	Team Health Dashboard to be developed – mock up to be presented to EWB at September 2014	DHR		March 2015	Please refer to Item 16.1	4
17.2	Ensure IBM aware of requirements.	DHR		March 2015	CIO aware of LiA MoC associated with IBM related projects. Meetings held with IBM representatives to coach and guide on LiA principles and approach. As a result LiA process included in pilot phase of Managed Print roll out at Glenfield. Further plans to include LiA in pilot of Paediatric Areas for Electronic Document Record Management	4
17.3	HR Senior Team aware of need to include Engagement event prior to formal consultation (with MoC impacting on staff – more than 25 people)	DHR		March 2015	MoC (HR) are including LiA as a precursor to formal consultation. A number of events have been concluded using LiA. A specific resource for LiA MoC has been developed	4

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

17.4	Include as regular agenda item on LiA sponsor group identifying activity and anticipated resources required	DHR		March 2015	Each of the LiA Work streams is included as standing items on LiA Sponsor Group meetings.	4
17.5	National data on UHL workforce numbers to be used by NHS England to get a sense of how many staff completed the survey (Same calculations being used for all other Trusts so variables consistent nationally).	NHS England		September 2015		4
17.6	Develop draft internal reports in development in readiness for possible analysis methodology used by NHS England in September 2014.	DHR		September 2015	Friends and Family Test for Staff: Submission of first UNIFY report submitted to NHS England in compliance with deadline and CQUIN target. Internal analysis of free text themes being undertaken. UHL data to be included in CE Briefing (August 2014). Awaiting information on how the data will be analysed and published by NHS England. Received email from NHS England Insight Team on 23 July 2014:	4
18	**Lack of effective leadership capacity and capability**					
18.1	Leadership into Action Strategy to be reviewed by Executive Workforce Board in September 2014	DHR		September 2014		4
18.2	Improve internal coaching and mentoring training provision in collaboration with HEEM and at phase 1 establish process for assigning coaches and mentors to newly appointed clinicians	DHR		December 2014		4
18.3	'Shadowing and Buddying' System being developed in partnership with HEEM and Assistant Medical Director to ensure support provided to newly appointed Consultants at initial phase (18.3)	DHR		April 2015		4
18.4	360 System Specification to be produced	DHR		August 2014		4

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

18.5	Support national and regional Talent Management and Succession Planning Projects by National NHS Leadership Academy , EMLA and NHS Employers	DHR		March 2015		4
18.6	Board Coach (on appointment) to facilitate Board Development Session	DHR		October 2014		4
18.7	Update of UHL Leadership Qualities and Behaviours to reflect Board Development, UHL 5 Year Plan and new NHS Healthcare Leadership Model	DHR/ CE		January 2015		4
19	**Failure to deliver financial strategy (including CIP).**					
19.1	Implement Finance Training Programme	DDF		July 2014	**Complete.** The finance training programme has started with the first CMG session being ESM on the 7th July. Will be rolled out across the Trust.	5
19.2	Production of a FRP to deliver recurrent balance within three years	DDF		August 2014	On track, though the timescale is 6 years subject to TDA approval of the LTFM	4
19.3	Health System External Review to define the scale of the financial challenge and possible solutions (19.3)	DDF		July 2014	**Complete.** Health system review has completed the initial phase of the programme and reported back to NHSE / TDA / Monitor on the scale of the challenge Directional plan for the system to close the financial gap in 5 years' time	5
19.4	Production of UHL Service & Financial Strategy including Reconfiguration/ SOC	DDF		July 2014	**Complete.** Submitted on the 20 June as part of the 5 year IBP and LTFM	5
19.5	Expedite agreement of CIP quality impact assessments with UHL and CCGs	DDF		August 2014	On track	4
19.6	PMO Arrangements need to be finalised	DDF		August 2014	On track – being led by the COO	4
19.7	Production of IBP(Activity, Capacity, Operational Targets, Workforce, CIPS, Budgets, Capital & Risks) (19.7)	DDF		July 2014	**Complete.** IBP and LTFM submitted on 20 June	5

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

19.8	Restructuring of financial management via MoC	DDF		~~July~~ Review August 2014	MoC consultation ended 6 June; recruitment to vacant posts on-going	3
19.9	Negotiate realistic contracts with CCGs and Specialised Commissioning - QIPP - Fines & Penalties - MRET rebase - Counting & Coding CCG Non Recurring Funding	DDF		July 2014	**Complete.** Contracts signed 30 June 2014	5
19.10	Business Cases to support Reconfiguration and Service Strategy	DDF		~~July~~ Review September 2014	The TDA have now confirmed that the IBP/LTFM submitted on the 20 June will act as the overall SOC. Individual business cases will be submitted to the Trust Board and TDA.	4
19.11	Agreement of long-term loans as part of June Service and Financial plan	DDF		~~June~~ August 2014	The Trust is in receipt of a £29m cash loan in line with the Plan and trajectory submitted to the TDA. The application for further loans will be submitted to the TDA on the 22 August 2014.	4
20	**Failure to deliver internal efficiency and productivity improvements.**					
20.1	Agree plans and targets for cross-cutting themes through the monthly cross cutting theme delivery board	COO		August 2014		4
21	**Failure to maintain effective relationships with key stakeholders**					
21.1	Qualitative survey by Trust Internal Audit (PWC)	DMC		October 2014		4
21.2	TBA			TBA		
21.3	Create a platform to launch Clinical Task Group	MD		September 2014		4
22	**Failure to deliver service and site reconfiguration programme and maintain the estate effectively**.					
22.1	Highlight report re PPI strategy to be presented at the August 2014 ESB meeting for sign off.	DS		August 2014		4
23	**Failure to effectively implement EPR programme**					

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

23.1	Work closely with finance, procurement and the NTDA to navigate the approvals process to submit OBC	CIO		August 2014	OBC is complete and we are now engaging with the NTDA prior to the Trust board in August	4
23.2	Ensure all clinicians have an opportunity to contribute to development of specification	CIO		July 2014	**Complete.** All levels of Clinical staff were invited to take part in the specification and scoring of the potential EPR vendors. We have a wide mix of people working with IM&T and IBM to take this work forward	5
23.3	Re-align the timetable to ensure best fit with clinical workload	CIO		July 2014	**Complete.** The timetable has been slipped by three weeks to support both the vendor submissions and provide better timeslots for clinical involvement	5
23.4	Improve communications to clinical staff/teams	CIO		July 2014	**Complete.** Further work has been undertaken by the CMIOs to extend their briefings and networks into more areas of UHL and LLR. Further work is still required to ensure we can prove that the consistent messages are being received and understood.	5
23.5	When the final vendor is chosen we will create and communicate the detail delivery plan and its dependencies.	CIO		September 2014	Plans are being developed to take this forward	4
23.6	Continue to communicate with the wider/non-involved clinicians throughout the procurement process	CIO		October 2014		
24	**Failure to implement the IM&T strategy and key projects**					
24.1	Develop, disseminate and implement the new prioritisation matrix	CIO		August 2014	To be presented to the Executive Team in August	4
24.2	All IT projects requested by CMGs to be formally signed off through their governance structures	CIO		August 2014	Forms have been changed to reinforce this requirement	3
24.3	All CMGs to hold formal monthly meeting with IM&T service delivery lead where these issues can be solved	CIO		September 2014	Not yet in place for all CMGs	3

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

Key

CEO	Chief Executive
DF	Director of Finance
MD	Medical Director
AMD	Assistant Medical Director
COO	Chief Operating Officer
DHR	Director of Human Resources
DDHR	Deputy Director of Human Resources
DS	Director of Strategy
DR&D	Director of R&D
DMC	Director of Marketing and Communications
DCQ	Director of Clinical Quality
CIO	Chief Information Officer
CMIO	Chief Medical Information Officer
CD	Clinical Director
CMGM	Clinical Management Group Manager
DDF	Deputy Director Finance
CN	Chief Nurse
AMD (CE)	Associate Medical Director (Clinical Education)
PPIMM	PPI and Membership Manager

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

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST

OPERATIONAL RISKS SCORING 15 OR ABOVE FOR THE PERIOD ENDING 31/07/2014

REPORT PRODUCED BY: UHL CORPORATE RISK MANAGEMENT TEAM

Key

Red	Extreme risk (risk score 25)
Orange	High risk (risk score 15 - 20)
Yellow	Moderate risk (risk score 8 - 12)
Green	Low risk (risk score below 8)

Risk ID	CMG	Specialty	Risk Title	Opened	Review Date	Description of Risk	Risk subtype	Controls in place	Impact	Likelihood	Current Risk Score	Action summary	Target Risk Score	Risk Owner	BAF Reference
2398	ITAPS	Theatres	There is a risk of patient cancellations due to the limited number of Cardiac Scrub Nurses with competence to perform the task	31/07/2014	31/10/2014	**Causes:** Insufficient cardiac trained staff to cover lists Insufficient staff to cover on call and be available for a shift the following day Unable to fulfil overtime shifts Slow process in training untrained staff No movement in cardiac staff from other parts of the country **Consequences:** Cancellation/delay in theatre starting Reduction in utilisation Inability to cover on call shifts Staff become tired resulting in sickness Using agency staff to fill shifts - financial	HR	Staff asked to undertake overtime Staff asked to come to work the next morning if not up in the night Staff asked to start an on call shift at 8 a.m. instead of 11 or 11.30 a.m. Agency staff employed who have the skills to undertake the role Attempt to cover with other staff in the department as coordinator although leave gap in scrub	Major	Almost certain	20	Recruitment premia agree by Executive Team for 12 months - 16/07/15 Undertake Team Staff Risk Assessment with H&S Team - 31/10/14	6	YF	
2400	Emergency and Specialist Medicine		Ward 23 has significantly reduced Nursing staffing levels increasing a risk of harm and quality of patient delivery	31/07/2014	31/08/2014	**Causes:** Increased vacancies and increased number of leavers by end of July 14 Nurse staffing levels will be reduced to 66% (6 WTE registered permanent nurses in workforce) Bank and Agency fill is not guaranteed and there is a risk these shifts will not get covered **Consequences:** Patient experience Patients safety (HAPU's, Falls, Medical Errors etc) Staffing for other areas where staff are having to move	Patients	Increased HCA numbers Movement of staff from better established Wards moved Removal of Bleep Holding shifts from Ward Sister	Major	Likely	16	Reduce No of Beds on Ward - 21/08/14 Matron base herself on Ward - 31/08/14 Move other staff from across CMG - 30/09/14 Act up Band 5 to do development role - 30/09/14 Targeted Recruitment for the Ward - 30/09/14	9	SBURT	

Risk ID	CMG	Specialty	Risk Title	Opened	Review Date	Description of Risk	Risk subtype	Controls in place	Impact	Likelihood	Current Risk Score	Action summary	Target Risk Score	Risk Owner	BAF Reference
2399	ITAPS	Theatres	Risk of not being able to deliver enough theatre additional sessions to meet the RTT Target for the Trust.	31/07/2014	30/09/2014	Risk of not being able to deliver enough theatre additional sessions to meet the RTT Target for the Trust. 1. RTT requires approximately a further 20 sessions per week. 2. Extended days and weekend working are above and beyond the staff's substantive hours. 3. 70wte vacancies is placing additional pressure and strain on staff to work additional hours. 4. These additional sessions pose challenges to cover with correct skill mix. 5. These additional sessions pose a risk of not having the correct equipment / sets available. 6. Complexity of case mix on RTT sessions results in difficulty to get skilled staff; resulting in the same group of staff having to work above and beyond their substantive hours. 7. Inability to forward plan in relation to kit required for Saturday and Monday due to short notice of case mix. 8. Complexity of case mix reduces the option for covering OT with staff from other specialties that have basic skills. 9. Risk of increasing sickness absence within teams due to increased workload / hours. 10. Risk to patient safety due to tiredness of staff.	HR	1. Monthly recruitment and overseas recruitment on-going. 2. Reinforcement to specialties that the RTT work will remain on a voluntary basis which can not be guaranteed until we have recruited into vacant posts. 3. Overtime is voluntary. 4. Recruitment premia agreed by Executive Team to further enhance recruitment drives success to substantive posts.	Major	Likely	16	Monthly recruitment and overseas recruitment on-going - 31/03/15 Reinforcement to specialties that the RTT work will remain on a voluntary basis which cannot be guaranteed until we have recruited into vacant posts 30/09/14. Overtime is voluntary - 01/04/15 Recruitment premia agreed by Executive Team to further enhance recruitment drives success to substantive posts - 17/07/15 Task and Finish Group to be established to review high risk specialties (for e.g. ENT) - 30/09/14	2	GHAR	

PAPER S Revised

	TRUST BOARD
From:	Rachel Overfield, Kevin Harris, Richard Mitchell Kate Bradley
Date:	**28th August 2014**
CQC regulation	All

Title:	**Quality & Performance Report**

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

Purpose of the Report:

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

The Report is provided to the Board for:

Decision			**Discussion**	√
Assurance	√		**Endorsement**	

Summary / Key Points:

This is the first Q&P with revised content and format following extensive review and consultation.

Thresholds, RAG rating and Exception Report criteria have been agreed for most indicators.

Finance is not included in the proposed new format and will be reported separately and following review by the Quality Assurance Committee, it was agreed that indicators relating to Facilities and IM&T did not need to be included in the Q&P as monitored elsewhere.

21 of the 75 indicators were RAG rated Red for the month of July.

Domain	Number of Indicators	Indicators with target to be confirmed	Number of Red Indicators
Safe	16	2	3
Caring	9	5	0
Well Led	14	7	3
Effective	14	1	0
Responsive	22	0	15

Exception reports were triggered for the following :

Safe

1) Overdue CAS alerts

Well Led

2) Emergency Department Friends & Family Participation

Responsive

3) Emergency Care – 4hr Wait – separate report
4) RTT – admitted, non-admitted and 52+ week waits
5) Cancer 31 and 62 day
6) Cancelled Operations on the day and rebooks within 28 days
7) Delayed Transfers
8) Ambulance Handovers

The 2014/15 NTDA Metrics and Weightings are included and following confirmation of the NTDA's methodology (expected September 2014) future reports will present UHL's NTDA scoring data.

The latest CQC Intelligent Monitoring Report for UHL is also included. Due to our recent inspection, the trust has not been given a Banding.

Also included is a summary of performance and RAG ratings received to date for both CCG and Specialised Services CQUINs and the CCG Quality Schedule.

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

Caring at its best

University Hospitals of Leicester NHS

NHS Trust

Quality & Performance

Report – July 2014

One team shared values

CONTENTS

1.0 Introduction

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

A review has been undertaken of the Trust's monthly, Quality & Performance Report (Q&P) taking into account both the updated version of the NHS Trust Development Authority's Accountability Framework, *'Delivering for Patients: the 2014/15 Accountability Framework for NHS trust boards'* and the Care Quality Commission's *Intelligent Monitoring* process. This is the first Q&P with revised content and format following extensive consultation.

Thresholds, RAG rating and Exception Report criteria have been agreed for most indicators. The expectation is that any locally developed indicators will have all these confirmed for the September version of the Q&P and The NTDA have advised that the final version of the Accountability Framework Indicators and thresholds will be available in September.

Finance is not included in the proposed new format and will be reported separately and following review by the Quality Assurance Committee, it was agreed that indicators relating to Facilities and IM&T did not need to be included in the Q&P as monitored elsewhere.

2.0 Performance Summary for July

21 of the 75 indicators were RAG rated Red for the month of July and 8 exception reports triggered.

Domain	Number of Indicators	Indicators with target to be confirmed	Number of Red Indicators	Number of Exception Reports	Exception Report
Safe	16	2	3	1	Overdue CAS alerts
Caring	9	5	0	0	
Well Led	14	7	3	1	ED F&FT Participation
Effective	14	1	0	0	
Responsive	22	0	15	6	Emergency Care – 4hr Wait – separate report RTT – admitted, non-admitted and 52+ week waits Cancer 31 and 62 day Cancelled Operations on the day and rebooks within 28 days Delayed Transfers Ambulance Handovers

DASHBOARD KEY

14/15 Target: i.e.
Monthly,
Cumulative
End of Year

Target Set by:
NTDA = Trust Development Authority
QS = Quality Schedule
QC = Quality Commitment

Red RAG/ Exception Report Threshold (ER)
Red threshold follows NTDA criteria, where applicable.
Criteria for Exception Report (ER) may not always be the same as the Red RAG threshold.

NTDA/CQC area indicators are mapped to

Performance data:
- 13/14 Out-turn = 13/14 full year
- Mthly data for prev 12 mths
- YTD = 14/15 to date

Indicator Ref Nos – within each NTDA/CQC area

Safe | Caring | Well Led | Effective | Responsive

KPI Ref	Indicators	Board Director	Lead Director/ Officer	14/15 Target	Target Set by	Red RAG/ Exception Report Threshold (ER)	13/14 Outturn	Aug-13	Apr-14	May-14	Jun-14	Jul-14	YTD
S1a	Clostridium Difficile	RO	DJ	FYE = 81	NTDA	Red / ER for Non compliance with cumulative target	66	5	4	6	5	6	21
S1b	Clostridium Difficile (Local Target)	RO	DJ	FYE = 50	UHL	Red = >5 per mth ER = YTD Red	66	5	4	6	5	6	21
S2a	MRSA Bacteraemias (All)	RO	DJ	0	NTDA	Red = >0	3	0	0	0	0	0	0
S2b	MRSA Bacteraemias (Unavoidable)	RO	DJ	0	UHL	Red = >0 in mth ER = in mth >0	1	0	0	0	0	0	0
S3	Never Events	RO	MD	0	NTDA	Red = >0 in mth ER = in mth >0	3	0	0	0	0	0	0
S4	Serious Incidents	RO	MD	tbc	NTDA	tbc	New Indicator - Definition to be confirmed						
S5	Proportion of reported safety incidents that are harmful	RO	MD	tbc	NTDA	tbc	New Indicator - Definition to be confirmed						

Definition to be confirmed - Performance data included where NTDA definitions considered to be unlikely to change. Where definition unclear - NTDA guidance due in September

Key for Lead Directors/Officers:
CA=Chris Allsager; CC=Charlie Carr; CF=Catherine Free; MD=Moira Durbridge; SH=Sharron Hotson; SJ=Steve Jackson; DJ=David Jenkins; SK=Suzanne Khalid; EM=Eleanor Meldrum; MM=Matt Metcalf; RP=Richard Power; PR=Pete Rabey; CR=Carole Ribbins; JR =John Roberts; ES=Emma Stevens; PW=Phil Walmsley

	KPI Ref	Indicators	Board Director	Lead Director/ Officer	14/15 Target	Target Set by	Red RAG/ Exception Report Threshold (ER)	13/14 Outturn	Jul-13	Aug-13	Sep-13	Oct-13	Nov-13	Dec-13	Jan-14	Feb-14	Mar-14	Apr-14	May-14	Jun-14	Jul-14	YTD
Safe	S1a	Clostridium Difficile	RO	DJ	FYE = 81	NTDA	Red / ER for Non compliance with cumulative target	66	6	5	9	6	6	5	10	0	4	4	6	5	6	21
	S1b	Clostridium Difficile (Local Target)	RO	DJ	FYE = 50	UHL	Red >5 per month, ER when YTD red	66	6	5	9	6	6	5	10	0	4	4	6	5	6	21
	S2a	MRSA Bacteraemias (All)	RO	DJ	0	NTDA	Red = >0	3	0	0	1	0	0	0	0	0	0	0	0	0	0	0
	S2b	MRSA Bacteraemias (Unavoidable)	RO	DJ	0	UHL	Red = >0 in mth ER = in mth >0	1	0	0	1	0	0	0	0	0	0	0	0	0	0	0
	S3	Never Events	RO	MD	0	NTDA	Red = >0 in mth ER = in mth >0	3	0	0	1	0	0	0	0	1	0	0	0	0	0	0
	S4	Serious Incidents	RO	MD	tbc	NTDA	tbc	60	9	5	4	5	8	4	3	4	5	4	6	3	7	20
	S5	Proportion of reported safety incidents that are harmful	RO	MD	tbc	NTDA	tbc	2.8%	3.1%			2.3%			2.3%			1.9%				1.9%
	S6	Overdue CAS alerts	RO	MD	0	NTDA	Red = >0 in mth ER = in mth >0	2	0	1	0	0	0	0	0	0	0	2	2	2	3	9
	S7	RIDDOR - Serious Staff Injuries	RO	MD	FYE = <47	UHL	Red / ER = non compliance with cumulative target	47	3	3	4	6	4	4	7	2	5	3	5	1	2	11
	S8	Safety Thermometer % of harm free care (all)	RO	EM	tbc	NTDA	Red = <92% ER = in mth <92%	93.6%	93.8%	93.5%	93.1%	94.7%	93.9%	94.0%	93.8%	94.8%	93.6%	94.6%	94.7%	94.2%	94.9%	94.6%
	S9	% of all adults who have had VTE risk assessment on adm to hosp	KH	SH	95% or above	NTDA	Red = <95% ER = in mth <95%	95.3%	95.9%	95.2%	95.4%	95.5%	96.7%	96.1%	95.6%	95.0%	95.6%	95.7%	95.9%	95.9%	96.3%	95.9%
	S10	Medication errors causing serious harm	RO	MD	0	NTDA	Red = >0 in mth ER = in mth >0	New Indicator - Definition to be confirmed														
	S11	Patient Falls	RO	EM	2270	QC	Red > 199 ER = 2 consecutive reds	2522	251	197	171	231	209	201	206	204	207	195	224	194	219	832
	S12	Avoidable Pressure Ulcers - Grade 4	RO	EM	0	QS	Red / ER = Non compliance with monthly target	1	0	0	0	1	0	0	0	0	0	0	0	0	0	0
	S13	Avoidable Pressure Ulcers - Grade 3	RO	EM	<8 a month	QS	Red / ER = Non compliance with monthly target	71	7	8	5	5	4	5	7	3	6	5	5	5	6	21
	S14	Avoidable Pressure Ulcers - Grade 2	RO	EM	<10 a month	QS	Red / ER = Non compliance with monthly target	120	21	10	5	7	8	5	10	8	9	6	6	6	7	25
	S15	Compliance with the SEPSIS6 Care Bundle	RO	MD	All 6 >75% by Q4	QC	Red/ER = Non compliance with Quarterly target	27.0%	New Indicator						27.0%			47.0%				47.0%
	S16	Nutrition and Hydration Metrics	RO	MD	All 90% by Q3	QC	Red / ER for Non compliance with cumulative target	N/A	New Indicator									71.0%	67.0%	75.0%		71.0%

Caring

KPI Ref	Indicators	Board Director	Lead Director/ Officer	14/15 Target	Target Set by	Red RAG/ Exception Report Threshold (ER)	13/14 Outturn	Jul-13	Aug-13	Sep-13	Oct-13	Nov-13	Dec-13	Jan-14	Feb-14	Mar-14	Apr-14	May-14	Jun-14	Jul-14	YTD
C1	Inpatient Friends and Family Test - Score	RO	CR	72 (Eng Avge - Mar 14)	NTDA	Red if <3SD. ER if <3SD or 3 mths deteriorating performance	68.8	66.0	69.6	67.6	66.2	70.3	68.7	71.8	69.0	69.9	69.6	71.0	74.5	73.8	72.2
C2	A&E Friends and Family Test - Score	RO	CR	54 (Eng Avge - Mar 14)	NTDA	Red if <3SD. ER if <3SD or 3 mths deteriorating performance	58.5	57.0	59.6	57.6	58.8	58.6	67.4	67.6	58.7	65.5	69.4	66.0	71.4	71.7	69.3
C3	Outpatients Friends and Family Test - Score	RO	CR	tbc	UHL	tbc	New Indicator available from October 2014														
C4	Maternity Friends and Family Test - Score	RO	CR	tbc	UHL	tbc	64.3				64.8	62.1	63.7	67.3	62.1	66.7	61.2	63.5	69.5	69.7	65.8
C5	Complaints Rate per 100 bed days	RO	MD	tbc	NTDA	tbc		0.4	0.4	0.4	0.4	0.3	0.3	0.3	0.5	0.4	0.4	0.3	0.4	0.5	0.5
C6	Complaints Re-Opened	RO	MD	FYE = tbc	UHL	tbc	272	28	19	19	20	27	11	28	14	16	20	20	15	25	80
C7	Single Sex Accommodation Breaches	RO	CR	0	NTDA	Red = >0 ER = in mth >0	2	0	0	0	0	2	0	0	0	0	4	2	0	0	6
C8	Improvements in the FFT scores for Older People (65+ year)	RO	CR	75	QC	Red / ER = End of Yr Targets non recoverable.	New Indicator for 14/15 Information Available for August Report														
C9	Responsiveness and Involvement Care	RO	CR	0.8 improve-ment	QC	tbc	New Indicator for 14/15										88.6	88.5	88.5		88.6

Well Led

KPI Ref	Indicators	Board Director	Lead Director/ Officer	14/15 Target	Target Set by	Red RAG/ Exception Report Threshold (ER)	13/14 Outturn	Jul-13	Aug-13	Sep-13	Oct-13	Nov-13	Dec-13	Jan-14	Feb-14	Mar-14	Apr-14	May-14	Jun-14	Jul-14	YTD
W1	Inpatient Friends and Family Test - Coverage	RO	CR	30% - Q4. 40% - Mar 15	NTDA / CQUIN	Red = Non compliance with monthly target ER = 2 consecutive mths non compliance	24.3%	24.8%	22.0%	25.8%	21.7%	25.4%	23.3%	24.5%	28.2%	28.8%	36.8%	38.1%	32.6%	30.8%	34.5%
W2	A&E Friends and Family Test - Coverage	RO	CR	20% for Q4	NTDA	Red = Non compliance with monthly target ER = 2 consecutive mths non compliance	14.9%	14.6%	16.1%	11.1%	16.3%	18.4%	16.4%	15.6%	18.4%	16.1%	15.2%	17.8%	14.9%	10.2%	14.5%
W5	NHS staff survey: % of staff who would recommend the trust as place to work	KB	ES	tbc	NTDA	tbc	New Indicator - Definition to be confirmed														
W6	NHS staff survey: % of staff who would recommend the trust as place to receive treatment	KB	ES	tbc	NTDA	tbc	New Indicator - Definition to be confirmed														
W7	Data quality of trust returns to HSCIC	KS	JR	tbc	NTDA	tbc	New Indicator - Definition to be confirmed														
W8	Turnover Rate	KB	ES	<10%	UHL	Red = >10% ER = 3 consecutive mths >10%	10.0%	9.5%	9.3%	9.7%	9.6%	9.7%	10.2%	10.6%	10.4%	10.0%	9.9%	10.0%	10.2%	10.0%	10.0%
W9	Sickness absence - 12 mths rolling	KB	ES	3.5% rolling 12 mths post validation	UHL	Red = >3.5% ER = 3 consecutive mths >3.5%	3.4%	3.2%	3.1%	3.1%	3.3%	3.5%	3.8%	3.8%	3.7%	3.5%	3.5%	3.5%	3.6%		3.5%
W10	Total trust vacancy rate	KB	ES	tbc	NTDA	tbc	New Indicator - Definition to be confirmed														
W11	Temporary costs and overtime as a % of total paybill	KB	ES	tbc	NTDA	tbc	New Indicator										9.4%	9.4%	8.1%	8.5%	8.5%
W12	% of Staff with Annual Appraisal	KB	ES	95%	UHL	Red = <90% Amber = 90-95% ER = <90%	91.3%	92.4%	92.7%	91.9%	91.0%	91.8%	92.4%	91.9%	92.3%	91.3%	91.8%	91.0%	90.6%	90.0%	90.0%
W13	Statutory and Mandatory Training	KB	ES	Jun 80%, Sep 85%, Dec 90%, Mar 95%	UHL	Red / ER for Non compliance with incremental target	76%	48%	49%	55%	58%	60%	65%	69%	72%	76%	78%	79%	79%	80%	80%
W14	% Corporate Induction attendance	KB	ES	95.0%	UHL	Red = <90% Amber = 90-95% ER = <90%	94.5%	90.0%	94.0%	94.0%	91.0%	87.0%	89.0%	93.0%	89.0%	94.5%	96.0%	94.0%	92.0%	96.0%	96.0%

Effective

KPI Ref	Indicators	Board Director	Lead Director/ Officer	14/15 Target	Target Set by	Red RAG/ Exception Report Threshold (ER)	13/14 Outturn	Jul-13	Aug-13	Sep-13	Oct-13	Nov-13	Dec-13	Jan-14	Feb-14	Mar-14	Apr-14	May-14	Jun-14	Jul-14	YTD
E1	Mortality - Published SHMI	KH	PR	Within Expected	NTDA	Higher than Expected	88.6	104.9	104.9	104.9	106.4	106.4	106.4	107.1	107.1	107.1	106.0	106.0	106.0	106.0	106.0
E2	Mortality - Rolling 12 mths SHMI (as reported in HED)	KH	PR	100 or below	QC	Red = >expected Amber =>100 ER = >Expected or 3 consecutive mths >100	102.1	107.5	108.0	107.1	106.8	106.4	106.7	104.7	103.8	102.1	100.3	Awaiting HED Update			100.3
E3	Mortality HSMR (DFI Quarterly)	KH	PR	Within Expected	NTDA	Red = >expected Amber =>100 ER = >Expected or 3 consecutive mths >100	87.9	91.4			86.0			82.2			Awaiting DFI Update				
E4	Mortality - Rolling 12 mths HSMR (Rebased Monthly as reported in HED)	KH	PR	100 or below	QC	Red = >expected Amber =>100 ER = >Expected or 3 consecutive mths >100	98.8	102.6	103.2	102.1	101.6	101.9	101.2	100.1	100.4	98.8	96.6	96.9	Awaiting HED Update		96.9
E5	Mortality HSMR Emergency Weekday Admissions - (HED) OVERALL Rebased Monthly	KH	PR	Within Expected	NTDA	Red = >expected Amber =>100 ER = >Expected or 3 consecutive mths >100	100.2	111.5	105.8	97.1	97.9	107.1	95.4	92.7	102.5	90.7	82.7	98.2	Awaiting HED Update		90.3
E6	Mortality HSMR Emergency Weekend Admissions - (HED) OVERALL Rebased Monthly	KH	PR	Within Expected	NTDA	Red = >expected Amber =>100 ER = >Expected or 3 consecutive mths >100	98.6	100.2	116.3	99.0	98.3	93.4	93.5	84.2	106.0	80.0	66.2	127.1	Awaiting HED Update		96.4
E7	Deaths in low risk conditions	KH	PR	Within Expected	NTDA	Red = >expected ER = >Expected or 3 consecutive mths >100	93.6	34.0	123.3	103.0	98.0	51.5	129.2	163.8	35.1	63.3	48.3	Awaiting DFI Update			48.3
E8	Emergency 30 Day Readmissions (No Exclusions)	KH	PR	Within Expected	NTDA	Higher than Expected	7.9%	7.5%	7.6%	7.8%	7.9%	7.8%	8.0%	8.7%	9.0%	8.8%	8.7%	8.7%	8.6%		8.7%
E9	No. of # Neck of femurs operated on 0-35 hrs - Based on Admissions	KH	RP	72% or above	QS	Red = <72% ER = 2 consecutive mths <72%	65.2%	59.1%	73.6%	67.1%	70.5%	73.6%	72.2%	68.2%	73.7%	54.7%	56.9%	40.6%	60.3%	76.9%	58.8%
E10	Stroke - 90% of Stay on a Stroke Unit	RM	CF	80% or above	QS	Red = <80% ER = 2 consecutive mths <80%	83.2%	87.1%	88.5%	89.1%	83.7%	78.0%	81.8%	89.3%	83.7%	83.5%	92.9%	80.5%	87.1%		87.0%
E11	Stroke - TIA Clinic within 24 Hours (Suspected High Risk TIA)	RM	CF	60% or above	QS	Red = <60% ER = 2 consecutive mths <60%	64.2%	60.5%	73.6%	64.6%	62.4%	76.8%	65.7%	60.5%	40.7%	77.9%	79.7%	58.8%	71.3%	62.8%	67.6%
E12	Communication - Outpatient, Discharge and Outpatient Letters	KH	SJ	tbc	QS	tbc	New Indicator for 14/15														
E13	Published Consultant Level Outcomes	KH	SH	>0 outside expected	QC	Red = >0 Quarterly ER = >0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
E14	Non compliance with 14/15 published NICE guidance	KH	SH	>0	QC	Red = in mth >0 ER = 2 consecutive mths Red	New Indicator for 14/15										0	0	0	0	0

Responsive

KPI Ref	Indicators	Board Director	Lead Director/ Officer	14/15 Target	Target Set by	Red RAG/ Exception Report Threshold (ER)	13/14 Outturn	Jul-13	Aug-13	Sep-13	Oct-13	Nov-13	Dec-13	Jan-14	Feb-14	Mar-14	Apr-14	May-14	Jun-14	Jul-14	YTD
R1	ED 4 Hour Waits UHL + UCC	RM	CF	95% or above	NTDA	Red = <95% ER via ED TB report	88.4%	88.3%	90.1%	89.5%	91.8%	88.5%	90.1%	93.6%	83.5%	89.3%	86.9%	83.4%	91.3%	92.5%	88.4%
R2	12 hour trolley waits in a&e	RM	CF	0	NTDA	Red = >0 ER via ED TB report	5	0	0	1	0	1	0	0	0	0	0	1	0	0	1
R3	RTT Waiting Times - Admitted	RM	CC	90% or above	NTDA	Red /ER = <90%	76.7%	89.1%	85.7%	81.8%	83.5%	83.2%	82.0%	81.8%	79.1%	76.7%	78.9%	79.4%	79.0%	80.9%	80.9%
R4	RTT Waiting Times - Non Admitted	RM	CC	95% or above	NTDA	Red /ER = <95%	93.9%	96.4%	95.5%	92.0%	92.8%	91.9%	92.8%	93.4%	93.5%	93.9%	94.3%	94.4%	95.0%	94.9%	94.9%
R5	RTT - Incomplete 92% in 18 Weeks	RM	CC	92% or above	NTDA	Red /ER = <92%	92.1%	93.1%	92.9%	93.8%	92.8%	92.4%	91.8%	92.0%	92.6%	92.1%	93.9%	93.6%	94.0%	93.2%	93.2%
R6	RTT 52 Weeks+ Wait	RM	CC	0	NTDA	Red /ER = >0	0	0	0	0	0	0	1	1	0	0	3	0	2	16	16
R7	6 Week - Diagnostic Test Waiting Times	RM	SK	1% or below	NTDA	Red /ER = >1%	1.9%	0.6%	0.8%	0.7%	1.0%	0.8%	1.4%	5.3%	1.9%	1.9%	0.8%	0.9%	0.8%	0.7%	0.7%
R8	Two week wait for an urgent GP referral for suspected cancer to date first seen for all suspected cancers	RM	MM	93% or above	NTDA	Red = <93% ER = Red for 2 consecutive mths	94.8%	94.2%	94.6%	93.0%	94.9%	95.7%	94.9%	95.3%	95.9%	95.3%	88.5%	94.7%	93.5%		92.2%
R9	Two Week Wait for Symptomatic Breast Patients (Cancer Not initially Suspected)	RM	MM	93% or above	NTDA	Red = <93% ER = Red for 2 consecutive mths	94.0%	93.6%	92.0%	95.2%	93.0%	91.3%	95.5%	96.8%	93.4%	94.3%	80.0%	95.0%	98.9%		92.4%
R10	31-Day (Diagnosis To Treatment) Wait For First Treatment: All Cancers	RM	MM	96% or above	NTDA	Red = <96% ER = Red for 2 consecutive mths	98.1%	98.3%	99.7%	99.1%	98.9%	96.2%	97.4%	97.2%	98.5%	98.2%	97.2%	92.9%	93.6%		94.6%
R11	31-Day Wait For Second Or Subsequent Treatment: Anti Cancer Drug Treatments	RM	MM	98% or above	NTDA	Red = <98% ER = Red for 2 consecutive mths	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%		100.0%
R12	31-Day Wait For Second Or Subsequent Treatment: Surgery	RM	MM	94% or above	NTDA	Red = <94% ER = Red for 2 consecutive mths	98.2%	100.0%	98.4%	88.6%	96.4%	97.1%	92.3%	94.8%	96.4%	98.6%	95.2%	97.0%	90.8%		94.2%
R13	31-Day Wait For Second Or Subsequent Treatment: Radiotherapy Treatments	RM	MM	94% or above	NTDA	Red = <94% ER = Red for 2 consecutive mths	96.0%	100.0%	100.0%	97.7%	97.5%	98.5%	98.1%	94.8%	96.3%	99.1%	97.3%	95.6%	93.9%		95.7%
R14	62-Day (Urgent GP Referral To Treatment) Wait For First Treatment: All Cancers	RM	MM	85% or above	NTDA	Red = <85% ER = Red for 2 consecutive mths	86.7%	85.8%	88.2%	87.4%	86.4%	85.7%	89.4%	89.1%	89.1%	92.4%	92.7%	85.5%	73.1%		84.1%
R15	62-Day Wait For First Treatment From Consultant Screening Service Referral: All Cancers	RM	MM	90% or above	NTDA	Red = <90% ER = Red for 2 consecutive mths	95.6%	90.6%	97.2%	96.2%	100.0%	97.0%	96.6%	97.1%	95.1%	91.7%	91.1%	67.4%	73.9%		78.0%
R16	Urgent Operations Cancelled Twice	RM	PW	0	NTDA	Red = >0 ER = >0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
R17	Cancelled patients offered a date within 28 days of the cancellations	RM	PW	100%	NTDA	Red = <100% ER = <100%	95.1%	99.1%	96.0%	98.6%	94.2%	97.7%	94.3%	94.1%	98.9%	94.2%	90.6%	96.1%	99.0%	99.0%	96.0%
R18	% Operations cancelled for non-clinical reasons on or after the day of admission	RM	PW	0.8% or below	Contract	Red = >0.8% ER = >0.8%	1.6%	1.2%	1.4%	2.3%	1.7%	1.8%	1.7%	1.6%	2.1%	1.5%	1.1%	0.8%	1.0%	0.9%	0.9%
	No of Operations cancelled for non-clinical reasons on or after the day of admission	RM	PW	N/A	UHL		1739	114	124	208	171	172	141	152	178	139	106	77	98	96	377
R19	Delayed transfers of care	RM	PW	3.5% or below	NTDA	Red = >3.5% ER = Red for 3 consecutive mths	4.1%	4.0%	3.9%	4.2%	4.6%	4.4%	3.6%	4.6%	4.3%	3.8%	4.6%	4.4%	4.2%	4.1%	4.3%
R20	Choose and Book Slot Unavailability	RM	CC	4% or below	Contract	Red = >4% ER = Red for 3 consecutive mths	13%	15%	14%	11%	16%	17%	14%	10%	16%	19%	22%	25%	26%	25%	25%
R21	Ambulance Handover >60 Mins	RM	CF	0	Contract	Red = >0 ER = Red for 3 consecutive mths	868	55	16	21	25	59	102	52	207	111	188	253	89	63	593
R22	Ambulance Handover >30 Mins and <60 mins	RM	CF	0	Contract	Red = >0 ER = Red for 3 consecutive mths	7,075	566	383	484	705	689	722	573	818	601	822	1,014	644	625	3,105

S6 – OVERDUE CAS ALERTS

What is causing underperformance?	What actions have been taken to improve performance?	Target (mthly / end of year)	Latest month performance	YTD performance	Forecast performance for next reporting period
There has been a decline in CMG performance during April - July 2014 culminating in a reduction of the number and percentage of CAS alerts closed within their deadlines. The data shows a reduction from 99% (to the end of 2013/14 Q4) to 81.3% (YTD to the end of July 2014). qThis can be accounted for by a number of This can be accounted for by a number of factors: • During Quarter 1, changes have been made to the CAS alert process, as result of the Management of Change of the Quality & Safety Managers. CAS alerts are now managed by Heads of Nursing and administered via CMG admin teams. • Change of UHL CAS process from 1/4/14 to include a move away from burdensome paper audit trails to electronic tracking leading to short term implementation issues but with longer term benefits.. • An increasing number of NHS England NPSAS alerts being issued (e.g. 1 alert received during 2013 and 13 received between 1/1/14 and 30/6/14).	Monthly reports are produced for EQB to show new National Patient Safety Alerting System (NPSAS) alerts received and to show any CAS alerts (which include NPSAS alerts) where a deadline has been missed. EQB will hold CMGs to account for the effective management of CAS alerts Quarterly reports are produced to demonstrate CAS performance. From September Monthly CAS reports will be produced to show individual CMG performance. Meetings between the UHL and CAS team and CMG CAS leads (HoN) are taking place during August/ September to address any outstanding issues in relation to the CAS process within UHL. Filtering of irrelevant alerts by CAS team to reduce burden on CMGs. CAS process guides developed and distributed for use in CMGs System of reminders for forthcoming CAS alert deadlines from UHL CAS team to CMG teams. Presentations from UHL CAS team to CMG management teams highlighting the importance of CAS alerts in relation to patient safety.	100% of alerts completed in deadline	4 missed deadlines (i.e. 55.5% compliance in July 2014)	9 missed deadlines (i.e. 81.3% compliance to end of July 2014)	1 missed alert (i.e.90% compliance in August)

CMG CAS Performance 01 Apr - 31 Jul 14	Alerts distributed	No of deadlines missed
CHUGS	6	0
CSI	8	0
Emergency and Specialist Medicine	11	2 (18%)
ITAPS	8	1 (13%)
MSK/SS	8	3 (38%)
RRC	6	1 (17%)
W&C	10	0
Alliance	23	0
NHS Horizons (including EFNs)	13	2 (15%)

Performance by Quarter

13/14 FYE	14/15 Q1	14/15 Q2	14/15 Q3	14/15 Q4
2 Missed deadlines (i.e. 99% compliance)	5 missed deadlines (i.e.87% compliance)			

Expected date to meet standard / target	October 2014
Revised date to meet standard	
Lead Director / Lead Officer	Moira Durbridge / Peter Cleaver

W2 – ED FRIENDS & FAMILY TEST PARTICIPATION

<table>
<tr><th>What is causing underperformance?</th><th>What actions have been taken to improve performance?</th><th>Target (mthly / end of year)</th><th>Latest month performance</th><th>YTD performance</th><th>Forecast performance for next reporting period</th></tr>
<tr><td rowspan="5">Whilst the 13/14 15% threshold was achieved for both April and May, there was a drop in performance in June and then a further significant drop in July.

Review of the process has identified two key contributory factors:

In previous months, members of staff who are on ‘non clinical duties’ due to health reasons, have been leading on asking patients to complete the F&F survey. During July, there were no staff working ‘non clinically’.

During July there has been the Rapid Cycle Testing approach to the ED workstreams ie assessment bay, minors and majors. This has involved staff being focused on reviewing processes relating to each of the above workstreams which is considered to have impacted on F&FT.</td><td rowspan="5">Member of staff currently working non clinically due to eye sight problems.

All staff reminded of need to continue focus on F&FT in addition to the Rapid Cycle Testing work.

Band 7 Nursing Team have been re-issued with their ‘F&FT quotas’

Daily review of numbers by Deputy CMG Head of Nursing

Discussion with Volunteers / Patient Advisor regarding their support of the F&FT process.</td><td>20% for Q4</td><td>10.2%</td><td>14.5%</td><td>>15% for August</td></tr>
<tr><td colspan="4">Performance by Quarter
<table><tr><th>13/14 FYE</th><th>14/15 Q1</th><th>14/15 Q2</th><th>14/15 Q3</th><th>14/15 Q4</th></tr><tr><td>14.9%</td><td>16%</td><td></td><td></td><td></td></tr></table></td></tr>
<tr><td colspan="2">Expected date to meet standard / target</td><td colspan="2">September 14</td></tr>
<tr><td colspan="2">Revised date to meet standard</td><td colspan="2"></td></tr>
<tr><td colspan="2">Lead Director / Lead Officer</td><td colspan="2">Rachel Overfield, Chief Nurse / Carole Ribbins, Deputy Chief Nurse</td></tr>
</table>

R3 – R6 REFERRAL TO TREATMENT – ADMITTED, NON-ADMITTED and 52+ WEEKS

Referral to Treatment		Target	Latest performance (July)	Year to date	Forecast for next reporting period
What is causing underperformance?	**What actions have been taken to improve performance?**	**95% Non Adm 90% Adm**	**94.9% 80.9%**	**NA**	**95.1% 81.0%**

Background

The reasons for UHL's deterioration in RTT performance are well documented. This report is the sixth monthly update. The high level trajectories are detailed in the attached Appendices.

For July the Trust is behind trajectory for admitted performance at a Trust Level, even when including Alliance activity.

For 'non admitted performance' the Trust is on trajectory although did not achieve the 95% as in the previous month (when including Alliance activity).

The Trust Development Authority have stipulated that they require Trust level performance to be delivered against both admitted and non admitted RTT standards by the end of September (September published data).

Admitted performance is expected to deliver in November 2014. The Trust in conjunction with CCG's have re submitted plans which anticipate best case position of 86% admitted performance in September.

Funding to support additional activity and additional costs incurred (including premium payments) is anticipated.

To support the delivery the following actions are being taken in addition to those already in place:

- Additional use of the independent sector both locally, Circle Nottingham and Ramsay health. This will be partly UHL sub contracting but CCGs have additionally agreed to the diverting of patients at receipt of referral for whole pathways of care. NB: UHL is seek full patient consent prior to diverting any referrals
- Validation of the UHL elective waiting list detailed in last month's report yielded the removal of 29 patients who no longer required their operation (all were reviewed clinically before the decision to take them off the waiting list).
- Additional administrative staff have being recruited to support these processes.

The Trust is continuing additional in house activity, mostly out of hours and at weekends.

Trust level backlog over 18 weeks Week Ending	Jan-14	Feb-14	Mar-14	Apr-14	May-14	Jun-14	Jul-14
RTT Non Admitted Backlog Actual No	1917	1558	1704	1527	1151	1594	1400
RTT Admitted Backlog Actual No	1416	1512	1527	1551	1310	1420	1400

Risks

The key risks remain the same as in previous reports and are in summary:

- Ability to deliver agreed capacity improvements including theatre, bed and outpatient space and staffing resources within agreed timelines
- Changes to emergency demand
- Patients unable or unwilling to transfer their care to alternative providers

Recommendations

The board are asked to:

- Note the contents of the report
- Acknowledge the improvement trajectory
- Acknowledge the key risks.

Referral to Treatment		Referral to Treatment	Latest performance (July)	Year to date	Forecast for next reporting period
What is causing underperformance?	**What is causing underperformance?**	**95% Non Adm 90% Adm**	**94.9% 80.9%**	**NA**	**95.1% 86.2%**
Performance overview UHL's RTT performance is mainly challenged in four specialities; ENT, ophthalmology, orthopaedics and general surgery. The two Appendices go into greater detail showing performance at speciality level and waiting list sizes for both outpatient and electives (key indicators of RTT backlog reduction). Significant progress has been made in Ophthalmology and the elective waiting list size for adult ENT is reducing in size. The planned additional elective activity for general surgery has slipped, mainly due to staffing shortages both in the theatres and wards, this is now scheduled to progress from mid September onwards. There will be 18 breaches of the 52 week standard within Restorative Dentistry. These patients are waiting for either dentures or crowns. Treatment takes place across two to four visits, however for the purposes of RTT the treatment start date is recorded as their first visit. There has been no patient harm due to the excessive waits. A breach report has been provided, MSS CMG will be undertaking lessons learnt. There will be automatic financial penalties of circa £90k as a result,		**Expected date to meet standard**		Non admitted in August 2014 Admitted in November 2014	
		Revised date to meet standard		-	
		Lead Director		Richard Mitchell, Chief Operating Officer	
		Clinical Lead		CMG Clinical Directors	
		Managerial Lead		Charlie Carr , Head of Performance	

Specialty Level Trajectory

	Admitted Trust level RTT														
	Jan-14	Feb-14	Mar-14	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15
Trajectory	80.8%	80.5%	81.2%	81.2%	82.3%	84.3%	86.9%	87.7%	86.2%	89.5%	90.5%	90.5%	90.5%	90.4%	92.0%
Actual	81.8%	79.3%	76.7%	75.7%	76.8%	77%	78.6%								
UHL + Alliance				78.9%	79.4%	79%	80.86%								
	Non admitted Trust level RTT														
	Jan-14	Feb-14	Mar-14	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15
Trajectory	92.3%	92.7%	92.8%	93.1%	93.6%	94.1%	94.8%	95.1%	95.3%	95.3%	95.5%	96.1%	96.1%	96.1%	96.1%
Actual	93.4%	93.5%	93.9%	93.4%	93.9%	94.3%	94.4%								
UHL + Alliance				94.3%	94.4%	95.0%	94.9%								
	Adult Ophthalmology Admitted RTT														
	Jan-14	Feb-14	Mar-14	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15
Trajectory	58.8%	61.0%	62.3%	63.1%	69.5%	80.4%	90.1%	90.2%	90.3%	90.6%	90.6%	90.5%	90.8%	90.7%	90.8%
Actual	57.8%	60.0%	53.6%	50.3%	52.5%	57.9%	65.6%								
	Adult Ophthalmology Non admitted RTT														
	Jan-14	Feb-14	Mar-14	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15
Trajectory	83.7%	83.1%	82.3%	85.3%	88.8%	89.1%	93.5%	95.4%	95.1%	95.0%	95.2%	95.2%	95.1%	95.1%	95.1%
Actual	86.6	90.2	91.46	89.80%	92.3%	93.8%	97.3%								
	Paediatric Ophthalmology Admitted RTT (other category)														
	Jan-14	Feb-14	Mar-14	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15
Trajectory	80.8%	80.5%	81.2%	81.2%	82.1%	84.4%	84.4%	86.6%	90.6%	90.2%	90.5%	90.5%	90.5%	90.4%	92.0%
Actual			80.1%	73.10%	72.5%	75.3%	65.3%								
	Paediatric Ophthalmology Non admitted RTT(other category)														
	Jan-14	Feb-14	Mar-14	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15
Trajectory	92.3%	92.7%	92.8%	93.3%	92.7%	95.1%	95.4%	95.6%	95.6%	95.6%	95.7%	95.3%	95.3%	95.3%	95.3%
Actual			93%	93.20%	93.9%	94%	94.4%								
	Adult ENT Admitted RTT														
	Jan-14	Feb-14	Mar-14	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15
Trajectory	62.6%	64.5%	61.3%	61.1%	66.1%	72.8%	75.0%	83.1%	90.5%	90.5%	90.4%	90.3%	90.3%	90.2%	90.4%
Actual	69.8%	56.3%	61.8%	61.90%	56.4%	59.2%	59.9%								
	Adult ENT Non admitted RTT														
	Jan-14	Feb-14	Mar-14	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15
Trajectory	89.0%	90.7%	90.4%	93.3%	92.4%	92.4%	93.4%	95.1%	95.4%	95.3%	95.5%	95.5%	95.5%	95.5%	95.5%
Actual	86%	82.7%	86.3%	86.70%	85.1%	87.6%	88.8%								
	Paediatric ENT Admitted RTT (other category)														
	Jan-14	Feb-14	Mar-14	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15
Trajectory	80.8%	80.5%	81.2%	81.2%	82.1%	84.4%	84.4%	86.6%	90.6%	90.2%	90.5%	90.5%	90.5%	90.4%	92.0%
Actual			80.1%	73.10%	72.5%	75.3%	65.3%								
	Paediatric ENT Non admitted RTT(other category)														
	Jan-14	Feb-14	Mar-14	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15
Trajectory	92.3%	92.7%	92.8%	93.3%	92.7%	95.1%	95.4%	95.6%	95.6%	95.6%	95.7%	95.3%	95.3%	95.3%	95.3%
Actual			93.0%	93.20%	93.9%	94.0%	94.4%								
	Orthopaedics Admitted RTT														
	Jan-14	Feb-14	Mar-14	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15
Trajectory	70.0%	69.7%	75.3%	75.5%	74.4%	76.2%	78.6%	75.9%	77.6%	79.7%	81.0%	82.3%	82.2%	82.3%	90.1%
Actual	70.1%	70.5%	66.5%	70.5%	71.5%	70.4%	80.1%								
	Orthopaedics Non admitted RTT														
	Jan-14	Feb-14	Mar-14	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15
Trajectory	78.8%	79.3%	80.4%	78.4%	80.7%	81.2%	82.0%	83.4%	84.1%	85.0%	86.0%	95.2%	95.1%	95.1%	95.1%
Actual	78.3%	78.4%	80.5%	76.0%	80.2%	81.1%	72.7%								
	General surgery Admitted RTT														
	Jan-14	Feb-14	Mar-14	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15
Trajectory	75.2%	72.8%	73.7%	74.4%	74.6%	73.3%	77.4%	82.5%	84.2%	88.2%	90.2%	90.2%	90.2%	90.2%	90.2%
Actual	65.9%	56.9%	66.2%	74.2%	71.6%	72.9%	67.9%								
	General surgery Non admitted RTT														
	Jan-14	Feb-14	Mar-14	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15
Trajectory	95.1%	95.1%	95.9%	95.1%	95.3%	95.9%	95.1%	95.3%	95.2%	95.3%	95.6%	95.1%	95.1%	95.1%	95.1%
Actual	84%	75.1%	96.7%	95.9%	96.1%	95.1%	95.6%								

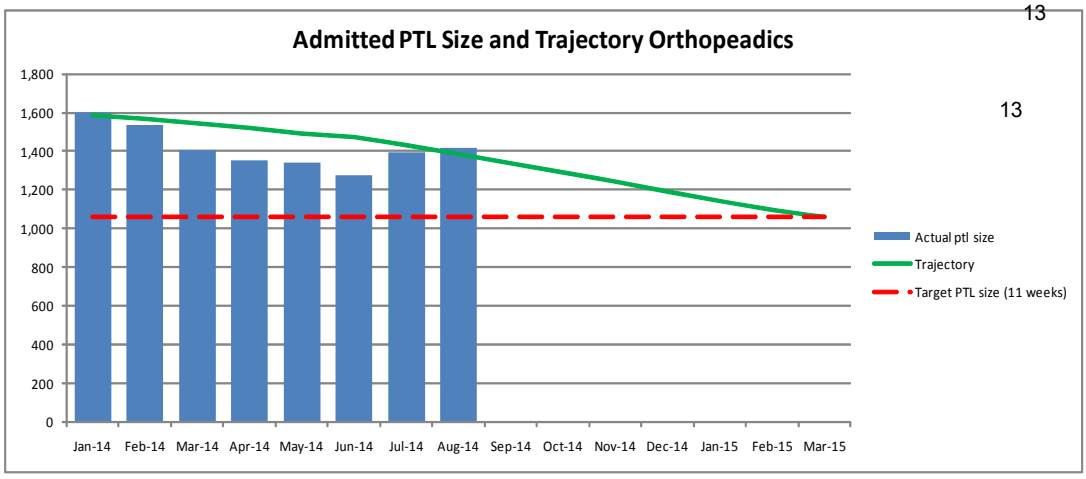
Inpatient Waiting List

Othopaedics

	Jan-14	Feb-14	Mar-14	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15
Actual ptl size	1,602	1,536	1,405	1,351	1,339	1,278	1,392	1,420	-						
Trajectory	1,587	1,565	1,542	1,518	1,491	1,476	1,431	1,383	1,336	1,288	1,241	1,193	1,145	1,098	1,062
Target PTL size (11 weeks)	1,062	1,062	1,062	1,062	1,062	1,062	1,062	1,062	1,062	1,062	1,062	1,062	1,062	1,062	1,062

13

13



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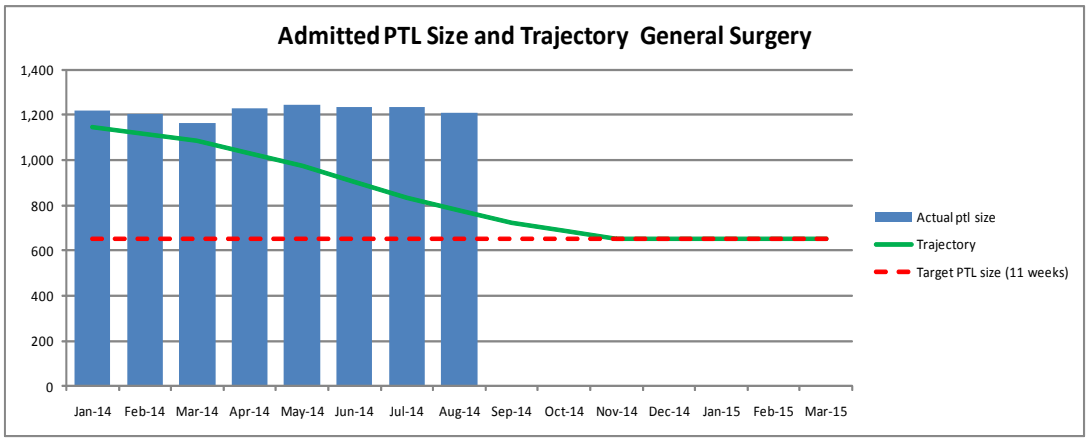
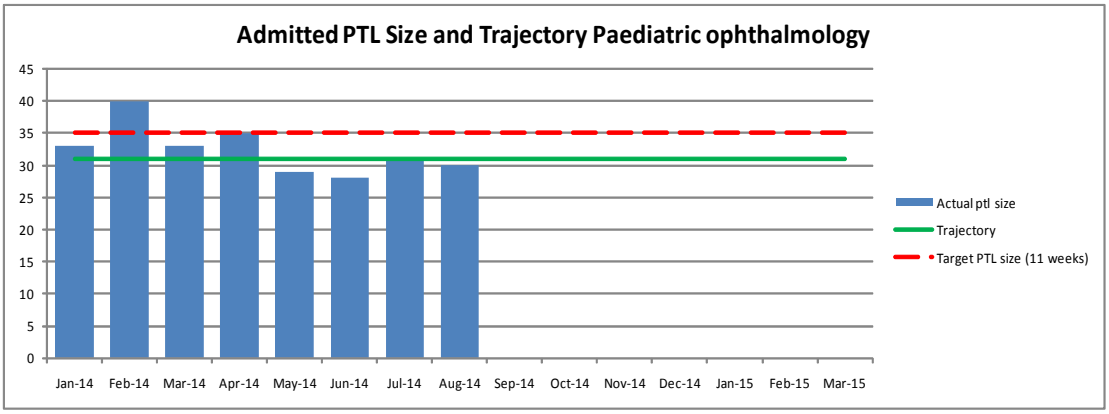
General surgery

	Jan-14	Feb-14	Mar-14	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15
Actual ptl size	1,220	1,205	1,162	1,227	1,242	1,236	1,236	1,209	-						
Trajectory	1,148	1,118	1,087	1,031	975	904	834	778	721	686	651	651	651	651	651
Target PTL size (11 weeks)	651	651	651	651	651	651	651	651	651	651	651	651	651	651	651



Paediatric ophthalmology

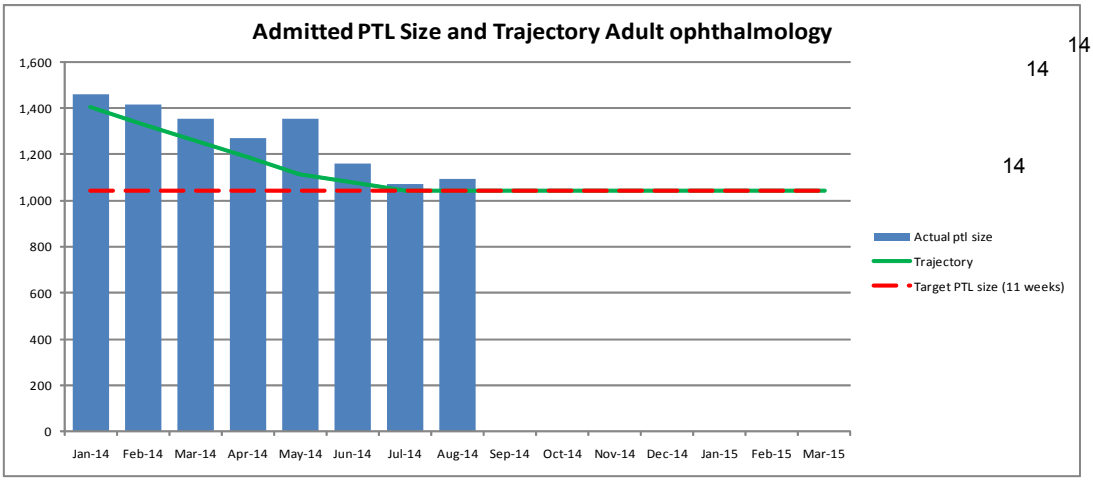
	Jan-14	Feb-14	Mar-14	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15
Actual ptl size	33	40	33	35	29	28	31	30	-						
Trajectory	31	31	31	31	31	31	31	31	31	31	31	31	31	31	31
Target PTL size (11 weeks)	35	35	35	35	35	35	35	35	35	35	35	35	35	35	35



Inpatient Waiting List (continued)

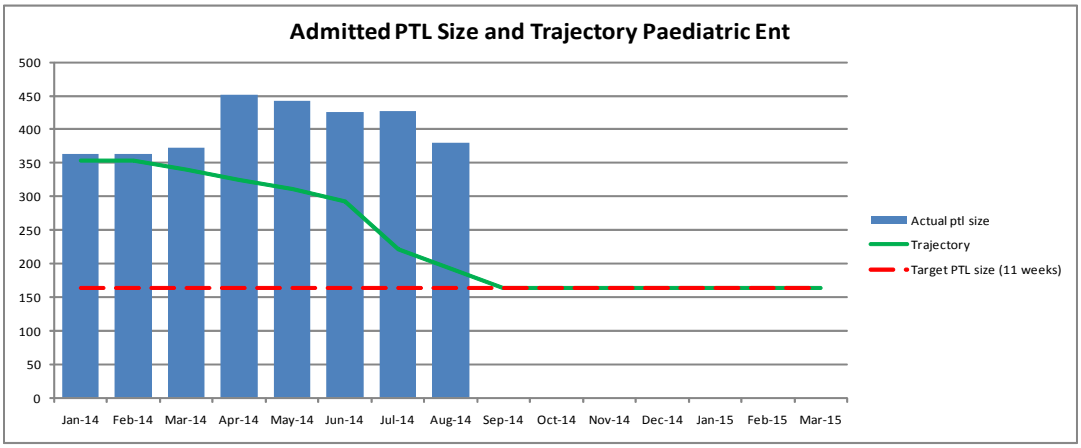
Adult ophthalmology

	Jan-14	Feb-14	Mar-14	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15
Actual ptl size	1,458	1,415	1,355	1,271	1,353	1,160	1,140	1,092	-						
Trajectory	1,402	1,330	1,258	1,186	1,114	1,078	1,042	1,042	1,042	1,042	1,042	1,042	1,042	1,042	1,042
Target PTL size (11 weeks)	1,042	1,042	1,042	1,042	1,042	1,042	1,042	1,042	1,042	1,042	1,042	1,042	1,042	1,042	1,042



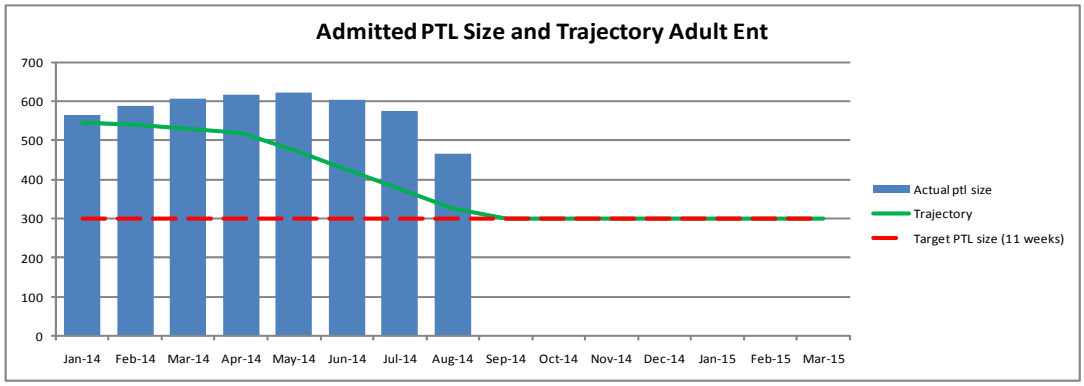
Paediatric ENT

	Jan-14	Feb-14	Mar-14	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15
Actual ptl size	364	364	372	452	442	425	428	380	-						
Trajectory	354	354	340	325	311	293	221	192	163	163	163	163	163	163	163
Target PTL size (11 weeks)	163	163	163	163	163	163	163	163	163	163	163	163	163	163	163



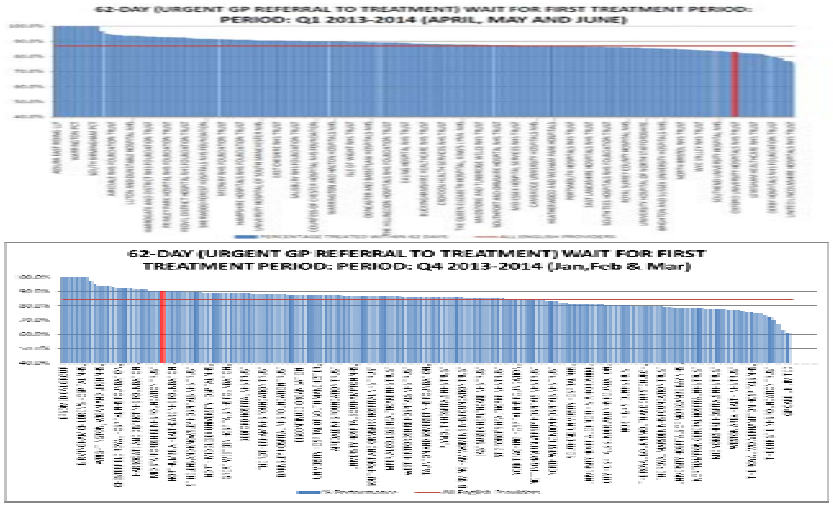
Adult Ent

	Jan-14	Feb-14	Mar-14	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15
Actual ptl size	565	589	606	618	621	604	575	467	-						
Trajectory	545	540	529	518	475	425	375	326	300	300	300	300	300	300	300
Target PTL size (11 weeks)	300	300	300	300	300	300	300	300	300	300	300	300	300	300	300



R10 and R14 CANCER WAITING TIMES PERFORMANCE

What is causing underperformance?	What actions have been taken to improve performance?	Target (mthly / end of year)	Latest month performance (June 2014)	YTD performance	Forecast performance for next reporting period (July 2014)
The measures instigated to address performance during 2013/14 which resulted in a Q1 to Q4 in-year transformation from lower to upper quartile performance when benchmarked nationally (see right) remain in operation. These delivered 12 consecutive months of performance exceeding target. The responsible factors for the abrupt deterioration by M3 of 14/15 are multiple and vary from one type of cancer to another. The overarching internal contributory factors to this are likely to relate to focus on competing priorities for the trust, including RTT recovery plans, Emergency performance and Finance. Externally there has been a very large increase in demand generated by 2WW referrals. This has particularly related to Breast Cancer.This has now translated to a very significant increase in activity required to service the relevant tumour sites. 2WW referrals were 13% higher per month in Q1 14/15 than the average for 13/14. July 14 2WW referrals are 25% higher than the average 13/14 levels. 62 day activity levels did not rise in Q1 compared with 13/14, but have jumped 20% in July, despite which the backlog has grown as a reflection of heavily increased demand. For 31 day the main reason for failure has been surgical capacity in breast.	The CMGs have analysed breach maps and delayed patient pathway tracking reports and derived evidence based recovery plans for the cancer types they host. CMGs have confirmed these plans to return performance by end of Q2 14/15. CSI has produced a supporting plan to continue improvements to delivery of cancer diagnostics to facilitate recovery. CMG and Cancer Centre to adopt joint ownership of Cancer Pathways through CMG Cancer Action Boards. Clinical engagement strengthened through revision of membership and TOR of clinical Cancer Board. Series of individual meetings between CMGs, Cancer Centre and COO, focussing on those hosting tumour sites with most challenged performance. Weekly high level cancer performance dashboard circulated to CMG managers/directors and COO with real time information to allow intervention in addition to scrutiny. This also standing item on Executive Performance Board. Establish work streams with CMGs to manage demand through appropriate policy, process and education. Surgical capacity in breast has been increased.	**62 day 85%**	**73.2%**	**84.1%**	**86.2%**
		31 day 96%	**93.6%**	**94.6%**	**91.4**



62 day Performance by Quarter

13/14 FYE	14/15 Q1	14/15 Q2	14/15 Q3	14/15 Q4
86.7%	84.1%	83%	85%	86%

Expected date to meet standard / target	September 2014
Revised date to meet standard	October 2014
Lead Director / Lead Officer	Richard Mitchell/Matt Metcalfe

R17 and R18 OPERATIONS CANCELLED ON THE DAY AND PATIENTS REBOOKED WITHIN 28 DAYS

Operations cancelled on the day for non clinical reasons			**July**		
What is causing underperformance?	**What actions have been taken to improve performance?**	**Target (mthly) 1)On day= 0.8% 2) 28 day = 0**	**Latest month performance**	**YTD performance**	**Forecast performance for next reporting period**
The cancelled operations target comprises of three components: 1. The % of cancelled operations for non clinical reasons on the day of admission 2. The % of patients cancelled who are offered another date within 28 days of the cancellation 3. The number of urgent operations cancelled for a second time. Cancellations on the day as a result of bed related issues has significantly reduced during July. Whereas non bed related issues have remained static.	The key action to ensure on going good performance is the daily expediting of patients at risk of cancellation on the day, following the UHL cancelled operations policy. For those cancelled on the day, adhering to the Trust policy of escalating to CMG Directors and General Managers for resolution. The 'Cancelled Operations' manager starts in post at the end of September. The key focus of their role will be to ensure both bed and non bed related cancellations continue to reduce and that all patients cancelled are rebooked within 28 days. Risks to delivery of recovery plan There are risks to delivery of the plan to reduce cancellations on the day. These are mainly associated with bed availability. Circa 75% of cancellations on the day are due to no bed.		1) UHL: 0.72% UHL & Alliance: 0.9% 2) 2 patients	UHL & Alliance: 1.0%	0.8%

UHL performance

1. The percentage of operations cancelled on/after the day for non-clinical reasons during July was 0.72% against a target of 0.8%.
2. The number of patients cancelled who breached the standard of being offered another date within 28 days in July was 2 with 97.2% offered a date within 28 days of the cancellation.
3. The number of urgent operations cancelled for a second time ; Zero

Combined UHL and Alliance performance

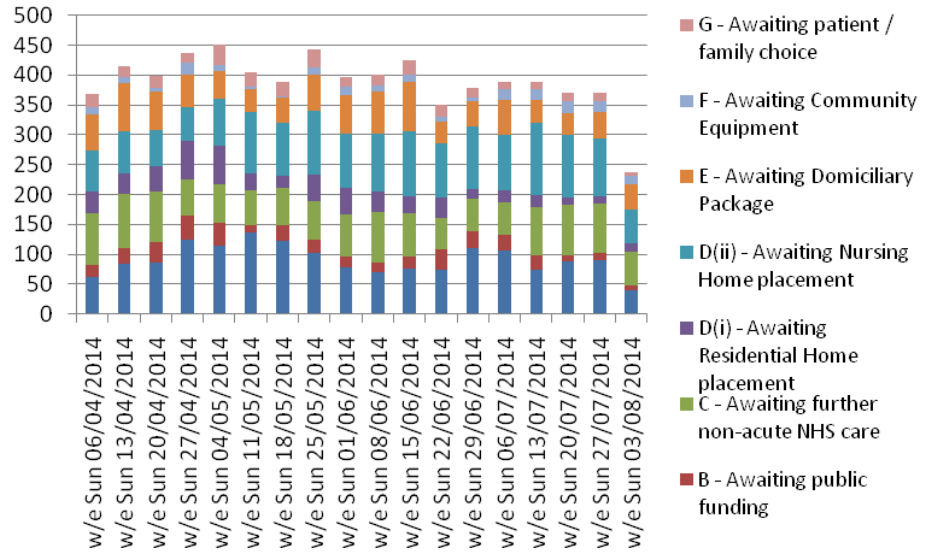
Due to exceptional circumstances during July a total of 23 patients were cancelled in the community hospitals for non clinical reasons (usually no more than 5 per month). Factors included equipment failure which resulted in high volume lists being cancelled.

13/14 FYE	**14/15 Q1**	**14/15 Q2**	**14/15 Q3**	**14/15 Q4**
1.6%	1.0%			

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

R19 DELAYED TRANSFERS OF CARE

What is causing underperformance?	What actions have been taken to improve performance?	Target (mthly / end of year)	Latest month performance	YTD performance	Forecast performance for next reporting period
Currently there are significant delays in DTOCs due to slow discharges to care homes. This is caused by families being slow to find appropriate care homes, carehomes being slow to come in to assess the patient as suitable or waiting for a bed to become available There are also delays in getting patients assessed using the CHC assessment package. There continue to be patients waiting for community hospital beds and home support.	We are currently looking at an external company to assess their ability to support transferring patients to their own homes or to carehomes more efficiently. Work is being done on increasing the number of available CHC assessors available within the trust. Whilst there is often community hospital capacity it is often in the wrong hospital geographically, so patients refuse to move out of UHL.	3.5%	4.1%	4.3%	4.1%



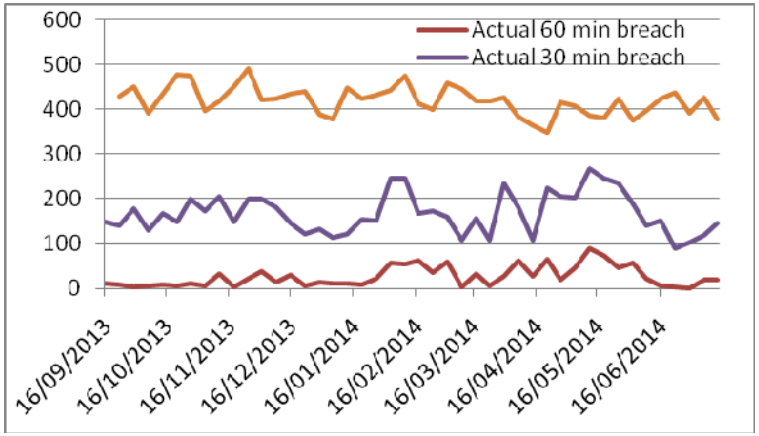
Performance by Quarter

13/14 FYE	14/15 Q1	14/15 Q2	14/15 Q3	14/15 Q4
		4.4%		

Expected date to meet standard / target	To be confirmed
Revised date to meet standard	
Lead Director / Lead Officer	Richard Mitchell/Phil Walmsley

R21 and R22 AMBULANCE HANDOVER >30 MINUTES

What is causing underperformance?	What actions have been taken to improve performance?	Target (mthly / end of year)	Latest month performance	YTD performance	Forecast performance for next reporting period
Delays in moving patients out of the assessment bay leads to delays in ambulance staff handing over to ED staff. The delays in the assessment bay in ED is caused by lack of capacity, which is mainly due to patients not flowing out of ED or a slow assessment process.	Work across the health economy, led by Dr I Sturgess is leading to improved flow from majors to the wards. A review of the assessment process in ED has led to changes that should see faster assessment bay processes. This will mean that there are more bays available as long as they flow out of majors is maintained. There has also been agreement that all patients going to resuscitation are assumed to be a 0 delay which commenced in August. This should lead to a small improvement in performance in the August figures.	0 delays over 30 minutes	> 60 min 1% 30-60 min – 12% 15-30 min – 38%	> 60 min 3% 30-60 min – 16% 15-30 min – 36%	



The target performance is to have no over 30 minute delays.

There has been a small improvement in reducing delays in the last months figures.

Expected date to meet standard / target	
Revised date to meet standard	To be confirmed.
Lead Director / Lead Officer	Richard Mitchell Phil Walmsley

2014/15 NTDA METRICS AND WEIGHTINGS

Responsiveness Domain

Metric	Standard	Weighting
Referral to Treatment Admitted	90	10
Referral to TreatmentNon Admitted	95	5
Referral to Treatment Incomplete	92	5
Referral to Treatment Incomplete 52+ Week Waiters	0	5
Diagnostic waiting times	1	5
A&E All Types Monthly Performance	95	10
12 hour Trolley waits	0	10
Two Week Wait Standard	93	2
Breast Symptom Two Week Wait Standard	93	2
31 Day Standard	96	2
31 Day Subsequent Drug Standard	98	2
31 Day Subsequent Radiotherapy Standard	94	2
31 Day Subsequent Surgery Standard	94	2
62 Day Standard	85	5
62 Day Screening Standard	90	2
Urgent Ops Cancelled for 2nd time (Number)	0	2
Proportion of patients not treated within 28 days of last minute cancellation	0	2
Delayed Transfers of Care	3.5	5
TOTAL - 15 Indicators		78

Effective Domain

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

Caring Domain

Metric	Standard	Weighting
Inpatient Scores from Friends and Family Test	80	5
A&E Scores from Friends and Family Test	46	5
Complaints	tbc	5
Mixed Sex Accommodation Breaches	0	2
Inpatient Survey Q 68 - Overall, I had a very poor/good experience	tbc	2
TOTAL - 5 Indicators		19

Safe Domain

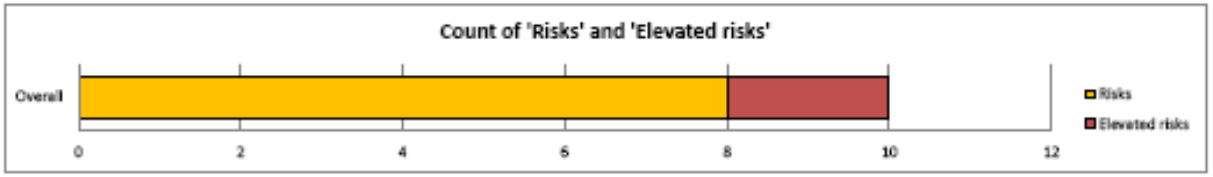
Metric	Standard	Weighting
Clostridium Difficile - Variance from plan	tbc	10
MRSA bactaraemias	0	10
Never events	0	5
Serious Incidents rate	0	5
Patient safety incidents that are harmful		5
Medication errors causing serious harm	0	5
CAS alerts	0	2
Maternal deaths	1	2
VTE Risk Assessment	95	2
Percentage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

Well Led Domain

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

University Hospitals of Leicester NHS Trust

Trust Summary



Priority banding for inspection	Recently Inspected
Number of 'Risks'	6
Number of 'Elevated risks'	2
Overall Risk Score	12
Number of Applicable Indicators	95
Percentage Score	6.32%
Maximum Possible Risk Score	190

Elevated risk	Composite Indicator: A&E waiting times more than 4 hours (05-Jan-14 to 30-Mar-14)
Elevated risk	Whistleblowing alerts (22-Mar-13 to 02-Jun-14)
Risk	Never Event Incidence (01-May-13 to 30-Apr-14)
Risk	Composite of Central Alerting System (CAS) safety alerts indicators (01-Apr-04 to 30-Apr-14)
Risk	SSNAP Domain 2: overall team-centred rating score for key stroke unit indicator (01-Oct-13 to 31-Dec-13)
Risk	Composite Indicator: Referral to treatment (01-Mar-14 to 31-Mar-14)
Risk	Proportion of ambulance journeys where the ambulance vehicle remained at hospital for more than 60 minutes (01-Apr-14 to 30-Apr-14)
Risk	Composite of PLACE indicators (01-Apr-13 to 30-Jun-13)
Risk	TDA - Escalation score (01-Nov-13 to 30-Nov-13)
Risk	GMC - Enhanced monitoring (01-Mar-09 to 21-Apr-14)

QUALITY SCHEDULE AND CQUIN SCHEMES PERFORMANCE REPORT FOR Q1 AND ANTICIPATED RAGS FOR JULY 14

Ref	Indicator Title	Q1 RAG	July RAG	Commentary
	QUALITY SCHEDULE			
PS01	Infection Prevention and Control Reduction.	G	G	C Diff Threshold for 14/15 is 81. UHL is aiming to achieve a reduction on last year's total of 66. UHL's IP Annual Programme has been shared with Commissioners.
PS02	HCAI Monitoring - MRSA	0	0	0 MRSA bacteraemias for Q1 or July 14.
PS03	Patient Safety – compliance with NHS SI framework and demonstrate lessons learnt and actions taken	0	0	There were no Never Events in Q1 or July. Q1 Patient Safety report presented with details of learning and actions taken
PS04	Duty of Candour	0	tbc	All patients have been notified of any moderate or serious incidents in Q1, where applicable. One justified breach in May. June's performance tbc.
PS05	Complaints and user feedback Management (excluding patient surveys).	A	tbc	Responses to NHS Choices/Patient Opinion being met. Complaints responses performance still below the 95% threshold following significant increase in numbers of complaints. All CMGs working towards improving performance in Q2. Performance slightly improved for GP concerns 25 day responses.
PS06	Risk Assurance / CAS Alerts	A	A	All Risks reviewed and actions on Track. Some delays with CAS alerts. Expected to be all closed by September.
PS07	Safeguarding	G	G	Assurance documentation sent to CCG Safeguarding leads for their review ahead of their observational visit to the Trust. – Reported to Safeguarding Cttee.
PS08	Reduction in Hospital Acquired Pressure Ulcer incidence.	G	G	Monthly thresholds achieved for both Grade 2 and Grade 3 HAPUs. 0 Grade 4s.
PS09	Medicines Management Optimisation	A	A	Deterioration in Controlled Drugs Audit results. Reaudit due in September. Progress made with development of LLR Medicines Optimisation Strategy.
PS10	Medication Errors	G	G	Increased reporting of medication errors. Actions being monitored by Medicines Optimisation Committee
PS11	Venous Thromboembolism (VTE)	95.7%	95.7%	Performance continues to be just above the national set threshold of 95% for all CMGs except CHUGs which are at 94%. RAG deferred until reporting of RCAs delayed to September CQRG
PS12	Nutrition and Hydration	G	G	Nursing Metrics amended to better monitor fluid and nutritional care. Work commenced to review Fluid Management Guidelines, taking into account the NICE IV Fluid Management guidelines. End of year threshold agreed.
PE1	Same Sex Accommodation Compliance	6	0	No breaches for July.
PE2	Patient Experience, Equality and Listening to and Learning from Feedback.	G	G	Triangulation of patient feedback completed and confirms 'waiting times' continue to be highest theme both in respect of complaints and Friends and Family 'detractors' free text comments
PE3	Improving Patient Experience of Hospital Care (NPS)	N/A	N/A	Not due to be reported until March 15
PE4	Equality and Human Rights	G	G	Progress report due for the August Trust Board.

QUALITY SCHEDULE AND CQUIN SCHEMES PERFORMANCE REPORT FOR Q1 AND ANTICIPATED RAGS FOR JULY 14

Ref	Indicator Title	Q1 RAG	July RAG	Commentary
CE01	Communication - Content	tbc	tbc	Commissioners agreed to defer reporting of Q1 performance until September in order to allow time for actions to be taken. Audit undertaken
CE02	Intra-operative Fluid Management	G	G	Clinical and Managerial Leads identified. Action Plan revised and performance on trajectory.
CE03	Clinical Effectiveness Assurance	G	G	Green RAG for Audit Programme - Reduction in number of audits behind schedule or action plans not on track National Quality Dashboard no longer being published. Compliance responses not received for all 13/14 published NICE Clinical Guidelines and Quality Standards. Responses/Compliance for 14/15 published guidance all on track.
CE04	Women's Service Dashboard	tbc	tbc	RAG to be confirmed at the September CQRG upon review of the updated dashboard and receipt of updated HIE report.
CE05	Children's Service Dashboard	A	A	Thresholds for Registrar training not met. Increased number of mediation errors reported following work undertaken by clinical lead.
CE06	Patient Reported and Clinical Outcomes	tbc	tbc	Publication of 13/14 PROMs data due later this month. Reporting to CQRG deferred until Oct meeting. Amber RAG anticipated due to delays in submission of data for DAHNO and Bariatric Surgery for 2014.
CE07	#NOF - Dashboard	51%	77%	72% threshold not met for any month in Q1. AMT and Orthogeriatric Assessment threshold not met. Commissioners requested to defer reporting of Action Plan till October meeting in order to allow time for recent changes to take impact.
CE08a	Stroke monitoring	86%	tbc	90% Stay on Stroke Unit performance just below 80% for May but overall achieved threshold for Q1. TIA performance below 60% for May but again achieved for Q1. Action Plans submitted and also proposed plans for increasing capacity within the TIA clinic and improvement in SSNAP.
CE08b	TIA monitoring	70%	62.8%	
CE09	Mortality	A	A	UHL's SHMI remains above 100. Mortality alert reviews completed on track and MRC work programme is on schedule.
CE10	MECC	tbc	tbc	STOP 'Bedside Project' commenced, Alcohol Liaison team weekend working continues. Little progress made with using Patient Centre to capture smoking status.
AS01	Cost Improvement Programme (CIP) Assurance	A	tbc	Assurance required that systems and on going monitoring processes in place. Audit trail in place for CIP schemes but lack of evidence about on-going assessment of risks associated with those schemes. – **Agenda Item 5.9 – Paper L**
AS02	Nursing Workforce and Ward Health-check	G	G	Recruitment of additional nurses continues.
AS03	Staffing governance	A	A	Due to non achievement of internal thresholds relating to Sickness and Appraisal.
AS04	Involving employees in improving standards of care.	G	G	
AS05	Staff Satisfaction	G	G	
AS06	External Visits and Commissioner Quality Visits	G	G	July CCG Quality Visits report received Action Plans to be submitted to Sept EQB meeting.
AS07	CQC Registration	G	G	Actions on track to achieve compliance. July 14 CQC IMR also identifies areas of risk –
	NATIONAL CQUINS			

QUALITY SCHEDULE AND CQUIN SCHEMES PERFORMANCE REPORT FOR Q1 AND ANTICIPATED RAGS FOR JULY 14

Ref	Indicator Title	Q1 RAG	July RAG	Commentary
Nat 1.1a	F&FT 1a - Staff	G	G	Implemented during May. National report expected in September. On track for next Staff F&FT before end of Q2.
Nat 1.1b	F&FT 1b - OutPt & Day Case	G	G	F&FT already happening in Day Case and has started in Outpatients.
Nat 1.2	F&FT 1.2 - Increased participation	16.5%	10%	Whilst the participation rate has continued at 15% for Q1. Participation dropped in July and the threshold for 14/15 CQUIN is to be at 20% by March 15.
Nat 1.3	**F&FT 1.3 - Inpt increase in March**	37.5%	37.5%	The participation rate for inpatients continues to increase and currently on track to achieve the March 15 40% threshold..
Nat 2.1	**ST 2.1 - ST data submission**	G	G	Data collection continues.
Nat 2.2	**ST 2.2 - LLR strategy**	tbc	G	LLR Strategy and Action Plan to be reviewed at the September CQRG. Continued progress with collaborative working across the health economy.
Nat 3.1	**Dementia 3.1 - FAIR**	G	tbc	90% threshold met for Q1. July data tbc.
Nat 3.2	**Dementia 3.2 - Training & Leadership**	G	G	Nicky Morgan is new Clinical Lead Dementia Category C Training Module reviewed and Training Programme to be amended following discussion with Commissioners
Nat 3.3	**Dementia 3.3 - Carers**	G	G	Survey Schedule agreed with Commissioners and implemented in Q1.
	LOCAL CQUINS			
Loc 1	**Urgent Care 1 (Discharge)**	tbc	tbc	Dependent upon agreement of definition and thresholds with Commissioners.
Loc 2	**Urgent Care 2 (Consultant Assessment)**	tbc	tbc	Dependent upon delivery of audit data and implementation plans.
Loc 3	**Improving End of Life Care (AMBER)**	G	tbc	On track to achieve the Q1 threshold but Q2 at risk due to both Facilitators leaving. Recruitment underway but likely to be a one month gap before both posts filled
Loc 4	**Quality Mark**	G	G	Provisional data received that Quality Mark achieved for 7 out of 8 wards.
Loc 5	**Pneumonia**	tbc	tbc	Q1 threshold is provision of baseline data and improvement plan. New CQUIN nurses appointed to replace previous post holders.
Loc 6	**Think Glucose**	G	G	Recruitment in progress. Q1 thresholds met and on track to achieve Q2 requirements.
Loc 7	**Sepsis Care pathway**	G	G	Good progress made with actions. Sepsis Nurse appointed. Audit confirmed achievement of the Q1 thresholds.
Loc 8	**Heart Failure**	G	G	Q1 threshold missed by 0.5% due to higher than usual number of admissions and annual leave. Commissioners given Green RAG in recognition of work undertaken.

QUALITY SCHEDULE AND CQUIN SCHEMES PERFORMANCE REPORT FOR Q1 AND ANTICIPATED RAGS FOR JULY 14

Ref	Indicator Title	Q1 RAG	July RAG	Commentary
Loc 9	**Medication Safety Thermometer**	41%	tbc	Q1 40% threshold achieved (44/105 wards commenced Think Glucose Programme)
	NATIONAL CQUINS			
SS1	National Quality Dashboards	G	G	Data collected for submission once confirmation of external provider received.
SS2	Breast Feeding in Neonates	73%	tbc	Q1 threshold exceeded.
SS3	Clinical Utilisation Review of Critical Care*			Full scope of CQUIN being finalised*
SS4	Acuity Recording*			Relates to implementation of eHandover and use of the system to capture Acuity scores for all patients.
SS5	Critical Care Standards – Disch*			Relates to reduction in delayed discharge for patients no longer needing Level 2 or Level 1 beds
SS6	Critical Care Outreach Team*			Relates to improved response times for Critical Care
SS7	Consultant Assessment			Links to the CCG CQUIN. Dependent upon provision of baseline data and implementation plan to improve performance
SS8	Highly Specialised Services Collaborative Workshop			Scope of CQUIN confirmed between Specialised Services and ECMO and PCO clinical leads

* Specialised CQUIN monies will be allocated over Q2-4 due to changes made to Schemes during Q1 in collaboration with Commissioners

University Hospitals of Leicester NHS
NHS Trust

To:	**Trust Board**
From:	**Simon Sheppard - Acting Director of Finance & Procurement**
Date:	**28th August 2014**
CQC regulation:	
Title:	**2014/15 Financial Position to Month 4**

Author/Responsible Director:
Simon Sheppard – Acting Director of Finance & Procurement

Purpose of the report:
This paper provides the Trust Board with an update on performance against the key financial duties:

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

The paper also provides further commentary on the key risks

The report is provided to the Trust Board for:

Decision		Discussion	√
Assurance	√	Endorsement	√

Summary/Key points:

- In month adverse movement to plan of £0.5m, with a year to date deficit to plan of £1.1m
- Year end forecast of £40.7m can be delivered
- CIP programme has identified £48.6m of plans against the £45m target. The significant improvement in month is identification of schemes against the workforce challenge target

Recommendations:
The Trust Board is **recommended** to:

- **Note** the contents of this report
- **Discuss and agree** the actions required to address the key risks/issues:
  - Additional capacity and RTT
  - Management of CMG recovery plans
  - Process to access the Operational Resilience Funds

Previously considered at another corporate UHL Committee?
Not applicable

Board Assurance Framework: Support delivery of controls within the BAF	**Performance KPIs year to date:** Not applicable

Resource implications (e.g. Financial, HR):
None

Assurance implications:
Provides assurance around delivery of financial plan

Patient and Public Involvement (PPI) implications:
Considered but not relevant to this paper

Stakeholder Engagement implications: Considered but not relevant to this paper
Equality impact: Considered but not relevant to this paper
Information exempt from disclosure: Considered but not relevant to this paper
Requirement for further review? None

Simon Sheppard
Acting Director of Finance & Procurement

28th August 2014

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST

REPORT TO: **TRUST BOARD**

DATE: **28th AUGUST 2014**

REPORT FROM: **SIMON SHEPPARD – ACTING DIRECTOR OF FINANCE & PROCUREMENT**

SUBJECT: **2014/15 FINANCIAL POSITION TO MONTH 4**

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1. Introduction and Context

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

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

1.2. The paper also provides further commentary on the key risks.

2. Key Financial Duties

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

Financial Duty	YTD Plan £'Ms	YTD Actual £'Ms	RAG	Forecast Plan £'Ms	Forecast Actual £'Ms	RAG
Delivering the Planned Deficit	(12.9)	(14.0)	A	(40.7)	(40.7)	G
Achieving the EFL	(7.6)	(12.9)	G	62.1	62.1	G
Achieving the Capital Resource Limit	13.7	6.0	A	34.2	34.2	G

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

Better Payment Practice Code	April - July YTD 2014	
	Number	Value £000s
Total bills paid in the year	43,877	211,248
Total bills paid within target	23,783	143,379
Percentage of bills paid within target	**54%**	**68%**

Key issues

- In month adverse movement to plan of £0.5m, with a year to date deficit to plan of £1.1m
- Year end forecast of £40.7m can be delivered
- CIP programme has identified £48.6m of plans against the £45m target. The significant improvement in month is identification of schemes against the workforce challenge target

3. Financial Position (Month 4)

3.1. The Month 4 results may be summarised as follows and as detailed in Appendix 1:

	July 2014			April - July 2014		
	Plan £m	Actual £m	Var (Adv) / Fav £m	Plan £m	Actual £m	Var (Adv) / £m
Income						
Patient income	61.6	60.9	(0.7)	232.2	230.2	(2.0)
Teaching, R&D	6.9	6.4	(0.4)	27.4	27.0	(0.4)
Other operating Income	3.2	3.5	0.3	12.6	12.9	0.3
Total Income	**71.7**	**70.9**	**(0.8)**	**272.2**	**270.1**	**(2.2)**
Operating expenditure						
Pay	41.1	40.5	0.6	164.0	161.9	2.1
Non-pay	27.7	27.9	(0.3)	106.0	107.0	(1.0)
Total Operating Expenditure	**68.8**	**68.4**	**0.3**	**270.0**	**268.9**	**1.1**
EBITDA	**2.9**	**2.4**	**(0.5)**	**2.2**	**1.2**	**(1.1)**
Net interest	0.0	0.0	0.0	0.0	0.0	0.0
Depreciation	(2.9)	(2.9)	-	(11.7)	(11.7)	0.0
PDC dividend payable	(0.9)	(0.9)	0.0	(3.5)	(3.5)	0.0
Net deficit	**(0.9)**	**(1.4)**	**(0.5)**	**(12.9)**	**(14.0)**	**(1.1)**
EBITDA %		**3.4%**			**0.4%**	

3.2 In the month of July, the Trust delivered a deficit of £1.4m against a planned deficit of £0.9m, an adverse variance of £0.5m.

3.3 Year to date, the deficit at the end of July is £14.0m, £1.1m worse than the £12.9m planned deficit.

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

Patient Care Income

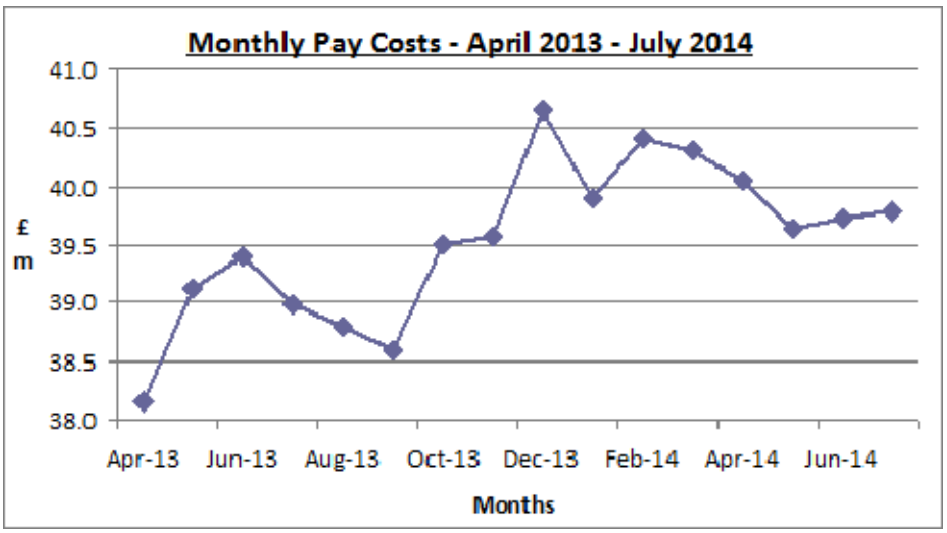
Patient income is £0.7m adverse to plan in month and £2.0m adverse to plan YTD (please refer to Appendix 2). Key areas of movement in month and YTD are as follows:

- Daycase and elective IP activity is £750k below plan in month, £381k of which is within General Surgery, Ophthalmology, ENT and Orthopaedics, the 4 specialties where the plan was increased in line with delivery of RTT trajectories. Year to date, these specialties are £1.1m below plan
- Critical Care activity is £365k below plan in month, £606k YTD, mainly within ITAPS
- Under-performance of £259k in month on Outpatients, £855k YTD, significantly MSK, CHUGS and W&C
- Penalties are £74k adverse to plan in month following assumed re-investment of ambulance penalties of £200k. In total, penalties are £1,526k adverse to plan YTD, relating to ambulance and RTT penalties
- Continuing ED over-performance of £91k in month and £577k YTD
- Emergency inpatients including MRET deduction, is £63k below plan in month and £280k above plan YTD. This is a slow down of emergency activity compared to earlier months
- Maternity activity £346k over plan in month, £618k YTD
- End Stage Renal Failure, £288k in month, £714k YTD

Pay

- Pay costs are £0.6m under plan in July and £2.1m under plan year to date:

  - Although slightly up in month, pay costs remain under budget and represent a decrease from Q4 of 2013/14. The graph below shows the pay cost trend, after excluding the impact of the Alliance Contract and the 2014/15 pay award
  - Premium pay costs in July were up slightly compared to June but are still at the lowest level since February 2013 as a result of continued substantive nurse recruitment and enhanced controls



Non Pay

- Non pay costs are £107m against a budget of £106m year to date, resulting in a £1m adverse position
- The in month overspend was driven most significantly by drugs, although drugs are underspent by £0.3m YTD. Overspends on non pay YTD relate to printing and stationery £0.3m, postage £0.1m, consultancy £0.3m and clinical supplies and services £0.3m
- The Trust continues to enact non pay controls across the CMGs and Corporate Directorates

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

Cost Improvement Programme

Appendix 3 shows CIP performance in July by CMG and Corporate Directorate against the original CIP plan. This currently shows an over-delivery against the target YTD of £1.1m, in the most part within pay due to the identification of schemes to deliver the workforce challenge.

The year end forecast reflects identified schemes of £48.6m against a target of £45m. Planning has now begun for identification of 2015/16 schemes.

4. Forecast Outturn

4.1 All areas have re-forecast at Month 4. The table below details the forecast outturn delivering in line with the planned deficit of £40.7m:

	Year End Forecast		
	Plan £m	Forecast £m	Var (Adv) / £m
Income			
Patient income	701.8	698.1	(3.7)
Teaching, R&D	82.3	82.0	(0.3)
Other operating Income	37.5	37.4	(0.1)
Total Income	**821.6**	**817.5**	**(4.1)**
Operating expenditure			
Pay	501.3	495.9	5.4
Non-pay	317.8	319.0	(1.3)
Total Operating Expenditure	**819.1**	**815.0**	**4.2**
EBITDA	**2.5**	**2.5**	**0.0**
Net interest	0.1	0.1	0.0
Depreciation	(32.9)	(32.9)	-
PDC dividend payable	(10.4)	(10.4)	0.0
Net deficit	**(40.7)**	**(40.7)**	**(0.0)**
EBITDA %		**0.3%**	

4.2 In order to meet this, it is assumed:

- CIP will deliver a minimum of £48.6m as forecast
- RTT trajectories are met with no spend above that planned
- Ambulance penalties of £1m are re-invested with no additional spend
- CMGs will deliver recovery plans in line with what they have presented
- Operational Resilience funding of £0.5m will be used to support costs for RTT that have been incurred. No other funding has been utilised to deliver £40.7m

5. Risks

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

- **Capacity** beyond the levels planned resulting in premium costs and the loss of elective income

  Mitigation: The Trust is planning to open an additional 23 beds for which capital costs are within the financial plan. Forecast costs are £1.4m of which £1.3m is within the plan. Costs are being reviewed to ensure they are delivered within the funding available

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

  The CCG contract has been signed with a penalty cap of £10m. In addition, CCGs have raised Activity Query Notices around emergency admissions and outpatients

  Mitigation: In order to deliver the planned deficit and prevent withholding of cash, AQN queries need to continue to be responded to robustly and in a timely fashion. Further work is ongoing with CCGs to identify a process for the resolution of queries going forward

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

  There is a risk to the delivery of the RTT target resulting in additional premium costs to ensure delivery or income lower than forecast. In addition, there is a risk that activity is lower than the plan

  Mitigation: RTT plan performance managed through fortnightly meetings with CCG/TDA and IST to review robustness of the plan. Forecasts for Month 4 include plans on delivery and include all costs to support delivery in line with plan

- **CIP Delivery**

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

  Mitigation: External consultancy support from Ernst & Young, along with revised CIP governance arrangements, a weekly CIP Board and CMG Performance Management meetings. £48.6m has been identified for 2014/15 and the programme for development of 2015/16 is in place

- **Liquidity**

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

  Mitigation: Application and successful receipt of Temporary Borrowing. £15.5m received in April and a further £13.5m in June. Further application for cash will be submitted in August to the NTDA to include the cash required to support the underlying deficit and capital programme

- **Unforeseen Events**

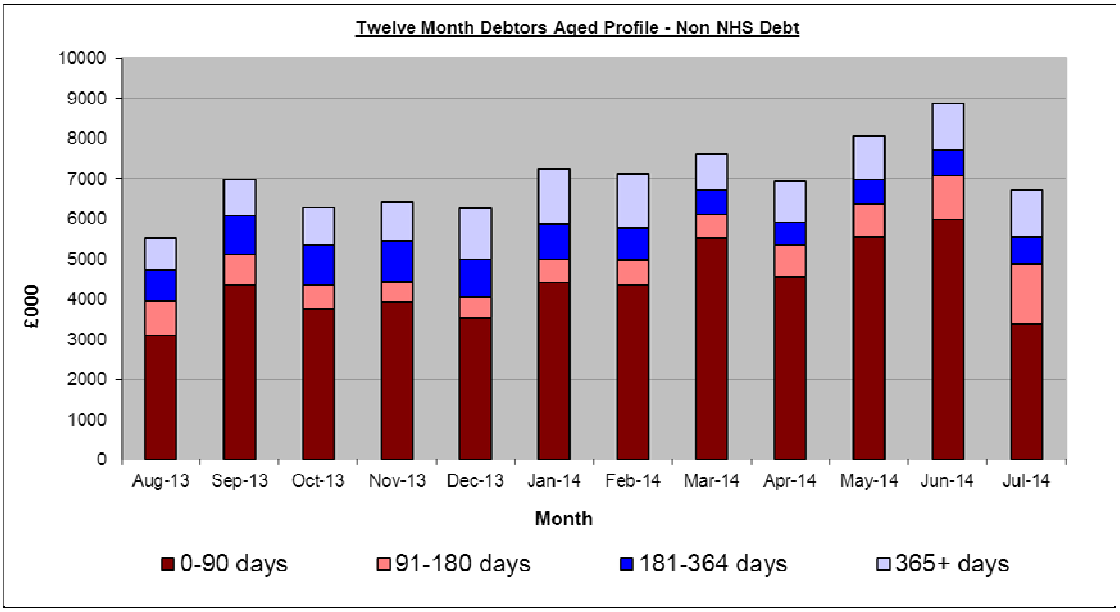
  The Trust has very little flexibility and a minimal contingency (£3.8m, 0.5% of turnover) for unforeseen financial pressures and as such any risks above the contingency will impact on the bottom line position

  Mitigation: The Trust is still holding the contingency at the end of Month 4 to support unforeseen events

6. Balance Sheet

6.1. The effect of the Trust's financial position on its balance sheet is provided in Appendix 4. The retained earnings reserve has reduced by the Trust's £14.0m deficit for the year to date

6.2. The level of non-NHS debt has fluctuated across the year as shown in the following table:



6.3. The overall level of non-NHS debt at the end of July has reduced from the previous month from £8.9m to £6.7m, primarily due to £2.3m of outstanding payments received from Interserve for car parking and catering. The proportion debt over 365 days (£1,184k) has increased slightly from 13% to 18% as a consequence of the overall reduction.

6.4. The Better Payments Practice Code (BPPC) performance for the end of July YTD (as shown in the table below) is a slight deterioration from the end of June YTD in terms of numbers of invoices paid:

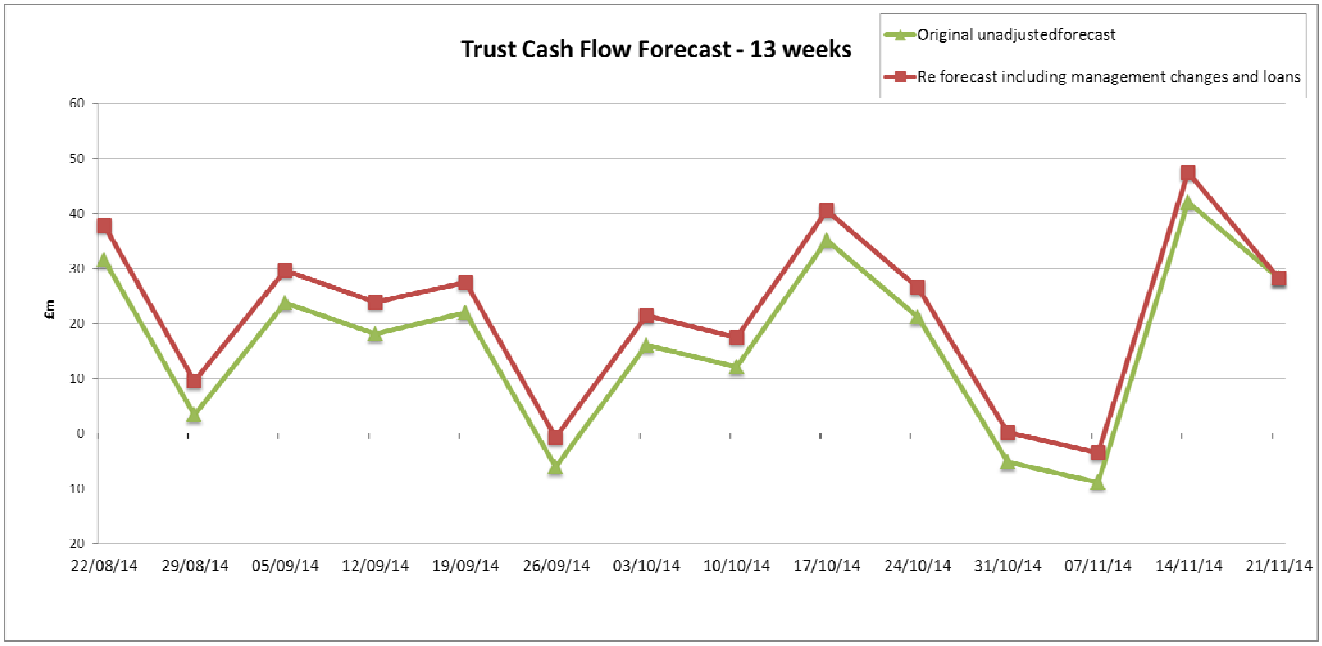
	By Volume Number	By Value £000s
Current Month YTD		
Total bills paid in the year	43,877	211,248
Total bills paid within target	23,783	143,379
Percentage of bills paid within target	**54%**	**68%**
Prior month YTD		
Total bills paid in the year	33,846	159,184
Total bills paid within target	19,658	108,343
Percentage of bills paid within target	**58%**	**68%**

7. Cash Flow Forecast

7.1. The Trust's cashflow forecast is consistent with the income and expenditure position. Cash has increased by £14.4m from the year end and this is predominantly due to the receipt of £29.0m of Temporary Borrowing Loans (TBLs) from the DoH. We have put measures in place to ensure that from August month end, the level of cash is minimised as far as possible in order to improve our BPPC performance.

7.2. We submitted an application to the NTDA's Independent Trust Financing Facility (ITFF) on 22nd August 2014 for external financing of £69.7m. This is to cover our £40.7m deficit for the current year, £12.7m of backlog creditors brought forward at the prior year end and £16.3m of capital expenditure. The Trust plans to achieve a year end cash balance for 2014/15 of £277k (2013/14 actual - £515k).

7.3. Following the review and approval process, we are expecting to be able to draw down this funding in mid to late November. Until then, we will continue to finance the Trust's cash expenditure, where necessary, through the TBLs which will be repaid once we receive the longer term financing. Our full year cash forecast anticipated that we would need additional TBL financing at the end of September. The graph below shows the 13 week cash forecast position:



7.4. The re-forecast line on the above graph shows that cash will go overdrawn in late September and October. At this stage, we are aiming to manage these shortfalls through internal actions, such as managing the timing of our payment runs, and we are hoping that no further TBL loans will be required prior to the receipt of ITFF funding in November. We will monitor the situation to ensure that we apply for any required TBL funding in sufficient time.

8. Capital

8.1. The total capital expenditure at the end of July 2014 was £6.1m against the year to date plan of £8.7m, an underspend of £2.6m. The capital plan and expenditure to date can be seen in Appendix 5.

8.2. At the end of July, there were £12.1m of orders outstanding. The combined position is that we have spent or committed £18.2m, or 36% of the annual plan.

9. Conclusion

9.1. The Trust, at the end of Month 4, has an adverse position of £1.1m against the planned deficit of £12.9m but is forecasting the delivery of all its financial duties at year end.

10. Next Steps and Recommendations

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

- **Note** the contents of this report
- **Discuss and agree** the actions required to address the key risks/issues:
  - Additional capacity and RTT
  - Management of CMG recovery plans
  - Process to access the Operational Resilience Funds

Income and Expenditure Account for the Period Ended 31 July 2014

	July 2014			April - July 2014		
	Plan £ 000	Actual £ 000	Variance (Adv) / Fav £ 000	Plan £ 000	Actual £ 000	Variance (Adv) / Fav £ 000
Elective	6,639	6,083	(556)	24,151	**23,140**	(1,011)
Day Case	5,517	5,303	(214)	20,087	**19,380**	(708)
Emergency (incl MRET)	14,930	14,950	20	58,557	**58,366**	(191)
Outpatient	9,572	9,216	(355)	35,308	**34,453**	(855)
Penalties	(292)	(366)	(74)	(1,167)	**(2,692)**	(1,526)
Non NHS Patient Care	460	363	(97)	1,833	**1,833**	0
Other	24,785	25,364	578	93,463	**95,713**	2,250
Patient Care Income	**61,611**	**60,913**	**(698)**	**232,233**	**230,192**	**(2,041)**
Teaching, R&D income	6,860	6,427	(433)	27,441	**27,026**	(415)
Other operating Income	3,205	3,520	315	12,575	**12,859**	284
Total Income	**71,676**	**70,860**	**(816)**	**272,249**	**270,077**	**(2,172)**
Pay Expenditure	**41,111**	40,499	**612**	**164,029**	**161,945**	**2,084**
Non Pay Expenditure	**27,660**	27,935	**(275)**	**106,016**	**106,982**	**(966)**
Total Operating Expenditure	**68,771**	**68,434**	**337**	**270,045**	**268,927**	**1,118**
EBITDA	**2,905**	**2,426**	**(479)**	**2,204**	**1,150**	**(1,054)**
Interest Receivable	8	9	1	32	**29**	(3)
Interest Payable	0	(3)	(3)	0	**(12)**	(12)
Depreciation & Amortisation	(2,934)	(2,934)	0	(11,725)	**(11,721)**	4
Surplus / (Deficit) Before Dividend and Disposal of Fixed Assets	**(21)**	**(502)**	**(481)**	**(9,489)**	**(10,554)**	**(1,065)**
Dividend Payable on PDC	(869)	(869)	0	**(3,476)**	**(3,476)**	0
Net Surplus / (Deficit)	**(890)**	**(1,371)**	**(481)**	**(12,965)**	**(14,030)**	**(1,065)**
EBITDA MARGIN		**3.4%**			**0.4%**	

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

Case mix	Plan to Date (Activity)	Total YTD (Activity)	Variance YTD (Activity)	Variance YTD (Activity %)	Plan to Date (£000)	Total YTD (£000)	Variance YTD (£000)	Variance YTD (Activity %)
Day Case	29,791	28,799	(992)	(3.33)	20,087	19,380	(708)	(3.52)
Elective Inpatient	7,768	7,226	(542)	(6.97)	24,151	23,140	(1,011)	(4.19)
Emergency / Non-elective Inpatient	34,037	34,552	515	1.51	60,724	61,188	463	0.76
Marginal Rate Emergency Threshold (MRET)	0	0	0	0.00	(2,167)	(2,821)	(654)	30.19
Outpatient	266,130	263,242	(2,887)	(1.08)	35,308	34,453	(855)	(2.42)
Emergency Department	47,581	50,919	3,338	7.01	5,161	5,718	557	10.80
Penalties	0	0	0		(1,167)	(2,692)	(1,526)	130.79
Other	2,825,790	2,720,940	(104,851)	(3.71)	90,136	91,828	1,692	1.88
Grand Total	**3,211,097**	**3,105,678**	**(105,419)**	**(3.28)**	**232,233**	**230,192**	**(2,041)**	**(0.88)**

Average tariff	Price Variance YTD %	Volume Variance YTD %	Price / Mix Variance (£000)	Volume Variance (£000)	Variance YTD (£000)
Day Case	(0.2)	(3.3)	(39)	(669)	(708)
Elective Inpatient	3.0	(7.0)	674	(1,684)	(1,011)
Emergency / Non-elective Inpatient	(0.7)	1.5	(456)	919	463
Marginal Rate Emergency Threshold (MRET)			(654)	0	(654)
Outpatient	(1.4)	(1.1)	(472)	(383)	(855)
Emergency Department	3.5	7.0	195	362	557
Penalties			(1,526)		(1,526)
Other			0	1,692	1,692
Grand Total	**2.5**	**(3.3)**	**(2,278)**	**237**	**(2,041)**

Financial Performance by CMG & Corporate Directorate

I&E and CIP - to July 2014

	Year to Date					
	I&E			CIP		
CMG / Directorate	YTD Budget £000s	YTD Actual £000s	Variance £000s	YTD Plan £000s	YTD Actual £000s	Variance £000s
CMGs:						
C.H.U.G.S	13,155	12,769	-386	1,704	1,713	8
Clinical Support & Imaging	-12,730	-12,916	-186	1,900	1,856	-44
Emergency & Specialist Med	3,440	4,080	640	1,944	2,702	758
I.T.A.P.S	-15,349	-16,343	-994	1,022	985	-37
Musculo & Specialist Surgery	11,838	10,388	-1,449	1,371	1,010	-360
Renal, Respiratory & Cardiac	9,352	8,866	-486	1,692	2,269	577
Womens & Childrens	12,137	12,698	561	2,135	2,031	-104
	21,843	**19,542**	**-2,301**	**11,766**	**12,566**	**799**
Corporate:						
Communications & Ext Relations	-242	-234	8	23	23	0
Corporate & Legal	-1,145	-1,211	-67	28	36	8
Corporate Medical	-1,072	-1,037	35	32	32	0
Facilities	-13,396	-12,820	575	120	132	12
Finance & Procurement	-2,281	-2,270	12	1,467	1,693	226
Human Resources	-1,509	-1,438	71	110	124	14
Im&T	-3,277	-3,208	68	72	107	36
Nursing	-7,086	-6,867	219	19	19	0
Operations	-2,536	-2,704	-168	32	36	4
Strategic Devt	-880	-775	105	67	67	0
	-33,422	**-32,564**	**858**	**1,970**	**2,270**	**300**
Other:						
Alliance Elective Care	-2	76	77			
R&D	1	-15	-16			
Central	-1,386	-1,068	318			
	-1,386	**-1,007**	**379**			
Total	**-12,965**	**-14,029**	**-1,064**	**13,736**	**14,835**	**1,099**

Balance Sheet

	Mar-14 £000's Actual	Apr-14 £000's Actual	May-14 £000's Actual	Jun-14 £000's Actual	Jul-14 £000's Actual	Mar-15 £000's Forecast
Non Current Assets						
Property, plant and equipment	362,465	360,188	359,769	358,289	359,152	380,902
Intangible assets	8,019	7,788	7,555	7,338	7,109	5,327
Trade and other receivables	3,123	3,311	3,152	3,115	3,002	2,503
TOTAL NON CURRENT ASSETS	**373,607**	**371,287**	**370,476**	**368,742**	**369,263**	**388,732**
Current Assets						
Inventories	13,937	13,711	14,633	14,627	15,390	14,200
Trade and other receivables	53,483	44,492	44,580	51,192	47,903	46,932
Other Assets	0	0	0	0	0	0
Cash and cash equivalents	515	13,850	5,838	13,662	14,954	277
TOTAL CURRENT ASSETS	**67,935**	**72,053**	**65,051**	**79,481**	**78,247**	**61,409**
Current Liabilities						
Trade and other payables	(112,726)	(102,381)	(100,604)	(100,725)	(100,661)	(92,743)
Dividend payable	0	(1,025)	(1,894)	(2,763)	(3,632)	0
Borrowings	(6,590)	(6,590)	(6,590)	(6,590)	(6,590)	(2,800)
Loan	0	(15,500)	(15,500)	(29,000)	(29,000)	0
Provisions for liabilities and charges	(1,585)	(1,585)	(1,585)	(1,585)	(1,585)	(426)
TOTAL CURRENT LIABILITIES	**(120,901)**	**(127,081)**	**(126,173)**	**(140,663)**	**(141,468)**	**(95,969)**
NET CURRENT ASSETS (LIABILITIES)	**(52,966)**	**(55,028)**	**(61,122)**	**(61,182)**	**(63,221)**	**(34,560)**
TOTAL ASSETS LESS CURRENT LIABILITIES	**320,641**	**316,259**	**309,354**	**307,560**	**306,042**	**354,172**
Non Current Liabilities						
Borrowings	(5,890)	(5,794)	(5,785)	(5,730)	(5,676)	(9,356)
Other Liabilities	0	0	0	0	0	0
Provisions for liabilities and charges	(2,070)	(2,048)	(2,022)	(2,006)	(1,830)	(1,873)
TOTAL NON CURRENT LIABILITIES	**(7,960)**	**(7,842)**	**(7,807)**	**(7,736)**	**(7,506)**	**(11,229)**
TOTAL ASSETS EMPLOYED	**312,681**	**308,417**	**301,547**	**299,824**	**298,536**	**342,943**
Public dividend capital	282,625	282,625	282,625	282,625	282,625	353,602
Revaluation reserve	64,598	64,598	64,598	64,598	64,598	64,628
Retained earnings	(34,542)	(38,806)	(45,676)	(47,399)	(48,687)	(75,287)
TOTAL TAXPAYERS EQUITY	**312,681**	**308,417**	**301,547**	**299,824**	**298,536**	**342,943**

Capital Plan

	Annual Budget £'000	Actual Spend £'000	Outstanding Commitments £'000	Total £'000	Variance £'000	Full Year Forecast Outurn £'000	Variance £'000
CHUGGS CMG							
Endoscopy GH	309	239	1	240	69	309	0
Lithotripter Machine	430	0	0	0	430	430	0
Sub-total: CHUGGS CMG	**739**	**239**	**1**	**240**	**499**	**739**	**0**
CSI CMG							
Aseptic Suite	400	213	178	391	9	400	0
MES Installation Costs	1,302	576	198	774	528	1,302	0
Sub-total: CSI CMG	**1,702**	**789**	**376**	**1,165**	**537**	**1,702**	**0**
Women's and Children's CMG							
Maternity Interim Development	1,000	362	439	800	200	1,000	0
Bereavement Facilities	62	0	0	0	62	62	0
Sub-total: Women's & Children's CMG	**1,062**	**362**	**439**	**800**	**262**	**1,062**	**0**
Renal, Respiratory & Cardiac CMG							
Renal Home Dialysis Expansion	708	(2)	145	144	564	535	173
Sub-total: Renal, Respiratory & Cardiac CMG	**708**	**(2)**	**145**	**144**	**564**	**535**	**173**
Emergency & Specialist Medicine CMG							
Brain Injury Unit (BIU) Works	47	0	0	0	47	47	0
Equipment: 8th Resus Bay	40	0	22	22	18	40	0
DVT Clinic Air Conditioning	30	0	14	14	16	30	0
Sub-total: Emergency & Specialist Medicine CMG	**30**	**0**	**14**	**14**	**16**	**30**	**0**
Corporate / Other Schemes							
Stock Management Project	2,212	3	0	3	2,209	2,212	0
Medical Equipment Executive	3,237	375	265	641	2,596	3,237	0
LiA Schemes	250	18	15	33	217	250	0
Odames Library	1,500	49	24	72	1,428	1,500	0
Other Developments	0	124	87	212	(212)	212	(212)
Donations	300	97	0	97	203	300	0
Sub-total: Corporate / Other Schemes	**7,499**	**666**	**391**	**1,057**	**6,442**	**7,711**	**(212)**
IM&T Schemes							
IM&T Sub Group Budget	2,000	247	146	393	1,607	2,000	0
Safer Hospitals Technology Fund	1,150	0	0	0	1,150	1,150	0
EDRM System	3,300	209	0	209	3,091	3,300	0
EPR Programme	3,100	693	50	743	2,357	3,100	0
Unified Comms	1,850	0	0	0	1,850	1,850	0
Sub-total: IM&T Schemes	**11,400**	**1,149**	**196**	**1,345**	**10,055**	**11,400**	**0**
Facilities / NHS Horizons Schemes							
Facilities Backlog Maintenance	5,500	690	407	1,097	4,403	5,500	0
Accommodation Refurbishment	1,200	0	0	0	1,200	1,200	0
CHP Units LRI & GH	800	339	371	711	89	1,012	(212)
Sub-total: Facilities / NHS Horizons Schemes	**7,500**	**1,029**	**778**	**1,808**	**5,692**	**7,712**	**(212)**
Reconfiguration Schemes							
Theatre Recovery LRI	2,785	114	2,717	2,831	(46)	2,785	0
Interim ITU LRI	500	299	263	562	(62)	500	0
Vascular Enabling	0	4	0	4	(4)	0	0
KSOPD Refurbishment	0	0	0	0	0	0	0
Ward 4 LGH	1,000	647	296	943	57	1,000	0
Additional Beds (GH & LRI)	2,000	23	18	41	1,959	2,000	0
Feasibility Studies	100	0	6	6	95	100	0
ED Early Works	3,500	0	0	0	3,500	4,500	(1,000)
Sub-total: Reconfiguration Schemes	**9,885**	**1,087**	**3,300**	**4,387**	**5,498**	**10,885**	**(1,000)**
Over Commitment against CRL	-6,405					(7,656)	1,251
Total Schemes funded via internal sources	**34,207**	**5,320**	**5,663**	**10,983**	**29,629**	**34,207**	**0**
Schemes to be funded via external loans							
ED Enabling Schemes							
Clinic 1 & 2 Works	814	9	10	19	795	814	0
Old Cancer Centre Conversion	1,050	37	875	912	138	1,050	0
Oliver Ward Conversion	1,260	179	983	1,162	98	1,260	0
Clinical Genetics	158	5	10	15	143	158	0
Chapel Relocation	315	7	37	45	270	315	0
Victoria Main Reception	525	7	32	39	486	525	0
Modular Wards LRI	3,700	381	2,624	3,005	695	3,700	0
Sub-total: ED Enabling schemes	**7,822**	**625**	**4,571**	**5,196**	**2,626**	**7,822**	**0**
Emergency Floor	6,000	77	1,226	1,303	4,697	6,000	0
GGH Vascular Surgery	2,500	64	638	702	1,798	2,500	0
Sub-total: External Loans	**16,322**	**765**	**6,436**	**7,201**	**9,121**	**16,322**	**0**
Total Capital Plan	**50,529**	**6,085**	**12,098**	**18,184**	**38,750**	**50,529**	**0**

Trust Board paper U

To:	**Trust Board**
From:	**Richard Mitchell, Chief Operating Officer**
Date:	**28 August 2014**
CQC regulation:	**As applicable**

Title:	Emergency Department Performance Report

Author: Richard Mitchell, Chief Operating Officer

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

The Report is provided to the Board for:

Decision		Discussion	
Assurance	√	Endorsement	

Summary / Key Points:

- Performance in July 2014 was 92.52% compared to 88.3% in July 2013 and 91.2% in June 2014.
- August 2014, month to date (17/8/14) is 89.31%.
- Emergency admissions (adult) remain constant in July; 204 compared to 206 per day in June and 203 per day in May.
- Emergency admissions (adult) are much higher than July 2013 when they averaged 185 per day (9% increase).
- Delayed transfers of care remain continually above the agreed performance level at 4.7%. Twenty seven per cent of delays are internal reasons, 49% are external and 24% are nursing homes.
- Key actions, including the request for external support, are being taken to reduce wait to be seen times and decision to treat/ admit/ discharge times in the emergency department out of hours.
- Delivering high quality emergency care for all, day in, day out, must be the number one priority for UHL and LLR. #everybodycounts

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

Previously considered at another UHL corporate Committee N/A

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

Resource Implications (eg Financial, HR)
Yes

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

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

Equality Impact
N/A

Information exempt from Disclosure
N/A

Requirement for further review
Monthly

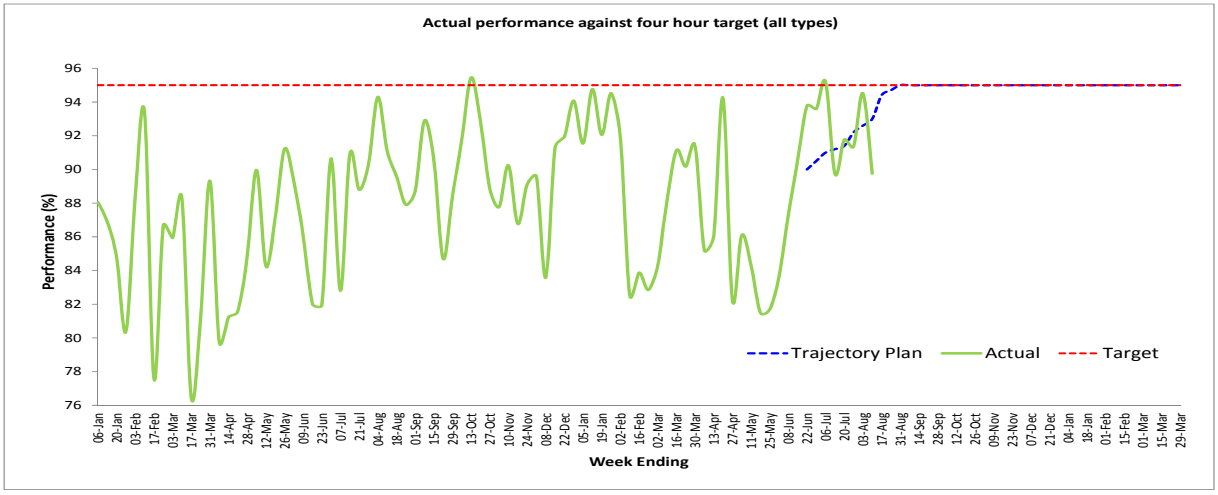
REPORT TO:	**Trust Board**
REPORT FROM:	**Richard Mitchell, Chief Operating Officer**
REPORT SUBJECT:	**Emergency Care Performance Report**
REPORT DATE:	**28 August 2014**

Introduction

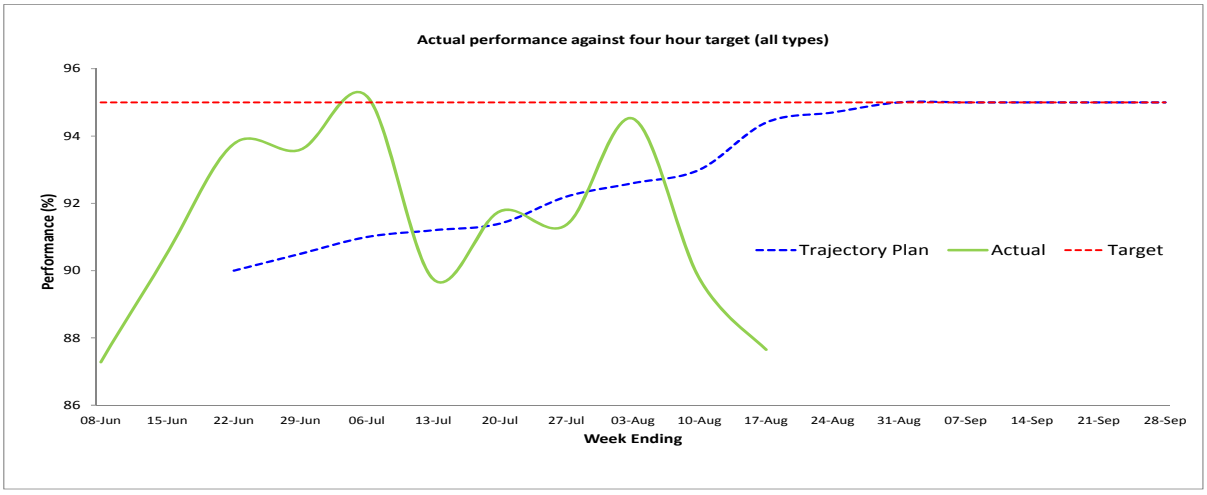
- Performance in July 2014 was 92.52% compared to 88.3% in July 2013 and 91.2% in June 2014.
- August 2014, month to date (17/8/14) is 89.31%.
- Emergency admissions (adult) remain constant in July; 204 compared to 206 per day in June and 203 per day in May.
- Emergency admissions (adult) are much higher than July 2013 when they averaged 185 per day (9% increase).
- Delayed transfers of care remain continually above the agreed performance level at 4.7%. Twenty seven per cent of delays are internal reasons, 49% are external and 24% are nursing homes.

Performance overview

Weekly performance is detailed in graph one below. There were no weeks of compliant performance in July, with the best week at 94.5%. An improvement trajectory has been agreed with the NTDA and is shown as the dotted blue line in graph two. The expectation is UHL becomes sustainably compliant by the last week in August 2014. UHL is currently behind plan and is reporting performance to the NTDA on a daily basis.

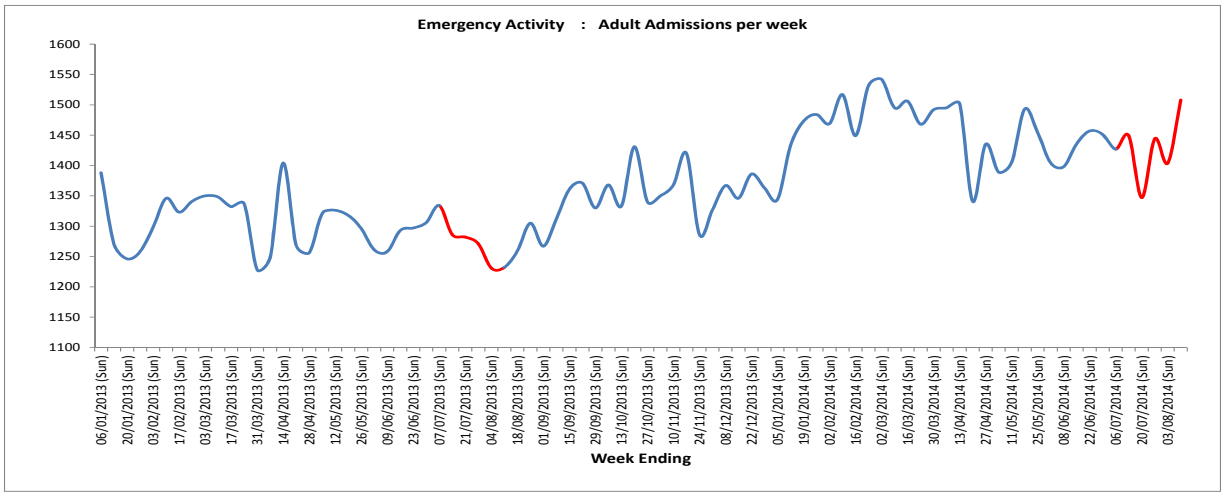


(graph one)



(graph two)

Weekly admissions are shown below in graph three. It is apparent from that despite admissions reducing from the high in the winter, they are still 9% higher than in the same month last year.



(graph three)

Key actions since the last report

- Emergency quality steering group has met each week with actions and timelines captured in a detailed plan (appendix).
- Rapid cycle testing initiatives continue in ED, MAU, base wards and CDU.
- The gold, silver and bronze command management structure is fully embedded.
- A reworked dashboard of metrics is in place.
- #everybodycounts social media was launched on 18 August 2014 (appendix).

Performance has not improved in line with the trajectory

The Trust Board report in July detailed a cautious yet optimistic position of improving performance. The improvement has not been maintained in August 2014. Over the last eight weeks there has been uninterrupted flow out of the emergency department on most days, because of the continuing efforts of the base ward teams, medical assessment unit teams and site managers. The introduction of the gold, silver and bronze command cells has increased the operational grip in the meetings. **Despite these actions and the seasonal reduction in attendances, wait to be seen times and decision to treat/ admit/ discharge times in the emergency department remain high, especially out of hours.**

Table one below details the volume of arrivals and breaches after 20:00 each night and the % of the day's total arrivals and breaches that occur after 20:00. There were 14 days out of the last 31 (up to 13 August 2014) when the proportions of the breaches were at least 10% greater than the proportion of the attendances. This is unacceptable because inflow has been low and there have been beds on the assessment units. This also has an impact on the performance and quality of care provided during the early hours of the next day. Over the last month there have been many days when over 80% of breaches occurred between 20:00 and 06:00.

		Vol arrivals	% arrivals	Vol breaches	% breaches
Monday	14/07/2014	82	19%	7	26%
Tuesday	15/07/2014	70	19%	0	0%
Wednesday	16/07/2014	80	21%	10	42%
Thursday	17/07/2014	77	20%	16	31%
Friday	18/07/2014	66	16%	25	24%
Saturday	19/07/2014	59	17%	8	14%
Sunday	20/07/2014	75	20%	0	10%
Monday	21/07/2014	77	18%	25	40%
Tuesday	22/07/2014	78	19%	23	38%
Wednesday	23/07/2014	73	18%	14	19%
Thursday	24/07/2014	78	20%	5	29%
Friday	25/07/2014	71	19%	3	42%
Saturday	26/07/2014	70	18%	18	49%
Sunday	27/07/2014	65	17%	8	12%
Monday	28/07/2014	66	15%	8	29%
Tuesday	29/07/2014	75	18%	3	19%
Wednesday	30/07/2014	71	19%	1	13%
Thursday	31/07/2014	69	19%	7	40%
Friday	01/08/2014	57	16%	4	22%
Saturday	02/08/2014	63	19%	7	57%
Sunday	03/08/2014	79	18%	28	30%
Monday	04/08/2014	80	18%	12	20%
Tuesday	05/08/2014	77	20%	12	41%
Wednesday	06/08/2014	75	19%	12	25%
Thursday	07/08/2014	82	19%	6	17%
Friday	08/08/2014	61	17%	20	35%
Saturday	09/08/2014	65	18%	24	27%
Sunday	10/08/2014	61	16%	6	9%
Monday	11/08/2014	63	15%	28	41%
Tuesday	12/08/2014	67	18%	0	9%
Wednesday	13/08/2014	85	22%	33	62%
			18%		28%

Better than	8
As expected	9
Significant deterioration	14

(table one)

There does not appear to be a correlation between days of the week and high out of hours breaches, nor between the consultants working and the high numbers of breaches. Table two details the doctors (anonymised) who were working each night. There were 19 different consultants who worked on the 11 different night shifts. This suggests that the poor performance, whilst maintaining outflow is more to do with culture and expectation within the department than failings linked to specific individuals.

	Doctor codes					
Wednesday 16 July	11	15	8	12	13	
Thursday 17 July	9	8	10	5		
Monday 21 July	6	3	17	12	15	
Tuesday 22 July	9	12	5	16	19	
Friday 25 July	6	18	12	10		
Saturday 26 July	11	2	10			
Thursday 31 July	4	15	5			
Saturday 2 August	14	15	4			
Tuesday 5 August	19	7	12	18	14	2
Monday 11 August	14	5	15	12		
Wednesday 13 August	14	18	1			

(table two)

Actions to resolve out of hours performance

It is apparent that the primary issue, at the moment, for the continuing level of poor performance is **what is** happening, or **not happening, in the emergency department between the hours of six pm and midnight.** The following actions are being taken to strengthen the performance and leadership out of hours:

- CMG directors have met with the Medical Director, Deputy Medical Director and Chief Operating Officer and have agreed to trial two super weeks of performance wc 15 September and then wc 29 September. The aims are to improve the level of in reach into the emergency department, reduce the decision making time and reduce the occupancy in the department. The proof of concept will

run Monday to Friday from 5pm to midnight. Key specialities include medicine, orthopaedics, gynaecology and intensive care. It is expected that if these actions improve performance, then they become business as usual as soon as possible.

- The emergency department have been asked to review their existing job plans to identify how their medical capacity can be increased between 5pm and midnight without incurring additional costs.
- The emergency department have been asked to stagger their nursing and medical handover times, a change that has already been made by the site team.
- The Emergency Care Intensive Support Team and the National Trust Development Authority have been asked to identify medical ED leaders who can come in to support evening performance.
- A high performing trust in the north of England have been approached and asked if their ED clinical director can work some evening shifts to give his opinion on what else should be happening.

Success is the sum of small efforts, repeated day in and day out. At present UHL is failing in its aim to deliver high quality emergency care for all, day in, day out. Over the last couple of years UHL has worked with ECIST, the NTDA, two management consultancies and Dr Ian Sturgess, a national lead in emergency care to deliver improvement. We have developed many improvement plans, some with partners in LLR, and have refined the actions when new challenges have presented themselves. Many improvements have been delivered and the provision of emergency care in UHL has fundamentally improved over the last 12 months, but we are still not consistently delivering high quality care. We are working very hard to resolve a deep rooted problem. If this was easy, it would have been sorted years ago.

Delivering high quality emergency care for all, day in, day out, must be the number one priority for UHL and LLR. #everybodycounts

Recommendations

The board are asked to:

- Note the contents of the report and action plan, in particular the actions being taken to reduce wait to be seen times and decision to treat/ admit/ discharge times in the emergency department out of hours.
- Support the actions being taken to improve performance.

University Hospitals of Leicester NHS
NHS Trust

Caring at its best

UHL Emergency Care Quality Improvement Charter

One team shared values

July 2014 vo.10

Contents

Background & Purpose

Background

The University Hospitals of Leicester Trust, UHL, has faced significant challenges over a number years in the delivery of an effective emergency care pathway.

The Leicester, Leicestershire and Rutland, LLR, system as well as UHL has had significant input from the Emergency Care Intensive Support Team, ECIST and Right Place Consulting. They have both identified the key processes that need to be improved to deliver an effective emergency care pathway.

However, there has not been universal ownership of the recommendations and not all those that were accepted have been embedded in a consistent manner.

Purpose

The main purpose of this Charter is to articulate how UHL will set out a clear vision and embark on a programme of change, driven by clinical leadership on the shop floor in order to deliver:

1.Reduced Mortality

2.Reduced Harm

3.Reduction in Long Term Care Placements from Hospital

4.Reduced Re-Admissions

5.Reduction in Complaints – Increase in Compliments

6.Reduced Cancellations of Electives

Scope

Emergency Care Pathway

The scope of this is limited to the Emergency Care Pathway within the hospital, from front to back, excluding:

- The elective care pathway
- Emergency outpatient pathway, (except hot clinics, which are included)

There are four principal areas or working groups that will drive the necessary changes on a day to day basis.

The Working Groups terms of reference are detailed in Appendix B, however, the high level roles are captured opposite.

Working Groups

1.Organisation - this covers the communication strategy, organisational development, customer service processes and Trust-wide systems/processes that impact on the emergency care pathway

2.Front Door – this deals with assessment, initial investigation, decision making, referral and short stay

3.Base Wards – will cover base wards and mono-organ Specialties looking specifically at effective case management for non-short stays

4.Frailty – this group will look at optimising the inputs and flow for all frail older patients admitted to the emergency pathway

Working Groups

Membership of Working Groups

The Working Groups will be Consultant led and will be made up of a multi-disciplinary team of clinicians (Organisation will be differently configured).

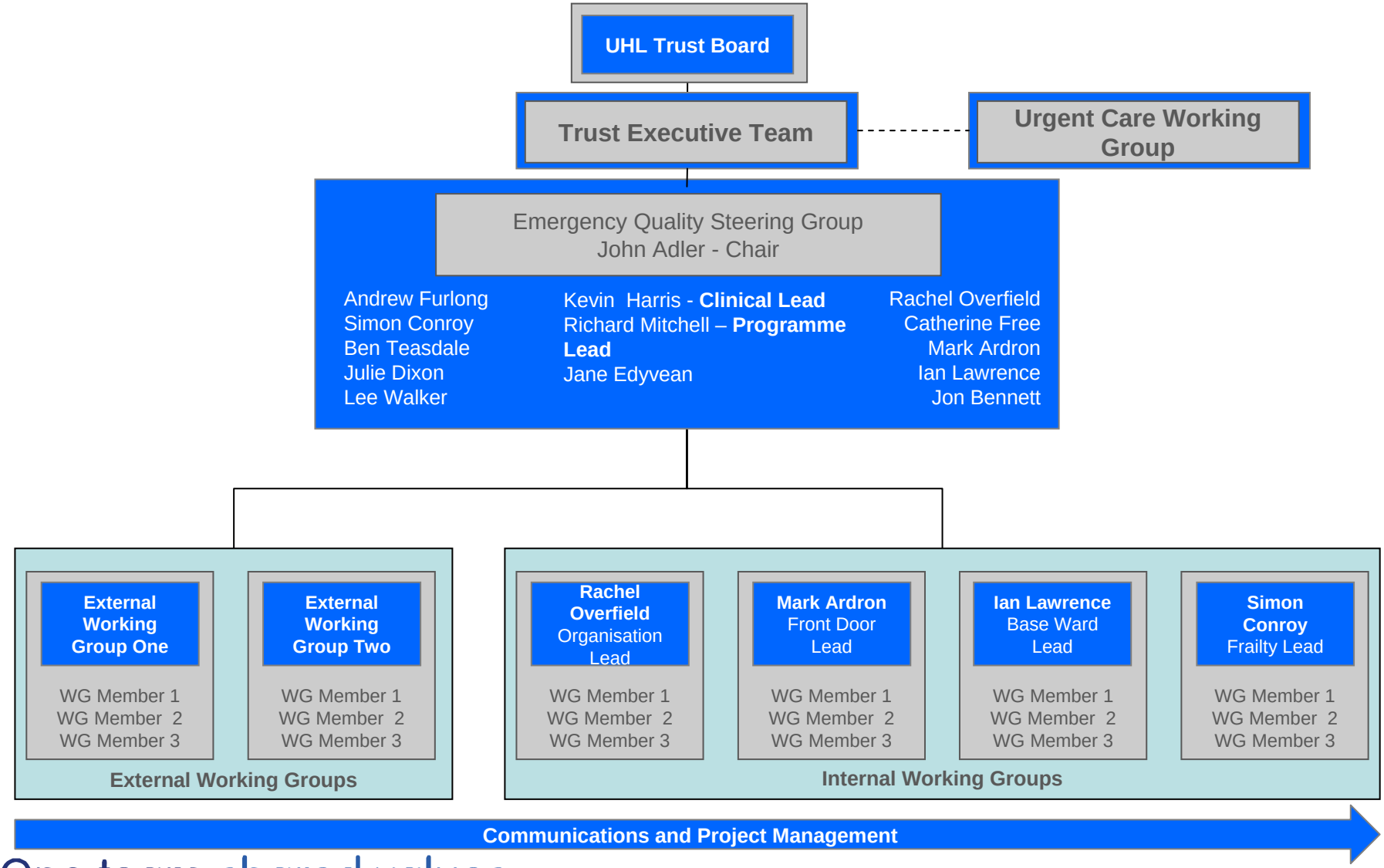
The broad remit of the Working Groups is to develop and implement known, effective ways of working in order to address the poor performing areas along the emergency care pathway.

The work of the Working Groups needs to be action focused, whereby:

- New ideas or processes can be deployed/tested quickly
- Feedback on new ideas or processes tested on wards can be received quickly
- Processes can be refined quickly, to achieve further improvement
- Good practice can be easily replicated and rapidly disseminated amongst the wider team
- Tracking of specific KPIs will provide “live feedback” on how well interventions are doing

An activity breakdown of the Working Groups plans is contained within appendix C.

Governance


UHL Trust Board
Trust Executive Team
Urgent Care Working Group
Emergency Quality Steering Group
John Adler - Chair
Andrew Furlong
Simon Conroy
Ben Teasdale
Julie Dixon
Lee Walker
Kevin Harris - Clinical Lead
Richard Mitchell – Programme Lead
Jane Edyvean
Rachel Overfield
Catherine Free
Mark Ardron
Ian Lawrence
Jon Bennett
External Working Group One
WG Member 1
WG Member 2
WG Member 3
External Working Group Two
WG Member 1
WG Member 2
WG Member 3
External Working Groups
Rachel Overfield Organisation Lead
WG Member 1
WG Member 2
WG Member 3
Mark Ardron Front Door Lead
WG Member 1
WG Member 2
WG Member 3
Ian Lawrence Base Ward Lead
WG Member 1
WG Member 2
WG Member 3
Simon Conroy Frailty Lead
WG Member 1
WG Member 2
WG Member 3
Internal Working Groups
Communications and Project Management

Roles and Responsibilities

Role	Responsibilities
UHL Trust Board	• The highest internal escalation point within the programme • Provides consent for any expenditure over £1m
Executive Team	• Holds collective responsibility for delivery of the improved emergency care pathway • Acts as escalation point for the Emergency Care Steering Group • Acts as link between the Trust and Local Health Economy, (via the Urgent Care Working Group) • Engaging external agencies in improving the quality of the Emergency Care Pathway • Approve any expenditure up to £1m
Urgent Care Working Group	• Membership made up of representatives from National Trust Development Agency, NHS England, East Midlands Ambulance Service, LLR CCGs • No formal role, however will receive regular updates from Executive Team on quality improvements in Emergency Care
Emergency Care Quality Steering Group	• Oversees internal and external activities to improve the quality of the Emergency Care Pathway • Acts as escalation point when issues can't be resolved at Working Group Level • Acts as senior decision making body, giving guidance where appropriate to the Working Groups
Clinical Lead	• Responsible for providing overall clinical leadership, unblocking issues in a timely manner • Acts as arbiter on conflicting priorities across Working Groups
Programme Lead	• Provides link across Working Groups • Acts as escalation point to Steering Group and Executive Team
Working Group Leads	• Leads and chairs Working Groups • Provides inspiration to Working Group members in idea generation and issue resolution
Working Group Members	• Act as champions of the Change, sharing and communicating best practice amongst clinical fraternity • Contributing regularly to Working Group Meetings and fostering engagement and input from the shop floor

Meetings

Working Group Meetings

Working Group meetings need to be action based meetings, focusing on the identification of what is working well and what needs changing.

It needs to take place on a weekly basis and to be chaired by the Working Group Lead.

The key items to be discussed are:

1. Performance against KPIs
2. Confirmation of interventions that are working well and how to spread them
3. Ideas for interventions not performing well
4. Key messages or escalations for Steering Group

Steering Group Meetings

The Steering Group has its own terms of reference, (see Appendix B), and will have oversight of both internal and external activities required to improve the emergency care pathway across the whole of the Local Health Economy.

The Steering Board will meet initially on a fortnightly basis, dropping to once a month once more grip and control is achieved across the whole emergency care pathway and performance indicators are above an agreed baseline and on a consistent upward trajectory.

Reporting and Feedback

Creation of KPI Measures

Each working group will create their own set of KPIs that will be signed off by the Steering Group. These KPIs will relate specifically to the outcome.

The main purpose of the KPIs is for the working groups to measure the efficacy of their actions taken in improving the Emergency Care Pathway.

The monitoring and reporting of the KPIs will occur at all levels from Ward to Board enabling:

1. *Clinicians*

-To receive live feedback on interventions

-To make quick improvements to processes

-To identify what works well, quickly

-Share good practice rapidly

2. *Working Groups*

- To review performance at weekly meetings
- To have clear oversight of what is working well
- To be responsive to what is working well and areas for improvement
- Provide updates on progress to Steering Group

3. *Clinical Lead*

- To have oversight of performance across all Working Groups
- Identify unintended consequences on one Working Group caused by actions in another
- Report on overall progress to the Steering Group

4. *Steering Group*

- See improvement right across the emergency pathway
- Provide evidence to the Urgent Care Working Group and other external stakeholders on improvements across the emergency pathway

Appendices

Appendix A – Working Groups ToRs (1/6)

Outcome Metrics for Front Door Working Group:

1.100% (excluding physiologically unstable patients needing resus as deemed by paramedics) of GP referred patients to assessment units by 31st July 2014

2.10% reduction in ED (non GP referred) emergency admissions by 31st August 2014

3.20% reduction in GP referrals translating in to an admission by 30th November 2014

4.5% reduction in deaths in first 48 hours by 30th November 2014

5.20% reduction in harm events by 30th November 2014

6.20% reduction in complaints re ED + Assessment Units by 30th November 2014

7.95% 4 hour emergency standard for total UCC/ED attendances by 31st August 2014

8.95% admitted patients to an in-patient bed in < 4 hours – reported by specialty by 31st October 2014

9.100% not admitted patients discharged home in 4 hours or less < by 31st October 2014

Front Door ToRs

The key a activities for this workstream are:

Optimisation of the following front of house processes that take place in A&E, Medical/Surgical Assessment and any other acute/emergency assessment areas, short stay including EDU:

- Assessment
- Initial Investigation
- Decision Making
- Referral
- Short Stay

The product of this working group will be an “assess once, investigate once and decide once” model.

Flow Metrics for Front Door Working Group:

1.Total and split admitted and not admitted 4 hour standard performance.

2.% admitted patients discharged in 12hours or less from transfer from ED/arrival from GP referral – aiming to achieve 30% of all admissions

3.% admitted patients discharged with LOS 2 days or less - aiming to achieve 70% of all admissions

4.% delivery of the Directory of Ambulatory Emergency Care for Adults (HRG Groups)

Appendix A – Working Groups ToRs (2/6)

Base Wards ToRs

This work-stream will be responsible for designing and delivering effective case management delivery for non-short stay admissions, minimising the impact of handover between the assessing team and the base ward team, and ensuring that all internal 'waits' are abolished.

The two key processes to optimise within this group will be the effective delivery of the 'board round' and the 'one stop ward round'.

Outcome Metrics for Base Ward Working Group

1.5% reduction in deaths in non-elective inpatients aged <75 with LOS > 2days by 30th November 2014

2.20% reduction in harm events in non-elective inpatients with LOS > 2days by 30th November 2014

3.20% reduction in complaints re Base Wards by 30th November 2014

Flow Metrics for Base Ward Working Group

1.Beds occupied on Base Wards reduced by >50 beds below seasonal baseline by end August 2014 and by >75 by end September 2014 and >100 by end October 2014

2.Discharges per week by ward.

Frailty ToRs

There is an overlap between this group and the assessment and base ward groups but this group will be tasked with optimising inputs and flow for all frail older patients admitted to any specialty in the emergency pathway.

The main purpose of this group will be to reduce the 'deconditioning' impact of hospitalisation by early and assertive management of patients with frailty.

Outcome Metrics for Frailty Working Group

1.5% reduction in deaths in non-elective inpatients aged >75 by 30th November 2014

2.20% reduction in harm events in non-elective inpatients aged >75 by 30th November 2014

3.20% reduction in complaints from patients/relatives aged >75 by 30th November 2014

4.10% reduction in Long Term Care Placements from Hospital by 30th November 2014

Flow Metrics for Frailty Working Group

1.Beds occupied by patients aged 75 and over with LOS 10 days or more – 25% reduction by end August 2014, 50% reduction by end October 2014.

2.Discharges per week by Older Peoples Wards to include Community Hospitals

Appendix A – Working Groups ToRs (3/6)

Organisation ToRs

The key a activities for this workstream are:

-Development of communication strategy

-Development of high-level metrics

-Organisational development

-Development of internal and external customer processes

-Act as arbiter across working groups

-Escalate inter-Working Group issues not resolved to Steering Group

-Develop knowledge management strategy for identifying and promulgating goo practice

Front Door ToRs

The key a activities for this workstream are:

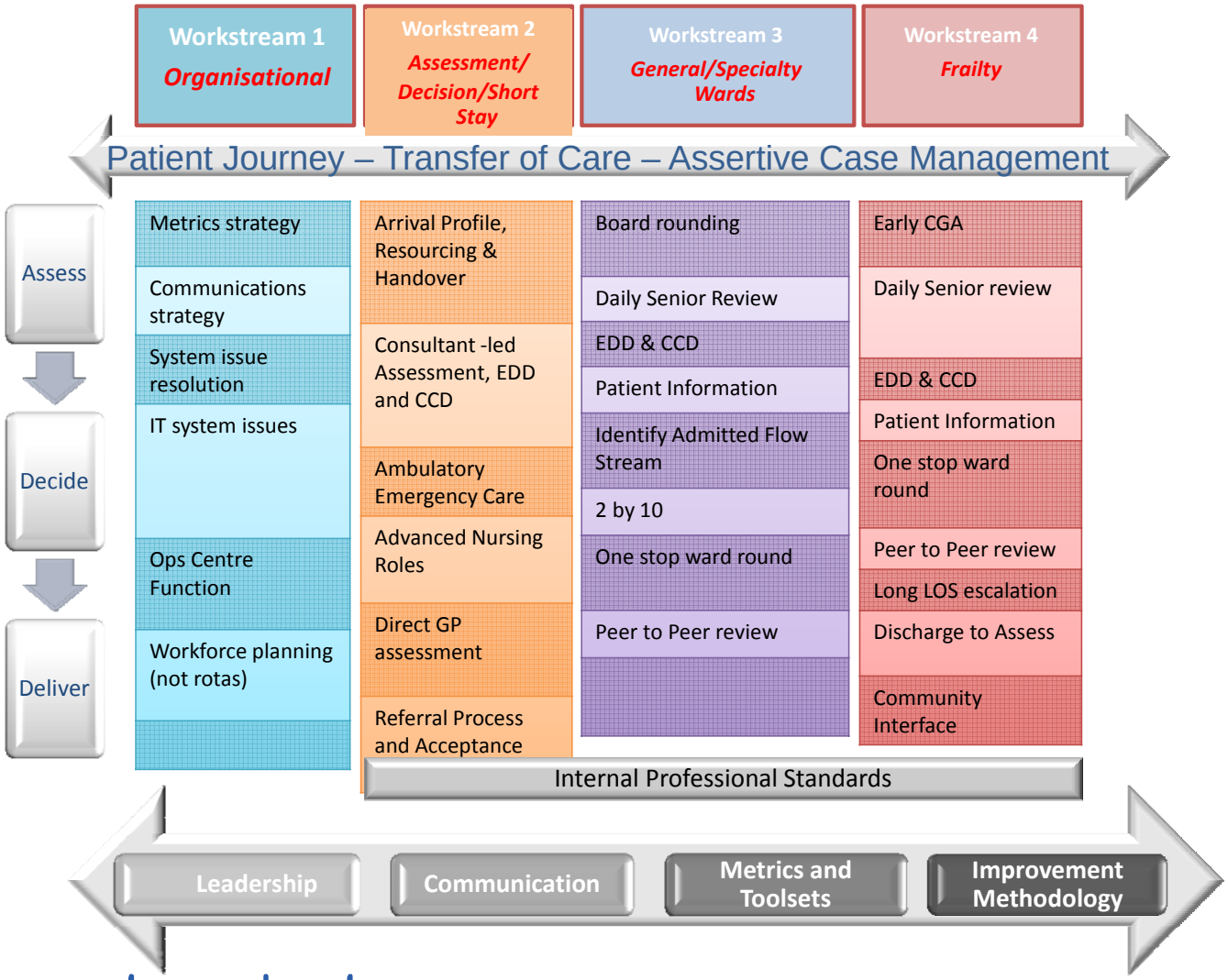
Optimisation of the following front of house processes that take place in A&E, Medical/Surgical Assessment and any other acute/emergency assessment areas, short stay including EDU:

- Assessment
- Initial Investigation
- Decision Making
- Referral
- Short Stay

The product of this working group will be an “assess once, investigate once and decide once” model.

Appendix A – Working Groups ToRs (4/6)

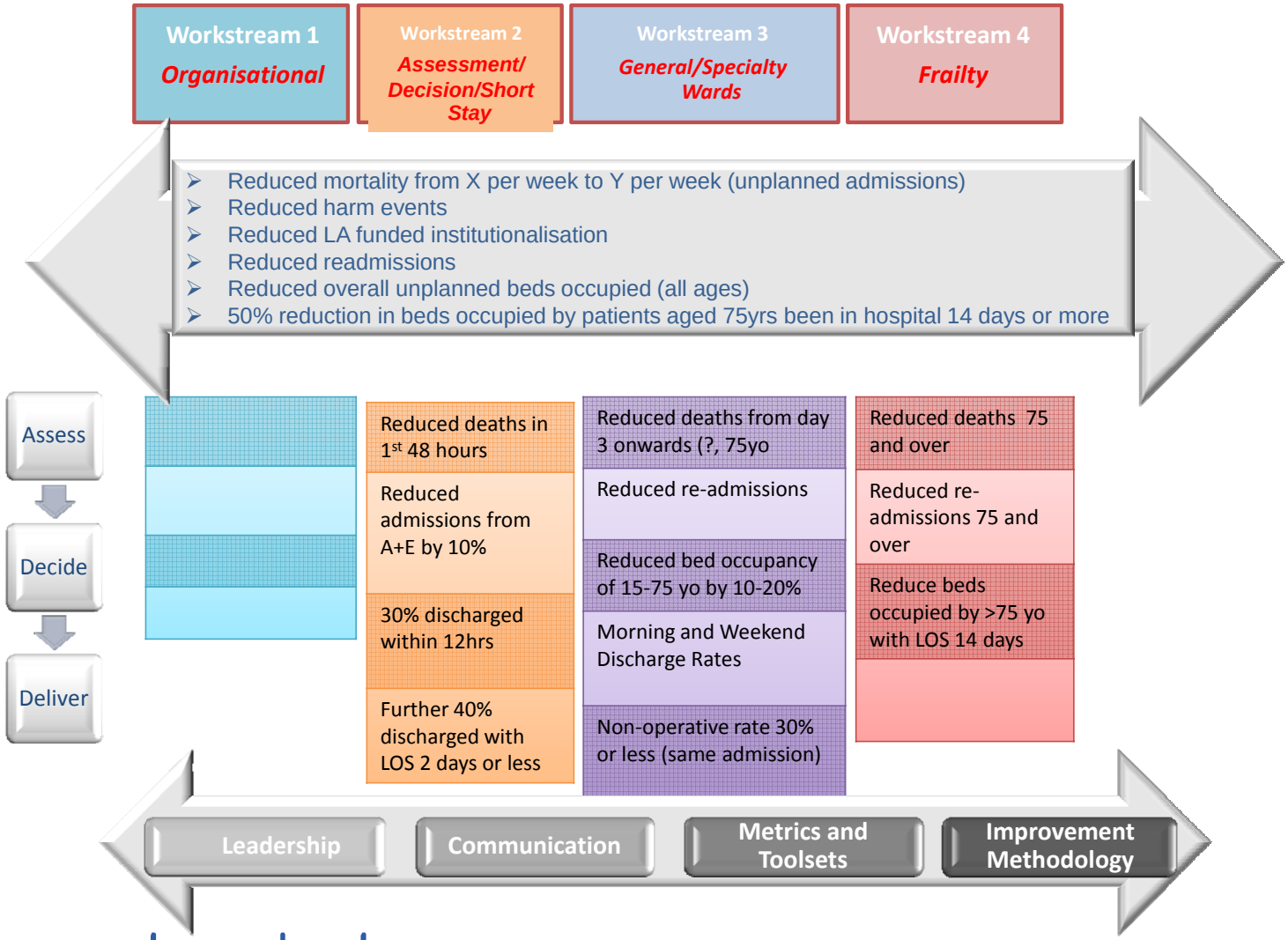
Emergency Care Programme – Work-stream Overview



One team shared values

Appendix A – Working Groups ToRs (5/6)

Emergency Care Programme – Outcome Metrics Overview



One team shared values

Appendix A – Working Groups ToRs (6/6)

Emergency Care Programme – Working Group Overview

Workstream 1 *Organisational*	Workstream 2 *Assessment/ Decision/Short Stay*	Workstream 3 *General/Specialty Wards*	Workstream 4 *Frailty*	Workstream 5 *Glenfield*

Membership:				
Rachel Overfield	Mark Ardron	Ian Lawrence	Simon Conroy	John Bennet
Julie Dixon	Ben Teasdale	Consultants x 2 – Med and Surg	Consultants x 2	Consultants x 2
	Lee Walker	Nursing Leads x 3	Nursing Leads x 3	Nursing Lead x 3
	Surgical Lead	AHP Lead	AHP Lead	AHP Lead
	Diagnostic Lead	Junior Doctors x 2	Junior Doctors x 2	Junior Doctors x 2
	Nursing Lead x 3	Managerial Lead	Managerial Lead	
	AHP Lead			
	Junior Doctor x 3			
	Managerial Lead			

Appendix B – Steering Group ToRs (1/3)

Purpose

To ensure the delivery of the Emergency Care Quality Programme, by monitoring and taking actions to address any potential failures to deliver.

To review performance against the expected benefits, receiving regular updates from each Working Group on progress against delivery.

To ensure all actions are completed within timescales set.

To gain assurance from individual Working Group Leads on the progress of quality improvement across the emergency care pathway.

To provide assurance to the Executive Team on the delivery of the Emergency Care Quality programme. To escalate as necessary to the executive team any issues for decision / discussion / assurance / endorsement.

To provide a forum of support for Working Group Leads in delivering enhanced quality performance across the emergency care pathway, enabling escalation of concerns, joint resolution of problems.

Appendix B – Steering Group ToRs (2/3)

Scope

The Emergency Care Steering Group will have oversight of all the Trust led Working Groups tasked to deliver quality improvements across the whole emergency care pathway, both within the Trust and with key partners outside of the Trust such as East Midlands Ambulance Service, Leicester, Leicestershire and Rutland CCGs, NHS England.

The Emergency Care Steering Group will meet on a fortnightly basis initially and will drop to monthly once performance levels have reached a pre-agreed level across the emergency care pathway.

Membership

The following are the substantive members:

Post / Remit	Post Holder(s)	Post / Remit	Post Holder(s)
Chief Executive Officer, CEO (Chair)	John Adler (chair)	Chief Operating Officer, (COO)	Richard Mitchell
		Chief Technical Advisor	Ian Sturgess
Clinical Lead	Kevin Harris	Organisation Working Group Lead	Julie Dixon
Deputy Medical Director	Andrew Furlong		
Deputy Medical Director	Peter Rabey	Front Door Lead	Mark Ardron
Clinical Director, Emergency Medicine	Catherine Free	Base Ward Lead	Ian Lawrence
		Frailty Lead	Simon Conroy
Director of Nursing	Rachel Overfield	Glenfield Lead	TBC
		Project Manager	Themba Moyo

Appendix B – Steering Group ToRs (3/3)

Constitutional Arrangements

1. A quorum shall be four members, one of these members must be the Chair or Clinical Lead and one must be either the COO or Deputy Medical Director.

2. The Emergency Care Quality Steering Group will meet fortnightly and run for two hours.

3. Minutes of this meeting will be provided to the Working Groups and Executive Team.

4. The Emergency Care Quality Steering Group is responsible and accountable to the Executive Team. The Chair will report on a fortnightly basis to the Executive Team and provide updates on progress.

5. Actions arising from the Emergency Care Steering Group will be captured and circulated to the membership, Working Groups and Executive Team post-meeting. Actions will further be captured in the Emergency Care Quality Action, Risk & Issue, (ARI), log, to be updated and circulated to all members post-meeting.

6. Attendance at the meeting is a mandatory requirement; where attendance is not possible due to annual leave, members must ensure a nominated deputy attends. The deputy should be fully conversant with all the key issues in their area.

7. All apologies are to be given to the Chair five days prior to the meeting along with the name of the nominated deputy.

8. Any associated papers must be forwarded electronically to the Chair three working days prior to the meeting, to enable review / consideration.

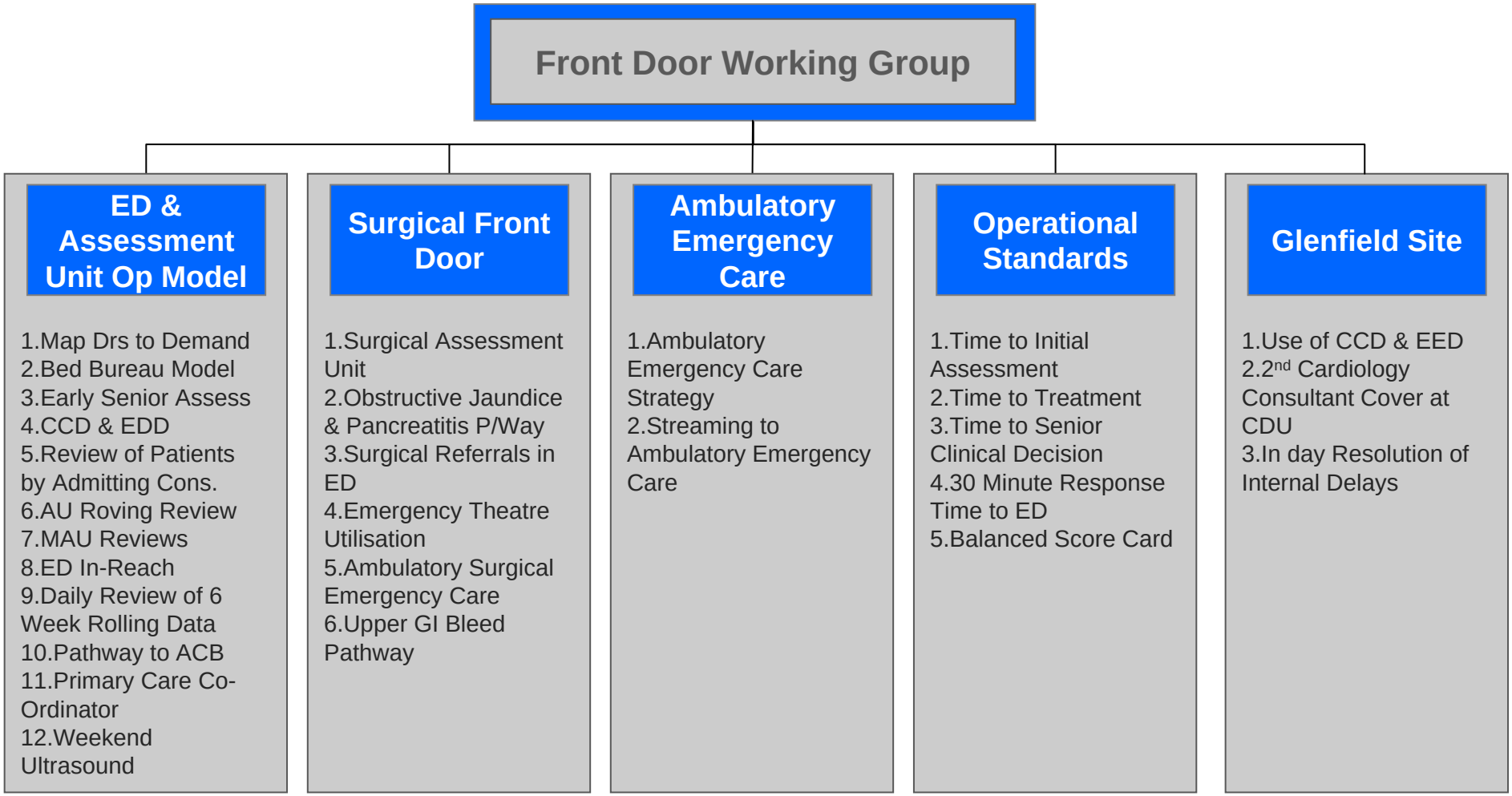
9. Co-option of key stakeholders will occur at the discretion of the Chair. Any individuals attending for ad-hoc agenda items are to be confirmed / agreed by the Chair prior to the meeting. The Chair will invite individuals to update the meeting as necessary.

10. In the interests of time management, meeting members must ensure timely attendance due to the information required to be reviewed at each meeting.

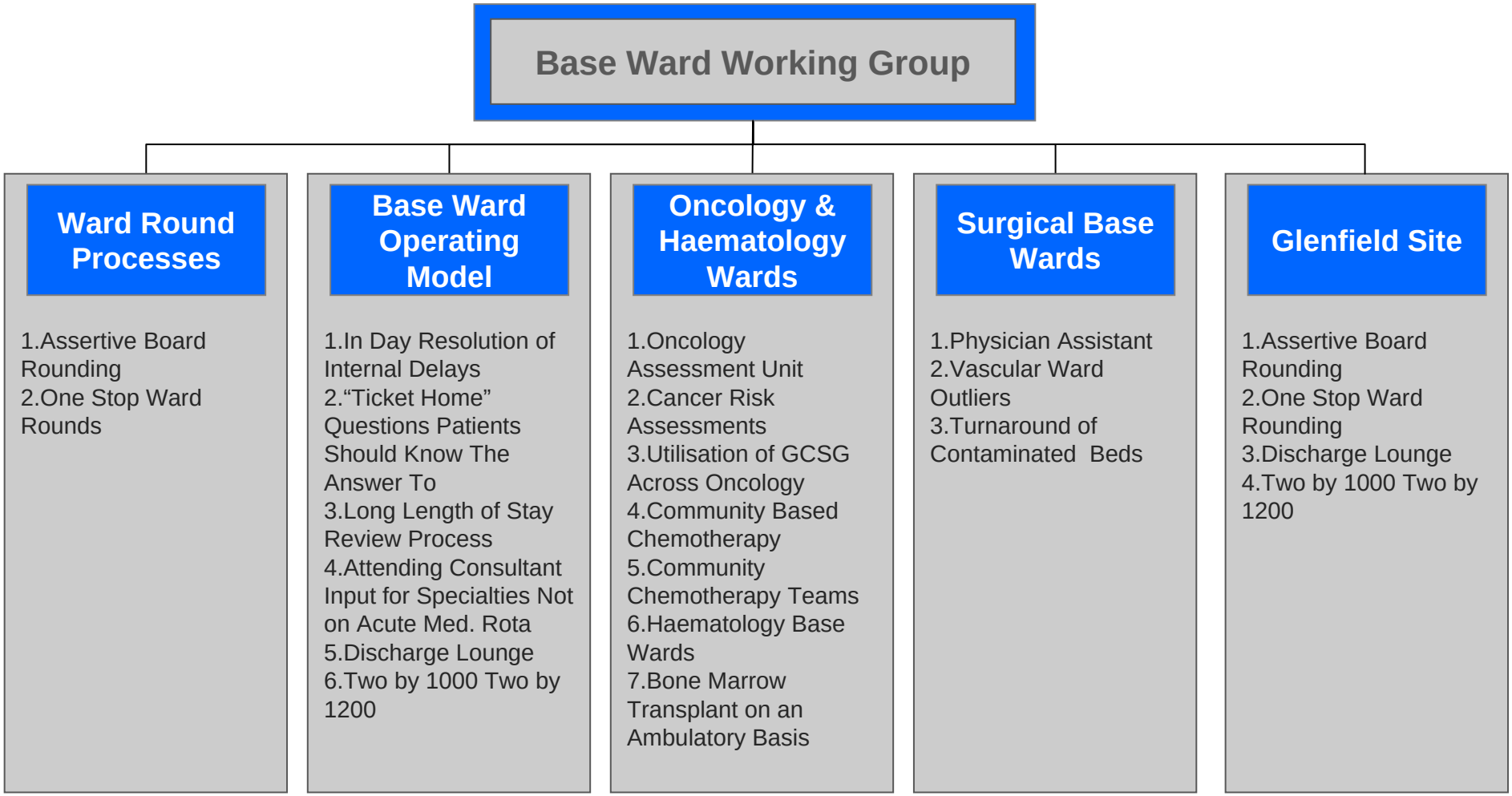
University Hospitals of Leicester NHS
NHS Trust

Caring at its best

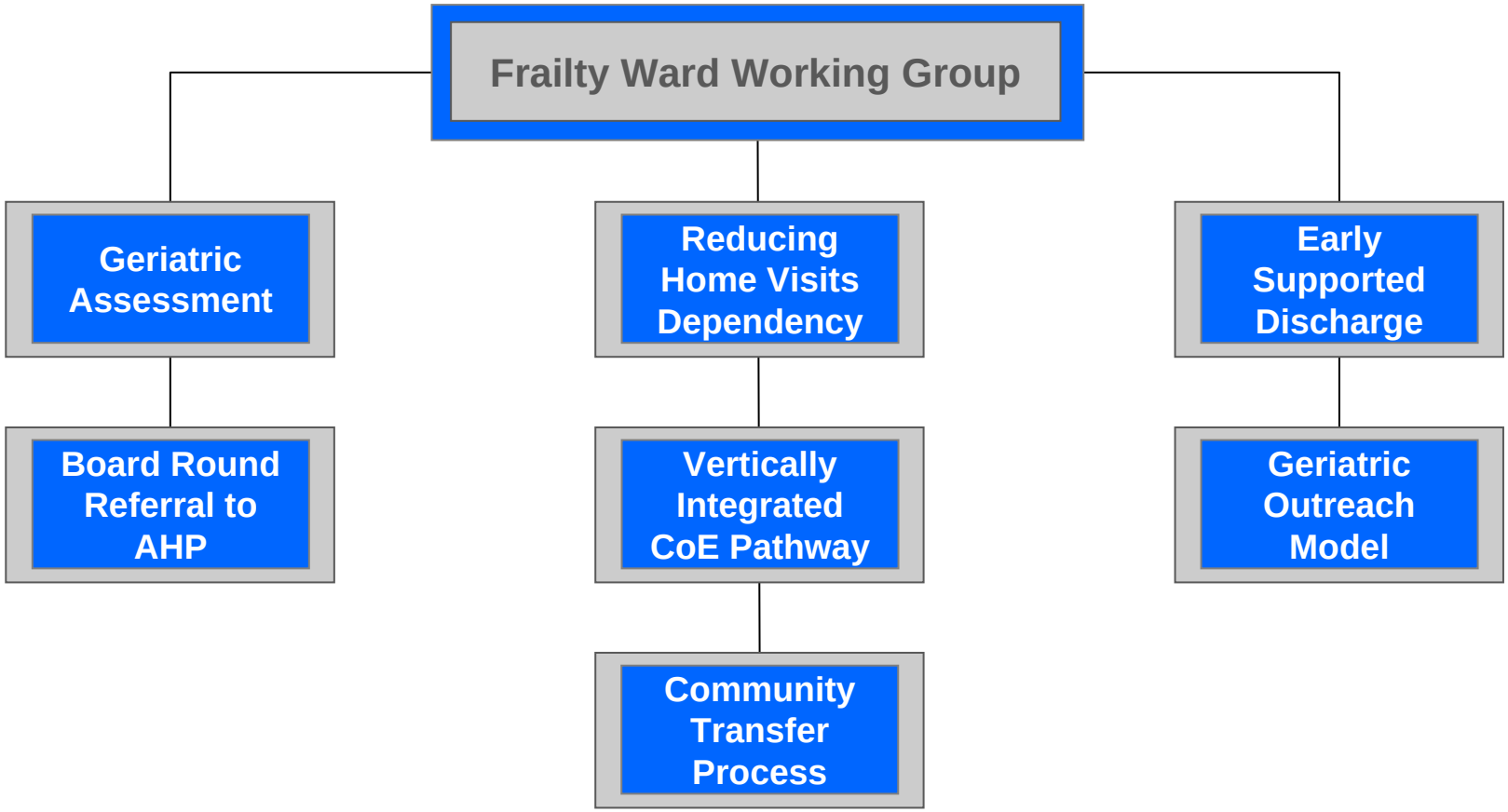
Appendix C – Activity Breakdown (1/4)



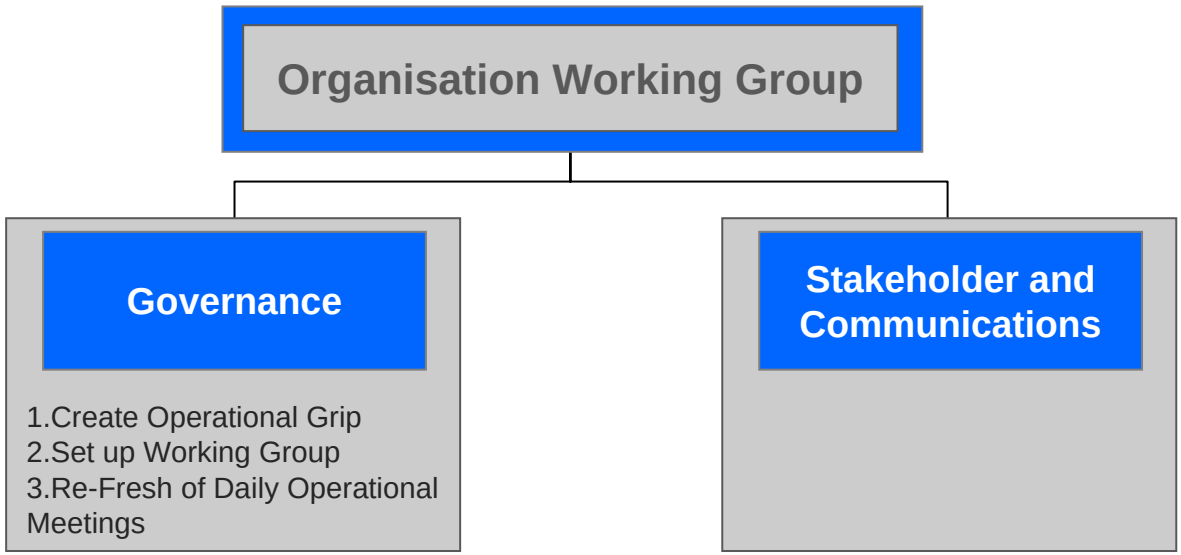
Appendix C – Activity Breakdown (2/4)



Appendix C – Activity Breakdown (3/4)



Appendix C – Activity Breakdown (4/4)



Appendix D – Project Management (1/4)

Defining and Capturing Risks

A risk in project terms is defined as "an uncertain event or set of events that, should it/they occur, will have an effect on the achievement of objectives". A risk is measured by a combination of the probability of a perceived threat or opportunity occurring, and the magnitude of its impact on objectives.

Project risks will be logged centrally in the Actions, Risk and Issues, (ARI), Log and capture the following:

1. A description of the risk
2. It's potential impact
3. Mitigating actions, (to reduce the chances of the risk occurring or to reduce the impact if it does occur)
4. The probability of the risk occurring
5. The potential impact of the risk occurring on the project
6. The overall risk score
7. A risk owner, (who is part of the project organisation), to lead on the mitigating actions

The risk owner is to provide an initial description and resolution plan for the risk to the Project Manager who is the "custodian" of the ARI log.

Appendix D - Project Management (2/4)

Probability Scoring Matrix

Probability		
What is the Likelihood that the Risk will Occur		
Level	Approach and Processes	
1	Not Likely	0 - 20% Probability of Occurrence
2	Low Likelihood	20 - 40% Probability of Occurrence
3	Likely	40 - 60% Probability of Occurrence
4	High Likely	60-80% Probability of Occurrence
5	Near Certainty	80 - 100% Probability of Occurrence

In order to arrive at an overall risk score, the probability of the risk occurring and the impact are multiplied, resulting in a risk score. The table below provides the combination of scores and corresponding RAG status that can occur using the matrices opposite.

Impact Scoring Matrix

Potential Impact			
Given the Risk is Realized, what would be the magnitude of the impact?			
Level	Technical	Schedule	Cost
1	Minimal OR No Impact	Minimal OR No Impact	Minimal or No Impact
2	Minor OR < 2%	Slight delay < 1 month	Budget Increase of (< £1M)
3	Moderate performance	Minor Schedule Slip	Budget Increase of (£1 - 2M)
4	High Performance	Major Schedule Slip	Budget Increase of (£2 - 5M)
5	Unacceptable; Over 10%	Unacceptable Schedule	Budget Increase of (> £5M)

Risk Score Matrix

Probability					
5	5	10	15	20	25
4	4	8	12	16	20
3	3	6	9	12	15
2	2	4	6	8	10
1	1	2	3	4	5
	1	*2*	*3*	*4*	*5*

Potential Impact

Appendix D - Project Management (3/4)

Defining and Capturing Issues

An issue in project terms is defined as "a relevant event that has happened, was not planned, and requires management action".

Project issues will be logged centrally in the ARI log and will capture the following:

1. A description of the issue
2. Its impact
3. A resolution plan
4. When the issue should be resolved by
5. The issue owner, (who is part of the project organisation), to lead on the mitigating actions
6. Status, (i.e. whether it is open or not)

As with risks, the issue owner is to provide an initial description and resolution plan for the issue to the Project Manager who is the "custodian" of the ARI log.

Appendix D - Project Management (4/4)

Purpose of the Action Log

The purpose of the action log is to capture important things that need to be done in a timely fashion but aren't large enough to warrant integrating into the project plan.

The action log should capture:

1. The action description
2. The owner
3. A deadline for completion of action
4. Any comments
5. Status, (i.e. whether the action is open or closed
6. Date of closure

Review of Action, Risk and Issue Logs

The action, risk and issue logs will be reviewed on a regular basis by the project manager.

As a minimum, the action and issue log should be reviewed and updated at every team meeting.

As a minimum the risk log will be reviewed in depth on a fortnightly basis ahead of each Steering Group meeting in order to ensure the risks are being proactively managed.

As with risks, the action owner is to provide an initial description of the action and progress update on the action to the Project Manager who is the "custodian" of the ARI log.

Task Name	Start	Finish	Resource Names	Status
1. Organisation			Rachel Overfield	
1.1 Governance				
Create Operational Grip	Mon 28/07/14	Fri 05/09/14		Closed
Set up Gold Command Group - Medical Director, Chief Nurse, COO	Mon 28/07/14	Fri 08/08/14	Rachel Overfield/Andrew Furlong/Richard Mitchell	
Set up Silver Command Group - CMGs CD's, Head of Nursing & Gen. Mgrs.	Mon 28/07/14	Fri 08/08/14	Julie Dixon	
Set Bronze Command Group - Heads of Service, Matrons & Business Mgrs.	Mon 28/07/14	Fri 08/08/14	Julie Dixon	
Organisational Working Group Set Up	Mon 21/07/14	Mon 18/08/14	Rachel Overfield	Closed
Draft Terms of Reference for Organisational Working Group	Mon 21/07/14	Fri 25/07/14	Rachel Overfield	
Identify metrics for Organisational Group	Mon 28/07/14	Fri 08/08/14	Rachel Overfield	
Obtain Steering Group Sign-Off on Working Group ToRs and Metrics	Mon 28/07/14	Fri 08/08/14	Rachel Overfield	
Working Groups to Meet on Weekly Basis	Mon 28/07/14	Fri 08/08/14	Rachel Overfield	
Re-Fresh of Daily Bed Meeting/Ops Centre/capacity staff roles	Mon 28/07/14	Fri 08/08/14	Julie Dixon	Closed
Identify and establish data set to enable 'real time' and predictive performance management	Mon 04/08/14	Fri 15/08/14	Julie Dixon/Simon Sutherland	
EPMA/ICE roll out	Mon 11/08/14	Fri 15/08/14	Rachel Overfield	
Invite Junior Doctors to Organisation Working Group for Input on TTO Process	Fri 29/08/14	Fri 29/08/14	Rachel Overfield	
Staffing gaps issue - 7 day snapshot/data capture	Mon 04/08/14	Fri 29/08/14	Julie Dixon	
1.2 Stakeholder and Communications				On Track
Develop Draft Communications Strategy	Mon 4/08/14	Fri 14/08/14	Nick Walkland	
Circulate Communications Strategy for Comment to Steering Group.	Mon 18/08/14	Fri 29/08/14	Nick Walkland	
2. Front Door			Mark Ardron	
2.1 ED & Assessment Unit Operating Model				
Map Consultant Presence to Demand Profile	Mon 04/08/14	Fri 31/10/14	Lee Walker	On Track
Receiving GP Bed Bureau Calls	Mon 04/08/14	Fri 26/09/14	Lee Walker	On Track
Create Process for Receipt of GP Bed Bureau Calls in MAU	Tue 05/08/14	Fri 26/09/14	Lee Walker	
Test Process for Receipt of GP Bed Bureau Calls in MAU	Tue 19/08/14	Fri 26/09/14	Lee Walker	
Early Senior Assessment in ED and Assessment Units	Mon 04/08/14	Fri 26/09/14	Lee Walker	On Track
Create Process for Early Senior Assessment in MAU	Tue 05/08/14	Fri 26/09/14	Lee Walker	
Test Process for Early Senior Assessment in MAU	Tue 19/08/14	Fri 26/09/14	Lee Walker	
Clinical Criteria for Discharge, (CCD) & Expected Date of Discharge, (EDD)	Mon 04/08/14	Fri 26/09/14	Lee Walker	On Track
Create Process for CCD & EDD	Tue 05/08/14	Fri 26/09/14	Lee Walker	
Test Process for CCD & EDD	Tue 19/08/14	Fri 26/09/14	Lee Walker	
Review of Patients by Admitting Consultant	Mon 01/09/14	Fri 26/09/14	Lee Walker	On Track
Create Policy for Review of Patients by Admitting Consultant	Mon 01/09/14	Fri 26/09/14	Lee Walker	
Test Policy for Review of Patients by Admitting Consultant	Mon 15/09/14	Fri 26/09/14	Lee Walker	
Assessment Unit Roving Review Process	Mon 01/09/14	Fri 26/09/14	Lee Walker	On Track
Create Process for MAU Roving Review and Ward Round	Mon 01/09/14	Fri 26/09/14	Lee Walker	
Test Process for MAU Roving Review and Ward Round	Mon 15/09/14	Fri 26/09/14	Lee Walker	
Twice Daily Review of New Admissions on MAUs	Mon 01/09/14	Fri 26/09/14	Lee Walker	On Track
Create Process for Twice Daily Review of New Admissions on MAUs	Mon 01/09/14	Fri 26/09/14	Lee Walker	
Test Process for Twice Daily Review of New Admissions on MAUs	Mon 15/09/14	Fri 26/09/14	Lee Walker	
ED In-Reach Process	Mon 01/09/14	Fri 27/03/15	Mark Lawden	On Track
Create ED In-Reach Process	Mon 01/09/14	Fri 27/03/15	Mark Lawden	
Test ED In-Reach Process	Mon 15/09/14	Fri 27/03/15	Mark Lawden	
Daily Review of Six Week Rolling Average Data Set	Mon 01/09/14	Fri 26/09/14	Catherine Free	On Track
Create Process for Daily Review of Six Week Rolling Average Data Set	Mon 01/09/14	Fri 26/09/14	Catherine Free	
Test Process for Daily Review of Six Week Rolling Average Data Set	Mon 15/09/14	Fri 26/09/14	Catherine Free	
Pathway to ACB	Mon 01/09/14	Fri 26/09/14	Lee Walker	On Track
Create Process for Patients Being Sent to ACB	Mon 01/09/14	Fri 26/09/14	Lee Walker	
Test Process for Patients Being Sent to ACB	Mon 15/09/14	Fri 26/09/14	Lee Walker	
Primary Care Co-Ordinator	Mon 01/09/14	Fri 26/09/14	Simon Conroy	On Track
Create Primary Care Co-Ordinator Process Across All MAUs	Mon 01/09/14	Fri 26/09/14	Simon Conroy	
Test Primary Care Co-Ordinator Process Across All MAUs	Mon 15/09/14	Fri 26/09/14	Simon Conroy	
Access to Ultrasound at Weekends	Mon 04/08/14	Fri 31/10/14	Andy Rickett	On Track
Improve Process for Accessing Ultrasound at Weekends	Mon 04/08/14	Fri 31/10/14	Andy Rickett	
Test Improved Process for Accessing Ultrasound at Weekends	Mon 18/08/14	Fri 31/10/14	Andy Rickett	
2.2 Surgical Front Door				
Surgical Assessment Unit	Mon 04/08/14	Fri 31/10/14	Chris Sutton	On Track
Create Pathway for Co-Management & Transfer of ED Surgical Referrals	Mon 04/08/14	Fri 31/10/14	Chris Sutton	
Test Pathway for Co-Management & Transfer of ED Surgical Referrals	Mon 04/08/14	Fri 31/10/14	Chris Sutton	
Obstructive Jaundice/Pancreatitis Pathway	Mon 04/08/14	Fri 27/03/15	Chris Sutton	On Track
Revise Jaundice/Pancreatitis Pathway	Mon 04/08/14	Fri 27/03/15	Chris Sutton	
Test Revised Jaundice/Pancreatitis Pathway	Mon 18/08/14	Fri 27/03/15	Chris Sutton	
Provision of Emergency Theatres	Mon 04/08/14	Fri 27/03/15	Chris Sutton	On Track
Review Current Provision of Emergency Theatres	Mon 04/08/14	Fri 27/03/15	Chris Sutton	
Identify Different Models Care for Improving Theatre Utilisation	Mon 11/08/14	Fri 27/03/15	Chris Sutton	
Test Different Models of Care for Improving Theatre Utilisation	Mon 01/09/14	Fri 27/03/15	Chris Sutton	
Select New Model for Improving Theatre Utilisation	Mon 22/09/14	Fri 27/03/15	Chris Sutton	
Roll Out New Theatre Model	Mon 06/10/14	Fri 27/03/15	Chris Sutton	
Ambulatory Surgical Emergency Care Service	Mon 04/08/14	Fri 27/03/15	Chris Sutton	On Track
Create Model for Surgical Emergency Care Service	Mon 04/08/14	Fri 27/03/15	Chris Sutton	
Test Model for Surgical Emergency Care Service	Mon 18/08/14	Fri 27/03/15	Chris Sutton	
Upper GI Bleed Pathway	Mon 04/08/14	Fri 31/10/14	Peter Wurm	
Revise Upper GI Bleed Pathway	Mon 04/08/14	Fri 31/10/14	Peter Wurm	
Test Revised Upper GI Bleed Pathway	Mon 18/08/14	Fri 31/10/14	Peter Wurm	
2.3 Implementation of AEC				
Ambulatory Emergency Care, (AEC), Strategy	Mon 04/08/14	Fri 31/10/14	Ruth Denton-Beaumont	On Track
Create AEC Strategy	Tue 05/08/14	Fri 31/10/14	Ruth Denton-Beaumont	
Implement AEC Strategy	Tue 19/08/14	Fri 31/10/14	Ruth Denton-Beaumont	
Streaming to Ambulatory Emergency Care, (AEC)	Mon 04/08/14	Fri 31/10/14	Ruth Denton-Beaumont	On Track
Create Process for Streaming to AEC	Tue 05/08/14	Fri 31/10/14	Ruth Denton-Beaumont	
Test Process for Streaming to AEC	Tue 19/08/14	Fri 31/10/14	Ruth Denton-Beaumont	
2.4 Operational Standards				
Time to Initial Assessment	Mon 04/08/14	Fri 31/10/14	Ben Teasdale	On Track
Create Policy for Time to Initial Assessment in ED	Tue 05/08/14	Fri 31/10/14	Ben Teasdale	
Test Policy for Time to Initial Assessment in ED	Tue 19/08/14	Fri 31/10/14	Ben Teasdale	
Time to Treatment	Mon 04/08/14	Fri 31/10/14	Ben Teasdale	On Track
Create Policy for Time to Treatment in ED	Tue 05/08/14	Fri 31/10/14	Ben Teasdale	
Test Policy for Time to Treatment in ED	Tue 19/08/14	Fri 31/10/14	Ben Teasdale	
Time to Senior Clinical Decision	Mon 04/08/14	Fri 31/10/14	Ben Teasdale	On Track
Create Policy for Time to Senior Clinical Decision in ED	Tue 05/08/14	Fri 31/10/14	Ben Teasdale	
Test Policy for Time to Senior Clinical Decision in ED	Tue 19/08/14	Fri 31/10/14	Ben Teasdale	
30 Minute Response Time to ED and Assessment Units, (AU), Referral	Mon 04/08/14	Fri 31/10/14	Ben Teasdale	On Track
Create Policy for 30 Minute Response Time to ED & AU Referrals	Tue 05/08/14	Fri 31/10/14	Ben Teasdale	
Test Policy for 30 Minute Response time to ED & AU Referrals	Tue 19/08/14	Fri 31/10/14	Ben Teasdale	
Create Balanced Score Card Template for Consultants	Mon 01/09/14	Fri 27/03/14	Catherine Free	On Track
Determine What Data Should be on Balanced Score Card	Mon 01/09/14	Fri 27/03/14	Catherine Free	
Create Process for Sharing Balanced Score Card Data	Mon 15/09/14	Fri 27/03/14	Catherine Free	
Test Process for Sharing Balance Score Card Data	Mon 29/09/14	Fri 27/03/14	Catherine Free	
Roll Out Balance Score Card Process	Mon 27/10/14	Fri 27/03/14	Catherine Free	
2.5 Glenfield Site				
Use of Clinical Criteria for Discharge, CCD, and Expected Date of Discharge, EDD	Tue 05/08/14	Fri 26/09/14	Jon Bennett	On Track
Create Process for Use of CCD/EDD as Part of Consultant Case Management	Tue 05/08/14	Fri 26/09/14	Jon Bennett	
Test Process for Use of CCD/EDD as Part of Consultant Case Management	Tue 19/08/14	Fri 26/09/14	Jon Bennett	
Create Second Cardiology Consultant to Cover CDU	Mon 04/08/14	Fri 27/03/15	Elved Roberts/Jan Kovac	On Track
Create Protocol for Second Cardiology Consultant Cover in CDU	Tue 05/08/14	Fri 27/03/15	Elved Roberts/Jan Kovac	
Test Protocol for Second Cardiology Consultant Cover in CDU	Tue 19/08/14	Fri 27/03/15	Elved Roberts/Jan Kovac	
In Day Resolution of Internal Delays in ED & MAUs	Mon 04/08/14	Fri 26/09/14	Lee Walker	On Track
Create Escalation Process for Delayed Referrals from ED/MAU to Specialties	Mon 04/08/14	Fri 26/09/14	Lee Walker	
Test Escalation Process for Delayed Referrals from ED/MAU to Specialties	Mon 18/08/14	Fri 26/09/14	Lee Walker	

Task Name	Start	Finish	Resource Names	Status
3. Base Wards			Ian Lawrence	
3.1 Ward Round Processes				
Assertive Board Rounding	Mon 04/08/14	Fri 26/09/14	Ian Lawrence	On Track
Create Assertive Board Rounding Process	Mon 04/08/14	Fri 26/09/14	Ian Lawrence	
Test Assertive Board Rounding Process	Mon 18/08/14	Fri 26/09/14	Ian Lawrence	
Roll Out Assertive Board Rounding to Rest of Hospital	Mon 29/09/14	Fri 19/12/14	Ian Lawrence	
One Stop Ward Round	Mon 04/08/14	Fri 26/09/14	Ian Lawrence	On Track
Create One Stop Ward Round Process	Mon 04/08/14	Fri 26/09/14	Ian Lawrence	
Test One Stop Ward Round Process	Mon 18/08/14	Fri 26/09/14	Ian Lawrence	
Roll Out One Stop Ward Round Process to Rest of Hospital	Mon 29/09/14	Fri 19/12/14	Ian Lawrence	
3.2 Base Ward Operating Model				
In Day Resolution of Internal Delays	Mon 04/08/14	Fri 26/09/14	Sue Burton	On Track
Create Escalation Process for In-Day Resolution of Delays	Mon 04/08/14	Fri 26/09/14	Sue Burton	
Test Escalation Process for In-Day Resolution of Delays	Mon 18/08/14	Fri 26/09/14	Sue Burton	
Roll Out Escalation Process for In-Day Resolution of Delays	Mon 15/09/14	Fri 19/12/14	Sue Burton	
"Ticket Home" Questions Patients Should Know the Answer To	Mon 04/08/14	Fri 26/09/14	Kath Higgins	On Track
Create Briefing on "Ticket Home" Questions	Mon 04/08/14	Fri 26/09/14	Kath Higgins	
Disseminate "Ticket Home" Questions Along with Briefing Pack	Mon 11/08/14	Fri 26/09/14	Kath Higgins	
Roll Out "Ticket Home" Questions to Rest of Hospital	Mon 29/09/14	Fri 19/12/14	Kath Higgins	
Long Length of Stay Review Process	Mon 04/08/14	Fri 26/09/14	Catherine Free	On Track
Create Long Length of Stay Review Process for Stranded Patients	Mon 04/08/14	Fri 26/09/14	Catherine Free	
Test Long Length of Stay Review Process	Mon 18/08/14	Fri 26/09/14	Catherine Free	
Roll Out Long Length of Stay Review Process to Rest of Hospital	Mon 29/09/14	Fri 19/12/14	Catherine Free	
Attending Consultant Input for Specialties Not on Acute Medicine Rota	Mon 04/08/14	Fri 26/09/14	Kerry Johnstone	On Track
Create Policy for Attending Consultant Input	Mon 04/08/14	Fri 26/09/14	Kerry Johnstone	
Test Policy for Attending Consultant Input	Mon 18/08/14	Fri 26/09/14	Kerry Johnstone	
Roll Out Policy for Attending Consultant Input	Mon 15/09/14	Fri 19/12/14	Kerry Johnstone	
Discharge Lounge	Mon 04/08/14	Fri 26/09/14	Ian Lawrence	On Track
Create Process of Identifying Patients for Next Day Discharge	Mon 04/08/14	Fri 26/09/14	Ian Lawrence	
Test Process of Identifying Patients for Next Day Discharge	Mon 18/08/14	Fri 26/09/14	Ian Lawrence	
Roll Out Discharge Lounge Process for Identifying Patients to Rest of Hospital	Mon 29/09/14	Fri 19/12/14	Ian Lawrence	
Two by 1000 and Two by 1200 Process	Mon 04/08/14	Fri 31/10/14	Ian Lawrence	On Track
Create Process for 2 Discharges by 1000 and 1200 for Each Ward	Mon 04/08/14	Fri 31/10/14	Ian Lawrence	
Test Process for 2 Discharges by 1000 and 1200 for Each Ward	Mon 18/08/14	Fri 31/10/14	Ian Lawrence	
Roll Out Process	Mon 15/09/14	Fri 19/12/14	Ian Lawrence	
3.3 Oncology & Haematology Base Wards				
Oncology Assessment Unit	Mon 04/08/14	Fri 27/03/15	David Peel	On Track
Create Process Enabling Twice Daily Ward Rounds	Mon 04/08/14	Fri 27/03/15	David Peel	
Test Process Enabling Twice Daily Ward Rounds	Mon 18/08/14	Fri 27/03/15	David Peel	
Multinational Association of Supportive Care in Cancer, MASCC, Risk Assessments	Mon 04/08/14	Fri 27/03/15	David Peel	On Track
Create MASCC Risk Assessment Process	Mon 04/08/14	Fri 27/03/15	David Peel	
Test MASCC Risk Assessment Process	Mon 18/08/14	Fri 27/03/15	David Peel	
Utilisation of Granulocyte-Colony Stimulating Factor, GCSF, Across Oncology	Mon 04/08/14	Fri 27/03/15	David Peel	On Track
Create Process for Utilising GCSF Across Oncology	Mon 04/08/14	Fri 27/03/15	David Peel	
Test Process for Utilising GCSF Across Oncology	Mon 18/08/14	Fri 27/03/15	David Peel	
Community Based Chemotherapy Service	Mon 04/08/14	Fri 27/03/15	David Peel	On Track
Create Protocols for Community Based Chemotherapy Service	Mon 04/08/14	Fri 27/03/15	David Peel	
Test Protocols for Community Based Chemotherapy Service	Mon 18/08/14	Fri 27/03/15	David Peel	
Community Chemotherapy Teams	Mon 04/08/14	Fri 27/03/15	David Peel	On Track
Create Delivery Model for Community Chemotherapy Teams	Mon 04/08/14	Fri 27/03/15	David Peel	
Test Delivery Model for Community Chemotherapy Teams	Mon 18/08/14	Fri 27/03/15	David Peel	
Haematology Base Wards	Mon 04/08/14	Fri 27/03/15	David Peel	On Track
Community Based Transfusion Service	Mon 04/08/14	Fri 27/03/15	David Peel	
Create Protocols for Transfusion Service	Mon 04/08/14	Fri 27/03/15	David Peel	
Test Protocols for Transfusion Service	Mon 18/08/14	Fri 27/03/15	David Peel	
Reduced Intensity Bone Marrow Transplant, BMT, Patients on an Ambulatory Basis	Mon 04/08/14	Fri 27/03/15	David Peel	On Track
Create Process for Delivering BMT on an Ambulatory Basis	Mon 04/08/14	Fri 27/03/15	David Peel	
Test Process for Delivering BMT on an Ambulatory Basis	Mon 18/08/14	Fri 27/03/15	David Peel	
3.4 Surgical Base Wards				
Physician Assistant	Mon 04/08/14	Fri 10/10/14	Surgical Consultant TBC	On Track
Create Role of Physician Assistant	Mon 04/08/14	Fri 15/08/14	Surgical Consultant TBC	
Test Role of Physician Assistant	Mon 18/08/14	Fri 12/09/14	Surgical Consultant TBC	
Vascular Ward Outliers	Mon 04/08/14	Fri 10/10/14	Surgical Consultant TBC	On Track
Review Protocols for Vascular Ward Outliers	Mon 04/08/14	Fri 15/08/14	Surgical Consultant TBC	
Test Updated Protocols for Vascular Ward Outliers	Mon 18/08/14	Fri 12/09/14	Surgical Consultant TBC	
Turnaround of Contaminated Beds	Mon 04/08/14	Fri 10/10/14	Surgical Consultant TBC	On Track
Create Process for Turning Around Contaminated Beds within 30 Mins	Mon 04/08/14	Fri 15/08/14	Surgical Consultant TBC	
Test Process for Turning Around Contaminated Beds within 30 Mins	Mon 18/08/14	Fri 12/09/14	Surgical Consultant TBC	
3.5 Glenfield Site				
Assertive Board Rounding	Mon 04/08/14	Fri 10/10/14	Jon Bennett	On Track
Create Assertive Board Rounding Process	Mon 04/08/14	Fri 15/08/14	Jon Bennett	
Test Assertive Board Rounding Process	Mon 18/08/14	Fri 12/09/14	Jon Bennett	
One Stop Ward Round	Mon 04/08/14	Fri 10/10/14	Jon Bennett	On Track
Create One Stop Ward Round Process	Mon 04/08/14	Fri 15/08/14	Jon Bennett	
Test One Stop Ward Round Process	Mon 18/08/14	Fri 12/09/14	Jon Bennett	
Roll Out One Stop Ward Round Process	Mon 15/09/14	Fri 10/10/14	Jon Bennett	
Discharge Lounge	Mon 04/08/14	Fri 10/10/14	Jon Bennett	On Track
Create Process of Identifying Patients for Next Day Discharge	Mon 04/08/14	Fri 15/08/14	Jon Bennett	
Test Process of Identifying Patients for Next Day Discharge	Mon 18/08/14	Fri 12/09/14	Jon Bennett	
Roll Out Process of Identifying Patients for Next Day Discharge	Mon 15/09/14	Fri 10/10/14	Jon Bennett	
Two by 1000 and Two by 1200 Process	Mon 04/08/14	Fri 10/10/14	Jon Bennett	On Track
Create Process for 2 Discharges by 1000 and 1200 for Each Ward	Mon 04/08/14	Fri 15/08/14	Jon Bennett	
Test Process for 2 Discharges by 1000 and 1200 for Each Ward	Mon 18/08/14	Fri 12/09/14	Jon Bennett	
Roll Out Process	Mon 15/09/14	Fri 10/10/14	Jon Bennett	
4. Frailty Wards			Simon Conroy	
Comprehensive Geriatric Assessment	Mon 04/08/14	Fri 10/10/14	Simon Conroy	On Track
Create Comprehensive Geriatric Assessment Process	Mon 04/08/14	Fri 15/08/14	Simon Conroy	
Test Comprehensive Geriatric Assessment Process	Mon 18/08/14	Fri 12/09/14	Simon Conroy	
Board Round Referral to AHP, (Abolishing Written Referral)	Mon 04/08/14	Fri 10/10/14	Simon Conroy	On Track
Create Process Enabling Verbal Board Round Referral to AHP	Mon 04/08/14	Fri 15/08/14	Simon Conroy	
Test Process Enabling Verbal Board Round Referral to AHP	Mon 18/08/14	Fri 12/09/14	Simon Conroy	
Reduce Dependency on Home Visits	Mon 04/08/14	Fri 10/10/14	Simon Conroy	On Track
Create Process to Reduce Dependency on Home Visits	Mon 04/08/14	Fri 15/08/14	Simon Conroy	
Test Process to Reduce Dependency on Home Visits	Mon 18/08/14	Fri 12/09/14	Simon Conroy	
Early Supported Discharge	Mon 04/08/14	Fri 10/10/14	Simon Conroy	On Track
Update Processes to Deliver Better Early Supported Discharge	Mon 04/08/14	Fri 15/08/14	Simon Conroy	
Test Processes to Deliver Better Early Supported Discharge	Mon 18/08/14	Fri 12/09/14	Simon Conroy	
Creation of Vertically Integrated Care Pathway for Elder People	Mon 04/08/14	Fri 10/10/14	Simon Conroy	On Track
Create Vertically Integrated Care Pathway	Mon 04/08/14	Fri 15/08/14	Simon Conroy	
Test Vertically Integrated Care Pathway	Mon 18/08/14	Fri 12/09/14	Simon Conroy	
Roll Out Vertically Integrated Care Pathway	Mon 15/09/14	Fri 10/10/14	Simon Conroy	
Creation of Geriatric Outreach Model	Mon 25/08/14	Fri 27/03/15	Simon Conroy	On Track
Create Geriatric Outreach Model	Mon 25/08/14	Fri 19/12/15	Simon Conroy	
Test Geriatric Outreach Model	Mon 05/01/15	Fri 27/02/15	Simon Conroy	
Roll Out Geriatric Outreach Model	Mon 02/03/15	Fri 27/03/15	Simon Conroy	
Develop "Referrer Decides" Protocol for Transfers to the Community	Mon 25/08/14	Fri 19/12/14	Simon Conroy	On Track
Create "Referrer Decides" Protocol for Transfers to the Community	Mon 25/08/14	Fri 12/09/14	Simon Conroy	
Test "Referrer Decides" Protocol for Transfers to the Community	Mon 15/09/14	Tue 30/09/14	Simon Conroy	
Roll Out "Referrer Decides" Protocol for Transfers to the Community	Wed 01/10/14	Fri 19/12/14	Simon Conroy	

Key

= Working Group Name

= High - Level Task/Activity

= Detailed Task to be Delivered

= The Detail of What Needs to be Delivered at Ward Level

To Be Started
Significant Delay
Slight Delay
On Track
Closed

From: Communications
Sent: 18 August 2014 11:09
Subject: Message from the Chief Executive: EVERYBODY COUNTS - play your part in our new campaign

Importance: High

Expires: 12 September 2014 17:00

Attachments: image001.jpg

Dear colleague

For the past few months I have shared with you, mainly via my monthly briefings, the work we are doing with Dr Ian Sturgess to improve emergency pathway care. PLEASE, do not stop reading now if you think this does not involve you….it does!

We all know the emergency pathway needs to change, as do many of our services. At Leicester's Hospitals, we need to provide safer and more effective care for patients - from the moment they come through the front door to when they are discharged. Lots of work is being done to make the most of our existing resources and to champion best practice, which encourages positive change benefitting patients and colleagues.

To make sustainable improvement we need change that is co-created; we need a social movement.

What is a social movement? A social movement is a large group of people who work together to bring about change. NHS Change Day which many of you will have supported, is a great example of a recent social movement.

We are a large group of like-minded people who want to bring about change. We all want to give our patients the best possible care, yet every day we see flaws in systems and processes which often hinder or slow this down. Now is the time to change that.

Everybody Counts is a new campaign we are launching today. It is about you, and what you are doing to improve care for the patients you come into contact with - directly and indirectly. It is about improvements we will make together to bring about positive change for colleagues. **Everybody Counts** is about **everybody**.

Everybody Counts is about sharing ideas – communicating with each other – from ward to senior leadership, across departments, between peers, and between staff and patients.

Everybody Counts is about what you are doing to bring about positive change. Positive change that you have made in your area or with your team may help others make improvements in their ward or department. The sharing of ideas will help spread good practice.

Everybody Counts is about our values. It is about treating people how we would like to be treated. It is about working together as one team. It is about focusing on what matters most. It is about doing what we say we are going to do. It is about creativity. And most importantly it is about caring at its best!

I am reminded about the NHS National Staff Survey, which asks staff 'if their role makes a difference', 'if staff are able to contribute towards improvements at work', 'if staff are able to make suggestions to improve the work of their team/department' and 'if their role makes a difference to patients'. This is what **Everybody Counts** is about. I want you to get involved in decisions that affect you and the services you provide so you feel empowered to put forward ideas to deliver better and safer services.

The campaign….

Everybody Counts needs **you** to make it work. The campaign will utilise social media and video and will encourage the exchange of ideas face to face. You will be able to access information through INsite http://insite.xuhl-tr.nhs.uk/everybodycounts and you will be able to access videos and updates via your personal smartphones or tablets, or on Trust PC's.

If you're on Twitter please follow us @Leic_Hospital using the hashtag #EverybodyCounts and share what you are doing.

Videos will be on our Vimeo account, and we will provide links from Twitter to share them.

I am really pleased to say that there are a lot of improvements taking placed already, designed by those at the centre of it – you! Much of this has been driven by Listening into Action, which continues to thrive and expand. And now we are implementing many changes, designed mainly by clinicians, which are improving the way in which the emergency care pathway works. There is a growing positive feeling of change taking place across our organisation, and I would like to encourage you to share your ideas with your manager and work together to test them. You

won't get it right first time, but you will get it right, for you and your patients. What **Everybody Counts** adds is the ability to share what is happening across our large organisation and thus inspire more change and improvement for patients.

We want everyone to understand and own the part they play in bringing about positive change across the whole of our organisation, no matter where they work.

I hope you will support this campaign and I look forward to seeing and hearing about how you are playing your part.

Best wishes,

John Adler
Chief Executive
University Hospitals of Leicester NHS Trust

www.leicestershospitals.nhs.uk
Twitter: @Leic_Hospital
#EverybodyCounts

University Hospitals of Leicester NHS
NHS Trust

Trust Board Paper V

To:	**Trust Board**
From:	**Kevin Harris – Medical Director**
Date:	**28 August 2014**
CQC regulation:	

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

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

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

The Report is provided to the Board for:

Decision		Discussion	x
Assurance	x	Endorsement	

Summary / Key Points:
UHL has an extensive R&D portfolio and is recognised nationally and international for excellence in many of its areas.
2013/14 was good year for initiation of studies and recruitment
R&D faces some challenges around delivering to recruitment targets – but an action plan is in place.
A number of new exciting initiatives are in the pipeline.

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

Previously considered at another corporate UHL Committee?
No

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

Resource Implications (eg Financial, HR):
Yes

Assurance Implications: yes

Patient and Public Involvement (PPI) Implications: yes

Stakeholder Engagement Implications: N/A

Equality Impact: considered and no impact

Information exempt from Disclosure: No

Requirement for further review? Quarterly report to the Trust Board

UHL R&D Quarterly Trust Board Report August 2014

1. Introduction

This is the fifth Trust Board Report since the R&D Committee became an executive committee and this report comprises a summary of the current situation. The report describes current performance against metrics, projects under development and new challenges.

2. Research Performance

UHL's performance in initiating and delivering research is monitored by the NIHR Central Commissioning Facility and the Clinical Research Network. In addition Research activity can now be reported at the UHL CMG level to reflect the recently introduced clinical structure.

2.1 NIHR reports UHL in the first division (out of 4) for research performance in initiating clinical research. In Q4 13/14 UHL initiated 116 clinical trials making UHL the 11th most prolific trust. Therefore in terms of number so trials initiated UHL performs well.
UHL is also judged by its performance in recruiting patients into initiated trials – the benchmark is to recruit the first patient into a trial within 70 days of submission by the investigator of a valid research application. Here UHL's performance is 36.1%, thus leaving significant room for improvement. Indeed NIHR will be comparing performance from Q4 13/14 with that in Q2 14/15 and is expecting to see a significant improvement from all trusts. Failure to show an improvement may result in a 5% reduction in research capability funding (RCF) from NIHR for 15/16 (for 14/15 UHL received circa £1.8 million RCF).
We have developed an action plan and communications strategy to mitigate this risk. The action plan has been discussed at Trust R&D Exec and is circulated with the minutes of the last meeting. We have designed a logo and text reminder to researchers to publicise the importance of the 70 day target (Figure 1). This has been well received and several other trusts have requested our permission to use this logo in their organisations with due recognition for UHL.

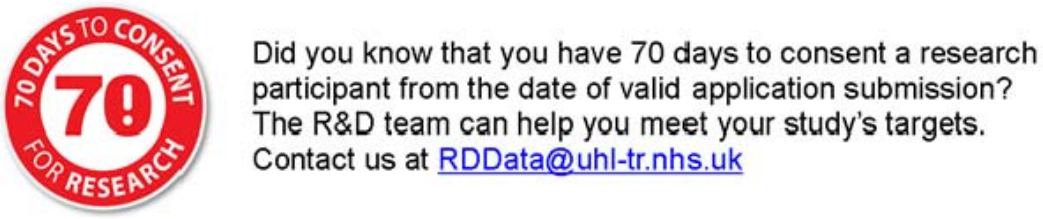
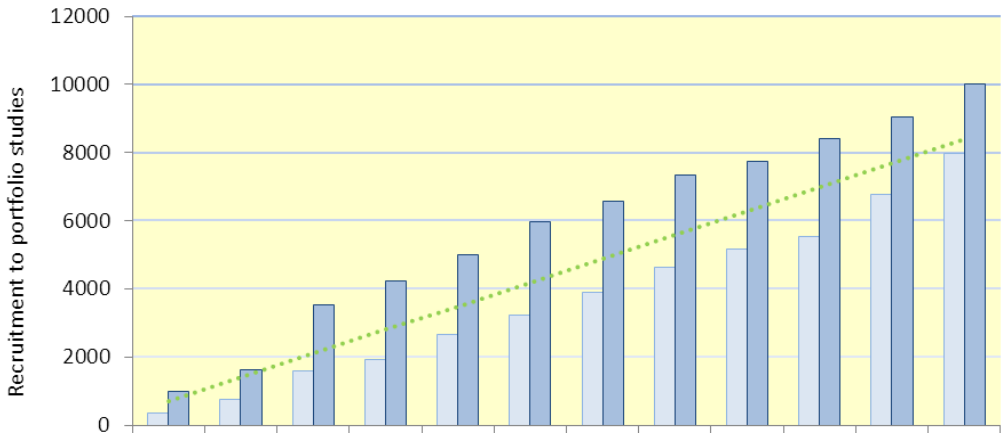


Figure 1. UHL's Logo and Reminder to Researchers of 70 day target

2.2. The last report received from the Clinical Research Network was from LNR CLRN in May 2014. The UHL hosted Clinical research Network East Midlands is still in the process of refining its data reports for trusts. For the year 13/14 recruitment of patients in UHL clinical studies exceeded targets, with over 10,000 patients recruited. This is a significantly positive outcome (Figure 2).



	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	JAN	FEB	MAR
2012-13 Recruitment	336	769	1596	1937	2662	3222	3912	4618	5158	5530	6756	7982
2013-14 Recruitment	985	1614	3514	4246	4996	5982	6561	7326	7746	8426	9046	10025
2013-14 Target	698	1397	2095	2794	3492	4191	4889	5587	6286	6984	7683	8381

Figure 2. UHL recruitment of patients into clinical studies by month and financial year.

3. Projects under development

There are currently 3 major projects in development.

3.1. Adult and Children's Clinical Research Facility. UHL has received capital funding to refurbish the Union Offices in LRI into a Children's Clinical Research Facility. This will be adjacent to the existing clinical research facility at LRI and will enable the establishment of a new joint Adult and Children's Clinical Research Facility. This will increase capacity for clinical research and maximise potential income from commercial studies. We have had enquiries from other Trusts about the possibility of contracting out clinical research capacity and a scoping exercise is currently underway to assess capacity implications of the new development.

3.2 The Life Study. UHL has been invited to develop a strategic partnership to host The Life Study. Led by academics from University College London the Life Study will collect information about babies and the determinants of their health, wellbeing and development. UHL will be one of a small number of centres hosting this important study. The aim is to recruit at least 50% of 11,000 deliveries annually at UHL. Participation will result in significant reputational enhancement for UHL and will generate R&D income from the Clinical Research Network based on recruitment levels.
Premises have been identified for refurbishment into the Life Centre and a capital solution appears to have been found. It has been agreed that UHL will now put this refurbishment out to tender. The aim is to have The Life Study centre completed and supporting recruitment by early 2015.

3.3. The 100,000 Genome Project. The aim of this project is to deliver advances in genomics to improve the lives of patients with rare/inherited diseases and cancer. In essence the programme aims to bring increased understanding of genomics, and to bring genomics into the clinical arena where it can be embedded, where appropriate,

as part of clinical care. UHL is bidding to become a Genomic Medicine Centre as part of an East of England Consortium comprising Cambridge, Derby, Norwich and Nottingham, in addition to UHL. Extensive discussions have taken place, and this proposal is fully supported by all Trusts at a senior level and by the EM AHSN. The deadline for first stage application is end Aug 2014 with a second stage application later in the year. If successful, UHL will begin recruiting to this project in Jan 2015.

4. New Challenges

The achievement of the 70 day target is a significant challenge and income is at stake. However a mitigation strategy is in place, and R&D staff are being trained to support delivery of research targets. In addition the recent appointment of an R&D Communications Manager will help disseminate messages and maintain profile.

The new EM CRN has not yet finalised how it will be managing its financial allocation process for 15/16. This is leading to some uncertainty, but relationships are good and we remain optimistic that the process and outcome will be fair and equitable.

Nigel Brunskill – Director of R&D
August 2014

University Hospitals of Leicester NHS
NHS Trust

To:	Trust Board
From:	Stephen Ward, Director of Corporate & Legal Affairs
Date:	28 August 2014
CQC regulation:	N/A

Title:	**NHS Trust oversight self certification**

Author/Responsible Director: Stephen Ward, Director of Corporate & Legal Affairs
Helen Stokes, Senior Trust Administrator

Purpose of the Report:

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

In accordance with the Accountability Framework, the Trust is required to complete two self certifications in relation to the Foundation Trust application process. Copies of the self certifications submitted in July 2014 (June 2014 position) are attached as Appendices A and B.

The Report is provided to the Board for:

Decision	X	Discussion	X
Assurance		Endorsement	

Summary / Key Points:

- Subject to discussion at the August 2014 Trust Board meeting on matters relating to operational and financial performance, it is proposed that the self certifications against Monitor Licensing Requirements (Appendix A) and Trust Board Statements (Appendix B) be updated following the Trust Board meeting to reflect the July 2014 position and submitted to the NHS Trust Development Authority accordingly

Recommendations:

The Trust Board is asked to provide the Director of Corporate and Legal Affairs with the delegated authority to agree a form of words with the Chief Executive in respect of this month's submission, with the self certifications then to be updated following the Trust Board meeting and submitted to the NHS Trust Development Authority accordingly.

Previously considered at another corporate UHL Committee? No

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

Resource Implications (eg Financial, HR): No

Assurance Implications: Yes

Patient and Public Involvement (PPI) Implications: No

Stakeholder Engagement Implications: No

Equality Impact: considered and no impact

Information exempt from Disclosure: None

Requirement for further review? All future Trust oversight self certifications will be presented to the Trust Board for approval

NHS TRUST DEVELOPMENT AUTHORITY

OVERSIGHT: Monthly self-certification requirements - Compliance Monitor
Monthly Data.

CONTACT INFORMATION:

Enter Your Name:* John Adler

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

Full Telephone Number:* 01162588940 Tel Extension: 8940

SELF-CERTIFICATION DETAILS:

Select Your Trust:* University Hospitals Of Leicester NHS Trust

Submission Date:* 31/07/2014 Reporting Year:* 2014/15

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NHS TRUST DEVELOPMENT AUTHORITY

Select the Month*

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

COMPLIANCE WITH MONITOR LICENCE REQUIREMENTS FOR NHS TRUSTS:

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

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

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

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

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

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16% Complete

NHS TRUST DEVELOPMENT AUTHORITY

COMPLIANCE WITH MONITOR LICENCE REQUIREMENTS FOR NHS TRUSTS:

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

1. Condition G4
Fit and proper persons as Governors and Directors.*
Yes

2. Condition G5
Having regard to monitor Guidance.*
Yes

3. Condition G7
Registration with the Care Quality Commission.*
Yes

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18% Complete

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NHS TRUST DEVELOPMENT AUTHORITY

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

4. Condition G8
Patient eligibility and selection criteria.*

Yes

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39% Complete

NHS TRUST DEVELOPMENT AUTHORITY

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

5. Condition P1
Recording of information.* Yes

6. Condition P2
Provision of information.* Yes

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

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

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45% Complete

NHS TRUST DEVELOPMENT AUTHORITY

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

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

Yes

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73% Complete

NHS TRUST DEVELOPMENT AUTHORITY

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

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

11. Condition C2
Competition oversight.*
Yes

12. Condition IC1
Provision of integrated care.*
Yes

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NHS TRUST DEVELOPMENT AUTHORITY

OVERSIGHT: Monthly self-certification requirements - Board Statements
Monthly Data.

CONTACT INFORMATION:

Enter Your Name:* John Adler

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

Full Telephone Number:* 0116 2588940 Tel Extension: 8940

SELF-CERTIFICATION DETAILS:

Select Your Trust:* University Hospitals Of Leicester NHS Trust

Submission Date:* 31/07/2014 Reporting Year:* 2014/15

Select the Month*

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

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NHS TRUST DEVELOPMENT AUTHORITY

BOARD STATEMENTS:

CLINICAL QUALITY
FINANCE
GOVERNANCE

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

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

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16% Complete

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NHS TRUST DEVELOPMENT AUTHORITY

BOARD STATEMENTS:

For CLINICAL QUALITY, that

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

1. CLINICAL QUALITY Yes
Indicate compliance.*

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16% Complete

NHS TRUST DEVELOPMENT AUTHORITY

BOARD STATEMENTS:

For CLINICAL QUALITY, that

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

2. CLINICAL QUALITY Yes
Indicate compliance.*

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22% Complete

NHS TRUST DEVELOPMENT AUTHORITY

BOARD STATEMENTS:

For CLINICAL QUALITY, that

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

3. CLINICAL QUALITY Yes
Indicate compliance.*

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28% Complete

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NHS TRUST DEVELOPMENT AUTHORITY

BOARD STATEMENTS:

For FINANCE, that

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

4. FINANCE
Indicate compliance.*

Yes

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34% Complete

NHS TRUST DEVELOPMENT AUTHORITY

BOARD STATEMENTS:

For GOVERNANCE, that

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

5. GOVERNANCE
Indicate compliance.*

Yes

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40% Complete

NHS TRUST DEVELOPMENT AUTHORITY

BOARD STATEMENTS:

For GOVERNANCE, that

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

6. GOVERNANCE Indicate compliance.*	Risk
Timescale for compliance:*	31/03/2015
RESPONSE:	UHL is currently non compliant with the ED 4-hour wait target. The Trust is working towards sustainable compliance with the ED target.
Comment where non-compliant or at risk of non-compliance*	UHL continues to experience high numbers of emergency admissions and until such time as the LLR health economy is able to respond to the required increase in discharges, UHL will continue to experience significant day to day capacity issues.

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46% Complete

NHS TRUST DEVELOPMENT AUTHORITY

BOARD STATEMENTS:

For GOVERNANCE, that

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

7. GOVERNANCE Yes
Indicate compliance.*

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52% Complete

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NHS TRUST DEVELOPMENT AUTHORITY

BOARD STATEMENTS:

For GOVERNANCE, that

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

8. GOVERNANCE Yes
Indicate compliance.*

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58% Complete

NHS TRUST DEVELOPMENT AUTHORITY

BOARD STATEMENTS:

For GOVERNANCE, that

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

9. GOVERNANCE
Indicate compliance.*

Yes

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64% Complete

NHS TRUST DEVELOPMENT AUTHORITY

BOARD STATEMENTS:

For GOVERNANCE, that

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

10. GOVERNANCE Indicate compliance.*	No
Timescale for compliance:*	31/03/2015
RESPONSE: Comment where non-compliant or at risk of non-compliance*	UHL is currently non complaint with the ED 4-hour wait target and the Referral to Treatment (RTT) admitted and non-admitted targets. UHL has not met the 2 week wait targets for all cancers and symptomatic breast patients due to a large increase in referrals in April 2014 (circa 20% increase). Tumour group level action plans are being developed to return cancer performance to compliant levels by the end of Quarter 2 of 2014-15. The Trust is working towards sustainable compliance with the ED target. An Emergency Care Improvement Hub has been established, which brings together partners from across health and social care. An RTT recovery plan has been agreed with Commissioners.

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70% Complete

NHS TRUST DEVELOPMENT AUTHORITY

BOARD STATEMENTS:

For GOVERNANCE, that

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

11. GOVERNANCE
Indicate compliance.*

Yes

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76% Complete

NHS TRUST DEVELOPMENT AUTHORITY

BOARD STATEMENTS:

For GOVERNANCE, that

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

12. GOVERNANCE
Indicate compliance.*

Yes

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82% Complete

NHS TRUST DEVELOPMENT AUTHORITY

BOARD STATEMENTS:

For GOVERNANCE, that

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

13. GOVERNANCE Yes
Indicate compliance.*

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88% Complete

NHS TRUST DEVELOPMENT AUTHORITY

BOARD STATEMENTS:

For GOVERNANCE, that

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

14. GOVERNANCE
Indicate compliance.*

Yes

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Trust Board Paper X

University Hospitals of Leicester NHS
NHS Trust

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST

REPORT BY TRUST BOARD COMMITTEE TO TRUST BOARD

DATE OF TRUST BOARD MEETING: 28 August 2014

COMMITTEE: Finance and Performance Committee

CHAIRMAN: Mr R Kilner, Non-Executive Director

DATE OF COMMITTEE MEETING: 30 July 2014

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

- Minute 75/14 – the 2014-15 UHL Working Capital Strategy is recommended for Trust Board approval (as appended to these Minutes).

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

- Minute 79/14/1 – Empath vision for a Joint Pathology Service between UHL and NUH
- Minute 79/14/4 – Vascular Service OBC
- Minute 80/14/1 – Month 3 cancer performance

DATE OF NEXT COMMITTEE MEETING: 27 August 2014

Mr R Kilner, Acting Trust Chairman
20 August 2014

Paper A

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST

MINUTES OF A MEETING OF THE FINANCE AND PERFORMANCE COMMITTEE, HELD ON WEDNESDAY 30 JULY 2014 AT 8.30AM IN THE SEMINAR ROOMS A AND B, CLINICAL EDUCATION CENTRE, LEICESTER GENERAL HOSPITAL

Present:
Mr R Kilner – Acting Chairman (Committee Chair)
Mr J Adler – Chief Executive
Colonel (Retired) I Crowe – Non-Executive Director
Mr R Mitchell – Chief Operating Officer (up to and including Minute 81/14/2)
Mr S Sheppard – Acting Director of Finance
Mr G Smith – Patient Adviser (non-voting member)

In Attendance:
Ms L Bentley – Head of Financial Management and Planning
Mr N Callow – Empath Finance Director (for Minute 79/14/1)
Mr A Chatten – Managing Director, NHS Horizons (for Minute 79/14/3)
Mr J Clarke – Chief Information Officer (for Minute 79/14/2)
Ms C Kerry – Administration Services Manager (for Minute 81/14/1)
Mr B Lambden – Observing
Ms E MacLellan-Smith – Ernst Young (for Minute 81/14/1)
Mrs K Rayns – Trust Administrator
Dr P Shaw – Empath Managing Director (for Minute 79/14/1)
Ms K Shields – Director of Strategy (up to and including Minute 79/14/5)
Mr N Sone – Financial Controller (from Minute 81/14/3 and Minute 75/14))

RECOMMENDED ITEM **ACTION**

75/14 2014-15 WORKING CAPITAL STRATEGY

Paper N provided the proposed strategy for managing UHL's working capital in a way that ensured it remained a 'going concern' and had access to sufficient cash and liquid assets to meet its financial obligations going forward, through achievement of the identified 4 key objectives. This report (as prepared by the Interim Director of Financial Strategy prior to the conclusion of his interim appointment) was deferred from the 25 June 2014 meeting due to time constraints at that meeting.

The Financial Controller attended the meeting for this discussion, briefing members on the timetable for submission of applications to the TDA on 22 August 2014 and the work planned to take place with the TDA prior to the DoH submission in November 2014. Discussion took place regarding the opportunities for temporary borrowing and longer term financing in the form of Public Dividend Capital (PDC) alongside the typical interest rates that might be applied, eg 1.4% for temporary borrowing and 3.5% for PDC. Members noted that whilst the temporary borrowing options would appear to be more cost-effective, TDA guidelines might restrict the Trust from pursuing this option on a recurrent basis. Monthly reports would be produced for the Finance and Performance Committee on cash balances, interest receivable and payable, 13 week cash forecast including any corrective actions planned, details of any new borrowing and the annual forecast cash outturn.

Recommended – that (A) the 2014-15 Working Capital Strategy be recommended for Trust Board approval on 28 August 2014, and **CHAIR**

(B) reports on the Trust's cash position, interest receivable and payable, 13 week cash forecasts, details of any new borrowing and the annual forecast cash outturn be presented to the Finance and Performance Committee on a monthly basis. **ADF**

RESOLVED ITEMS **ACTION**

76/14 APOLOGIES

Apologies for absence were received from Ms J Wilson, Non-Executive Director.

77/14 MINUTES

Resolved – that the Minutes of the 25 June 2014 Finance and Performance Committee meeting (paper A) be confirmed as a correct record.

78/14 MATTERS ARISING PROGRESS REPORT

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

(a) Minute 67/14/4 of 25 June 2014 – a post-implementation review of the Da Vinci robot would be presented to the Finance and Performance Committee in December 2014; **ADF**

(b) Minute 67/14/5 of 25 June 2014 – a briefing note on TTO prescriptions had been circulated by the Medical Director. The briefing note highlighted various risk mitigation measures but did not appear to fully address the Committee's concerns. A follow-up report was requested for presentation to the Quality Assurance Committee in September 2014; **MD/ CD, CSI**

(c) Minute 67/14/6(a) of 25 June 2014 – the Medical Director had escalated concerns regarding CMG delays in providing the trajectories for completion of medical job planning and the position had since improved. The Deputy Medical Director had also included an update on job planning software technical issues within paper B;

(d) Minute 67/14/6(b) of 25 June 2014 – the Chief Operating Officer confirmed that Obstetrics would be the "early adopters" of the e-rostering system for medical staff;

(e) Minute 67/14/8(b) of 25 June 2014 – the Director of Strategy advised that the job description and banding for the substantive Director of the Alliance was being finalised with a view to advertising the post in September 2014. It was agreed that the Alliance delegated approval limits would therefore be reviewed in December 2014; **ADF**

(f) Minute 67/14/8(c) of 25 June 2014 – the next update on the Alliance contractual performance would be provided to the Committee in October 2014; **IDA/DS**

(g) Minute 67/14/8(d) and (e) of 25 June 2014 – an update on opportunities for Asteral to support the Alliance and potential transfer of assets to UHL would be presented to the Committee in September 2014; **DS**

(h) Minute 68/14/1 of 25 June 2014 – assurance relating to any clinical risks relating to long waiting patients had been referred to the Quality Assurance Committee for further scrutiny. The Chief Operating Officer advised that any long waiting RTT patients had been addressed and that 90% of the outpatient lists had been validated; **QAC CHAIR**

(i) Minute 68/14/1(b) of 25 June 2014 – ambulance handover times were now included in the quality and performance report (paper J) and further discussion on the actions underway to improve ambulance handover arrangements took place under Minute 80/14/1(e) below;

(j) Minute 69/14/1 of 25 June 2014 – a report on workforce plans and the Trust's LTFM would be scheduled on the August 2014 Finance and Performance Committee meeting agenda, and **DHR**

(k) Minute 45/14/1(c) of 23 April 2014 – a meeting had been arranged between the Director of Strategy and the Medical Director to consider the arrangements for benchmarking performance of small clinical teams and seeking assurance that performance was being monitored appropriately. An update would be provided to the September 2014 Finance and Performance Committee meeting. **DS/MD**

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

79/14 STRATEGIC MATTERS

79/14/1 Delivering the Empath Vision for a Joint Pathology Service between UHL and NUH

Mr N Callow, Empath Finance Director and Dr P Shaw, Empath Managing Director attended the meeting to present paper C, a briefing on the development of Empath and the process for submission of the Full Business Case (FBC) for the Hub lease, managed equipment service, managed IT service and logistics service to the Trust Development Agency (TDA). Paper C1 provided a copy of the Outline Business Case (OBC) as presented to the TDA on 22 July 2014. The Committee received an overview of the key challenges and risks, particularly noting:-

(a) the continued focus on development of a single operating model;
(b) that the date for TDA consideration of the FBC had now slipped from November 2014 to December 2014;
(c) that a penalty clause relating to the remaining term of UHL's managed equipment service would be factored into the financial scenario modelling and that both host Trusts would be kept fully informed on the position; **DS**
(d) the verbal information provided in respect of additional third party contract developments and tender opportunities;
(e) risks surrounding the possibility of losing the rights to lease the Hub pending TDA approval;
(f) the challenges associated with maintaining performance and capacity with the existing staffing structures over the next 12-18 months prior to implementation of the single operating model;
(g) that the Empath 5 year business plan would be presented to the host Trust Boards in September 2014 for approval; **DS**
(h) receipt of new legal advice relating to the preferred governance model for Empath, which indicated that a separate governance entity might be established instead of the existing proposal for one of the host Trusts to assume the lead role.

Resolved – that (A) the Finance and Performance Committee endorsed the Empath OBC and the process for developing the FBC (as set out in papers C and C1) for Trust Board approval on 31 July 2014;

(B) the host Trusts (UHL and NUH) be kept fully informed of the position relating to an identified penalty clause within UHL's existing contract for managed equipment services, and **DS**

(C) a report on the Empath 5 Year Business Plan be presented to the UHL and NUH Boards in September 2014. **DS**

79/14/2 Managed Print Service

The Chief Information Officer attended the meeting to present paper D, providing the Committee with assurance on the next phase for the deployment of a managed print service on the Leicester Royal Infirmary Site. The paper was taken as read and the Chief Information Officer highlighted the successful implementation at Glenfield Hospital, noting the key lessons learned and some "softer" unseen benefits (eg scanning documents for

pharmacy) that had arisen from this project during the Glenfield Hospital implementation phase.

Following discussion at the Executive Performance Board on 29 July 2014, the Chief Executive briefed the Committee on the additional financial benefits which would be enhanced by increasing capital investment and reducing revenue expenditure. The Acting Director of Finance confirmed that the overall financial contribution of this project would be reviewed 6 months after implementation. Members queried whether there were any particular challenges associated with the LRI site and noted in response that estates issues (eg power sockets and network points) would be addressed in advance and that positive feedback from Glenfield Hospital staff would help to support any required changes in staff culture and working practices. **CIO/ ADF**

<u>Resolved</u> – that (A) the Finance and Performance Committee endorsed the Business Case for Managed Print Services at the LRI (as set out in paper D) for Trust Board approval on 31 July 2014, and

(B) a detailed 6 month post-implementation evaluation be undertaken to assess the financial and "softer" benefits of the project, and any opportunities to harness further changes in technology be highlighted within the Trust accordingly. **CIO/ ADF**

79/14/3 <u>Report by the Chief Executive</u>

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

79/14/4 <u>Vascular Services Outline Business Case</u>

The Director of Strategy introduced paper F, seeking the Committee's endorsement of the Vascular Services OBC for Trust Board approval on 31 July 2014. The OBC incorporated the transfer of vascular and supporting services from the LRI to Glenfield Hospital, including an inpatient ward, surgical admissions area, vascular studies unit, angiography suites and a new hybrid theatre. She highlighted the additional clarity provided in terms of the clinical case for change and strategic imperatives since the OBC was reviewed by the Capital Investment and Monitoring Committee on 27 June 2014 and the Executive Team on 15 July 2014.

Members noted the importance of this cross-CMG scheme as an enabler for UHL's 5 year Integrated Business Plan and that the benefits of the transitional costs would extend beyond the sustainability of vascular, cardiac and cardiology services (due to the release of clinical and theatre space on the LRI site). Transitional funding had not yet been agreed for this scheme, but significant opportunities for this were being explored as part of the external work being undertaken by Ernst Young.

Focused work was taking place to address clinical coding issues, income generation and appropriate commissioning of the one stop clinics which alleviated the need for patients to attend 3 separate clinics. The capital outlay was currently included in the 2014-15 capital programme and additional financial benefits were expected to be delivered through increased operational efficiency and reduced cancellations.

The Committee Chairman sought robust assurance that the relocated service would be able to provide 7 days per week services and that there would be no negative impact upon patient mortality as a result of the relocation. In response, the Director of Strategy confirmed that 7 day working could be accommodated in the operational model and that clear arrangements had been made for vascular support at the LRI in the event of any urgent clinical need (eg major bleeding in ED or maternity services). She undertook to ensure that such assurance was included within the service model and the FBC on these **DS**

2 aspects.

Following a further detailed query on the percentage of ED and maternity patients requiring vascular expertise at the LRI, it was agreed that separate assurance on the arrangements for urgent vascular intervention on the LRI site (and any associated impact upon patient mortality) would be presented to the next available Executive Quality Board and the Quality Assurance Committee. **DS/ QAC CHAIR**

Resolved – that (A) the Finance and Performance Committee endorsed the Vascular OBC (as set out in paper F) for Trust Board approval on 31 July 2014, and

(B) assurance be provided to the next available Executive Quality Board and Quality Assurance Committee in respect of the arrangements for urgent vascular intervention on the LRI site (and any associated impact upon patient mortality). DS/ QAC CHAIR

79/14/5 Capital Funding for Re-provision of Clinical Space/Modular Wards

Paper G provided an update on the replacement support accommodation required at the LRI site and the new modular wards to support additional bed capacity, as part of the enabling works for the new emergency floor. The total value of the 2 schemes was noted to be £8.0m. The Committee received assurance that the 2 schemes represented good value for money and that the modular wards would act as an enabler to ring fence elective bed capacity.

The report recognised that whilst funding for these schemes had been allocated within the Trust's capital programme, this was currently overcommitted and external Public Dividend Capital (PDC) funding was now being sought from the TDA to support these 2 projects – as part of the wider application to be submitted to the TDA's Independent Trust Financing Facility (ITFF) by 22 August 2014.

Resolved – that the application for £8m Public Dividend Capital funding to support the re-provision of clinical space/modular wards (as set out in paper G) be endorsed for TB approval on 31 July 2014.

79/14/6 Terms of Reference for the Capital Monitoring and Investment Committee and the Revenue Investment Committee

Paper H provided the terms of reference for the Capital Monitoring and Investment Committee and the Revenue Investment Committee and set out the Trust's investments decision process for identified capital and revenue cost thresholds. The Committee Chairman received assurance that the Executive Director management resources for the respective Committees would provide appropriate added value.

The Director of Strategy suggested that the number of in-year business cases might reduce once the IBP process became embedded, although the Chief Executive advised that detailed business cases would still require approval even if they were reflected within the relevant annual capital programme.

Resolved – that the terms of reference for the Capital Monitoring and Investment and the Revenue Investment Committees (as set out in paper H) be approved.

79/14/7 Forward Schedule of Capital Schemes and Business Cases

The Acting Director of Finance introduced paper I, providing an update on the forward schedule of key capital schemes and business cases. This document had also been shared with the TDA to enable them to align their resources around the timetable for TDA approvals. In discussion on the report, members:-

(a) commented upon the key interdependencies between some of the schemes;
(b) queried the proposed funding source for the multi-storey car park at the LRI. The Committee recognised the need to accrue for such expenditure pending a due diligence process relating to appropriate use of NHS funding;
(c) queried the arrangements for co-locating children's cardiac services with other children's services, noting the requirements of the Safe and Sustainable Review of Paediatric Cardiac Services and opportunities to seek charitable funding in this area;
(d) requested further details of the planned £9m expenditure on the LGH site;
(e) queried the proposed funding source for the new LRI entrance, and
(f) noted the intention to brief staff on the draft schedule of capital schemes in the next edition of his "Blue Print" newsletter.

In light of the discussion above and the number of key issues raised, the Committee Chairman recommended that the proposed schedule of capital schemes and business cases be presented to the August 2014 Trust Board meeting. **ADF/TA**

Resolved – that the forward schedule of capital schemes and business cases (paper I) be presented to the 28 August 2014 Trust Board meeting. **ADF/TA**

80/14 PERFORMANCE

80/14/1 Month 3 Quality, Finance and Performance Report

Paper J provided an overview of UHL's quality, patient experience, operational targets, HR and financial performance against national, regional and local indicators for the month ending 30 June 2014 and a high level overview of the Divisional Heatmap report. The Chief Operating Officer reported on the following aspects of UHL's operational performance:-

(a) Emergency Care 4 hour waits – performance stood at 91.3% for June against the 95% target and a detailed report was scheduled on the 31 July 2014 Trust Board agenda;

(b) RTT 18 weeks – non-admitted compliance had been achieved 2 months ahead of plan, but admitted performance remained behind plan due to the ongoing work to reduce the backlogs. Appendix 3 to paper J provided a detailed report on the RTT improvement plan. It was particularly noted that the Ophthalmology service was forecast to achieve 90% in August and be compliant in November 2014;

(c) Cancer Targets – performance against a number of the targets had deteriorated and a detailed exception report was provided in appendix 4. Regular tumour site meetings were being held with each of the specialties and a weekly cancer predictive performance dashboard was now produced and circulated. Performance was not expected to be fully compliant until September 2014, but the position was being monitored closely. Discussion took place regarding the significant increase in symptomatic breast referrals and members noted that an activity query had been raised with Commissioners. The Committee requested that Mr M Metcalfe, Cancer Centre Lead Clinician be invited to attend the October 2014 Finance and Performance Committee meeting to brief the Committee on any lessons learned and opportunities to highlight any deteriorations earlier in the process; **COO/ TA**

(d) Cancelled Operations – an exception report was included at appendix 5. Due to 1 patient breach, the target to offer all patients another date within 28 days had been non-compliant. This position was expected to recover for July 2014;

(e) Ambulance Handover Times – this data had been included in the quality and performance report for the first time this month. Members considered the impact on patient experience and the scale of financial penalties. The Chief Operating Officer briefed the Committee on the actions underway to improve the factual accuracy of data, noting the joint workstreams being undertaken with EMAS and the CCGs to

address this and the relevance of the work being undertaken by Dr I Sturgess. Colonel (Retired) I Crowe, Non-Executive Director queried whether there were any standard operating procedures for ambulance handovers, noting in response that such procedures were in place but adherence to them became more challenging during times of high ED attendances;

(f) Patient Safety – responding to a query raised by Colonel (Retired) I Crowe, Non-Executive Director, the Chief Operating Officer confirmed that CMG compliance with the Central Alerting System (CAS) alerts was regularly reviewed via the CMG performance management meetings, and

(g) Delayed Transfers of Care (DTOC) – the Committee Chairman noted that DTOC trends appeared to have stagnated during the last 3 years and he queried how further progress might be made. In response, the Chief Executive noted the importance of this workstream as one of the key urgent care system outputs, where it was intended to focus on a smaller number of priorities and KPIs (including DTOCs).

Resolved – that (A) the month 3 Quality, Finance and Performance report (paper J) and the subsequent discussion be received and noted, and

(B) Mr M Metcalfe, Cancer Centre Lead Clinician to be invited to attend the October 2014 Finance and Performance Committee meeting to present an update on cancer performance lessons learned and opportunities to highlight any deteriorations in performance earlier in the process. **COO/ TA**

80/14/2 Clinical Letter Update

Further to Minute 68/14/3 of 25 June 2014, the Chief Operating Officer presented paper K, updating the Committee on progress with reducing the backlog of outpatient clinical letters which was also presented to the Executive Team on 8 July 2014. Appendix 1 summarised the key issues contributing to the failure to achieve the 10 day standard and appendix 2 provided a service level backlog report. Members noted the historical approach to addressing clinical letters within the CMGs and that a task and finish group had now been established to undertake an options appraisal on the IT systems used for such letter generation.

The Committee Chairman queried the scope for a more radical solution to address clinical letters performance (eg outsourcing), and received additional information on the wide range of 'other duties' undertaken by UHL's medical secretaries, who were also supporting the validation work in respect of follow-up appointments and RTT pathways. Some clinicians had queried whether Dictate IT was the right software for UHL to be using, and the system had recently suffered some down time. Members noted that lack of IT support for Dictate IT and wide spread system variation were 2 of the key issues to be resolved.

Colonel (Retired) I Crowe, Non-Executive Director commented upon the high quality of service provided by the Glenfield Hospital booking centre, and queried the scope to increase the volume of UHL's outpatient bookings handled in this way, noting the potential benefit of reducing patient complaints relating to call handling. The Patient Adviser commented upon the reputational risks associated with poor handling of outpatient bookings. The Chief Operating Officer confirmed that ways of centralising the booking process for outpatient appointments were being explored as part of the outpatients cross-cutting CIP scheme.

Resolved – that (A) the progress report on reducing the backlog of clinical letters be received and noted, and

(B) a further progress report on Clinical Letters performance be provided to the **COO**

August 2014 Finance and Performance Committee (including outputs from the task and finish groups if available).

81/14 FINANCE

81/14/1 2014-15 Cost Improvement Programme

Further to Minute 69/14/1 of 25 June 2014, the Chief Operating Officer introduced paper L, updating the Committee in respect of progress towards the 2014-15 CIP target of £45m, noting that the total value of schemes on the CIP tracker now stood at £45.45m and the risk adjusted value stood at £38.295m. Ms E MacLellan-Smith, Ernst Young and Ms C Kerry, Administration Services Manager attended the meeting for this item.

The Acting Director of Finance reported verbally on Corporate Directorate and CMG-level progress towards the 1% in year target and 2% recurrent target for workforce related savings, noting that 179 post reductions had been identified to date. The outputs of the 1% workforce reductions had not yet been included in the CIP tracker. However, it was noted that a discussion on the next steps and additional resources investment required to deliver the Trust's key objectives would take place later in the agenda (paper R and Minute 81/14/6 below refer).

Finance and Performance Committee members noted the need for continued focus on converting the red and amber rated CIP schemes to green, strengthening the arrangements for delivery of the cross-cutting themes and ongoing short term cost controls. A degree of autonomy was beginning to emerge amongst the CMGs, with the high performing CMGs being reviewed on a monthly basis and others being reviewed on a fortnightly schedule (or weekly from mid-August 2014). The following comments and queries were raised in respect of paper L:-

(a) Colonel (Retired) I Crowe, Non-Executive Director congratulated the team for closing the gap between the CIP target and the tracker, but he noted the risks surrounding £2m which were not yet reflected in Commissioner plans. In response, it was noted that further pipeline schemes were being developed to mitigate any slippage;
(b) the Committee Chairman queried whether the cross-cutting CIP schemes were adequately resourced, noting in response the Chief Operating Officer' view that they were not and that further discussion would take place later in the agenda on this aspect (Minute 81/14/6 below refers);
(c) a clarification that the term SAS doctors (as referred to within the Medical Productivity scheme) related to Staff Grades and Associate Specialists;
(d) the Chief Executive advised of his clear expectation that the WTE impact of all CIP schemes would be clearly set out within the CIP report for the August 2014 Finance and Performance Committee meeting (as previously requested); **COO**
(e) noting that a CIP master class had recently been held by the CSI CMG and that plans to roll out such classes were being developed for other CMGs, the Committee Chairman requested that he be invited to attend the next session, and
(f) the Committee Chairman thanked Ms MacLellan-Smith and Ms C Kerry for attending the meeting and paid tribute to the work of Ms C Kerry in supporting the Trust's CIP workstreams going forward. **COO**

Resolved – that (A) the 2014-15 CIP update be received and noted;

(B) the Chief Operating Officer be requested to ensure that the WTE impact of all CIP schemes was clearly set out within the August 2014 iteration of the CIP report, and **COO**

(C) arrangements be made to invite the Committee Chairman to attend the next CMG CIP Master Class (when scheduled). **COO**

81/14/2 2014-15 Financial Position to Month 3

Papers M and M1 provided an update on UHL's performance against the key financial duties surrounding delivery of a planned surplus, achievement of the External Financing Limit (EFL) and achievement of the Capital Resource Limit (CRL), as submitted to the 31 July Trust Board and the 29 July Executive Performance Board (respectively). The Acting Director of Finance summarised the key points arising from paper M1, noting a year to date adverse variance to plan of £0.6m, a forecast shortfall of £1.4m in CIP delivery, an improved position in respect of premium pay (which was at its lowest level since January 2013) and opportunities for reinvestment of RTT and ambulance turnaround penalties.

Discussion took place regarding 17 detailed activity queries between UHL and Commissioners. These were being processed appropriately but a wider focus was being developed in respect of the levels of admissions, readmissions, GP referrals, SLA cash flow and arrangements for withholding payments. It was agreed that an update on the contractual position would be provided to the August 2014 Finance and Performance Committee to inform a discussion on the cash implications and escalation procedure. In the meantime, the Chief Executive undertook to commence a dialogue with Mr T Sanders, Managing Director, West Leicestershire CCG on the contractual position and arrangements for withholding SLA payments.

Resolved – that (A) the briefings on UHL's Month 3 financial performance be received and noted as paper M and M1,

(B) an update on activity queries and the contractual position with Commissioners be provided to the August 2014 Finance and Performance Committee meeting, and **ADF**

(C) the Chief Executive be requested to commence a dialogue with Mr T Sanders, Managing Director, WLCCG on the contractual position and the arrangements for withholding payments. **CE**

81/14/3 2014-15 Operational Resilience Funding

The Acting Director of Finance presented paper O, briefing the Committee on the arrangements for additional funding for urgent and emergency care which was due to be allocated to the CCGs on a fair share basis by NHS England. Additional funding was also being made available to support the delivery of elective care and backlog reduction. The published framework guidance was appended to the report for information (Publication Gateway Reference 01632).

Particular discussion took place regarding the RTT elements of the funding (including the level of RTT activity which was delivered elsewhere in the local health economy), UHL's allocation of winter funding and re-investment in UHL's services arising from MRET and re-admissions penalties. It was agreed that an update on these issues would be incorporated into the Month 4 financial performance report for consideration at the 27 August 2014 Finance and Performance Committee meeting. **ADF**

Resolved – that (A) the briefing on 2014-15 Operational Resilience Funding be received and noted (as paper O), and

(B) a position statement on operational resilience funding be incorporated into the Month 4 financial performance report for the 27 August 2014 Finance and Performance Committee meeting. **ADF**

81/14/4 Patient Level Information and Costing System (PLICS), Service Line Reporting (SLR) and Reference Costs

The Acting Director of Finance introduced paper P providing an update on the continued development of PLICS and SLR and detailing the 2013-14 Reference Costing Submission. A copy of the reference costing self assessment checklist was provided at appendix 2. Noting that all the appropriate guidance had been followed, the Finance and Performance Committee endorsed the reference costing return for submission by the 31 July 2014 deadline.

Resolved – that the UHL Reference Costing Return be endorsed for submission by the 31 July 2014 deadline. **ADF**

81/14/5 Financial Management of Overseas Visitors and Private Patients

The Financial Controller introduced paper Q, outlining a number of actions required to strengthen the financial management of overseas visitors and private patients. The report was taken as read and discussion took place regarding the reasons why these 2 distinctly separate sections of the Trust's business were bundled together (apart from the fact that the teams were co-located and co-managed).

Following a Listening into Action event held on 9 July 2014 a number of key themes had been identified to improve the arrangements for treatment of overseas visitors in line with changes in the national process. The Acting Director of Finance noted the additional resources required to deliver and embed new overseas visitor processes and that the proposals were expected to be self-financing through increased income recovery (Minute 81/14/6 below refers). Subject to approval of the additional resources, the new process was expected to take effect from January 2014.

Colonel (Retired) I Crowe, Non-Executive Director queried whether the target 25% collection rate for overseas visitor debts was sufficiently ambitious and commented that the Trust should not be losing any money on private patients. Members noted that private patients would be clearly defined as either medical insurance patients or self-financing patients within the Private Patient Strategy and that debt recovery for self-funding patients might be challenging for a variety of reasons (including patient mortality).

Resolved – that the update on arrangements for improving the financial management for overseas visitors and private patients be received and noted.

81/14/6 Investment in Management Resources to Support the Delivery of UHL's Key Objectives

The Acting Director of Finance introduced paper R highlighting the investment required to support delivery of UHL's key objectives, noting that the report had been supported at the previous day's Executive Performance Board meeting. In discussion on this report:-

(a) the Committee Chairman commented upon an apparent disconnect between the cost centre for hosting the additional resources and the cost centre that would benefit from the CIP savings;
(b) the Chief Executive noted the significance of the proposed investment in non-patient facing roles but added some contextual information regarding the areas where UHL was currently under-resourced. He queried whether there was any scope to develop more moderate proposals, and
(c) Colonel (Retired) I Crowe, Non-Executive Director queried whether it would be feasible to adopt an incremental approach with an initial focus on clinical coding staff and the Ernst Young contract extension.

The Committee supported the direction of travel for investing in management resources, on the basis that such resources would be part funded by some transitional support and mitigated by an element of additional winter funding. It was agreed that a further detailed update would be provided to the 27 August 2014 Finance and Performance Committee meeting for approval.

Resolved – that a further detailed update on the additional management resources required to deliver the Trust's key objectives be presented to the 27 August 2014 Finance and Performance Committee meeting. **ADF**

81/14/7 Update on Financial Forecasting and 2013-14 Lessons Learnt

Further to Minute 57/14/3 of 28 May 2014, the Acting Director of Finance introduced paper S which provided an updated action plan for improving the robustness of financial monitoring and forecasting. Members noted the significant contribution by Ms L Bentley, Head of Financial Management and Planning in helping the Trust to strengthen its understanding of the risks and opportunities underlying the forecasting process.

Members commended the work undertaken, noting the resource implications that might be involved in carrying out the proposed changes. It was agreed that a further update would be presented to the Finance and Performance Committee in 6 months' time.

Resolved – that an updated action plan for improving the robustness of financial monitoring and forecasting be presented to the Finance and Performance Committee in January 2015. **ADF**

82/14 SCRUTINY AND INFORMATION

82/14/1 Clinical Management Group (CMG) Performance Management Meetings

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

82/14/2 Executive Performance Board

Resolved – that the notes of the 24 June 2014 Executive Performance Board meeting (paper U) be received and noted.

82/14/3 Quality Assurance Committee (QAC)

Resolved – that the 25 June 2014 QAC Minutes (paper V) be received and noted.

83/14 ITEMS FOR DISCUSSION AT THE NEXT FINANCE AND PERFORMANCE COMMITTEE

Paper W provided a draft agenda for the 27 August 2014 meeting and it was agreed that the agenda would be revised and re-circulated.

Resolved – that the items for consideration at the Finance and Performance Committee meeting on 27 August 2014 be revised and re-circulated.

84/14 ANY OTHER BUSINESS

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

85/14 ITEMS TO BE HIGHLIGHTED TO THE TRUST BOARD

Resolved – that the following issues be highlighted verbally to the Trust Board meeting on 31 July 2014:-

- Minute 75/14 – recommendation re: 2014-15 Working Capital Strategy (to be appended to the Minutes for Trust Board approval);
- Discussion under confidential Minute 78/14/3
- Minute 79/14/1 – Empath vision for a Joint Pathology Service between UHL and NUH

- Minute 79/14/4 – Vascular Service OBC
- Minute 80/14/1 – Month 3 cancer performance;

86/14 DATE OF NEXT MEETING

Resolved – that the next Finance and Performance Committee be held on Wednesday 27 August 2014 from 8.30am – 11.30am in Seminar Rooms A and B in the Clinical Education Centre at Leicester General Hospital.

The meeting closed at 11:23am

Kate Rayns, Trust Administrator

Attendance Record 2014-15

Name	Possible	Actual	% attendance	Name	Possible	Actual	% attendance
R Kilner (Chair)	4	4	100%	P Hollinshead	3	3	100%
J Adler	4	4	100%	S Sheppard	1	1	100%
I Crowe	4	3	75%	G Smith *	4	4	100%
R Mitchell	4	4	100%	J Wilson	4	3	75%

* non-voting members

To:	**Finance and Performance Committee**
From:	**Simon Sheppard – Acting Director of Finance and Procurement**
Date:	**30th July 2014**
CQC regulation:	**All applicable**

Title:	**2014/15 Working Capital Strategy**

Author/Responsible Director:
Peter Hollinshead – Interim Director of Financial Strategy

Purpose of the report:
To set out the Trust's strategy for managing its working capital in a way that ensures it remains a 'going concern' and has access to sufficient cash and other liquid assets to meet its financial obligations

The report is provided to the Finance and Performance Committee for:

Decision	√	Discussion	√
Assurance	√	Endorsement	√

Summary/Key points:
This Strategy covers the following areas:

- Roles and responsibilities in relation to the Strategy, including the Trust Board, Finance and Performance Committee, Audit Committee, Financial Controller and Financial Services Team
- Background to the Trust's cash restrictions in 2013/14 and the impact of this on the BPPC and supplier payments
- Key objectives of the Strategy:
    1. To maintain the cash balance as planned during the year including drawing down temporary and permanent borrowing and managing our other working capital balances
    2. To improve the BPPC performance and achieve nationally recognised targets
    3. To achieve the statutory EFL and CRL targets
    4. To further develop monitoring and reporting processes to ensure that there are robust linkages between cash balances; revenue income and expenditure; and capital spend
- Forecasting, monitoring and reporting arrangements for cash, including the annual, monthly and weekly cash forecasting methods
- Investing surplus cash in either the GBS account or with the National Loans Fund and the likely benefit of investing

Recommendations:
That the Finance and Performance Committee recommend that the 2014/15 Working Capital Strategy be endorsed and recommended to the Trust Board for formal approval

Previously considered at another Corporate UHL Committee?
No

Board Assurance Framework: G. – To be a sustainable, high performing NHS FT	**Performance KPIs year to date:** -

Resource implications (e.g. Financial, HR): No resource implications identified
Assurance implications: None identified
Patient and Public Involvement (PPI) implications: Considered but not relevant to this paper
Stakeholder Engagement implications: Considered but not relevant to this paper
Equality impact: Considered but not relevant to this paper
Information exempt from disclosure: None
Requirement for further review? Annual review and quarterly update required

Peter Hollinshead
Interim Director of Financial Strategy

25th June 2014

University Hospitals of Leicester NHS
NHS Trust

WORKING CAPITAL STRATEGY 2014-15

1 Introduction

1.1 This document sets out the Trust's strategy for managing its working capital in a way that ensures it remains a 'going concern' and has access to sufficient cash and other liquid assets to meet its financial obligations.

2 Aims

2.1 The aims and objectives of the Working Capital Strategy ('the Strategy') are:

- To support the delivery of the Trust's objectives by ensuring short and long term liquidity.
- To ensure that working capital is effectively managed and cash is reported appropriately.

3 Scope of the Strategy

3.1 This Strategy covers the following areas:

- Roles and responsibilities in relation to the Strategy.
- Key objectives of the Strategy.
- Forecasting, monitoring and reporting arrangements for cash.
- Investing surplus cash.

3.2 The following individuals are required to support the Strategy:

a) Director of Finance and Procurement.
b) Directorate Senior Operational Management Team.
c) Financial Controller.
d) Finance staff.

3.3 The following are not within the scope of this Strategy:

- Long term investments.
- The management of patient monies.
- Petty cash procedures.
- Charitable funds banking and working capital arrangements.

3.4 The Strategy is supported by a number of detailed treasury procedures within the Treasury Management section, including:

- Cashflow procedures.
- Citibank and RBS banking procedures.
- Investing procedures.

4 Roles and Responsibilities

4.1 The following groups and individuals have responsibilities in relation to the Strategy:

Trust Board of Directors

4.2 The Trust's Board of Directors are responsible for approving external funding arrangements and the overall Strategy. The Trust Board delegates responsibility for approval of the Trust's treasury procedures, controls, and detailed policies to the audit committee,

Finance and Performance Committee

4.3 Monitor's guidance recommends the setting up of a Cash Committee to report to the Board. Given the status of the Trust and scope of its current treasury function this role is delegated to the Finance and Performance Committee.

4.4 The Finance & Performance Committee is responsible for reviewing cash management decisions and receiving reports on the cash position.

Audit Committee

4.5 The responsibilities of the Audit Committee in relation to treasury management is to monitor compliance with treasury policies and procedures.

Director of Finance and Procurement.

4.6 The Director of Finance and Procurement has the following responsibilities:

- Approving cash management systems.
- Ensuring approved bank mandates are in place for all accounts and that they are updated regularly for any changes in signatories and authority levels.
- Holding regular meetings with the Senior Finance Team and Financial Controller to discuss issues and consider any points that should be brought to the attention of the Audit Committee and Finance & Performance Committee.

Financial Controller / Financial Services Team

4.7 The Financial Controller and the Financial Services team have the following responsibilities.

- Defining the Trust's Treasury approach.
- Reporting on the Treasury activities on an accurate and timely basis.
- Managing key banking relationships.
- Managing treasury activities within agreed policies and procedures.
- Maintaining accurate and timely accounting records of treasury activities.
- Ensuring all applications for temporary and permanent financing are submitted accurately and on time and are fully supported by the required cashflow forecasting.
- Ensuring sufficient cash is available at all times to meet operational requirements.
- Producing detailed cashflow forecasts on a daily, weekly, monthly and annual basis to aid operational decision making.

4.8 The Trust's Treasury procedures will become subject to periodic review by both the internal and external auditors as part of their audit undertakings and any significant deviations from agreed policies and procedures will be reported, where appropriate, to the Audit Committee or Trust Board.

5 2014-15 Working Capital Strategy

5.1 This section sets out a series of actions aimed at improving working capital management over the forthcoming financial year.

Background

5.2 The Trust experienced significant cash restrictions in 2013-14 leading to poor performance against the Better Payment Practice Code (BPPC) and overdue payments to suppliers. The Trust considered options for applying for either temporary borrowing or longer term financing in the form of 'distress' PDC.

5.3 The Trust was not in a position to apply for longer term financing given the timescales and lack of certainty concerning its granting. Equally, temporary borrowing would have been repayable by the 31st March 2014 and this would not have solved the year end liquidity problem.

5.4 The Board approved a number of measures for the management of cash balances to the year-end, including: the limiting of payment runs; earlier in-month receipts of SLA cash; re-profiling of non-essential capital expenditure; improved accounts receivable performance; and other working capital adjustments. These measures provided sufficient flexibility to cover payments in the latter part of 2013-2014 without prejudicing the Trust's liquidity.

5.5 The measures taken to preserve the cash position had consequences for the Trust's supplier payments. The final BPPC position for 2013-14 is set out in Table 1 below and shows that the Trust failed to achieve the BPPC target of 95% of invoices paid within 30 days for NHS and Non-NHS payments.

Table 1: BPPC performance 2013-14

	NHS			Non-NHS			Total		
	Paid within 30 days	Total Paid	%	Paid within 30 days	Total Paid	%	Paid within 30 days	Total Paid	%
Value £	133,356	163,108	**81.76%**	271,621	396,204	**68.56%**	404,977	559,312	**72.41%**
Volume	2,549	4,654	**54.77%**	59,150	128,364	**46.08%**	61,699	133,018	**46.38%**

5.6 The BPPC underperformance has continued into the early part of 2014-15 due to the fact that there was a large backlog of overdue invoices carried forward over the year end. As these invoices are paid in 2014-15 they will breach the 30 day BPPC target.

5.7 The year-end balance sheet position for current assets is set out below:

Table 2: Statement of financial position as at 31/03/2014

	31 March 2014	31 March 2013	Movement
	£000s	£000s	£000s
Current assets:			
Inventories	13,937	13,064	873
Trade and other receivables	49,892	45,649	4,243
Other current assets	0	40	(40)
Cash and cash equivalents	515	19,986	(19,471)
Total current assets	**64,344**	**78,739**	**(14,395)**
Current liabilities			
Trade and other payables	(109,135)	(76,594)	(32,541)
Provisions	(1,585)	(1,906)	321
Borrowings	(6,590)	(2,727)	(3,863)
Total current liabilities	**(117,310)**	**(81,227)**	**(36,083)**
Net current liabilities	**(52,966)**	**(2,488)**	**(50,478)**

5.8 Cash decreased over the year by £19m (97%) against a backdrop of a considerable increase in expenditure

5.9 The NHS Trust Development Authority (NTDA) reset our External Financing Limit (EFL) from (£1.4m) to £20.7m. This enabled us to reduce our year-end cash balance to £0.5m and minimise the level of backlog invoices whilst still achieving the EFL, which is a mandatory target for the Trust.

5.10 There was a net rise in creditors of £32.5m during the year reflecting the cashflow restrictions and BPPC performance as well as considerable expenditure on capital at the year-end which increased capital creditors by £7.5m; and an increase in deferred income of £5.5m due to the changes to the funding of the maternity pathway.

5.11 The overall ratio of current assets to current liabilities worsened from 97% to 55% during the year. The Trust has been shadow monitoring the FT risk rating and achieved the following performance at the 2013-14 year-end:

Table 3: Shadow Monitor Risk Rating as at 31/03/2014

Financial Criteria	Metric	Rating	Score
Achievement of Plan	EBITDA Achieved (% of plan)	3.3	1
Underlying Performance	EBITDA Margin %	0.2	1
Financial Efficiency	I&E Surplus Margin	(5.1)	1
Liquidity	Liquidity Ratio (Days cover)	(31)	1
Weighted Average			**1**

5.12 The forecast position at the end of 2014-15 indicates no change to the overall risk rating

Key objectives for 2014-15

5.13 The Trust has set four clear objectives relating to cashflow for 2014-15:

1. To maintain the cash balance as planned during the year including drawing down temporary and permanent borrowing and managing our other working capital balances.
2. To improve the BPPC performance and achieve nationally recognised targets
3. To achieve the statutory EFL and CRL targets
4. To further develop monitoring and reporting processes to ensure that there are robust linkages between cash balances; revenue income and expenditure; and capital spend.

Objective 1: Cash balances and external financing

5.14 The Trust plans to slightly reduce cash to £277k at the end of 2014-15. This is line with the Department of Health expectation that we should be working to a minimum level of cash of less than £500k.

Table 6: Cash plan

Balance sheet as at 2014-15 plan	Opening Balance 01/04/14 £000s	Closing Balance 31/03/15 £000s	Movement £000s
Cash and Cash Equivalents	515	277	(237)

5.15 The Trust's cash monitoring for 2014-15 is clearly linked to the Trust's forecast I&E position and capital expenditure. The Trust submitted a two year plan to the NTDA which indicated a deficit of £40.7m for 2014-15 and planned CRL capital expenditure of £50.5m, of which £17.5m will need to be funded from external sources.

5.16 The statement of cashflows in table 7 below shows that the Trust needs to secure a total of £71m PDC financing to fund the following:

- capital programme £17.5m;
- deficit plan £40.7m; and
- brought forward unpaid creditor invoices £12.7m.

Table 7: Statement of cashflows for 2014-15 full year

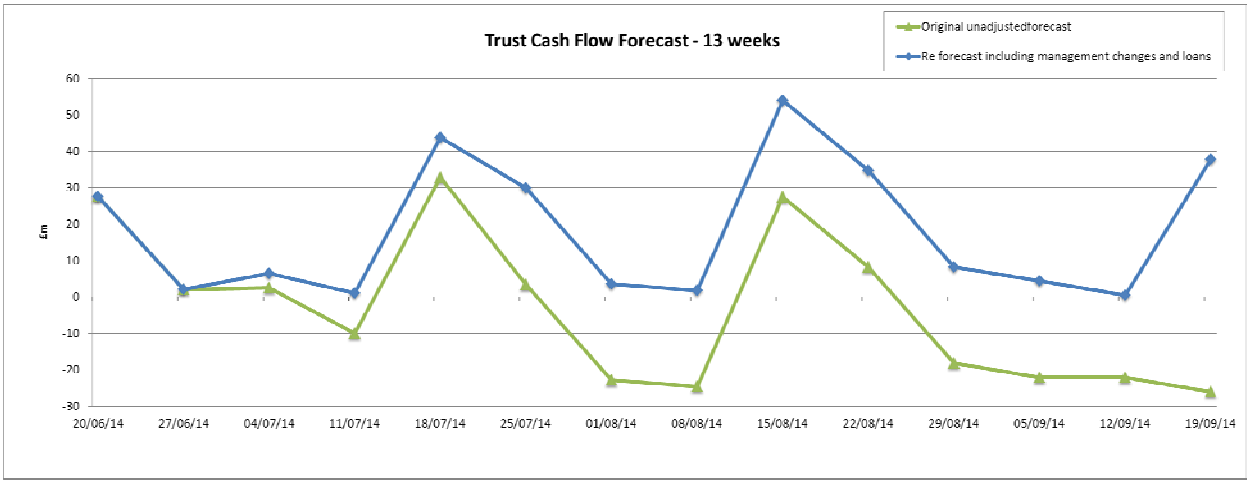
Statement of Cash Flows (CF)	2014/15 £000s
Cash flows from operating activities	
Operating Surplus/(Deficit)	(28,769)
Depreciation and Amortisation	32,996
Impairments and Reversals	(1,448)
Interest Paid	(456)
Dividend (Paid)/Refunded	(12,236)
(Increase)/Decrease in Trade and Other Receivables	(5,827)
(Increase)/Decrease in Other Current Assets	14,400
Increase/(Decrease) in Trade and Other Payables	(15,414)
Provisions Utilised	(1,267)
Increase/(Decrease) in Movement in non -cash Provisions	10,632
Net Cash Inflow/(Outflow) from Operating Activities	**(7,386)**
Cash flows from investing activities	
Interest Received	96
(Payments) for Property, Plant and Equipment	(54,790)
Net Cash Inflow/(Outflow) from Investing Activities	**(54,694)**
NET CASH INFLOW/(OUTFLOW) BEFORE FINANCING	**(62,080)**
Cash flows from financing activities	
New Public Dividend Capital received in year: PDC Capital	17,534
New Public Dividend Capital received in year: PDC Revenue	53,443
Capital element of payments relating to PFI, LIFT Schemes and finance leases	(9,132)
Net Cash Inflow/(Outflow) from Financing Activities	**61,845**
NET INCREASE/(DECREASE) IN CASH AND CASH EQUIVALENTS	**(238)**
Cash and Cash Equivalents (and Bank Overdraft) at Beginning of the Period	**515**
Cash and Cash Equivalents (and Bank Overdraft) at the end of the period	**277**

5.17 The Trust has held discussions, and is in regular contact, with the NTDA in relation to the timing and type of financial support that is required in 2014-15. Ultimately we will be applying for permanent PDC financing for the full £71m requirement later in the year following submission of our Integrated Business Plan (IBP) and Long Term Financial Model (LTFM). We are likely to be applying for PDC in two phases, the first of which would be used to fund the enabling works for the emergency floor scheme.

5.18 In the meantime the Trust will be applying for several Temporary Borrowing Loans (TBLs) in order to maintain liquidity up to the receipt of the PDC financing. The phasing of the TBL receipts has been built into our cashflow forecasting. Normally the TBLs would be repayable within three months of receipt but based on discussions with the NTDA we are not expecting that our TBLs will be repayable until we receive the PDC financing.

5.19 The chart overleaf shows the 13 week cash forecast position. The two lines on the graph represent the cash position both with and without the TBLs and clearly show that without these we would be considerably short of cash and would need to take other measures to maintain liquidity, including withholding supplier payments.

Chart 1: 13 week cashflow forecast as at 31/05/2014



5.20 This monitoring illustrates the requirement that the detailed cashflow forecasts that support each TBL application must demonstrate that we need the funding and that without it we would be overdrawn.

5.21 We will also need to manage accounts payable and receivable in order to maintain satisfactory liquidity. The following table shows the ageing of NHS and Non-NHS receivables and payables as at the end of May 2014.

Table 5: Aged payables and receivables as at 31/05/2014

Aged Receivables/Payables:	Total As at end May 2014 £000s	0-30 days		30 - 60 Days		60-90 Days		Over 90 Days	
		£000s	%	£000s	%	£000s	%	£000s	%
Receivables Non NHS	**7,219**	2,864	40%	1,195	17%	1,491	21%	1,669	23%
Receivables NHS	**16,150**	991	6%	8,744	54%	3,271	20%	3,144	19%
Payables Non NHS	**(8,958)**	(3,510)	39%	(2,963)	33%	(2,327)	26%	(158)	2%
Payables NHS	**(2,042)**	(73)	4%	(958)	47%	(15)	1%	(996)	49%

5.22 The NTDA target is for us to have less than 5% of aged payables or receivables over 90 days. Aged debtors include several legacy debts which will be paid soon. We plan to significantly reduce the profile of the aged debt and direct effort on those debts that are in the 30-60 days aged category before they become problematic.

5.23 We will establish monitoring arrangements within finance to determine the level of accruals at the month end which should have been invoiced. It is important for 2014-15 that we are invoicing as promptly as possible in order to collect the cash as soon as possible.

5.24 Aged NHS payables relate to a very low number of invoices and the over 90 days total is expected to reduce whilst effort will be directed to those invoices in the 30-60 days aged category. The Trust pays on average £7m of creditors each week. Payment runs are constructed to ensure maximum compliance with the BPPC target with priority being given to trade creditors.

5.25 The strategy for 2014-15 will ensure that onus is placed on paying all approved invoices, including significant NHS creditors such as the NHS Blood & Transplant authority, Supply Chain and NHSLA; and non-NHS creditors such as Interserve, IBM and Asteral. We continue to prioritise payments to small, local suppliers.

5.26 Sufficient external financing has been factored into the 2014-15 plan to ensure creditor payments can be maintained. Creditor payment runs will only be limited in value if there is an adverse revenue position against plan and we are not subsequently able to secure additional external financing.

Objective 2: BPPC performance

5.27 The Trust will improve its performance against the Better Payment Practice Code (BPPC) in 2014-15 as a result of the financing outlined in the previous section. The financing solutions will give us sufficient cash to ensure all invoices can be paid within the 30 day payment terms within 2014-15.

Stock

5.28 The Trust is rolling out an electronic stock system during 2014-15 with a view to improving stock control and generating both a better understanding of the I&E impact month on month and in targeting areas where overall stock levels can be improved. We will factor in any impact on cash as this becomes known.

Objective 3: EFL and CRL targets

5.29 The Trust's initial capital allocations are shown in the following table.

Table 4: Initial cash limits 2014-15

Capital Resource Limits (CRL) and External Financing Limits (EFL)	Initial Limits	
	CRL £000s	EFL £000s
Initial Capital Allocations	32,995	(8,897)

5.30 The EFL is primarily a full year limit so performance against this can fluctuate during the year. The CRL is more of a cumulative target that we can measure our trajectory against. We will monitor both limits on a regular basis and report to the Finance and Performance Committee where any potential adverse variance is identified.

Objective 4: Cash monitoring and reporting

5.31 The Trust's cashflow monitoring has been improved over the last 18 months and roles and responsibilities are currently being reviewed within financial services to allow for further improvement to the analysis, monitoring and reporting of cash throughout the year. The Financial Controller and Treasury management team will produce the following reports and forecasts throughout the year.

Annually

5.32 The following will be prepared on an annual basis

- Treasury Management Strategy.
- Annual cash plan - based on the Trust's I&E forecast and capital plan.
- Annual 12 month cashflow forecast.
- Annual Accounts including statement of cashflows.

Monthly

5.33 A monthly report will be produced for the Finance and Performance Committee to include:

- Cash balances on all accounts.
- Actual cash balances against plan for the month and a comparison with the previous month with any material variances explained.
- Interest receivable and payable.
- 13 week forecast cash position including management actions necessary to correct any adverse variance.
- Aged debtors and creditors including an analysis of accrued income and expenditure and impact on cash.
- Details of all new borrowing.
- Annual forecast cash outturn.

5.34 Monthly bank account reconciliations will also continue to be undertaken which reconcile the ledger to the cashbook and bank statements. These are subject to both internal and external audit.

Weekly

5.35 A 13 week cash forecast will be prepared on a weekly basis (reported monthly), based on detailed information from the ledger system on accounts payable and receivable. This will be used to update the daily cashflow forecast.

Daily

5.36 We will continue to produce a rolling cashflow forecast which is updated on a daily basis and projects forward 12 months. This will initially be based on the cashflow plan and will be consistent with the 13 week cashflow forecast. It will be updated for any known changes in the Trust's I&E and capital positions and any anticipated changes to the value of accounts payable and receivable.

5.37 Appropriate escalation plans are in place should any of the cash forecasting indicate problems, such as anticipated cash falling below zero at any stage in the following 12 months.

6 Investing surplus cash

6.1 It is the Trust's policy to invest surplus cash in order to gain additional interest. The Trust operates one commercial bank account with the Royal Bank of Scotland (RBS). We restrict the balance on this to £50,000 to ensure that most of the NHS Trust's cash holdings are kept within the Government sector via a Citibank account within the Government Banking Service (GBS).

6.2 The cashflow will highlight any surplus cash available for investment. As an NHS Trust we are only currently able to invest in the following secure funds:

- Government Banking Service (GBS).
- National Loans Fund – Temporary Deposit Facility (NLF).

6.6 The National Loans Fund Temporary Deposit Facility is operated by HM Treasury Exchequer Funds and Accounts (EFA) Team. The scheme allows approved depositors to deposit sums in round thousands of pounds for periods of one week to six months at current market interest rates. The minimum investment is £1 million.

6.7 Maturity dates for all investments will be set before or as close to the date when invested funds will be required and we will ensure that there is no risk to the Trust's liquidity.

6.8 The most likely period for surplus cash to be available is between the 15th of each month following receipt of the main SLA funding, and the last Thursday of each month which is the Trust's payroll date. We need to retain at least £23m between these dates to cover payments to staff.

6.9 We currently receive around £8k per month in interest from the GBS account. As at the end of May the interest rate on the GBS account was 0.25% and the Bank of England base rate was 0.5%

6.10 Using June as an example if we were to invest £23m for 10 days between the 16th and 25th June (the day before the payroll date) we could increase the monthly interest received by a further £2k. As interest rates rise and we undertake more regular investing activity this interest would increase further.

6.11 All investments will be reported to the Finance and Procurement Committee on a monthly basis.

Trust Board Paper Y

University Hospitals of Leicester NHS
NHS Trust

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST

REPORT BY TRUST BOARD COMMITTEE TO TRUST BOARD

DATE OF TRUST BOARD MEETING: 28 August 2014

COMMITTEE: Quality Assurance Committee

CHAIRMAN: Ms J Wilson, Non-Executive Director

DATE OF COMMITTEE MEETING: 30 July 2014

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

- **None.**

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

- **Fractured Neck of Femur Performance Report and Action Plan (Minute 55/14/1), and**
- **Quality and Performance Report – Proposed New Format, specifically action (iii) – Minute reference 55/14/7.**

DATE OF NEXT COMMITTEE MEETING: 27 August 2014

Dr S Dauncey, Non-Executive Director
Acting QAC Chairman for 30 July 2014 meeting
20 August 2014

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST

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

Present:
Dr S Dauncey – Non-Executive Director (Acting Chair)
Mr J Adler – Chief Executive (from Minute 54/14/2 onwards)
Mr M Caple – Patient Adviser (non-voting member)
Dr K Harris – Medical Director (from Minute 54/14 onwards)
Ms R Overfield – Chief Nurse
Mr P Panchal – Non-Executive Director

In Attendance:
Mrs G Belton – Trust Administrator
Mr A Chatten – Managing Director, NHS Horizons (for Minute 56/14/1 only)
Dr B Collett – Associate Medical Director (Clinical Effectiveness) – from Minute 54/14/1(part)
Mr I Crowe – Non-Executive Director
Miss M Durbridge – Director of Safety and Risk
Mrs S Hotson – Director of Clinical Quality
Mr B Lambden – Management Trainee
Dr N Moore – Clinical Director, RRC CMG (for Minute 54/14/1)
Mr R Power – Clinical Director, MSS CMG (for Minute 55/14/2)
Ms E Tebbutt – Performance and QA Manager, NHS Horizons (for Minute 56/14/1 only)

RESOLVED ITEMS **ACTION**

51/14 APOLOGIES

Apologies for absence were received from Ms C O'Brien, Chief Nurse and Quality Officer, East Leicestershire CCG; Mrs C Ribbins, Director of Nursing; Ms J Wilson, Chair of QAC and Non-Executive Director and Professor D Wynford-Thomas, Non-Executive Director and Dean of the University of Leicester Medical School.

52/14 MINUTES

Resolved – that the Minutes of the previous meeting held on 25 June 2014 (papers A and A1) be confirmed as a correct record.

53/14 MATTERS ARISING REPORT

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

(a) Minute 41/14 (regarding the potential implementation of deputising arrangements for Patient Advisers) – Mr Caple, Patient Adviser, agreed that this would be helpful, and undertook to discuss this proposal with the other Patient Advisers; **PA**
(b) Minute 43/14d – it was noted that the revised format Quality and Performance report was now available and had been included on the agenda as paper 'M1';
(c) Minute 43/14h (regarding submission of the completed proforma templates in respect of the quality impact assessment of CIP schemes) – the Chief Nurse noted that it would be October or November 2014 before details regarding all schemes would be available, and it was agreed to amend the timescale in relation to this item from August 2014 to October / November 2014; **CN/TA**
(d) Minute 43/14j (regarding the five KPIs to be monitored by the Health and Safety Committee) – it was noted that information in relation to monitoring against the specified KPIs would be detailed within the quarterly Health and Safety reports;

(e) Minute 44/14/1 (regarding aspects relating to audit following the SUI report into the retained vaginal swab) – it was agreed that a date required insertion into the relevant column, and this was agreed as September 2014; **TA**

(f) Minute 44/14/6a (regarding action planning arising from the Trent Neonatal Survey Report) – it was noted that this was not an action for QAC to monitor, and it was agreed that this required removal from future iterations of the Matters Arising log; **TA**

(g) Minute 44/14/7c (regarding receipt of the RCA report in respect of the SUI in ED) – the Director of Safety and Risk anticipated that this should be available for receipt at the QAC meeting in September 2014; **DSR/TA**

(h) Minute 44/14/7d (regarding reviewing the out-puts of the ED Risk Review at the Trust Board) – it was agreed that given the operational nature of this task, it was not appropriate for this work to be undertaken at Trust Board level, and that the Executive Quality Board would monitor the progression of this work; **CN**

(i) Minute 45/14/3 (regarding proposed discussion between the Chief Nurse and the Chief Operating Officer in respect of the fact that the Discharge Lounge was not under the responsibility of a Matron or Head of Nursing) – the Chief Nurse updated members of the subsequent agreement that Operations would continue to manage the Discharge lounge, but there would be reinstatement of the Head of Nursing overseeing this area;

(j) Minute 40/14/3 (regarding the Thrombosis Committee giving consideration to reporting avoidable hospital acquired VTEs as incidents) – it was noted that this was not an action for QAC to monitor, and it was agreed that this required removal from future iterations of the Matters Arising log; **TA**

(k) Minute 40/14/7 (regarding determining an appropriate Chair for the Organ and Tissue Donation Committee when Mr Panchal, Non-Executive Director and current Chair of the OTD Committee, left the Trust) – in discussion, members considered it most appropriate that a Clinical Lead was identified to chair this Committee (as per the arrangements for the other EQB Sub-Committees); **MD**

(l) Minute 40/14/9 (regarding the lack of assurance in respect of the Resuscitation Committee Annual Report) – it was noted that the Deputy Medical Director had now been appointed Chair of the Resuscitation Committee;

(m) Minute 22/14/3(c) (regarding the medical staffing review comprising part of the workforce item scheduled for discussion at a future Trust Board Development session) – it was noted that this action had now been completed, and could be RAG-rated '5' in the next iteration of the Matters Arising log. It was agreed that Dr Daucey, as Acting QAC Chair, would query the date of this Trust Board Development Session at the Trust Board meeting due to be held the following day, and **TA** **SD**

(n) Minute 13/14/3 (regarding the QAC work plan requiring updating on the basis of the outputs of the EWB work plan which was currently under revision) – the Chief Nurse highlighted the recently agreed proposed changes to the EQB in terms of its membership and meeting dates which would be applicable from September 2014 (as also detailed in paper S).

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

54/14 SAFETY

54/14/1 Report from the Clinical Director, RRC

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

54/14/2 Report from the Director of Safety and Risk

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

54/14/3 Patient Safety Report

The Director of Safety and Risk presented paper 'E', which provided the Committee with an update on a range of initiatives and measures in relation to patient safety (as outlined on the cover sheet to the report).

In respect of the information detailed under point 6 of the report, the Director of Safety and Risk noted that the next iteration of this report would include a line within the graph presented indicating the numbers of incidents. She further noted, in respect of RCA 45 day performance, that 8 cases had been closed in the last month.

Particular discussion took place regarding the following:

(i) the need for improvements in achieving the relevant deadlines (table 1 of the report refers) albeit note was made of the number of alerts having increased significantly in the last quarter which, in conjunction with the introduction of a new system, had led to the CMGs performing well in light of these extenuating circumstances;

(ii) the lack of concerns raised through the staff '3636' reporting line (this was the first month when none had been reported via this mechanism) and the potential reasons for this, noting the other mechanisms available to staff to raise and escalate issues through the normal course of their duties – it was suggested that this could be cross-checked against the results of the Staff Survey. It was also noted that a report on mechanisms by which staff could raise issues was due to be received at the EQB meeting on 6 August 2014, and

(iii) specific feedback reported to Mr Panchal, Non-Executive Director regarding the e-rostering system.

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

54/14/4 "Sign Up to Safety" Report

The Director of Safety and Risk presented paper 'F', which provided an overview of the national 'Sign Up to Safety' campaign and also detailed organisational improvements / recommendations for inclusion in the Sign Up to Safety campaign.

Particular discussion took place regarding the need for this to connect to the Urgent Care work, and the links to the Learning Lessons to Improve Care work streams. Note was made of the need for this work to link into on-going work rather than form a separate work stream and action plan, and it was therefore agreed that this report would be discussed first at the EQB meeting due to be held on 6 August 2014, after which an update would be provided to QAC in three month's time (i.e. November 2014). **DSR/TA**

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

(B) this report be submitted to the EQB meeting due to be held on 6 August 2014, and thereafter an update report be provided to QAC in three month's time (November 2014). **DSR/TA**

54/14/5 Report from the Director of Nursing

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

54/14/6 Report from the Medical Director

Resolved – that this Minute be classed as confidential and reported in private

accordingly.

55/14 QUALITY

55/14/1 Fractured Neck of Femur Performance Report and Action Plan

Mr R Power, Clinical Director, MSS attended to present paper 'H', which detailed performance for April and May 2014 in respect of fractured neck of femur indicators. He noted verbally that he was now in receipt of the unvalidated data for June 2014, which was showing significant improvement and he noted that the main issues related to (a) getting patients to theatre on time and (b) orthogeriatric input. In respect of the latter issue, an additional session had been arranged for Orthogeriatrician input.

Particular discussion took place regarding the following points:

(i) the means by which the action plan was addressing the non-clinical reasons for delays in getting patients to theatre – there was now a new Head of Service for Trauma who was providing significant input in this respect. The service were also moving towards the establishment of a new post of Chief Resident for Trauma;
(ii) the issues arising from split-site working for trauma, in terms of both the positive and negative effects of this;
(iii) the shorter term solutions being implemented (actions to ensure the system was working properly) and on-going work and developments which would benefit spinal surgery;
(iv) in response to a query raised, confirmation was provided that the dedicated wards and dedicated bay within another ward implemented to increase capacity continued to work well, and
(v) it was agreed that Dr Dauncey (as Acting QAC Chair) would provide a verbal update on this matter at the Trust Board meeting due to be held the following day. **SD**

In conclusion, the Committee thanked Mr Power for attending the meeting and requested that he return to the QAC meeting in October 2014 to provide an update on progress. **CD,MSS**

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

(B) Dr Dauncey (as Acting QAC Chair) be requested to provide a verbal update on this matter at the Trust Board meeting due to be held the following day, and **SD**

(C) Mr Power, Clinical Director MSS, be requested to attend the QAC meeting in October 2014 to provide an update on progress. **CD,MSS**

55/14/2 Learning Lessons to Improve Care

The Medical Director presented paper 'I', which provided a summary of the actions being undertaken by the Trust in response to the themes identified by the LLR Quality Review, noting that this item was scheduled for discussion at the public Trust Board meeting due to be held the following day.

Specific discussion took place regarding the following points:

(i) the letters sent to the families of deceased patients whose medical notes had been included within the audit, and of the Call Centre established to respond to any queries arising from these;
(ii) the methodology utilised for the review and the reasons for this;
(iii) the view taken that over-treatment could be as inappropriate as under-treatment;

(iv) the similar findings arising from a national review undertaken by Sir Liam Donaldson and Mr A Darzi;

(v) the fact that the outcome of this review offered lessons to be learnt across the whole health community (this review was not specific to one organisation) as a result of which there was a health community-wide action plan in addition to an action plan specific to each organisation involved in the review, and

(vi) note was made of the need for clarity as to the structural mechanism to progress the health community-wide action plan, and the Chief Executive undertook to seek clarification in this respect. **CEO**

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

(B) the Chief Executive be requested to ascertain the structural mechanism for taking forward the health community-wide action plan. **CEO**

55/14/3 CQC Intelligent Monitoring Report

The Director of Clinical Quality presented paper 'J', which informed the Committee of the findings from the latest CQC Intelligent Monitoring Report (IMR) published in the week commencing 28th July 2014. Appendix 1 to the report detailed the Trust response.

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

55/14/4 CQC Action Plan

The Director of Clinical Quality presented paper 'K', which provided an update on progress against compliance actions detailed in the CQC action plan, noting that progress was closely monitored by the Executive Quality Board. She also noted that this report, and a further report regarding the 'should do' actions arising from the CQC review were scheduled on the agenda for the EQB meeting being held on 6 August 2014.

Particular discussion took place regarding specific actions which were being progressed by the Resuscitation Committee (a sub-committee of the EQB) which was now under the leadership of Dr Rabey, Deputy Medical Director.

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

55/14/5 Keogh, Berwick and Francis – Integrated Action Plan Update

The Director of Clinical Quality presented paper 'L', which detailed the final report on the integrated action plan for themes from the Keogh, Berwick, Francis Reports and the Government's final response to the Francis Report – Hard Truths, and she noted in particular that the report presented did not comprise the full action plan, but an update on those actions RAG-rated 'amber' when the report was last submitted to the Committee.

In discussion, the Committee noted that the majority of actions had now all been completed and agreed that any work which remained in progress was for inclusion within existing practice (and not for monitoring as a separate work stream). Consequently, it was agreed that this specific work would be closed down as completed, with no further reports submitted to QAC.

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

(B) it be agreed that this work stream be closed down as completed, with any work remaining in progress included within existing practice.

55/14/6 Quality and Performance Update – Month 3

Members received and noted the contents of paper 'M', which detailed the Month 3 (June 2014) update on quality and performance. The Chief Nurse noted that this was the last time this report would be submitted to the Committee in this particular format (Minute 55/14/7 below also refers).

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

55/14/7 Quality and Performance Report – Proposed New Format

The Chief Nurse presented paper 'M1' which detailed a proposed new format for future iterations of the Quality and Performance report which was produced on a monthly basis and highlighted the references made within the covering report as to what was currently included / excluded in the revised format, in respect of which views were requested from QAC.

The following points were raised in the discussion on this item:

(i) members made the following comments in terms of what they considered should be included / excluded from the report:
   (a) the WHO Safety Checklist required incorporation into the report, in the dashboard section;
   (b) the need for tracking of progress against the Critical Safety Actions was noted with one RAG rating given to each individual action (it was noted that this was addressed through the Quality Commitment, but was referenced with a different title);
   (c) it was not considered that the 'block' graphics at the front of the report added any additional value;
   (d) the need to focus on 'exception' reporting where applicable was highlighted;
   (e) it was considered that Whistleblowing could be removed from the Q & P report as it was covered in the Intelligence Monitoring Report and elsewhere, as could C Section Rates and also information relating to the Nursing Workforce, as this was received in a separate report by QAC (which it was also requested include ward performance reviews). Also agreed for removing from the report was the IM&T Service information as this was monitored through the Joint Governance Board, and also the removal of the 10 times medication errors and incidents relating to staffing levels on pages 5 and 6 of the report;
   (f) QAC members were requested to highlight any further items for addition or removing to the Chief Nurse outwith the meeting (if any); **CN**

(ii) the Chief Nurse was requested to discuss, with the Director of Human Resources, the need for any quality and safety issues arising from the Executive Work Board's review of the clinical workforce to be submitted to QAC, as and when required, and **CN**

(iii) the Chief Nurse and Medical Director, in conjunction with relevant others, were requested to consider scheduling the Q & P report as the focus of a future Trust Board Development session (particularly in light of the fact that a number of new Non-Executive Directors would shortly be joining the Trust). **CN/MD**

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

(B) the Chief Nurse be requested to amend the suggested format for future iterations of the Q & P report as per the suggestions of QAC members (point (i) above), **CN**

(C) the Chief Nurse be requested to undertake the action outlined under point (ii) above, and **CN**

(D) the Chief Nurse and Medical Director be requested to give consideration to the suggestion outlined in point (iii) above. **CN/MD**

55/14/8 RTT Update (including safety implications and clinical quality risk assessments)

In the absence of the Medical Director, who had been called out of the meeting on urgent business, it was agreed to defer this item until the next QAC meeting to be held on 26 August 2014. **MD/TA**

Resolved – that this item be deferred until the QAC meeting in August 2014.

55/14/9 Current Position of Electronic Prescribing and the ePMA-ICE TTO Interface

In the absence of the Medical Director, the Chief Nurse presented paper 'N', which provided an update on the current position of electronic prescribing and the ePMA-ICE TTO interface.

The Chief Nurse noted that this work was being progressed through the emergency care work and noted that the ePMA-ICE interface was the most significant issue currently as this was not working as well as had been anticipated. She noted that this did not represent a risk issue, but a quality issue. Note was made that the relevant system was due to be running in time for the Junior Doctor Changeover at the start of August 2014, and the Committee requested that Dr Bourne / Dr Jackson / Mr Mistry were invited to attend the next QAC meeting in August 2014 to provide a further update on progress.

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

(B) Dr Bourne / Dr Jackson / Mr Mistry be invited to attend the next QAC meeting in August 2014 to provide a further update on progress. **TA**

55/14/10 Infection Prevention Annual Report

The Director of Nursing presented paper 'O', which detailed the Infection Prevention Annual Report for 2013/14 and highlighted key points (as per section 2 of the report).

Particular discussion took place regarding the following points:

(i) the current outbreak of ebola in Africa and the implications of this for the Trust if patients travelled from Africa to the UK – note was made of the very effective communication from Public Health should a case be identified in the UK, and of the standard questions asked of patients seen in the Trust as to whether they had recently travelled abroad;

(ii) congratulations were expressed to the Infection Prevention Team in respect of their work over the past year as detailed within the report – it was agreed that the Acting Chair would write to the team congratulating them on their report, and would also request at this time that future reports were accompanied by a front sheet highlighting key points to assist Committee members. Note was made that the content of the front sheet to be completed was currently under review following recommendations made by PwC, and a communication regarding this matter would be sent to EQB Sub-Committees accordingly in due course, and **Acting QAC Chair/ DCQ**

(iii) the resourcing of the IP Team, noting that they had taken on the responsibility for the Alliance (and its respective buildings).

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

(B) the Acting QAC Chair be requested to undertake the action identified under point (ii) above. **Acting QAC Chair**

55/14/11 Quarterly Claims and Inquests Report

Members received and noted the contents of paper 'P', which detailed the second in a series of quarterly reports to the EQB / QAC at the request of the Chief Nurse regarding Claims and Inquests.

In discussion, members noted the need to ensure issues relating to Regulation 28 letters were recorded when completed, with EQB monitoring and formally signing off action plans accordingly. It was agreed helpful for such reports to be submitted on a quarterly basis to QAC. **DSR**

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

(B) that reports regarding Regulation 28 issues be submitted to QAC on a quarterly basis, as appropriate. **DSR/TA**

56/14 PATIENT EXPERIENCE

56/14/1 Results of PLACE Audits

Mr A Chatten, Managing Director NHS Horizons and Ms E Tebbutt, Performance and QA Manager, attended to present paper 'Q', which detailed the informal results of the 2014 Patient Led Assessment of the Care Environment carried out across a sample of wards and outpatient departments across all three sites. Mr Chatten made particular reference to the excellent work which Ms Tebbutt had undertaken with the Assessors this year, and noted that provision had been made within the backlog capital to make the changes required as a result of the assessments. Ms Tebbutt further noted the significant commitment invested in the process by the 19 assessors who had contributed and of the proposal to develop an over-arching trust action plan which highlighted the relevant priorities.

In discussion on this item, members:

(i) congratulated Ms Tebbutt on the results of the work undertaken;
(ii) noted specific findings of the audit as highlighted by Ms Tebbutt during her presentation of the report;
(iii) queried the process in terms of nominations from Healthwatch – it was noted that some of the Assessors had been members of Healthwatch, but had been involved in the process as individuals, rather than as nominated representatives of Healthwatch;
(iv) queried any inputs into the process from an external perspective – it was noted that an external validator had been involved, and would continue to be involved in future audits;
(v) noted the potential benefits by being able to benchmark UHL against other comparable Trusts nationally;
(vi) noted the comments of the Director of Safety and Risk in terms of actions being undertaken to address specific points arising from the review (regarding information governance, waste segregation and cleanliness), and
(vii) agreed that the action plans arising from this audit should be submitted to the EQB, and that this item should constitute an item on the QAC agenda on a quarterly basis. **PQAM/TA**

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

(B) actions plans arising from this audit be submitted to the EQB, and this item constitute an item on the QAC agenda on a quarterly basis. **PQAM/TA**

56/14/2 Length and Content of the Paper Inpatient Experience Survey

Members received and noted the contents of paper 'R', and supported that no changes were made to the Patient Survey at the current time in line with the outcome of the survey undertaken with patients with specific regard to the content of the current Patient Survey.

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

(B) the proposal that no change was made to the current Patient Survey be supported.

57/14 ITEMS FOR THE ATTENTION OF QAC

57/14/1 EQB Meeting of 2 July 2014 – Items for the attention of QAC

Members received and noted the contents of paper 'S', which detailed the notes of the EQB meeting held on 2 July 2014. It was noted that all of the items specifically recommended for the attention of QAC by the EQB had been covered during the course of the meeting, with the exception of the ED Risk Review, in respect of which the Chief Nurse briefed members (action note 5.2 of paper S specifically refers). It was agreed that QAC would be notified (via EQB) of any relevant issues relating to this work, as required. **CN/TA**

Resolved – that (A) the contents of the EQB action notes arising from the meeting held on 2 July 2014 (paper S) be received and noted, and

(B) QAC be notified (via EQB) of any relevant issues in relation to the ED Risk Review as required. **CN/TA**

58/14 MINUTES FOR INFORMATION

58/14/1 Finance and Performance Committee

Resolved – that the public Minutes of meeting of the Finance and Performance Committee held on 25 June 2014 (paper T) be received and noted.

58/14/2 Executive Performance Board

Resolved – that the Minutes of the Executive Performance Board meeting held on 24 June 2014 (paper U refers) be received and noted.

59/14 ANY OTHER BUSINESS

59/14/1 Report from the Consultant Cytopathologist (QAC Meeting 25 June 2014 – Paper D refers)

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

60/14 IDENTIFICATION OF ANY KEY ISSUES FOR THE ATTENTION OF THE TRUST BOARD

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

- **Report from the Clinical Director, RRC (Minute reference 54/14/1);**
- **Fractured Neck of Femur Performance Report and Action Plan (Minute reference 55/14/1), and**
- **Quality and Performance Report – Proposed New Format, specifically action (iii) – Minute reference 55/14/7).**

61/14 DATE OF NEXT MEETING

Resolved – that the next meeting of the Quality Assurance Committee be held on Wednesday 27 August 2014 from 12.30pm until 3.30pm in Seminar Rooms 1A and 1B, Clinical Education Centre, Leicester General Hospital.

The meeting closed at 3.36pm.

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

Name	*Possible*	*Actual*	*% attendance*	*Name*	*Possible*	*Actual*	*% attendance*
J Adler	4	3	75	*R Overfield*	4	3	75
*M Caple**	4	2	50	*P Panchal*	4	3	75
S Dauncey	4	3	75	*J Wilson (Chair)*	4	3	75
K Harris	4	3	75	*D Wynford-Thomas*	4	1	25
K Jenkins	1	0	0				
*C O'Brien – East Leicestershire/Rutland CCG**	4	2	50				

- ** non-voting members*

Gill Belton
Trust Administrator

Trust Board Paper Z

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST

Trust Board Bulletin – 28 August 2014

The following reports are attached to this Bulletin as items for noting, and are circulated to UHL Trust Board members and recipients of public Trust Board papers accordingly:-

- **Revised Trust Board meeting January 2015 to March 2016** – Lead contact point Mr S Ward, Director of Corporate and Legal Affairs (0116 258 8615) – **paper 1**;
- **Members' Engagement Forum Minutes** – Lead contact point Mr M Wightman Director of Marketing and Communications (0116 258 8615) – **paper 2**;
- **UHL Patient Advisers' Meeting Minutes** – Lead contact point Mr M Wightman Director of Marketing and Communications (0116 258 8615) – **paper 3**, and
- **Board Effectiveness Action Plan** – Lead contact point Mr S Ward, Director of Corporate and Legal Affairs (0116 258 8615) – **paper 4**.

It is intended that these papers will not be discussed at the formal Trust Board meeting on 28 August 2014, unless members wish to raise specific points on the reports.

This approach was agreed by the Trust Board on 10 June 2004 (point 7 of paper Q). Any queries should be directed to the specified lead contact point in the first instance. In the event of any further outstanding issues, these may be raised at the Trust Board meeting with the prior agreement of the Chairman.

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST

TRUST BOARD MEETING DATES JANUARY 2015 – MARCH 2016

Starting in January 2015, the formal Trust Board meeting will move to the FIRST Thursday of every month.

Revised dates – venues to be confirmed

THURSDAY 8 JANUARY 2015

THURSDAY 5 FEBRUARY 2015

THURSDAY 5 MARCH 2015

THURSDAY 2 APRIL 2015

THURSDAY 7 MAY 2015

THURSDAY 4 JUNE 2015

THURSDAY 2 JULY 2015

THURSDAY 6 AUGUST 2015

THURSDAY 3 SEPTEMBER 2015

THURSDAY 1 OCTOBER 2015

THURSDAY 5 NOVEMBER 2015

THURSDAY 3 DECEMBER 2015

THURSDAY 7 JANUARY 2016

THURSDAY 4 FEBRUARY 2016

THURSDAY 3 MARCH 2016

University Hospitals of Leicester NHS Trust

Members' Engagement Forum Meeting 16/06/2014

Minutes

In attendance
Richard Kilner, Acting Chairman, UHL
Jane Wilson, Non Executive Director
Kevin Harris, Medical Director
Mark Wightman, Director of Communications and Marketing
Karl Mayes, Patient and Public Involvement / Membership Manager

Apologies
Stephen Ward, Director of Corporate and Legal Affairs

1. Welcome and Introductions

1.1 Participants were welcomed to the meeting by Mr Richard Kilner, Acting Chair of the Trust who started the meeting with an update on Trust business. He noted that for both last year and this year the Trust had a forecast deficit of just under £40 million. As of month one and two, finances this year were in line with the Trust's plan, which is an achievement in itself. Richard acknowledged that there is still much to do but said that the Trust was on plan.

1.2 Emergency Care performance remains a huge challenge for the organisation. In particular Richard noted the four hour waiting targets but added that this was just one part of the overall challenge. He said that the Trust is seeing a significant increase in the number of admissions with admissions approximately 12% higher than the year before. He also noted the trend for seeing patients that were more unwell and needing admission.

1.3 Richard said that in conjunction with the CCGs the Trust had recently employed Dr Ian Sturgess, an expert in Emergency Care, to explore how we may improve the Emergency Care pathway. Dr Sturgess would be with the Trust for six months. His early assessment is that while we are doing a lot right, there is clearly room for improvement, particularly around clinical leadership.

1.4 Work has now started on a series of enabling schemes which will pave the way for the construction of the Trust's new Emergency Floor development. Modular wards are well underway opposite the Windsor building which will allow us to move patients in to these areas and help uys cope with Winter 14/15 pressures.

1.5 Richard said that it was essential that the Trust get smarter in how it works. An example of this is the journey to electronic patient records. The Trust has now rolled out two pilot schemes in MSK and Clinical Genetics which have seen 18,000 patient files digitized. In these areas clinics are now run completely paperless which makes us more productive and effective as an organisation. The Trust intends to run a vendor selection process and roll out electronic patient records in the new ED floor when it opens.

1.6 Richard then spoke about the selection process for the position of Trust Chair person. He said that the National Trust Development Authority (NTDA) is responsible for recruiting the Chair. They hafve been working with a recruitment consultancy and

have seen a broad range of candidates applying for the position. The closing date is on June 27th, with interviews on 21st July. An appointment is expected in early September. Richard reminded the group that an open session is planned for 19th June in which interested candidates could meet Board members.

1.7 Following input from the group at previous meetings, Richard provided an update on the Trust's approach to complaints. He noted that in the private part of the Board the Board have been reviewing complaints. He said that it is important that the Board understand the frustration patients and families have felt. He added that much of the content of complaints relate to areas that can be fixed. Richard said that the Trust's complaints team, in conjunction with Healthwatch had recently held a user experience event to explore how we could improve complaints and also to make suggestions about external scrutiny of the complaints process.

1.8 The group had also raised issues around car parking at UHL, in particular the LRI site. Richard said that the Trust had made a firm commitment to building a multi storey car park at the site and foresaw this being completed within 24 months.

2.0 The floor was opened for questions from the group at this point.

2.1 How much is it costing to hire an external consultant to assist with the Chair recruitment?

Richard Kilner said that he is not privy to that information as it is the NTDA that are working with the recruitment consultants. He did stress how important it is to get the right expertise in to the Trust and therefore to find the right candidate for the job. Richard noted the high attrition rate for Trust Chairs at the moment which he said was around 20%. It is vital that we get the right candidate for the job. The Chair has a very important leadership role in a challenging environment for the NHS.

2.2 Wouldn't it be advisable to set up a pay on exit system at the LGH car park? Patients are already anxious when they come for appointments, if their clinic runs late, worrying about car parking only adds to this anxiety.

Richard Kilner acknowledged that he had heard the same thing from executive walkabouts. Mark Wightman said that the Trust has asked our facilities provider Interserve for costs for installing and managing a pay on exit system at both the LGH and GH. Once these costs are in we will review the matter.

2.3 Members are worried about the Chapel at the LRI being demolished. Can you assure us that an alternative will be provided and that this project will not be shelved?

Richard Kilner said that the Trust has been working with architects to explore alternatives to demolition and to preserve the chapel. Sadly this has not proved feasible. There is an acknowledgment by the Board that it is an incredible space and there are a number of artefacts within it that we want to preserve and incorporate in to any new space. We have also begun talking about a new Welcome Centre which may also provide opportunities to display some artefacts from the chapel. Mark Wightman thanked the Nurses' League for their engagement on this issue. He acknowledged that it is a difficult subject and the decision to build in this area was not taken lightly. Unfortunately the chapel stands in the space on which the new children's Emergency Department will go. Our Head of Chaplaincy, Mark Burleigh has ensured that before going ahead an alternative space will be provided and this will happen.

2.4 Will the Trust make sure that it consults with conservation experts to correctly store the artefacts from the chapel?

Mark Wightman said that the windows int eh Chapel were designed by Mark Kemp, a prominent artist in the Arts and Crafts movement. Preserving them is a high priority for the Trust and we will indeed be seeking expert opinion on the best mode of storage.

2.5 There are concerns about protecting privacy with the introduction of electronic patient records. It would be interesting to have a presentation on this to assure us that adequate measures are being put in to place to protect privacy.

Richard Kilner said that he was happy for this to be brought back to the group. He added that there will also be engagement form clinicians and patients as we develop the situation. There are a number of examples where the system is working well.

2.6 I have heard that car parking prices will not rise this year. Is this correct?

Richard Kilner confirmed that this was correct.

2.7 With the recruitment of the Chair it is important that the Trust does not lose the opportunity to appoint someone with strong local connections. We should look to have a patient representative on the selection and interview panels.

Mark Wightman reminded the group that the Chair recruitment is run at arms length by the NTDA. For the previous recruitment process the Trust set up a stakeholder panel who met candidates and fed in to the recruitment process. The Trust is keen to do this again for the current process.

2.8 Has the Trust received approval for the funds to build the ED floor?

Richard Kilner said that we have received approval for the enabling works. He added that the Trust's five year plan is nearing completion and a key input of this is the development of the ED floor.

2.9 Will any excess be picked up? It is common for developments ot finish above the initial projected cost.

Richard Kilner said that the Trust allows for contingency in any business plan. UHL has a good track record of delivering projects within budget.

2.10 Will the introduction of electronic patient records improve patient letters for outpatients?

Richard Kilner said that the process would indeed significantly improve the efficiency of outpatient letters.

2.11 The Trust was right to run a stakeholder meeting about the complaints process. It is important that we get this right. People still struggle however to know who to complain to and would benefit from a single point of access.

Richard Kilner noted the considerable time and resource put in to responding to complaints. He said that a more virtuous approach would be to stop them happening in the first place.

3.0 The group were shown a video produced by the Kings Fund which explored the experience of older, frail patients and their journey in to hospital. The video highlighted the ways in which patients can sometimes become "lost" in the system and end up with inappropriate referrals and where treatment could be more effective.

3.1 Medical Director Kevin Harris reflected on the issues raised by the video noting that acute hospitals were seeing increasing numbers of frail older people. If we get their care wrong we end up making people worse rather than better. While it is a generalisation, if people spend more than five days in hospital they risk deteriorating. Referring to the pathway illustrated by the video Kevin noted that there was a lack of clarity in what the benefits of referrals would be. The patient in the video had fallen. She was on a number of medications which may have contributed to her fall and there was no clear plan of what to do once she was admitted. At no time did anyone ask "why is she here and what are we going to do"? Overall the patient was debilitated by a lengthy stay in hospital.

3.2 Kevin said that it was important to have a clear holistic view of the patient and to ask whether they might be better treated at home. Hospital treatment has been the way in which we historically behave. Our mind set needs to change and we need to ensure that we have the facilities in place to enable this.

3.3 In terms of the Better Care Together programme who is taking control? We have £400 million to save over 5 years. Who is driving this agenda?

Kevin Harris said this question is best split in to two; who takes control of the system and who takes control of the patient. For the latter the central point is the General Practitioner. Kevin acknowledged the challenge in Primary Care around resources. However Primary Care has a key role. In reference to the video he said that the patient's experience was probably predictable once she was admitted to an acute hospital. Primary Care should have identified her needs and a plan and resources put in place to meet them.

3.4 There seems to be a culture among GPs that they are too ready to advise patients to call an ambulance. This should be addressed to ensure GPs are taking more responsibility for their patients. What communication does the Trust have with GPs when patients are admitted?

Kevin Harris said that GPs are informed within 24 hours of a patient being admitted.

3.5 Why aren't GPs then involved shortly after this to ensure they are appropriately discharged in to their care?

Richard Kilner said that this was exactly what needed to be addressed, for example, through the Better Care Together initiative. However, Primary Care is also very challenged. The key is to work harder on prevention and dealing with issues earlier on. He added that there were also complications with the interface between health and social care. We work with a complex structure that is not always joined up at either a local or national level. Locally we have UHL, LPT, the CCGs, in short, many silos which all add complexity and the potential for failure. We still have a lot to do to improve how healthcare is delivered.

3.6 Mark Wightman suggested that the next time the group meet we should focus on the Trust's Older People's Strategy.

4.0 Mark Wightman then provided an overview of the Trust's Five Year Plan. He said that the Trust recognised that it will be running at a deficit for the next five years. Despite projected savings of £45 million per year we will still not break even.

4.1 One of the key shifts in how we work responds to the recent Keough and Francis reports which advocate a move to 7 day a week 24 hour services.

4.2 The LLR forecast demonstrates the size of the challenge, suggesting that if nothing changes, by 2018/19 we are looking at a £395 million gap. This does not include Social Care.

4.3 Mark said that at the same time as UHL developing their five year plan the whole health economy was also drawing up a five year plan under the banner of Better Care Together. What we do clearly needs to be grounded in the whole helath economy's direction of travel.

4.4 In terms of service challenge we currently have a "hot" emergency system. We are seeing increasing numbers of people coming to UHL in crisis. This is compouinded by delayed transfers of care in which patients are ready to leave the acute site but have nowhere to go on to. This affects our referral to treatment (RTT) times because with pressures on the emergency flow we are obliged to cancel some elective procedures.

4.5 The five year plan has two chief components. The first will ensure that we do things better in hospitals. As such we will increase the number of day cases and reduce length of stay. To achieve this we need to work with colleagues in other parts of the health community to build up capacity to take people out of hospitals when the acute phase of their care is finished. We will also be creating a stand alone facility for electives so they aren't affected by fluctuations in the emergency pathway.

4.6 Phase two relates to reconfiguration. If we are on plan we will need fewer beds. As such, the LRI and GHG will become our acute centres of excellence. The LGH will concentrate on sub acute care, but will retain centres of excellence such as our Diabetes unit. For example, our Renal department will move to the GH where it will sit alongside Cardiovascular and Vascular services providing an optimal clinical configuration.

4.7 Mark noted that there was much to do and that the plan was, at this stage, still a work in progress. He invited questions from the floor.

4.8 With more people treated in the community and smaller hospitals there is a projected saving of £300 million. When does this start to happen?

Mark Wightman said that this was already beginning but noted the importance of building up an appropriate infrastructure in Primary Care to accommodate the shift. The Department of Health has top sliced £2.6 billion to support this shift nationally under the Better Care Fund. If this money isn't spent on measures to reduce hospital care there are penalties.

4.9 What is happening to Social Care with local authority cut backs? The voluntary sector play an important role in preventing people coming in to

hospital, for example supporting people with dementia. What will the effects of these cuts be on the five year plan for the health economy?

Mark Wightman said that the Better Care Together programme has brought together all of the key stakeholders in the health economy, including Social Services. As such they are all involved in discussions to ensure the system is joined up.

4.10 Can't the Trust open up the Brandon Unit [LGH Site] as a discharge unit, freeing up beds?

Mark Wightman said that the utilisation of the Brandon Unit has been looked at but the costs to upgrade the building were prohibitive. It could certainly be argued that the city lacks a community hospital. LPT are responsible for commissioning intermediate care and this issue will rest with them. The point is that many patients shouldn't be in hospital in the first place. The answer isn't to build larger hospitals but to address what is not working elsewhere.

4.11 The Trust has taken a lot of stick for the time it takes patients to get through the emergency system. In the last fortnight we have been told of two community hospitals closing and we know that care homes are also shutting down. GPs are not working 7 days a week. What pressure can UHL bring to ensure there are adequate plans to create capacity in Primary Care?

Mark Wightman said that UHL certainly needs to maintain some system leadership. He also urged the Patient Voice to hold us to account through this and other forums.

4.12 At a recent conference 2017 was spoken about as the tipping point for Dementia in the UK. If we push people out to the community what happens if there simply aren't enough carers to look after them?

Mark Wightman said that if we take beds out of acute care we need to make sure they are replaced in the community. Nationally, alternative solutions are being explored in terms of how we meet the growing demand for health and social care. For example, should we all pay more tax to support care needs? Richard Kilner noted that the percentage of GDP spent on helath and social care had fallen in recent years. While we all recognise the growing problem, with a growing economy should spending on the NHS decline as a percentage of overall GDP? With the challenges of an ageing population this is counter intuitive.

5.0 Richard Kilner drew the meeting to a close, thanking both speakers and participants for their time and contribution to the meeting.

Meeting of the Patient Advisors Support Group
17th July 2014
Meeting held in the Large Committee Room, Leicester General Hospital

Attendees:	**Apologies**
Martin Caple	Khudeja Amer Sharif
Mary Gordon	Pratiba Mkadmi
Anthony Locke	
Jenny Wells	
Paul Burlingham	
David Gorrod	
Geoff Smith	
Rosemary Stokes	
David Allen	
Tony Patel	
Nadine Wood	
Mark Wightman	
Karl Mayes	

Guest: Richard Kilner, Acting Chair of UHL

1. UHL Values – Mark Wightman

1.1 Mark noted several discussions he and others had had over recent months which indicated that there was a degree of discontent within the Patient Advisor group. One of the key issues seems to relate to the different perceptions held of the PA role among the group. As such, the group arguably lacks a clear shared common purpose. Mark noted the importance of Patient Advisors to the Trust and said that it was desirable to invest some time and resource in to the group.

1.2 In dialogue with other UHL colleagues, Mark suggested a time out day for the group which would be led by the Trust's Organisational Development (OD) team. The OD team generally work with clinical teams to develop a sense of common purpose and to look at how the team can work most effectively together to meet its common aims. The session would be led by Bina Kotecha and Helen Mancini.

1.3 The aim of the session would be a clearer focus on how the team operates. Mark shared an early suggestion for the agenda;

- What are the expectations of Pas?
- What are the benefits of the PA role for the Trust and patients?
- Where can we add most value?
- What are the barriers?

The group were asked for their reflections on the time out day.

1.4 Paul Burlingham supported the idea, saying that it would bring focus to the group and look at how it may be supported to achieve its aims.

1.5 Geoff Smith noted that if the Trust were recruiting new Patient Advisors it may wish to postpone such a session until new recruits were in place. Mark Wightman said that his preference was for the session to go ahead, not least to ensure that any new Pas come in to a group with a clear sense of direction.

1.6 Rosemary Stokes said that this may be a good time to review the core purpose of the role by asking the question “why does the Board want Patient Advisors”?

1.7 Martin Caple noted that when the Patient Advisor role was created it fulfilled a need to engage with members of the public. However, since then there are a number of other patient / public groups with whom the Trust has a relationship. Martin cited the examples of Healthwatch, the Mercury Patients’ Panel and the Members’ Engagement Forum. Martin agreed with Rosemary that this was something for the Board to reflect on.

1.8 David Allen wondered whether a change of name from Patient Advisor might now be necessary; a point Richard Klner thought was a good idea.

1.9 Paul Burlingham asked for two or three dates to be mooted to ensure we get the best attendance at the session. He also said that he hoped the time out session would allow the group to craft a 12 – 18 month plan.

1.10 Mark Wightman noted that he would like the session “co-created” with Martin Caple’s input. Martin Caple agreed and asked the group to submit any thoughts they had for the structure and content of the session to be submitted to him.

Action – Patient Advisors to submit thoughts on the time out day to Martin Caple please.

1.11 Tony Patel said that he felt the group lacked transparency and accountability. He also said that there was too little focus on outcomes and whether Patient Advisors made a difference.

1.12 Mary Gordon said that her experience of being a Patient Advisor has been very positive and she knows that she is making a difference and can see evidence of that in the CMG she is attached to.

1.13 Richard Kilner said that he has taken on board the need to do something to clarify both the role of Pas and the understanding that the Board has of the role. He said that the Board will be discussing engagement in the near future and this would form part of that discussion.

1.14 Martin Caple noted that the real work of Pas should take place in the CMGs, coordinated by the CMG leads. There was some disparity noted by the group in relation to how proactive these leads are.

1.15 Paul Burlingham asked if a representative from the Trust Board could be invited back to give the group some feedback on actions the Trust has taken since the publication of the Francis report. This would follow up the Patient Advisors engagement with John Adler on the topic some months ago.

Action – Karl Mayes to offer an invitation to the Trust Board to provide this update to the group.

2. Minutes of the last meeting and matters arising.

2.1 The minutes of the last meeting were agreed as a true record.

Matters arising;

2.2 Complaints Engagement Session
Martin Caple gave an overview of the recent complaints engagement session that he, David Gorrod, Geoff Smith and Tony Patel had attended. The event was run jointly by Moira Durbridge and her team and Leicester City Healthwatch. The event was well attended with a wide range of stakeholders. During the event the complaints process, external scrutiny and how we might simplify the process for complainants were topics of discussion. Martin collated themes with Micheal Smith from Healthwatch. These have been passed to Moira and we are awaiting feedback.

2.3 PPI Strategy
Karl Mayes gave some feedback on the development of the new PPI strategy. There had been a delay in pulling this document together. The group expressed the desire to have some input in to the document and for it to reflect the outcome of the Patient Advisors' away day. As such, Mark Wightman suggested that the paper be developed following the away day in September. Richard Kilner supported this approach.

2.4 Sharing of Information
Martin Caple drew the group's attention to the feedback form he had circulated prior to the meeting. The form aims to provide a template for Patient Advisors to summarise their activity. Martin asked for comments. Tony Patel said that the form provided some structure and was heading in the right direction. Geoff Smith said that he would like to see how the form performed in use. Paul Burlingham noted that Pas would need to be disciplined in order to keep their accounts brief.

Action: It was agreed that all Patient Advisors should , if possible, use the template to report their activities to each meeting in future.

2.5 Timing of meetings
Martin Caple noted that following the last meeting he had canvassed the views of Patient Advisors regarding their preferred times for PASG meetings. The majority view was to

alternate times between morning and afternoon meetings, with the occasional evening meeting. Martin suggested that evening meetings could take place in the summertime to make use of the longer evenings. Geoff Smith suggested that evening meetings could be scheduled before the Members' Engagement Forum meetings to encourage PAs to attend. Tony Patel supported this saying that he has attended the last five meetings and found them to be a good opportunity to understand the wider strategic issues affecting the Trust. Martin Caple reminded the group that the next meeting in September would start at 3pm. Venue TBC.

3. Richard Kilner, Acting Chairman

3.1 Martin gave the floor to Richard Kilner who updated the group on the Chair recruitment process that was taking place at the time. He noted that the stakeholder engagement session had taken place the night before and that interviews were being held in Birmingham on the following Monday.

3.2 Richard then updated the group on the current situation with Non Executive Directors (NEDs) of the Trust. He said that recently three NED terms of service had expired and that in line with recent TDA guidance these NEDs are required to reapply for the positions. He also added that a fourth NED role was becoming available to replace his own position. Of these NEDs, Kiran Jenkins will not be reapplying. Prakash Panchal has extended his tenure until September but will not be applying for a further term. Sarah Dauncey has also extended her tenure until September, after which she is intending to reapply. Richard added that Stephen Ward has developed a NED induction which may be useful as a basis for future PA inductions.

3.3 Richard acknowledged that the PA group had discussed both the role of a NED PPI "champion" and attachment of a NED to the PASG. Richard said that he is happy for a NED to attend the group but was more in favour of this being done on a rotational basis rather than allocating a single NED to the role.

3.4 Richard then shared his thinking on the Board cycle noting that historically Boards had met a week after committee meetings. More recently this was one day after. The recent Board review showed that this was not optimal. He also questioned the efficacy of holding 12 Board meetings a year , noting that many Trusts hold between 8 – 10 meetings per year. A further issue related to the times of Board meetings. Public attendance is limited when meetings are held on week days. Richard was keen to explore the possibility of weekend meetings. This would not only encourage public attendance but might also attract a more diverse range of people to the NED position (i.e. working people and those with caring responsibilities).

3.5 The Chairman then shared with the group a brief overview of the financial position of the Trust. He said that UHL has historically broken even. Over the last few years this has been achieved through the late adjustment of contracts. When the Trust entered the 2013/14 financial year, it did so with the assumption of a certain level of funding from CCGs. This transitional funding transpired to be much less than expected. Because the Trust entered the year with flawed financial assumptions its income was effectively £20 million short. This also included an overspend, some of which was investment in nurses (*post Francis). As such the forecast predicts a further deficit at year end. This year, in the first three months we have

managed pay and non pay costs in line with our targets. As such Richard is confident that the organisation has a grip on its finances. He noted that we are a large, expensive Trust to run, particularly on 3 hospital sites. We have a significant over spend on emergency activity and the penalties are high. The Trusts five year plan builds in a programme of transition and service reconfiguration that will end up with us moving to a position of small surplus.

3.6 Martin Caple thanked Richard for his update and opened the floor to questions from Patient Advisors.

3.7 David Gorrod suggested that the Trust might focus more on income generation at the same time as its focus on cost control. He said that we should be more proactive in selling our services and attracting revenue. Richard Kilner said that we are moving in to a climate of greater competition which is driving the need to expand. For example the Trust recently got the business case through for vascular services to move, co-locating them with cardiac services. This will improve the service and make us more competitive.

3.8 Paul Burlingham noted that Outpatient activity is a significant aspect of what the Trust does. Paul understood that this is run on a payment by procedure basis and asked if this produced a perverse incentive. In other words, would it be more cost effective if UHL were paid for looking after a patient over the entire pathway? Some appointments could be conducted over the telephone. Paul asked what process existed to negotiate with commissioners on this. Richard Kilner said that much activity should be conducted in the community, not at an acute hospital site. This is better for patients. He noted that Outpatients currently lose around £8 million a year. He said that the Trust is working with the Better Care Together programme to improve the situation. As Paul suggests, the starting point is to review what consultations may be conducted virtually.

3.9 Tony Patel said that historically a NED was appointed to act as a PPI lead at Board. He suggested that if clear leadership was to be given in this area there should be one person taking responsibility. Martin Caple added that David Tracy used to occupy this role. Richard Kilner said that this was an important topic. On reflection he felt that there is a great value to exposing all the NEDs to Patient Advisors. One of the benefits of this model would be that the group would get the opportunity to meet with NEDs with different interests and responsibilities. For example, one month they would meet with the chair of the Audit Committee, another month the Chair of the Finance and Performance committee etc. Jenny wells said that she supported the idea of rotation, arguing that this would give the Board a better understanding of what PAs do. Mark Wightman noted that there are advantages to having a named NED who keeps their “foot on the ball” at Board, as is the case, for example, for the Older People’s strategy. Richard Kilner suggested that one named person could take responsibility but he felt that rotational attendance at the PASG was still preferable.

3.10 Anthony Locke remarked on what he felt were increasingly longer private sessions of the Trust Board. This was, he said, effectively shortening the public Board session. Richard Kilner said that in reality the private business of the Board was not growing. However, there were necessarily issues of commercial sensitivity and that information must be taken in private. Some Trusts cover such issues in Board Development sessions. Richard added that the Board Effectiveness review highlighted the need to shorten Board lengths which

may see shorter public sessions in the future. One way of making the public sessions more effective may be, as other Trusts do, to take questions in advance of the meeting and give responses at Board.

3.11 Tony Patel said that Foresight had judged the Trust to be effective but he is aware that the TDA have concerns. He asked how the two views could be reconciled. Richard Kilner said that the Board Effectiveness review did highlight some concerns. For example, the question was asked; why does the Board not have a NED who has been a NED on a successful Foundation Trust?

3.12 Anthony Locke said that at the recent UHL leadership conference John Adler stressed the need for staff to recognise that there was always a danger of slipping in to Special Measures and that was why strong leadership was needed. Richard Kilner said that John Adler was right to raise these concerns. There is a clear need to make changes both at UHL and in the wider Health economy. He added that this is true of the NHS as a whole.

3.13 Summarising, Martin Caple said that there were three issues the group would like Richard Kilner to take away from the meeting;

- The enthusiasm and support for the organisation within the group.
- The group would like improved liaison and clearer direction from the Board.
- PPI is on the Trust's risk register and is patchy in the CMGs. Martin said that whatever influence Richard might bring to bear on this would be appreciated.

3.14 Martin Caple thanked Richard Kilner for coming to the meeting. Richard Kilner then left the meeting.

4. Feedback from Chair Recruitment stakeholder group.

4.1 Martin Caple gave some feedback on the Chair Recruitment stakeholder session that he attended the previous evening. Martin said that the event was very successful and had good engagement from all present. Mark Wightman pointed to the quality of the questioning of each candidate.

5. Feedback from Committees

5.1 Geoff Smith gave some feedback on the PIPEEAC meetings (detail in Geoff's paper circulated with the last minutes). He noted that PIPEEAC represented a sea change in embedding PPI in to the organisation. He also noted that the partnership between the PPI leads and Patient Advisors is crucial. David Allen noted that he and PA colleagues had now had five meetings with their PPI lead cancelled. He agreed that this relationship was important.

5.2 Geoff Smith and Martin Caple gave feedback from the Finance and Performance Committee and Quality Assurance Committee respectively (see papers circulated with the last minutes). Martin Caple noted that the Quality Account this year did seem to take in to account the feedback from patient Advisors.

5.3 Paul Burlingham spoke about his involvement with the Charitable Funds Committee. He began by offering his resignation from this group. Paul said that he would like to open up the opportunity to other Patient Advisors. Five meetings are held per year, which consider bids greater than £10,000. The committee receives funding applica6tions and Pas would be required to read and consider the case. Meetings are held on Friday afternoons and attendance is logged and a percentage rating formulated at the end of the year. The purpose of the group is to approve funding for initiatives that will bring staff or patient benefit. Paul said that he has enjoyed the variety of people and organisations he has come in to contact with through the committee; from parents who have lost children and are fund raising to relationships with other charities. Both Jenny Wells and David Gorrod said that they may be interested in sitting on the Committee. Patient Advisors are asked to submit their expression of interest to Karl Mayes by email.

Action: Patient Advisors interested in sitting on the Charitable Funds Committee to contact Karl Mayes by 31 July with a written expression of interest.

5.4 Jenny Wells gave some feedback from the Research Committee that she sits on. Jenny felt that the Trust should do more to publicise the positive outcomes of research and understands that a post was recently created to do this. Jenny said that she was recently involved in a project with schools to promote careers in health.

6. Round up of Patient Advisor activity

6.1 Rosemary Stokes has been involved in reviewing patient information with the infection prevention team. She is also now sitting on the women's AND Children's CMG Board.

6.2 Mary Gordon sits on the ITAPS Board, she has also participated in ward rounds looking at improvements to ICU. She has participated in the development of an action plan and also participated in Cancer peer reviews.

6.3 Nadine Wood sits on the CMG, Quality and Safety and Infection Prevention Boards. She has also been active with patient surveys and is getting involved in work on hearing services for older people. Martin Caple said that he had been involved in a similar project and suggested that he and Nadine touch base to avoid duplication.

6.4 Jenny Wells has participated in a survey of external signage for outpatients.

6.5 David Allen has been sitting on the Strat3egic Dementia Committee with Rutland Helathwatch and has drawn on his contacts at UHL for this work.

6.6 Geoff Smith and Tony Patel have provided written reports of their activity.

6.7 Martin Caple said that he has been very encouraged by the work that Pas are doing in ITAPS. He has also been involved in Cancer peer reviews.

6.8 Paul Burlingham has been involved with infection prevention audits and also facilitated at a Urology patient feedback day.

7. Evaluation of meeting

7.1 Martin Caple asked the group to reflect on the meeting, asking if it met its objectives and we had met the values of the Trust, which Geoff Smith highlighted. . Paul Burlingham said that he appreciated Richard Kilner's input. Geoff Smith noted that the atmosphere for the meeting was much better, more collegiate. Paul Burlingham praised Martin's chairing and felt that there was a good balance to the meeting. Martin Caple also said that the meeting felt more positive this time.

Date of the Next Meeting

September 18th 2014
3pm – 5pm
Venue to be confirmed.

Trust Board Bulletin 28 August 2014 – paper 4

To:	**Trust Board**
From:	**ACTING CHAIR AND DIRECTOR OF CORPORATE AND LEGAL AFFAIRS**
Date:	**28 AUGUST 2014**
CQC regulation:	N/A

Title:	**BOARD EFFECTIVENESS ACTION PLAN**

Author/Responsible Director: DIRECTOR OF COPORATE AND LEGAL AFFAIRS

Purpose of the Report: To update the Trust Board on the implementation of the Board effectiveness action plan.

The Report is provided to the Committee for:

Decision		Discussion	
Assurance	√	Endorsement	

Summary / Key Points:
The attached action plan was approved by the Trust Board at its meeting on 31 July 2014. It was agreed by the Board to receive an update at each Board meeting on the implementation of the action plan.

Recommendations:
To receive and note the report.

Previously considered at another corporate UHL Committee? Action plan approved by the Trust Board on 31 July 2014.

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

Resource Implications (e.g. Financial, HR): The proposed appointment of a Board Coach will have resource implications.

Assurance Implications: N/A

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

Stakeholder Engagement Implications: N/A

Equality Impact: None associated with the implementation of the action plan appended..

Information exempt from Disclosure: N/A

Requirement for further review? Trust Board to receive an update at each public Trust Board meeting.

ACTION TRACKER FOR THE BOARD EFFECTIVENESS ACTION PLAN 2014/15

Monitoring body (Internal and/or External):	Trust Board
Reason for action plan:	To strengthen the effectiveness of the Trust Board
Date of this review	**August 2014**
Frequency of review:	Monthly
Date of last review:	July 2014

REF	What will be different?	What will we do to make it different?	Lead Officer	Lead Director	Date to be completed	Progress/Update	Status
Workstream 1: Formulating Strategy							
1.1	There will be a clear/shared outcome of the Board's role in formulating and determining strategy reflected in a systematic, iterative process for engaging CMGs/Executive Team/external partners/stakeholders and the Trust Board.	Trust Board to agree a revised strategic planning process which will : • Be clear and transparent; • Describe how CMGs will be engaged; • Describe how the external environment will be assessed and managed; • Agree the minimum products that CMGs will produce in the planning round; • Identify the Board meeting dates at which strategic business will be transacted.	HBPD	DS	31.7.14	A report entitled 'Developing a strategic planning function for 2014/15 and beyond' was approved by the Trust Board on 31 July 2014.	5

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

REF	What will be different?	What will we do to make it different?	Lead Officer	Lead Director	Date to be completed	Progress/Update	Status
Workstream 2: Ensuring Accountability							
2.1	'Intelligence' for the Board will be reshaped to improve insight which assures/warns we are or are not delivering the Trust's strategy.	Revise the Trust's quality and performance report.	ADI	CN	31.8.14	New quality and performance report discussed at Trust Board development session on 14th August 2014 and revised version to be submitted to the Trust Board on 28th August 2014.	4
		Revise the Trust's Board Assurance Framework	DSR	CN	31.8.14	New version of Board Assurance Framework in the process of being developed : revised version submitted to and approved by the Trust Board on 31 July 2014; and fully populated version to be submitted to the Trust Board on 28th August 2014.	4
		Commence bi-annual reporting to Trust Board on the delivery of Caring at its Best	STA	DCLA	31.10.14	First report on 'Caring at its Best' delivery for H1 2014/15 scheduled for submission to the Trust Board on 30th October 2014.	4

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

2.2	Re-sequencing of Board and Board Committee meetings to ensure more effective and formal assurance.	Trust Board to agree a revised calendar of Board and Board Committee meetings/	STA	DCLA	31.8.14	The sequencing of Trust Board meetings will change from January 2015. Trust Board meetings will take place in the first week of the month from January 2015, commencing 8 January 2015. Board members have been canvassed on their availability for new Board meeting dates to March 2016 and these are included in the Trust Board bulletin for 28th August 2014.	4
2.3	Re-ordering of business to be transacted at Trust Board meetings to take the most important items early.	Implement a revised approach to the ordering of Trust Board business.	STA	DCLA	31.8.14	In consultation with the Acting Chair and Chief Executive, a revised approach to the ordering of Trust Board business will be implemented with effect from the Trust Board meeting on 28th August 2014.	4
2.4	Reduce the amount of time taken up at Trust Board and Board Committees in 'covering the same ground' and ensure that the Board and its Committees are a focus for escalation – with detailed intelligence primarily provided in the form of exception reports – while ensuring that we also take time to celebrate success.	Map what information goes where against the Board assurance '3 lines of defence'.	DCLA	DCLA	30.9.14	Outcome of mapping and recommended changes to the way in which Board business is processed to be reported to Trust Board on 25th September 2014.	4
		Standardise exception reporting in line with the production of a new quality and performance report.	ADI	CN	31.8.14	New quality and performance report in the process of being developed in consultation with the Executive Team and revised version to be submitted to the Trust Board on 28th August 2014.	4

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

REF	What will be different?	What will we do to make it different?	Lead Officer	Lead Director	Date to be completed	Progress/Update	Status
2.5	Improved Trust Board profile by putting in place regular feedback from the Board to staff so that staff understand the Trust's key priorities and how they contribute as individual staff members to delivering these priorities.	Summary of up to 5 key decisions/discussions will be agreed by the Trust Board at the close of each Board meeting and communicated to all staff via a 'Chair's Bulletin'.	Acting Chair/ HOC	DCM	31.10.14	At its meeting on 31 July 2014, the Trust Board instituted a new approach of agreeing the key headlines for this month's 'Chair's Bulletin'. The Bulletin will be communicated to all staff. An item to agree the 'Chair's Bulletin' will feature as a standard item on all Trust Board agendas following the commencement in post of the new Trust Chair on 1 October 2014.	4

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

REF	What will be different?	What will we do to make it different?	Lead Officer	Lead Director	Date to be completed	Progress/Update	Status
Workstream 3: Shaping A Healthy Culture, Corporate Working and Good Social Processes							
3.1	There will be focused and systematic Trust Board engagement with CMGs and clinical leaders.	Quarterly informal Trust Board/CMG clinical leaders sessions to be established.	CE	CE	To commence from Q3 2014/15	Consideration being given by Chief Executive to the purpose and most appropriate format of the Trust Board/CMG clinical leaders sessions.	4
3.2	A Board 'Coach' will be appointed to support and challenge the Board in its quest to become more effective.	The Trust Board will agree a clear specification for the role of Board 'Coach' and make an appointment.	DHR	DHR	In time for Trust Board development session to be held on 16 October 2014.	Director of Human Resources in discussion with The Foresight Partnership on the appointment of Board 'Coach'. Sue Rubinstein has agreed to act as the Board Coach but this is subject to agreement with the newly appointed Trust Chair.	4
3.3	The Trust Board will discuss and agree : (a) the overall leadership model that the Board (in its role) and Executive Team (in its role) are seeking to build; and (b) the Board culture that it is seeking to shape and exemplify, and the need for positive alignment between Board and organisational culture shaping activity.	Dedicate a Trust Board development session, facilitated by the person appointed as Board 'Coach' (see item 3.2 above), to discuss and agree our position.	DHR	DHR	16.10.14 (Trust Board development session earmarked for this purpose)	As above. The date has been scheduled for a facilitated session with Sue Rubinstein on 16 October 2014 subject to the outcome of the discussion referred to in 3.2 with the newly appointed Trust Chair.	4

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

REF	What will be different?	What will we do to make it different?	Lead Officer	Lead Director	Date to be completed	Progress/Update	Status
3.4	The Trust Board will discuss and agree its role in shaping leadership, as part of a systematic approach to engagement.	Dedicate a Trust Board development session to discuss and agree our position on this subject.	DCM/ DS	CE/DCM/DS	End Q2 2014/15	Trust Board development session 18th September 2014 earmarked for this purpose.	4

KEY	
LEAD OFFICER	
ADI	Assistant Director of Information
DSR	Director of Safety and Risk
HBPD	Head of Business Planning and Development
HOC	Head of Communications
STA	Senior Trust Administrator
LEAD DIRECTOR	
CE	Chief Executive
CN	Chief Nurse
DCLA	Director of Corporate and Legal Affairs
DMC	Director of Marketing and Communications
DHR	Director of Human Resources
DS	Director of Strategy

Stephen Ward
Director of Corporate and Legal Affairs

15th August 2014

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