UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST

TRUST BOARD

MEETING TO BE HELD ON THURSDAY 29 MAY 2014 FROM 10AM IN SEMINAR ROOMS 2 & 3, CLINICAL EDUCATION CENTRE, GLENFIELD HOSPITAL

Public meeting commences at 12noon

AGENDA

Please take papers as read

Item no.	Item	Paper ref:	Lead	Discussion time
1.	**EXCLUSION OF THE PRESS AND PUBLIC** It is recommended that, pursuant to the Public Bodies (Admission to Meetings) Act 1960, the press and members of the public be excluded from the following items of business, having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest (items 1-14).			-
2.	**APOLOGIES AND WELCOME** To receive apologies for absence, including Col (Ret'd) I Crowe.	**-**	**Acting Chairman**	-
3.	**DECLARATIONS OF INTERESTS** Members of the Trust Board and other persons attending are asked to declare any interests they may have in the business on the agenda (Standing Order 7 refers). Unless the Trust Board agrees otherwise in the case of a non-prejudicial interest, the person concerned shall withdraw from the meeting room and play no part in the relevant discussion or decision.			
4.	**ACTING CHAIRMAN'S AND CHIEF EXECUTIVE'S OPENING COMMENTS**	**-**	**Acting Chairman and Chief Executive**	10am – 10.05am
5.	**CONFIDENTIAL MINUTES** Confidential Minutes of the 24 April 2014 Trust Board meeting. *For approval*	**A**	**Acting Chairman**	10.05 – 10.07am
6.	**MATTERS ARISING** Confidential action log from the 24 April 2014 Trust Board. *For approval*	**B**	**Acting Chairman**	10.07 – 10.20am
7.	**REPORT BY THE DIRECTOR OF STRATEGY** *Commercial interests*	**C (to follow)**	**Director of Strategy**	10.20 – 10.30am
8.	**JOINT REPORT BY THE CHIEF EXECUTIVE AND THE INTERIM DIRECTOR OF FINANCIAL STRATEGY** *Commercial interests*	**D**	**Chief Executive and Interim Director of Financial Strategy**	10.30 – 10.40am
9.	**REPORT BY THE DIRECTOR OF HUMAN RESOURCES** *Prejudicial to the conduct of public affairs and personal data*	**E**	**Director of Human Resources**	10.40 – 10.55am
10.	**REPORT BY THE CHIEF NURSE** *Personal data*	**F**	**Chief Nurse**	10.55 – 11.05am

11.	**REPORTS BY THE DIRECTOR OF CORPORATE AND LEGAL AFFAIRS** *Personal data and prejudicial to the conduct of public affairs*	**G & G1**	**Director of Corporate and Legal Affairs**	11.05 - 11.25am
12.	**REPORTS FROM BOARD COMMITTEES**			11.25 – 11.29am
12.1	**AUDIT COMMITTEE** Confidential Minutes of the 15 April 2014 meeting for noting and endorsement of any recommendations. *Prejudicial to the conduct of public affairs*	**H**	**Audit Committee Chair**	
12.2	**FINANCE AND PERFORMANCE COMMITTEE** Confidential Minutes of the 23 April 2014 meeting for noting and endorsement of any recommendations. *Prejudicial to the conduct of public affairs*	**I**	**Acting Chairman**	
12.3	**QUALITY ASSURANCE COMMITTEE** Confidential Minutes of the 23 April 2014 meeting for noting and endorsement of any recommendations. *Prejudicial to the conduct of public affairs*	**J**	**QAC Chair**	
12.4	**REMUNERATION COMMITTEE** Confidential Minutes of the 24 April 2014 meeting for noting and endorsement of any recommendations. P*ersonal information and prejudicial to the conduct of public affairs*	**K**	**Acting Chairman**	
13.	**PRIVATE TRUST BOARD BULLETIN MAY 2014** *No items for noting.*	**-**		-
14.	**ANY OTHER BUSINESS**	**-**	**Acting Chairman**	11.29 – 11.30am
	Comfort break until 12noon			
15.	**DECLARATION OF INTERESTS**	**-**	**Acting Chairman**	-
	Members of the Trust Board and other persons attending are asked to declare any interests they may have in the business on the public agenda (Standing Order 7 refers). Unless the Trust Board agrees otherwise in the case of a non-prejudicial interest, the person concerned shall withdraw from the meeting room and play no part in the relevant discussion or decision.			
16.	**ACTING CHAIRMAN'S OPENING COMMENTS**	**-**	**Acting Chairman**	12noon – 12.05pm
17.	**MINUTE**			12.05 – 12.06pm
	Minutes of the 24 April 2014 Trust Board meeting. *For approval*	**L**	**Acting Chairman**	
18.	**MATTERS ARISING**			12.06 – 12.15pm
	Action log from the 24 April 2014 meeting. *For approval*	**M**	**Acting Chairman**	
19.	**REPORT BY THE CHIEF EXECUTIVE**			12.15 – 12.20pm
19.1	**MONTHLY UPDATE REPORT – MAY 2014** *For discussion and assurance*	**N**	**Chief Executive**	
20.	**STRATEGY, FORWARD PLANNING AND RISK**			
				12.20 –

20.1	**CARING FOR THE OLDEST OLD** *For assurance and approval*	**O**	**Director of Marketing and Communications/ Chief Nurse**	12.40pm
20.2	**BED CAPACITY PLAN** *For approval*	**P (to follow)**	**Chief Operating Officer**	12.40 – 12.55pm
20.3	**UHL AND LLR 5-YEAR PLANS – UPDATE** *For assurance*	**verbal**	**Director of Strategy**	12.55 – 1.15pm
20.4	**DELIVERING CARING AT ITS BEST – UPDATE** *For discussion and assurance*	**Q**	**Chief Executive**	1.15 – 1.25pm
20.5	**BOARD ASSURANCE FRAMEWORK – UPDATE** *For discussion and assurance*	**R**	**Chief Nurse**	1.25 – 1.40pm
21.	**CLINICAL QUALITY AND SAFETY**			
21.1	**PATIENT EXPERIENCE** *For discussion and assurance*	**S**	**Chief Nurse**	1.40 – 2pm
22.	**FORMAL ADOPTION OF THE ANNUAL ACCOUNTS 2013-14**			2 – 2.20pm
22.1	**UHL STATUTORY ACCOUNTS 2013-14 AND MANAGEMENT RESPONSE TO THE ISA 260 REPORT** *For approval*	**T**	**Interim Director of Financial Strategy**	
22.2	**ANNUAL GOVERNANCE STATEMENT (AGS) 2013-14** *For approval*	**T1**	**Chief Executive**	
22.3	**AUDIT COMMITTEE CONSIDERATION OF UHL'S ANNUAL ACCOUNTS AND AGS 2013-14** Verbal report on the Audit Committee's consideration of the statutory accounts 2013-14 (meeting held on 27 May 2014). *For assurance*		**Audit Committee Chair**	
22.4	**LETTER OF REPRESENTATION** *For approval*	**T2 (to be tabled)**	**Interim Director of Financial Strategy**	
22.5	**APPROVALS** The Trust Board is invited to:- • note the contents of the reports in section 22; • approve the statutory accounts for the year ending 31 March 2014, and • approve the signing (**in non-black ink**) of the relevant certificates by members of the Trust Board, as follows (*signatories are shown in brackets*):- o **Statement of Directors' responsibilities in respect of Internal Control** *(Chief Executive);* o **Annual Governance Statement 2013-14** *(Chief Executive);* o **Directors' Statements – Statement of the Chief Executive's responsibilities as the Accountable Officer of the Trust** *(Chief Executive)***, and Statement of Directors' Responsibilities in**		**Named Executive Directors**	

	respect of the accounts *(Chief Executive, and the Interim Director of Financial Strategy);* o **Balance Sheet** *(Chief Executive), and* o **Letter of Representation** *(Chief Executive)*			
23.	**QUALITY AND PERFORMANCE** *For assurance*			
23.1	**MONTH 1 QUALITY, FINANCE AND PERFORMANCE REPORT** *For assurance* ***The Trust Board is invited to identify key issues for discussion at the meeting, noting the overall structure of this item as follows:-*** **Quality** (a) The **Non-Executive Director Chair** of the **Quality Assurance Committee** will be invited to comment verbally on the month 1 position, as considered at the meeting held on 28 May 2014 (the Minutes of which will be presented to the 26 June 2014 Trust Board); (b) **Lead Executive Directors** will then be invited to comment **by exception** on their respective sections of the month 1 report, specifically:- • **Chief Nurse** – patient safety and quality, quality commitment, patient experience; • **Medical Director** – mortality rates; **Finance and Performance** (c) **Acting Trust Chairman** to comment verbally on the month 1 position, as considered at the **Finance and Performance Committee** meeting held on 28 May 2014 (the Minutes of which will be presented to the 26 June 2014 Trust Board). (d) **Lead Executive Directors** will then be invited to comment **by exception** on their respective sections of the month 1 report, specifically:- • **Chief Operating Officer** – operational performance and exception reports; • **Director of Human Resources** – staff appraisal, sickness absence and statutory and mandatory training compliance; • **Chief Executive** – information management and technology performance, and • **Chief Nurse** – facilities management.	**U**	**QAC Chair** **Chief Nurse** **Medical Director** **Acting Trust Chairman** **Chief Operating Officer** **Director of Human Resources** **Chief Executive** **Chief Nurse**	2.20 – 2.40pm
23.2	**NURSE STAFFING UPDATE** *For assurance*	**V**	**Chief Nurse**	2.40 – 2.50pm
23.3	**2014-15 MONTH 1 FINANCIAL POSITION AND REVISED CAPITAL PLAN** *For assurance and approval*	**W**	**Interim Director of Financial Strategy**	2.50 – 3.05pm
23.4	**EMERGENCY CARE PERFORMANCE AND RECOVERY PLAN** *For discussion and assurance*	**X**	**Chief Operating Officer**	3.05 – 3.35pm

23.5	**NHS TRUST OVER-SIGHT SELF CERTIFICATION** *For discussion and approval*	**Y**	**Director of Corporate and Legal Affairs**	3.35 – 3.40pm
24.	**REPORTS FROM BOARD COMMITTEES**			3.40 – 3.45pm
24.1	**AUDIT COMMITTEE** Minutes of the 15 April 2014 meeting for noting and endorsement of any recommendations.	**Z**	**Audit Committee Chair**	
24.2	**FINANCE AND PERFORMANCE COMMITTEE** Minutes of the 23 April 2014 meeting for noting and endorsement of any recommendations.	**AA**	**Acting Chairman**	
24.3	**QUALITY ASSURANCE COMMITTEE** Minutes of the 23 April 2014 meeting for noting and endorsement of any recommendations.	**BB**	**QAC Chair**	
25.	**TRUST BOARD BULLETIN – MAY 2014**	**CC**	-	-
26.	**QUESTIONS FROM THE PUBLIC RELATING TO BUSINESS TRANSACTED AT THIS MEETING**		**Acting Chairman**	3.45 – 4pm
27.	**ANY OTHER BUSINESS**		**Acting Chairman**	4 – 4.05pm
28.	**DATE OF NEXT MEETING**			
	The next Trust Board meeting will be held on **Thursday 26 June 2014** from **9.30am** in **the C J Bond Room, Clinical Education Centre, Leicester Royal Infirmary.**	**-**		

Helen Stokes
Senior Trust Administrator

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST

MINUTES OF A MEETING OF THE TRUST BOARD, HELD ON THURSDAY 24 APRIL 2014 AT 10AM IN THE C J BOND ROOM, CLINCIAL EDUCATION CENTRE, LEICESTER ROYAL INFIRMARY

Present:
Mr R Kilner – Acting Trust Chairman
Mr J Adler – Chief Executive
Colonel (Retired) I Crowe – Non-Executive Director
Dr S Dauncey – Non-Executive Director
Dr K Harris – Medical Director
Ms K Jenkins – Non-Executive Director
Mr R Mitchell – Chief Operating Officer (from part of Minute 117/14/1)
Ms R Overfield – Chief Nurse
Mr P Panchal – Non-Executive Director
Ms J Wilson – Non-Executive Director

In attendance:
Dr T Bentley – Leicester City CCG (from Minute 111/14)
Ms K Bradley – Director of Human Resources
Reverend M Burleigh – Head of Chaplaincy and Bereavement Services (for Minute 118/14/1)
Mr P Burlingham – Time for a Treat Volunteer, UHL (for Minute 116/14/2)
Mr E Charlesworth – Healthwatch Representative (from Minute 111/14)
Mr P Hollinshead – Interim Director of Financial Strategy
Ms H Leatham – Head of Nursing
Ms C Love-Rouse – Interim Chief Operating Officer, NIHR Clinical Research Network: East Midlands (for Minute 119/14/1)
Mr A Powell – Head of Performance and Quality Assurance, NHS Horizons (for Minute 106/14/2)
Mrs K Rayns – Trust Administrator
Ms A Reynolds – Volunteer Services Co-Ordinator (for Minute 116/14/2)
Mr C Reynolds – Meet and Greet Volunteer, LGH (for Minute 116/14/2)
Ms K Shields – Director of Strategy
Ms N Topham – Project Director, Site Reconfiguration (for Minute 118/14/1)
Ms J Waite – Ward Support/Mealtime Assistant, LRI (for Minute 116/14/2)
Mr S Ward – Director of Corporate and Legal Affairs
Mr M Wightman – Director of Marketing and Communications

ACTION

97/14 EXCLUSION OF THE PRESS AND PUBLIC

Resolved – that, pursuant to the Public Bodies (Admission to Meetings) Act 1960, the press and members of the public be excluded during consideration of the following items of business (Minutes 97/14 – 110/14), having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest.

98/14 APOLOGIES

Apologies for absence were received from Professor D Wynford-Thomas, Non-Executive Director and it was noted that the Chief Operating Officer would be arriving late due to a meeting with the Local Area Team (which he was attending on behalf of the Chief Executive).

99/14 DECLARATIONS OF INTERESTS IN THE CONFIDENTIAL BUSINESS

There were no declarations of interests regarding the business being transacted.

100/14 ACTING CHAIRMAN'S AND CHIEF EXECUTIVE'S OPENING COMMENTS

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

101/14 CONFIDENTIAL MINUTES

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

102/14 CONFIDENTIAL MATTERS ARISING REPORT

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

103/14 REPORT BY THE DIRECTOR OF HUMAN RESOURCES

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

104/14 REPORT BY THE MEDICAL DIRECTOR

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

105/14 REPORT BY THE INTERIM DIRECTOR OF FINANCIAL STRATEGY

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

106/14 REPORT BY THE CHIEF NURSE

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

107/14 REPORT BY THE DIRECTOR OF CORPORATE AND LEGAL AFFAIRS

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

108/14 REPORTS FROM BOARD COMMITTEES

108/14/1 Finance and Performance Committee

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

108/14/2 Remuneration Committee

Resolved – that the confidential Minutes of the 27 March 2014 Remuneration

Committee (paper J) be received, and the recommendations and decisions therein be endorsed and noted respectively.

109/14 PRIVATE TRUST BOARD BULLETIN – APRIL 2014

There were no Bulletin items for noting.

110/14 CORPORATE TRUSTEE BUSINESS

110/14/1 Charitable Funds Committee

Resolved – that the confidential Minutes of the 14 April Charitable Funds Committee meeting (paper K) be received and noted.

111/14 DECLARATIONS OF INTERESTS IN THE PUBLIC BUSINESS

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

112/14 ACTING CHAIRMAN'S AND CHIEF EXECUTIVE'S OPENING COMMENTS

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

(a) the start of the 2014-15 financial year and the challenges surrounding the £40.8m deficit forecast position for UHL, noting that deficit forecasts had also been submitted by a number of other acute Trusts for 2014-15;
(b) a strong focus on producing LLR whole health system plans and delivering these through the Better Care Together 2014 programme;
(c) the dominant theme for UHL to strive to return to financial balance whilst maintaining the current focus on the quality of care provided and patient safety;
(d) UHL had invested £6m in increasing the ward staffing levels during the last financial year and this level of investment would continue with active recruitment processes ongoing to fill existing nursing vacancies;
(e) the positive outcome from the CQC inspection which had highlighted good work in respect of patient experience, reductions in patient falls, pressure ulcer prevention and reductions in hospital acquired infections. He particularly highlighted UHL's creditable performance in meeting the challenging threshold for clostridium difficile infections, noting that no other Trust of a similar size to UHL had delivered its trajectory, and
(f) the update on the Trust's Emergency Floor project (paper X refers) and the associated planning application to Leicester City Council to dismantle St Luke's Chapel and re-provide a permanent replacement Christian chapel as part of the proposed multi-faith centre on the LRI site.

Resolved – that the information be noted.

113/14 MINUTES

Resolved – that the Minutes of the 27 March 2014 Trust Board be confirmed as a correct record.

114/14 MATTERS ARISING FROM THE MINUTES

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

(a) **item 5** (Minute 88/14/1 of 27 March 2014) – it had been confirmed at the Trust Board development session on 10 April 2014 that further analysis and comparisons of the UHL

Listening into Action Pulse Check survey was not possible within the functionality of the system;

(b) **item 7** (Minute 89/14/1 of 27 March 2014) – details of the never event investigation would be presented to the Quality Assurance Committee in May 2014 and the Medical Director would report verbally on this incident during presentation of the Quality and Performance report (Minute 117/14/1 below refers);

(c) **item 11** (Minute 90/14/1 of 27 March 2014) – the timescales for the respective actions arising from consideration of the 2 year operational plan were agreed as set out in paper M;

(d) **item 14** (Minute 91/14/1) – clarity would be sought from the Chief Operating Officer regarding the date for commencement of quarterly reviews of risk 2 (failure to transform the emergency care system); **COO**

(e) **item 16** (Minute 95/14/3) – whilst the action to contain all future Trust Board reports to a maximum of 10 pages (subject to recognised exceptions) was marked as complete, the Acting Chairman requested that this be retained as a standing item to serve as a reminder of this ambition going forwards; **STA**

(f) **item 17** (Minute 56/14/3 of 27 February 2014) – the Chief Executive was requested to seek an indicative date for submission of the EDRM business case to the TDA; **CE**

(g) **item 18** (Minute 58/14/1 of 27 February 2014) – this action relating to consideration of a never event through EQB and QAC would be removed as it appeared to replicate the agreed action under item 7; **STA** **CN**

(h) **item 19** (Minute 61/14/1 of 27 February 2014) – the annual review (and refresh if necessary) of the Board Assurance Framework had been scheduled for the 12 June 2014 Trust Board development session, and

(i) **item 20** (Minute 22/14/2 of 30 January 2014) – consideration of the arrangements for raising awareness of dementia related issues and the Care of the Elderly Strategy were provisionally scheduled for the May 2014 Trust Board meeting.

Ms K Jenkins, Non-Executive Director commented upon the unexplained use of acronyms within the matters arising report, noting the example of item 17 which referred to POC (proof of concept) and EDRM (electronic document and records management). The Acting Chairman suggested that the scope to compiling a standardised list of acronyms be explored outside the meeting. **DCLA/ STA**

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

(B) consideration be given to compiling and circulating a list of commonly used acronyms. **DCLA/ STA**

115/14 REPORT BY THE CHIEF EXECUTIVE

115/14/1 <u>Monthly Update Report – April 2014</u>

The Chief Executive advised that most of the key issues within his monthly report at paper N were covered on the Trust Board agenda. He particularly noted that UHL had not exceeded the forecast deficit for the 2013-14 financial year end which was an indicator that the Trust had good control of its forecasting processes.

Emergency Care performance continued to be heavily reliant upon the level of emergency admissions and the last week's performance (which stood at 94.2%) was felt to be directly correlated to a reduction in the level of admissions, which had since increased again. Discussion on increases to UHL's bed capacity was scheduled later in the agenda (Minute 117/14/3 below refers). The Chief Operating Officer was currently attending a meeting with the Local Area Team (LAT) in order to review the local health economy's whole system recovery plans and its position against the nationally mandated action plan. The Chief Executive highlighted a range of investments which had been put in place over the winter

period to manage high emergency activity levels. Some of these had since ceased but others were required on an ongoing basis and the Trust was reviewing which of these could be maintained once the additional £15m non-recurrent funding came to an end.

In terms of strategy, the Chief Executive highlighted the crucial importance of the LLR 5 Year Health and Social Care Strategy in relation to the development of UHL's Integrated Business Plan (IBP) and Long Term Financial Model (LTFM). The IBP/LTFM submission was due to be provided to the Trust Development Authority on 20 June 2014. Tangible progress was being made in respect of the LLR 5 Year Strategy and a set of framework principles and long term goals had been identified. To achieve the vision, some significant changes in service delivery and patient activity modelling would be required and a collaborative process with robust PPI engagement had been agreed. The Chief Executive noted his concerns that the individual organisations were being required to develop their plans within a parallel process, suggesting that a sequential planning process would be more effective. He had alerted Ernst Young (who were supporting this LLR workstream) to this issue with a recommendation to consider staggering the phasing of each workstream. Further progress reports would be provided to the Trust Board at appropriate intervals. **CE**

Finally, the Chief Executive sought and received the Trust Board's approval to appoint the Director of Corporate and Legal Affairs as the Trust's Senior Information Risk Owner (SIRO), noting the logical alignment with his existing governance portfolio. **DCLA**

Resolved – that (A) the Chief Executive's April 2014 monthly update be noted;

(B) regular progress reports on the development of the LLR 5 Year Health and Social Care Strategy be provided to the Trust Board, and **CE**

(C) the proposal to appoint the Director of Corporate and Legal Affairs as the Trust's Senior Information Risk Owner (SIRO) be approved. **DCLA**

116/14 CLINICAL QUALITY AND SAFETY

116/14/1 Renal Transplant Service

Further to Minute 7/14/2 of 31 January 2014, paper O provided an update on the findings of the external review of UHL's Renal Transplant Service and the precautionary measures implemented upon advice received from the review team to suspend renal transplantation in Leicester for a minimum of 2 weeks to allow for implementation of the wider recommendations. Professor C Rudge, CBE had been appointed to oversee the embedding of the recommendations and NHS Blood and Transplant (NHSBT) had since re-visited the unit on 17 April 2014 and confirmed their support to re-open the service, subject to the satisfactory conclusion of UHL's own assurance processes.

The Medical Director advised that a formal recommendation to re-start the service would be presented to the Executive Team on 29 April 2014. Subject to the Executive Team supporting this proposal, he requested that the Trust Board delegated authority to the Acting Chairman and the Non-Executive Director Chair of the Quality Assurance Committee to approve the arrangements to re-commence renal transplantation (potentially within the next 7 days). The Trust Board noted the ongoing assurance processes surrounding external leadership, guidance and monitoring and provided the delegated authority as requested. **CHAIR/ QAC CHAIR**

Discussion took place regarding the scope for a "lessons learned" review, whether the Trust Board had been sighted to any of the issues through the organisational risk register, and whether any similar external reviews were likely. The Medical Director reminded Board members of the timely nature of his briefing on issues affecting the Renal Transplant Service at the 31 January 2014 Trust Board meeting and he confirmed that he was not aware of any other forthcoming external reviews.

The Non-Executive Director Chair of the Audit Committee noted the need for a robust process for capturing all risks and she queried the criteria upon which the outputs of the Executive Team review and the delegated authority would be based. The Medical Director noted that the NHSBT had provided very clear guidance on the requirements for a CMG risk assessment, scheduling of joint team meetings, individual Consultant timetables, protocols and standard operating procedures. Responding to a Non-Executive Director concern, the Medical Director confirmed that the risks associated with re-starting a service which had been closed for such a short period of time were minimal. However, in the event of a longer closure, specific assurance processes would require to be followed.

The Director of Marketing and Communications particularly commended the transparent approach to discussion of this important patient safety issue within the public section of the Board agenda.

Resolved – that, subject to appropriate assurance being confirmed by the Executive Team on 29 April 2014, delegated authority be provided to the Acting Chair and the Non-Executive Director Chair of the Quality Assurance Committee to approve the re-commencement of renal transplantation in Leicester. **MD/ CHAIR/ QAC CHAIR**

116/14/2 Patient Experience – Message Through a Volunteer

In presenting paper P, the Chief Nurse welcomed the Volunteer Services Co-Ordinator and 3 volunteers to the meeting. Introductions took place and each volunteer spoke for a few minutes about their personal experiences of listening to patients' comments during the course of their voluntary activities and the benefits of having a formalised system for capturing such feedback through the "message through a volunteer" slips. The volunteer representatives highlighted their:-

- experiences of guiding patients from the front entrance desk to their clinic appointments on the LGH site and the confusing abbreviations and acronyms used within UHL's appointment letters. As a result of such feedback, improvements had been made to the clinic letters which provided greater clarity regarding the location of the appointment and the most appropriate hospital entrance to use. Clearer hospital site maps had also been developed;
- practice of spending up to 75 minutes talking to patients during "time for a treat" hand and foot massage sessions. One patient had revealed that the Trust's day parking passes were valid for multiple access and egress during the day on the Glenfield and LGH hospital sites, but would only allow 1 visit per day on the LRI site. This issue had since been escalated appropriately and resolved, but until the issue had been raised, the Trust had not been aware that this issue was causing patients and their visitors any concern, and
- work as a patient mealtime volunteer, often assisting elderly patients and patients suffering from dementia with their meals. During the course of this role, volunteers had noticed that when plastic teaspoons and disposable plates were replaced with more substantial crockery and cutlery, patients responded positively to the feel and weight of the spoon on their lips or the plate in their hand (or on their laps) and they were encouraged to eat more readily as a result.

In discussion on the presentation, the Board:-

a) commented upon the valuable links between the volunteer services and the Charitable Funds Committee, noting that a charitable funding application to purchase specialist crockery and cutlery for care of the elderly wards had been approved recently;
b) noted the immense value of gathering patient feedback and the formalised process for capturing and acting upon suggested improvements;
c) thanked all of the volunteers for attending the meeting and invited them to suggest any

additional actions the Trust could take to support them in their roles. In response, the Board noted the need for additional mealtime assistants in some areas. More generally there was a feeling that suggestions were being acknowledged and acted upon which was reassuring and helped to maintain satisfaction within the volunteer role and retention of volunteers on a long term basis. The volunteers also advised that they felt well supported by both clinical and non-clinical staff in their roles and that the Trust's culture led to them feeling well utilised and part of the wider team;

d) commented upon the scope for developing further Listening into Action enabled workstreams relating to volunteering and the sense of identity created by the volunteers' aqua t-shirts which were well recognised around the Trust, and
e) recognised the significant contribution of Mr P Burlingham in his role as Patient Adviser and in respect of re-formatting the patient clinic letters and hospital site maps.

Resolved – that the information and discussion on the Message Through a Volunteer system be noted.

116/14/3 CQC Inspection Report and Action Plan

Paper Q provided the following electronic link to the 5 CQC inspection reports for UHL as a whole and the 4 individual sites:- www.leicestershospitals.nhs.uk/aboutus/performance/care-quality-commission/

The Chief Nurse confirmed that the first draft of the action plan to respond to the CQC inspection had been reviewed at the 23 April 2014 Quality Assurance Committee meeting and that printed copies were available upon request (at the request of the Acting Chairman, copies were circulated to all Trust Board members by email following the meeting). Members noted the intention to submit version 1 of the action plan to the CQC alongside some accompanying narrative to explain the dynamic nature of this document and advising that further iterations would be issued as and when the ongoing review work was completed.

The Non-Executive Director Chair of the Quality Assurance Committee commended this comprehensive action plan and the assurance received that the Clinical Management Group (CMG) teams were actively engaged in the improvement plans.

Resolved – that progress of the action plan (and any future iterations of this document) be monitored by the Quality Assurance Committee on a regular basis. **CN/ QAC CHAIR**

116/14/4 2014-15 Quality Commitment

Further to discussion at the 10 April 2014 Trust Board development session, paper R provided a single page summary of UHL's revised Quality Commitment Priorities for 2014-15. The Chief Nurse noted the intention to capture the essential workstreams rather than all the desirable elements and advised that appropriate outcome statements had been provided at the top of each column. She confirmed that the aims were designed to be applied consistently year to year and that the focus would be on delivering the agreed priorities listed below each heading.

During discussion at the 23 April 2014 Quality Assurance Committee meeting, the Committee had agreed to change the heading of the left hand column from "Be Effective – Reduce Mortality" to "Be Effective – Improved Patient Outcomes". The Director of Marketing and Communications challenged the impact of this as a statement of intent and queried how the Trust would be able to present this. In response, the Chief Nurse identified the challenges associated with measuring reductions in patient mortality. The Trust Board agreed that the Chief Executive would liaise with the Chief Nurse to finalise the wording of the top left hand corner of the Quality Commitment structure. **CN/CE**

Resolved – that the 2014-15 Quality Commitment be approved, subject to the final **CN/CE**

wording of the top left hand corner being agreed between the Chief Executive and the Chief Nurse.

117/14 QUALITY AND PERFORMANCE

117/14/1 Month 12 Quality and Performance Report

The month 12 quality and performance report (paper S – month ending 31 March 2014) advised of red/amber/green (RAG) performance ratings for the Trust, and set out performance exception reports in the accompanying appendices. Ms J Wilson, Non-Executive Director and Quality Assurance Committee (QAC) Chair drew members' attention to the following issues as discussed at the 23 April 2014 QAC meeting:-

- forthcoming changes to the format of the Quality and Performance reporting in line with the structure of the 2014-15 Quality Commitment;
- progress with statutory and mandatory training compliance which had risen from circa 40% to 76% within the last 12 months – work was continuing in order to meet the 95% target and a specific focus on "hotspot" areas was being developed;
- a comprehensive action plan presented to the Committee in response to 10 times medication errors in neonatal prescribing;
- patient feedback on the dementia implementation plan, and
- the outputs arising from the triangulation of several sources of patient feedback – a summary of the main themes had been circulated to Trust Board members following the QAC meeting. The Acting Chairman queried whether volunteer feedback had been incorporated into this analysis and noted in response that it was not, but there were volunteer representatives on the Patient Experience Group.

With regard to the quality section within the month 12 report, members commended the Trust's achievement of the clostridium difficile trajectory and the anticipated green RAG ratings for the majority of the Quality Schedule and CQUIN indicators. In respect of never events, the Medical Director advised of a correction to the 2013-14 data, advising that a retained vaginal swab (designed to be left in situ to prevent further bleeding) was not reportable as a never event under new guidance, despite a failure to remove the swab at a later point. Consequently, the Trust had reported a total of 3 never events for the year which was half the number reported in 2012-13. The year to date crude mortality rate for April 2013 to February 2014 was also noted to be lower than the 2012-13 rate.

In discussion on the quality issues within the month 12 report, the Trust Board:-

(a) sought and received additional information regarding the process to achieve compliance with the "Right Blood" alert, including the ongoing training issues and the challenges surrounding traceability within a paper based system;
(b) expressed disappointment at the red RAG rating in respect of the timescales for responding to patient complaints, and
(c) noted that the Chief Nurse would forward additional supporting information to the Non-Executive Director Chair of the Audit Committee to clarify the meaning and impact of the Quality Schedule and CQUIN indicators. **CN**

The Chief Operating Officer summarised operational performance, particularly noting the trajectory for achieving RTT compliance for admitted performance by November 2014 and for non-admitted performance by August 2014. In respect of operations cancelled on the day of surgery, he noted that the target had not been achieved within the last 36 months and advised of a requirement for dedicated project management support to address this. Assurance was provided that the appropriate clinical prioritisation process was applied prior to any cancellation of procedures. All 8 key cancer targets had been achieved for the last 3 consecutive months. In discussion on operational performance, the CCG Representative queried what the impact on Choose and Book slot availability would be, if the 4 challenged **COO**

RTT specialties were removed. The Chief Operating Officer agreed to respond to the CCG Representative on this point outside the meeting.

Lead Directors advised that there were no specific HR, IM&T or FM issues to report beyond the information within paper S. The Acting Chairman commented upon the target to deliver 95% compliance with statutory and mandatory training compliance by the end of March 2015 and the Chief Executive suggested that the Director of Human Resources consider setting interim milestones within the overall target. **DHR**

Following a recent ward visit, the Acting Chairman highlighted issues with the battery functionality for the wheeled computer workstations and commented that the laptops provided to support the e-prescribing system could also be used as regular UHL computer terminals.

A report on UHL's year-end financial performance was considered under Minute 117/14/2 (below). Mr R Kilner, Acting Trust Chairman and Finance and Performance Committee Chair, reported on the 23 April 2014 Finance and Performance Committee's discussions on the following items of note:-

- progress with the 2014-15 Cost Improvement Programme;
- an analysis of GP bed bureau admissions showing a significant increase in the number of admissions by a small number of GP practice – this information had been shared with the CCGs some 2 months previously;
- central intervention being undertaken to address clinical letters performance, and
- the risk of emergency admission rates impacting upon the Trust's agreed trajectory for achieving RTT compliance.

Resolved – that (A) the quality and performance report for month 12 (month ending 31 March 2014) be noted;

(B) the Chief Nurse arrange to provide supporting information on the Quality Schedule and CQUINS to the Non-Executive Director Chair of the Audit Committee outside the meeting; **CN**

(C) the Chief Operating Officer respond to the CCG Representative's query regarding Choose and Book outside the meeting, and **COO**

(D) consideration be given to setting milestone targets for statutory and mandatory training compliance. **DHR**

117/14/2 2013-14 Year-End Financial Position

Paper T advised members of UHL's draft year-end financial position (subject to audit of the draft annual accounts), including performance against the Trust's 3 statutory financial duties (as set out in section 2.1 of paper T). In light of the £39.8m year-end deficit, UHL had not met its duty to deliver a planned surplus and an adverse value for money opinion was expected on its accounts therefore. The remaining two statutory financial duties (External Financing Limit and Capital Resource Limit) had been delivered. In terms of cash flow, the Trust had secured short term temporary borrowing, but longer term financing would be reliant upon the Trust's ability to submit a robust financial plan by the end of June 2014 demonstrating that the Trust would achieve financial balance within the next 3 years.

Resolved – that the 2013-14 financial year-end position be noted.

117/14/3 Update on Submission of UHL's 2-Year Annual Operating Plan

Further to Minute 90/14/1 of 27 March 2014 and the Trust's submission of the 2 year annual

operating plan to the TDA on 4 April 2014, paper U provided updated information in respect of finance, capacity planning and workforce planning. Each of the Executive Director leads briefed the Trust Board on their respective sections as follows:-

Finance – the Interim Director of Financial Strategy introduced appendix A highlighting the completion of the integrated business planning process for CMGs and Corporate Directorates, which would be used as the basis for performance management going forwards. In future years, he noted the intention to commence the business planning process earlier in the year, eg September or October. In respect of the Trust's 3 year recovery plans, he reported on the key risks and opportunities surrounding CIP delivery, fines and penalties, operational targets, bed capacity and winter activity plans;

Capacity – the Chief Operating Officer introduced appendix B which detailed the short term proposals to expand UHL's bed capacity for 2014-15 by introducing an additional 55 beds (as supported by the Executive Team and the Finance and Performance Committee). He highlighted the associated capital and revenue cost pressures and the opportunities to ring fence more of UHL's elective beds in order to reduce cancelled operations and improve the arrangements to cohort emergency patients within the Trust. In addition, he highlighted developments towards carrying out more elective procedures as day cases and more day cases as outpatient procedures. Reducing delayed transfers of care (DTOCs) was also considered to be a key factor in increasing UHL's capacity and whilst the methodology was in place to achieve this, the Chief Operating Officer noted the complex nature of this work and advised that this issue was unlikely to be fully resolved within the current financial year, and

Workforce – the Director of Human Resources introduced appendix C, reporting progress on the development of 5 year (outline) and 2 year (detailed) Workforce Plans. She drew members' attention to the challenges relating to the cost of staffing the additional 55 beds and delivering the £45m CIP target with only a small percentage of schemes being forecast to deliver headcount savings – the current total stood at 59 whole time equivalents. Recent changes in the Trust's workforce profile had included an additional 218 staff associated with the Elective Care Alliance and significant growth in nursing and medical staffing costs. The Chief Executive provided feedback from the previous day's discussions at the Finance and Performance Committee meeting where a high-level mismatch between CIP schemes and their associated workforce impact had been noted. He indicated that the workforce impact of some less-developed schemes had not yet been calculated, and that the Committee had requested greater visibility of the workforce impact of CIP schemes going forwards.

In discussion on paper U, the Trust Board:-

(a) noted the assurance provided by the Chief Executive that appropriate arrangements were being explored to mitigate against the additional capital and revenue costs associated with providing the additional bed capacity and that this might include deferring items of less strategic importance from the 2014-15 Capital Programme and reviewing the use of continued winter activity initiatives;
(b) received an update from the Interim Director of Financial Strategy (in response to a Healthwatch query) on the 2014-15 contract arbitration process and the ongoing discussions with Commissioners to finalise the position regarding those issues which fell outside the formal arbitration process (eg performance penalties and their reinvestment within UHL's services);
(c) queried which services had benefited from recent increases in medical workforce establishment, noting in response that 14 posts had been created in Intensive Care and that the remainder were spread across a range of services and were not limited to Consultant grades. The Director of Marketing and Communications commented upon the scope to review medical productivity to demonstrate UHL's return on investment and the Interim Director of Financial Strategy confirmed that this was one of the Trust's key cross-cutting CIP themes for 2014-15;

(d) agreed that additional clarity regarding workforce plans would emerge from the bottom up approach towards service planning within each CMG and the wider local health economy;
(e) noted that Ernst Young had been benchmarking UHL's staffing costs against a range of similar non-London Trusts and that the outputs of this workstream would be presented to the Executive Team in the near future;
(f) debated the importance of bed capacity as a key performance constraint, noting that other factors such as attendance levels and systems and processes were also crucial. The Chief Operating Officer confirmed that the checklist for developing operational best practice would continue in parallel, but there was a direct correlation between bed capacity and effective emergency care performance. Until the additional 55 beds came on line, bed occupancy levels would continue to be higher than ideal and whilst unregulated emergency demand continued, the system would struggle to cope with surges in emergency attendances until the whole LLR health economy strategy for reducing emergency demand began to take effect;
(g) noted the flexible nature of UHL's bed base and that additional capacity would only remain open whilst absolutely necessary. The Director of Strategy briefed members on the opportunities to work with the Trust's health care partners for service re-design which might result in future changes to the cohorts of patients requiring acute healthcare. She highlighted opportunities for stepped changes in bed capacity over the next 5 years, and
(h) received confirmation that the additional beds would be predominantly staffed by agency nurses and that staffing levels would be risk assessed together with any potential impact upon length of stay. The Acting Chairman suggested that it would be helpful for the Board to receive an update on nurse recruitment (including overseas recruitment campaigns) in May 2014.

Resolved – that (A) the updated 2 year annual operating plan be received and noted (as presented in paper U);

(B) the detailed budget book for 2014-15 be approved; **IDFS**

(C) the direction of travel for the 2014-15 Capacity Plan be supported and final proposals be presented to the May 2014 Trust Board meeting for approval; **COO**

(D) the process for development of the 2014-19 Workforce plan be noted and the need for continued challenge in respect of workforce numbers be supported, and **DHR**

(E) the Chief Nurse be requested to report on progress of nurse recruitment processes to the May 2014 Trust Board meeting. **CN**

117/14/4 Emergency Care Performance and Recovery Plan

Paper V from the Chief Operating Officer advised members of recent performance against the 4 hour emergency care target and detailed the key actions underway to deliver an improved position. March 2014 performance against the target stood at 89.7% and the 2013-14 year-end performance stood at 88.37%, due primarily to increased admissions, a fixed bed base and deteriorations in internal processes as a result of sustained pressures on the emergency care system. He briefed the Board on discussions held that morning at a meeting involving NHS England, the Local Area Team and Commissioners in respect of outline high level plans to reduce the number of admitted patients and reduce the level of ED attendances.

The Acting Chairman highlighted a recent analysis of GP bed bureau admissions which had evidenced increased admission levels from a small number of GP practices. The Chief Operating Officer confirmed that this data had been discussed at the Emergency Care working group alongside a detailed breakdown of patient length of stay by GP practice and

this data had indicated that such patients were staying at UHL for an average of 4 days. The CCG representative suggested that this length of stay was a fair indicator that the GP admissions were clinically appropriate and he commented that it would also be helpful to contrast the data with non-GP referral ED attendances broken down by GP practice. In discussion, the Trust Board:-

(a) considered the arrangements for strengthening UHL's relationships with GPs and Community Hospitals as part of the LLR 5 Year Strategy;
(b) noted the action plan appended to paper V and the wide range of initiatives being pursued, some of which would require input from UHL's partner agencies;
(c) commented upon an increase in primary care attendances which was perceived as an indicator of more wide-spread general increases in health care demand;
(d) queried whether the 11% increase in admissions between the final quarters of 2012-13 and 2013-14 reflected the national trend. The CCG representative suggested that this was not a consistent increase throughout the whole year and noted that it did not differentiate between City and County admissions;
(e) noted that Dr I Sturgess had been appointed to undertake a piece of whole system redesign work across the health economy for a 6 month period starting on 19 May 2014. Feedback from the diagnostic phase of this workstream was expected to be available for consideration at the June 2014 Trust Board meeting, and **COO**
(f) confirmed that a House of Commons report on emergency care performance had already been shared with Board members. The Chief Operating Officer noted some material errors contained within this report which were attributed to the data set of unified submissions. Including the Urgent Care Centre, UHL actually had the 5th largest number of attendances nationally, but the national data set did not reflect this point. The Non-Executive Director Chair of the Audit Committee sought and received assurance that UHL's data submissions were factually correct and members noted the negative impact of this report upon staff morale.

Resolved – that (A) the monthly update on Emergency Care performance be received and noted, and

(B) feedback from the diagnostic phase of the health economy system redesign work being undertaken by Dr I Sturgess be presented to the June 2014 Trust Board meeting (if available). **COO**

117/14/5 NHS Trust Over-Sight Self Certifications

The Director of Corporate and Legal Affairs introduced UHL's self certification returns for April 2014 (paper W), inviting any comments or questions on this report. Members noted the need to change the wording to reflect (i) the outcome of the CQC inspection, (ii) recent emergency care performance, and (iii) RTT improvement plans. Delegated authority was provided to the Chief Executive and the Director of Corporate and Legal Affairs to finalise the amendments required. Subject to those updates, the April 2014 self certification against Monitor Licensing Requirements (appendix A), and Trust Board Statements (appendix B) were endorsed for signature by the Chief Executive and submission to the NTDA accordingly. **DCLA/ CE**

Resolved – that, subject to the changes above, the NHS Trust Over-Sight Self Certification returns for April 2014 be approved for signature by the Chief Executive, and submitted to the NTDA as required. **CE**

118/14 STRATEGY AND FORWARD PLANNING

118/14/1 Emergency Floor Update

The Project Director, Site Reconfiguration and the Head of Chaplaincy and Bereavement

Services attended the meeting to present paper X, providing an update on the development of the Emergency Floor scheme and requesting the Trust Board to (i) reflect upon the heritage issues presented in the paper, (ii) ratify the preferred option approved at the October 2013 Trust Board meeting which required the dismantling of St Luke's Chapel, and (iii) commit to a firm plan for the provision of a permanent replacement chapel as part of a multi-faith centre on the LRI site. In respect of recommendation (iv) within paper X, separate alternative arrangements were now being made for approving the proposed palette of materials for the external facades of the new building.

Particular discussion took place regarding the spiritual and heritage issues associated with dismantling the Chapel, the arrangements for preservation of the artefacts currently housed there, and the engagement that had taken place with the League of Nurses, Chaplaincy and the Civic Society. Members noted that whilst this decision was regrettable, it did represent the only clinically and financially sustainable solution. The feasibility of retaining the Chapel within a small courtyard and building around it had been fully explored but this was found not to be viable. Reverend Burleigh, Head of Chaplaincy and Bereavement Services briefed members on the deep concerns that had been raised by 2 groups and provided his assurance that the impact of the loss of this facility was understood and well recognised and that the decision had not been taken lightly. During the substantial engagement activity with a range of UHL stakeholders and staff and following discussion with the Bishop of Leicester and the Archdeacon, assurances had been provided regarding the Trust's commitment to re-providing an uplifting and inspirational permanent replacement Christian Chapel as part of a multi-faith centre on the LRI site.

In further discussion on this report:-

(a) the Director of Strategy confirmed the timescales for the planning application, noting that the submission was due on 17 May 2014 and that the outcome was expected to be known by 20 August 2014. Clarity was also provided that the Chapel was not a listed building;
(b) in response to Non-Executive Director queries regarding the artefacts, it was confirmed that interim on-site storage would be provided for all artefacts with the exception of the communion rail and the organ – alternative locations would be sought for these due to their size. However, public access to the artefacts would not be available during their interim storage;
(c) the Director of Strategy reported on the scoping work for the provision of the interim solution and opportunities to engage with a wide range of religious groups and explore the use of charitable funding for some elements of the scheme, and
(d) members acknowledged the immense value of the Chapel for staff, patients and relatives, noting that some staff used the facility on a daily basis, but it was difficult to gather data on overall usage as not all users made an entry in the visitors' book.

<u>Resolved</u> – that (A) the progress report on development of the Emergency Floor scheme be received and noted;

(B) the preferred option for the Emergency Floor be supported (including the dismantling of St Luke's Chapel) as approved at the October 2013 Trust Board meeting; **DS**

(C) Trust Board commitment to firm plans for the provision of an interim Christian Chapel and a permanent replacement Christian Chapel as part of a multi-faith centre on the LRI site be confirmed, and **DS**

(D) alternative arrangements be established to seek Trust Board approval of the materials for the external facades of the new building. **DS**

118/14/2 <u>Delivering Caring at its Best – Update</u>

Further to Minute 90/14/2 of 27 March 2014, the Chief Executive presented paper Y, updating the Board on 'Delivering Caring at its Best' (DCAIB), particularly noting the content and governance structure chart on page 2 and the focus on developing the next stages and strengthening the project management disciplines. A separate Project Management Office (PMO) function had been agreed for each domain (quality, performance, strategy and workforce), but he clarified that no new resources would be required, as there were already people working in each of these areas. He outlined Ernst Young's supporting role in relation to 'System Improvements' and 'Best use of Staff' and noted the need to replace this PMO on a sustainable basis moving forwards.

Trust Board members noted the ongoing development of an action plan to establish the DCAIB infrastructure and the need to establish a coherent approach to Trust-wide reporting and Trust Board oversight. A progress update on these aspects would be presented to the May 2014 Trust Board meeting. **CE**

The Acting Chairman noted his view that the PMO functions should be co-located within the same room to prevent potential 'silo working'. A variety of views were expressed regarding the optimum management arrangements for the PMO functions to ensure both flexibility and manageability within the final structure. Responding to a Non-Executive Director query, the Director of Marketing and Communications advised that the relationship between the Older People's Strategy workstream and dementia care would be clarified in a report on this strategy to the May 2014 Trust Board meeting. **DMC**

Resolved – that (A) a further update on Delivering Caring at its Best be provided to the 29 May 2014 Trust Board, and **CE**

(B) a report on the Older People's Strategy (including the links with dementia care) be presented at the May 2014 Trust Board meeting. **DMC**

118/14/3 UHL-Northants Cancer Alliance

Paper Z provided a briefing note on the development of a provider alliance across the Leicester, Northamptonshire and Rutland for Specialised Services. The Director of Strategy reported verbally on progress with the cancer alliance between UHL and Northamptonshire and Kettering and commented upon the scope to extend such arrangements within other services, eg cardiac surgery, vascular services, children's services and potentially orthopaedics. She stressed that any such arrangements would be developed as partnerships with existing providers and would focus on redesigning patient pathways. She undertook to present a high level timetable and programme of work to a future Trust Board meeting. In discussion on paper Z, the Board:- **DS**

(a) commented upon internal management capacity to drive this workstream and whether a risk assessment had been conducted;
(b) noted the challenges that might be associated with working with more than one Local Area Team;
(c) queried whether any Leicester or Leicestershire patients would have to travel outside of the county for their treatment. In response, the Director of Strategy advised that the proposed arrangements would not diminish the range of services offered and would be more likely to protect patients from this eventuality;
(d) noted the scope to explore commercial opportunities in order to improve the Trust's financial sustainability, and
(e) supported the direction of travel, subject to clarification of how performance would be measured.

Resolved – that (A) the information on the development of specialised services provider alliances be received and noted, and

(B) indicative timescales and work programme for building such alliances be presented to a future Trust Board meeting (together with an assessment of UHL's internal capacity to drive this workstream). **DS**

118/14/4 Establishment of UHL Members' Engagement Forum

Paper AA from the Director of Marketing and Communications provided a briefing on the development of the UHL Members' Engagement Forum, the Minutes of the 17 March 2014 Prospective Governors' Meeting and the proposed Terms of Reference for the Members' Engagement Forum for Trust Board approval.

Discussion took place regarding the proposed venues for the meetings and the Director of Marketing and Communications clarified that all meetings were expected to be held on UHL premises and that most members appeared to prefer the LGH site for ease of car parking. The Acting Chairman highlighted the need to ensure that non-car drivers were not disadvantaged in any way. Mr P Panchal, Non-Executive Director noted the need to ensure ease of access for any disabled attendees, advising that a lift was currently out of order on the LRI site, which might have prevented disabled people from attending today's Trust Board meeting. **DMC**

Ms J Wilson, Non-Executive Director queried the links between this Forum and other stakeholder groups. In response, the Director of Marketing and Communications advised that the Stakeholder Engagement Strategy was being amended to take account of this new group, which he noted would be more outward-looking than the internally-focused Patient Advisers Group. Engagement with a wide range of stakeholders, including Healthwatch, the Leicester Mercury Patients' Panel and Patient Advisers would be included within the scope and governance arrangements.

During the 17 March 2014 Prospective Governors' Meeting, members had considered opportunities for the UHL Members' Engagement Forum to be Co-chaired, but this was not currently reflected in the Terms of Reference. The Director of Marketing and Communications was requested to clarify the group's views on this point. **DMC**

Resolved – that, subject to clarification of the arrangements for Co-chair and venues for meetings, the Terms of Reference for the UHL Members' Engagement Forum be endorsed. **DMC**

119/14 RESEARCH, DEVELOPMENT AND EDUCATION

119/14/1 National Institute for Health Research Clinical Research Network (NIHR CRN): East Midlands Annual Plan and Assurance Framework

Paper BB sought UHL Trust Board approval of the following documents as host organisation for the NIHR CRN: East Midlands:- (a) Annual Plan 2014-15, (b) Financial Planning Principles 2014-15 and (c) Governance Framework. Ms C Love-Rouse, Interim Chief Operating Officer for the Network attended the meeting for this item.

The Medical Director briefed the Trust Board on the background behind the formation of this Network effective from 1 April 2014 and UHL's accountability in this respect. He apologised that these documents had not been presented for approval at the March 2014 meeting, noting the developmental processes that were still being finalised. He confirmed that the documents being presented for approval today had been appropriately reviewed by the Directorates of Human Resources and Finance and Procurement.

Ms Love-Rouse commented upon the indicative nature of the financial plans advising that the budgets had been through a period of transition and were awaiting final sign-off by the

partner organisations and affiliated organisations. Close working relationships were being maintained with all the partner and affiliated organisations and a shared target had been developed to recruit 50,000 patients to participate in high quality research.

The Interim Director of Financial Strategy noted the need for UHL (as the host organisation) to maintain transparency in respect of the flow of funds on a trading basis. He advised that the governance arrangements would be subject to an early Internal Audit review as required by the NIHR. The Acting Chairman noted the requirements outlined within paper BB for monthly monitoring of financial performance. Clarity was provided that the 512 whole time equivalent posts referred to in the paper were employed by the NIHR CRN: East Midlands and not by the host Trust.

Resolved – that the following NIHR CRN: East Midlands documents be approved (as presented in paper BB):- **CE**

- **Annual Plan 2014-15;**
- **Financial Planning Principles 2014-15, and**
- **Governance Framework.**

119/14/2 Research and Development Quarterly Update

The Medical Director introduced paper CC, providing the quarterly update on research and development activity and challenges. He drew members' attention to the commencement of work to support the Biomedical Research Unit re-application processes and the risks of NIHR penalties being incurred for non-achievement of the 80% target for recruiting the first patient into clinical trials. Discussion took place regarding the importance of renewing the BRUs within the 2 year timescale and the Trust's aspiration to become a Biomedical Research Centre, building upon the relationships with the University of Leicester and Loughborough University.

The Director of Marketing and Communications commented upon the 2013-14 recruitment by Topic Network for the category of 'aging' and he queried whether there were any opportunities to develop relationships with age-related charities (similar to the Cancer-Research UK model for supporting cancer research). The Medical Director responded that age-related charitable organisations tended to be more patient-facing, but there might be some scope to develop relationships with several charities in respect of Alzheimer's disease research. The Director of Marketing and Communications agreed to liaise with the Director of Research and Development to incorporate appropriate research themes into the Older People's Strategy (due to be presented to the May 2014 Trust Board meeting). **DMC**

Trust Board members noted the scope to improve the format of this quarterly update report by reducing the emphasis on the standard data set and including more of a narrative commentary and additional information on UHL's research and development activities. The Medical Director agreed to provide this feedback to the Director of Research and Development accordingly. **MD**

Resolved – that (A) the Director of Marketing and Communications be requested to liaise with the Director of Research and Development before finalising the Older People's Strategy to incorporate any research related themes, and **DMC**

(B) the Medical Director be requested to feedback the Board's comments to the Director of Research and Development on potential improvements to the quarterly reporting format. **MD**

119/14/3 Medical Education – Quarterly Update Including the Quality Dashboard

The Medical Director introduced paper DD, providing the quarterly update on medical education and training issues at UHL and outlining the key priorities. He particularly

highlighted significant changes in the funding streams for post graduate medical training and the requirement for each CMG to deliver their training activity and appropriately capture this information within the accountability framework. The Acting Chairman advised that he would be attending a meeting on 25 April 2014 between the Associate Medical Director, Medical Education and the CMG Medical Education leads.

The Chief Executive drew members' attention to the University of Leicester's proposals to use SIFT funding allocations to improve the facilities in the Robert Kilpatrick Building on the LRI site and suggested that the scope to include this work in the Trust's Capital Programme be explored in the first instance. Members noted that the full Quality Dashboard was still under development but some CMG-level data against key education performance indicators was provided at appendix 2. The Chief Executive noted that the Associate Medical Director, Medical Education had been requested to liaise with her opposite number at Sandwell and West Birmingham NHS Trust, where the Dashboard had been used to good effect.

In discussion on the format of the report, members noted the scope to provide greater clarity and assurance within the narrative and opportunities to include an action plan (in the Trust's standard format). The Interim Director of Financial Strategy commented upon opportunities to mainstream the reporting of SIFT and MADEL funding and agreed to follow up opportunities for capitalising the planned works to the Robert Kilpatrick Building. The Chief Executive requested that this quarterly report also be presented to the Executive Workforce Board.

Resolved – that (A) comments on the format of the quarterly report be provided to the Associate Medical Director, Clinical Education; **MD**

(B) the Interim Director of Financial Strategy be requested to explore opportunities to mainstream the reporting for SIFT and MADEL funding and follow up the issue regarding financial arrangements for the proposed works to the Robert Kilpatrick Building, and **IDFS**

(C) the quarterly medical education report be presented to the quarterly Executive Workforce Board meetings. **MD**

120/14 RISK

120/14/1 Board Assurance Framework (BAF) Update

The Chief Nurse presented the latest iteration of UHL's BAF (paper EE) and the report was taken as read, noting that all Executive Leads and risk owners would be providing progress reports on any follow-up actions to the Risk and Assurance Manager outside the meeting. In respect of the 3 risks selected for detailed consideration, the Trust Board noted the following information:-

- **risk 1** (failure to achieve financial sustainability) – the Interim Director of Financial Strategy had recently re-cast this section, which had been supported by the Finance and Performance Committee on 26 March 2014. This was now in the process of being populated with the controls and timescales to meet any gaps in assurance;
- **risk 5** (ineffective strategic planning and response to external influences) – the Director of Strategy advised that she had re-written the narrative description of the processes and output measures for monitoring the high level plans. She sought members' views on a proposal to retain the current risk rating (16) and noted the Board's preference to increase the current rating to 25, and **DS**
- **risk 7** (failure to maintain productive and effective relationships) – the Director of Marketing and Communications reported on work in progress to address the gap in assurance relating to the statement on "no external and 'dispassionate' professional view of stakeholder/relationship management activity". He proposed that the Board

undertake a more informed review of this risk in June 2014. He also provided updated information in respect of the key controls, noting the arrangements for (i) the Board to meet in external venues hosted by stakeholders 3 times per year, (ii) meetings with CCG Lay Members and (iii) Healthwatch's new monthly briefing report to the Trust Board.

In discussion on the Board Assurance Framework:-

(a) the Non-Executive Director Audit Committee Chair sought and received clarity in respect of risk 1 (above) that the June 2014 timescale referred to the submission date for plans to achieve financial balance and not the date for achieving a financially balanced position;
(b) the Non-Executive Director Quality Assurance Committee Chair requested that the current risk rating for risk 3 (inability to recruit, retain, develop and motivate staff) be reviewed in the light of additional bed capacity plans and the Trust's ability to recruit sufficient staff;
(c) the Director of Strategy requested that engagement with the Trust's Commissioners be included within risk 7 (above), and
(d) the Acting Chairman noted the intention to hold a Trust Board development session on the 2014-15 BAF on 12 June 2014 and discussion took place regarding a previous suggestion that PWC might facilitate this event. In response, the Director of Corporate and Legal Affairs advised that the Director of Safety and Risk and the Risk and Assurance Manager would be liaising with PWC on this point to clarify the Trust's intentions for the structure of this development session. **DSR/ RAM**

<u>Resolved</u> – that (A) the Board Assurance Framework be noted;

(B) the risk score for risk 5 be amended to 25 (5x5); **DS**

(C) a further Trust Board review of risk 7 be undertaken in June 2014 and this risk be updated to include engagement with the Trust's Commissioners; **DMC**

(D) the score and actions for risk 3 be reviewed, factoring in the impact of additional bed capacity upon staffing levels, and **DHR**

(E) the Director of Safety and Risk and the Risk and Assurance Manager liaise with PWC to confirm the intended structure for the June 2014 Trust Board development session. **DSR/ RAM**

121/14 REPORTS FROM BOARD COMMITTEES

121/14/1 <u>Audit Committee</u>

The Minutes of the 15 April 2014 Audit Committee meeting will be submitted to the 28 May 2014 Trust Board meeting. Ms K Jenkins, Non-Executive Director Audit Committee Chair reported verbally on that Committee's meeting, noting in particular the Committee's review of the template for the Annual Governance Statement and her request to review a draft version before it was presented to the 27 May 2014 Audit Committee and the External Auditors. She also highlighted the need for the Audit Committee to review a wider range of assurance sources. **DCLA**

<u>Resolved</u> – that (A) the 15 April 2014 Audit Committee Minutes be presented to the 29 May 2014 Trust Board meeting, and

(B) a copy of the draft Annual Governance Statement be provided to the Audit Committee Chair for review, prior to submission to External Auditors and the Audit Committee. **DCLA**

121/14/2 Finance and Performance Committee

Resolved – that the 26 March 2014 Finance and Performance Committee Minutes be received, and the recommendations and decisions therein be endorsed and noted respectively.

122/14 TRUST BOARD BULLETIN

Resolved – that the contents of the April 2014 Trust Board Bulletin be noted as follows:-

(1) 2014-15 Annual Update of Trust Board Declarations of Interests; **ALL**
(2) Quarter 4 Sealings report, and
(3) Updated TDA Accountability Framework.

123/14 CORPORATE TRUSTEE BUSINESS

123/14/1 Charitable Funds Committee

Paper HH provided the Minutes of the 14 April 2014 Charitable Funds Committee meeting. Noting that parts of the meeting had been inquorate, the Trust Board endorsed Minutes 12/14 to 15/14 inclusive (as Corporate Trustee) and approved the applications detailed in Minute 16/14 due to their value being over the Committee's delegated authorisation limit of £25,000.

The Acting Chairman advised that he had attended the above meeting and he highlighted the need for a future Trust Board discussion on the strategies for charitable funding expenditure and investment of funds. Some high level discussion took place regarding the quantum of funds currently held and the level of return on investments. Assurance was provided that the Charity's Fund Managers reported regularly to the Charitable Funds Committee on the Charity's risk/reward strategy and that the next such presentation was due to feature on the 9 June 2014 meeting agenda. **CHAIR/ DCLA**

Resolved – that (A) the 14 April 2014 Charitable Funds Committee Minutes be received, and the recommendations and decisions therein be endorsed and noted respectively;

(B) specific Trust Board approval (as Corporate Trustee) be granted for application numbers 4949, 4952, 4892 and 4893 (as detailed within Minute 16/14), and **IDFS**

(C) consideration be given to scheduling a future Trust Board discussion on the Leicester Hospital Charity's strategies for Charitable Funds Committee expenditure and investment. **CHAIR/ DCLA**

124/14 QUESTIONS AND COMMENTS FROM THE PUBLIC RELATING TO BUSINESS TRANSACTED AT THIS MEETING

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

(1) an expression of support for the Renal Transplantation team from a member of the public who was also pleased to understand that arrangements were now being made to re-start UHL's transplantation service in the near future;

(2) a comment that some of the acronyms used within reports and during the meeting had made proceedings (in some areas) difficult to follow for members of the public, and

(3) a query regarding the additional bed capacity approved under Minute 117/14/3 above

and whether there were any Children's services beds included in the total number. In response, the Chief Operating Officer advised that UHL's bed base for Children's services was currently considered to be sufficient, although the Chief Executive and Chief Nurse noted some scope to improve the effective use of paediatric beds and recruit to any vacant posts.

Resolved – that the questions above and any related actions be noted and progressed by the responsible Executive Director.

125/14 ANY OTHER BUSINESS

125/14/3 Potential Venue for a Temporary Chapel/Multi-faith Centre

The CCG representative commented briefly upon the potential suitability of the C J Bond room at the LRI as a potential facility for an interim Chapel or a multi-faith centre.

Resolved – that the position be noted.

125/14/5 Use of Acronyms

Colonel (Retired) I Crowe, Non-Executive Director highlighted the availability of a dedicated electronic NHS acronym buster and advised that he would be happy to provide the details of this upon request.

Resolved – that the position be noted.

126/14 DATE OF NEXT MEETING

Resolved – that the next Trust Board meeting be held on Thursday 29 May 2014 in the Seminar Rooms, Clinical Education Centre, Glenfield Hospital.

The meeting closed at 3.58pm

Kate Rayns
Trust Administrator

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

Name	Possible	Actual	% attendance	Name	Possible	Actual	% attendance
R Kilner (Acting Chair)	1	1	100	R Mitchell	1	1	100
J Adler	1	1	100	R Overfield	1	1	100
T Bentley*	1	1	100	P Panchal	1	1	100
K Bradley*	1	1	100	K Shields*	1	1	100
I Crowe	1	1	100	S Ward*	1	1	100
S Dauncey	1	1	100	M Wightman*	1	1	100
K Harris	1	1	100	J Wilson	1	1	100
P Hollinshead*	1	1	100	D Wynford-Thomas	1	0	0
K Jenkins	1	1	100				

* non-voting members

University Hospitals of Leicester NHS Trust

Progress of actions arising from the Trust Board meeting held on Thursday 24 April 2014

Item No	Minute Reference	Action	Lead	By When	Progress Update	RAG status*
1	114/14 (d)	Clarity to be provided regarding the timescale for commencement of the quarterly BAF reviews of risk 2 (failure to transform the emergency care system).	COO	29.5.14	**Verbal update to be provided on 29 May 2014.**	
2	114/14 (f)	Chief Executive to provide an indicative date for submission of the Electronic Document and Records Management (EDRM) business case to the TDA.	CE	29.5.14	The two pilot areas are underway and are in the proving stage as requested. This stage will be complete in June. The main task of the pilot was to prove the benefits within the case and as soon as we have the final report confirming the original benefits and the newly identified ones the business case will be complete and ready to submit for approval at the end of June The initial view from the work with clinical genetics is that we have under-estimated the benefits that can be achieved as well as potential other models for the deployment.	4
3	114/14	Use of acronyms within Trust Board reports to be reviewed and the scope to provide a standardised list of commonly used acronyms to be explored.	DCLA/STA	Ongoing	Actioned. Glossary of standard NHS acronyms and UHL-specific terms to be handed out to public attendees at Trust Board meetings.	5
4	115/14	Progress reports to be provided to the Trust Board on the development of the LLR 5 Year Health and Social Care Strategy.	CE	As appropriate	Actioned. Verbal update to be included in the May 2014 Trust Board Chief Executive's report.	5
5	115/14	Director of Corporate and Legal Affairs to assume the role of Trust Senior Independent Risk Owner (SIRO) with effect from 24 April 2014.	DCLA	Immediate	Actioned. Director of Corporate and Legal Affairs has attended the 12 May 2014 Privacy Board and is arranging attendance at an external training course.	5

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

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

6	116/14/2	Subject to Executive Team approval on 29 April 2014, Acting Chairman and QAC Chair to approve the re-commencement of UHL's renal transplant service.	CHAIR/ QAC CHAIR	As appropriate	Actioned. Approval given to recommencement of service.	5
7	116/14/3	Progress of CQC action plan and future iterations of this document to be monitored by the Quality Assurance Committee.	CN/ QAC CHAIR	As appropriate	Actioned. Item features on QAC agenda for 28 May 2014.	5
8	116/14/4	Wording within the 2014-15 UHL Quality Commitment to be finalised through discussion between the Chief Nurse and the Chief Executive.	CN/CE	29.5.14	Actioned. Item features on QAC agenda for 28 May 2014.	5
9	117/14/1(b)	Chief Nurse to provide the Audit Committee Chair with supporting additional information on the meaning and the impact of the Quality Schedule and CQUIN indicators.	CN	Immediate	**Verbal report to be provided at the 29 May 2014 Trust Board.**	
10	117/14/1(c)	Chief Operating Officer to respond to the CCG Representative's query (re: the impact on Choose and Book if particular clinical specialties were excluded from the data) outside the meeting.	COO	Immediate	The Head of Performance Improvement provided this information to the CCG Representative by email on 24 April 2014.	5
11	117/14/1(d)	Director of Human Resources to consider setting milestones towards achievement of the 95% target for statutory and mandatory training compliance by the end of March 2015.	DHR	29.5.14	Under consideration.	4
12	117/14/3(c)	Finalised UHL Capacity Plan for 2014-15 to be presented for Trust Board approval in May 2014.	COO	29.5.14	Actioned. Featured on the 29 May 2014 Trust Board agenda.	5
13	117/14/3(e)	Progress report on UHL's nurse recruitment programme to be presented to the May 2014 Trust Board meeting.	CN	29.5.14	Actioned. Featured on the 29 May 2014 Trust Board agenda.	5
14	117/14/4	Feedback from the diagnostic phase of the health economy redesign work being undertaken by Dr I Sturgess be presented to the June 2014 Trust Board meeting (subject to availability).	COO	26.6.14	Dr I Sturgess is attending the 29 May 2014 Trust Board.	4
15	118/14/1	Alternative arrangements be developed for seeking Trust Board approval of the materials for the external facades of the new emergency floor building.	DS	29.5.14	Actioned at the Trust Board Deevlopment Session on 15 May 2014.	5
16	118/14/2(a)	Update on Delivering Caring at its Best to be presented to the May 2014 Trust Board meeting.	CE	29.5.14	Actioned. Featured on the 29 May 2014 Trust Board agenda.	5

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

17	118/14/2(b)	Older People's Strategy (including the links with dementia care) to be presented to the May 2014 Trust Board meeting.	DMC	29.5.14	Featured on the agenda for 29 May 2014 Trust Board.	5
18	118/14/3	Indicative timescales and work programme for building further specialised service alliances be presented to a future Trust Board meeting – to include an assessment of UHL's internal capacity.	DS	TBA	**Verbal update to be provided on 29 May 2014.**	
19	118/14/4	Director of Marketing and Communications to provide clarity on the outcome of the proposal that the UHL Members Engagement Forum to be co-chaired and provide assurance that any non-car drivers amongst the membership would not be disadvantaged by holding meetings on the LGH site.	DMC	29.5.14	**Verbal update to be provided on 29 May 2014.**	
20	119/14/2(a)	Director of Marketing and Communications to liaise with the Director of Research and Development with a view to incorporating any research related themes into the Older People's Strategy.	DMC	29.5.14	Actioned.	5
21	119/14/2(b)	Medical Director to provide feedback to the Director of Research and Development highlighting opportunities to include additional narrative commentary on current UHL R&D activities in future quarterly reports and reduce the emphasis on standard data sets.	MD	Immediate	**Verbal update to be provided on 29 May 2014.**	
22	119/14/3(a)	Medical Director to provide feedback to the Associate Medical Director, Clinical Education on opportunities to improve the format of future quarterly reports, providing greater detail of assurance and possibly including progress against an action plan (using the standard UHL template).	MD	Immediate	**Verbal update to be provided on 29 May 2014.**	
23	119/14/3(b)	• Opportunities to be explored to mainstream the reporting processes for SIFT and MADEL funding, and • funding resources for proposed works to the Robert Kilpatrick Building to be explored.	IDFS	29.5.14	Initial discussions held with the Associate Medical Director (Clinical Education) regarding financial reporting, progress will be reported through the Finance and Performance Committee. Proposed works to the Robert Kilpatrick Building will be discussed through the Capital Group and prioritisation of the programme will be agreed through the Trust Board.	4
24	119/14/3(c)	Quarterly Medical Education reports to be presented to the new quarterly Executive Workforce Board meetings.	MD	3.6.14 & ongoing	Provisionally scheduled on the 3.6.14 Executive Workforce Board agenda.	4

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25	120/14/1	Board Assurance Framework:- • the risk score for risk 5 be amended to 25 (5x5); • further Trust Board review of risk 7 be undertaken in June 2014 and this risk be updated to include engagement with the Trust's Commissioners • the score and actions for risk 3 be reviewed, factoring in the impact of additional bed capacity upon staffing levels, and • the Director of Safety and Risk and the Risk and Assurance Manager liaise with PWC to confirm the intended structure for the June 2014 TB development session.	DS DMC DHR DSR/RAM	29.5.14 29.5.14 29.5.14 12.6.14	Actioned.	5
26	121/14/1	Copy of the draft Annual Governance Statement to be shared with the Audit Committee Chair, prior to submission to the 27 May 2014 Audit Committee meeting and the External Auditors.	DCLA	Urgent	Actioned.	5
27	123/14/1(b)	Trust Board approval be granted for charitable funding application numbers 4949, 4952, 4892 and 4893 (as Corporate Trustee).	IDFS	Immediate	Actioned.	5
28	123/14(c)	Consideration be given to scheduling a future Trust Board discussion on the Leicester Hospital Charity's strategies for Charitable Funds Committee expenditure and investment.	DCLA/CHAIR	2014/15	Under consideration as part of a new Board effectiveness plan.	4

Matters arising from previous Trust Board meetings

Item No	Minute Reference	Action	Lead	By When	Progress Update	RAG status*
27 March 2014						
1.	90/14/1	*(2-year operational plan)* • clinical and strategic rationale for the vascular services proposals to be reported to the June 2014 Trust Board. • revised approach to considering business cases to be discussed by the Finance and Performance Committee and Trust Board. • timetable of Trust Board-required approvals for the individual capital schemes, to be developed and advised to Board members.	MD/DS IDFS IDFS	TB 26.6.14 31.5.14 by 24.4.14	Provisionally scheduled for 26 June 2014 Trust Board. To be considered as part of the review of the working of the Commercial Executive. Report to be considered by the 25 June 2014 Finance and Performance	4

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					Committee.	
2.	95/14/3	*(any other business)* (subject to recognised exceptions such as the quality finance and performance report, and formal business cases) All future Trust Board papers to be a maximum of 10 pages in length with no appendices, wherever possible.	All EDs	From April 2014 TB	Actioned.	5

tem No	Minute Reference	Action	Lead	By When	Progress Update	RAG status*
27 February 2014						
3.	56/14/3	EDRM business case to be submitted to the NDTA in parallel with the POC rather than afterwards.	CE/CIO	ongoing	In progress.	4
4.	61/14/1	*(Board assurance framework)* May 2014 Trust Board Development Session to review (and refresh as required) the Board Assurance Framework.	CN/ ALL	15.5.14 TBDS	timescale now agreed as the Trust Board Development Session on 12 June 2014.	4
20 December 2013						
5.	342/13/3	Trust Board development time to be allocated for discussion of issues relating to the UHL Travel Plan.	DCLA	~~31.3.14~~	Now programmed for quarter 2 2014-15 Trust Board development programme.	4
6.	344/13/1	Equality and Diversity report to feature earlier in the agenda in July 2014 and consideration be given to holding a Board development session on equality and diversity.	DCLA	31.7.14	Now programmed for quarter 2 2014-15 Trust Board development programme.	4
7.	344/13/2	Assurance, Escalation and Response Framework to be updated, implemented as a "live" document and further reviewed in March 2014.	DCLA	27.3.14	Provisionally scheduled on the 27 March 2014 Trust Board agenda. Deferred to the June 2014 Trust Board with the agreement of the Acting Chairman and Chief Executive.	3
8.	344/13/3	Trust Board calendar of business to be refreshed and presented to the February 2014 Board meeting for approval.	DCLA	27.2.14	Provisionally scheduled on the 27 February 2014 Trust Board agenda. Deferred to the June 2014 Trust Board with the agreement of the Acting Chairman and Chief Executive.	3

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University Hospitals of Leicester NHS
NHS Trust

To:	**Trust Board**
From:	**CHIEF EXECUTIVE**
Date:	**29 May 2014**
CQC regulation:	N/A

Title:	**MONTHLY UPDATE REPORT – MAY 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: **29 MAY 2014**

REPORT BY: **CHIEF EXECUTIVE**

SUBJECT: **MONTHLY UPDATE REPORT – MAY 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) the Trust's financial position as at month 1 2014/15;

(b) emergency care performance;

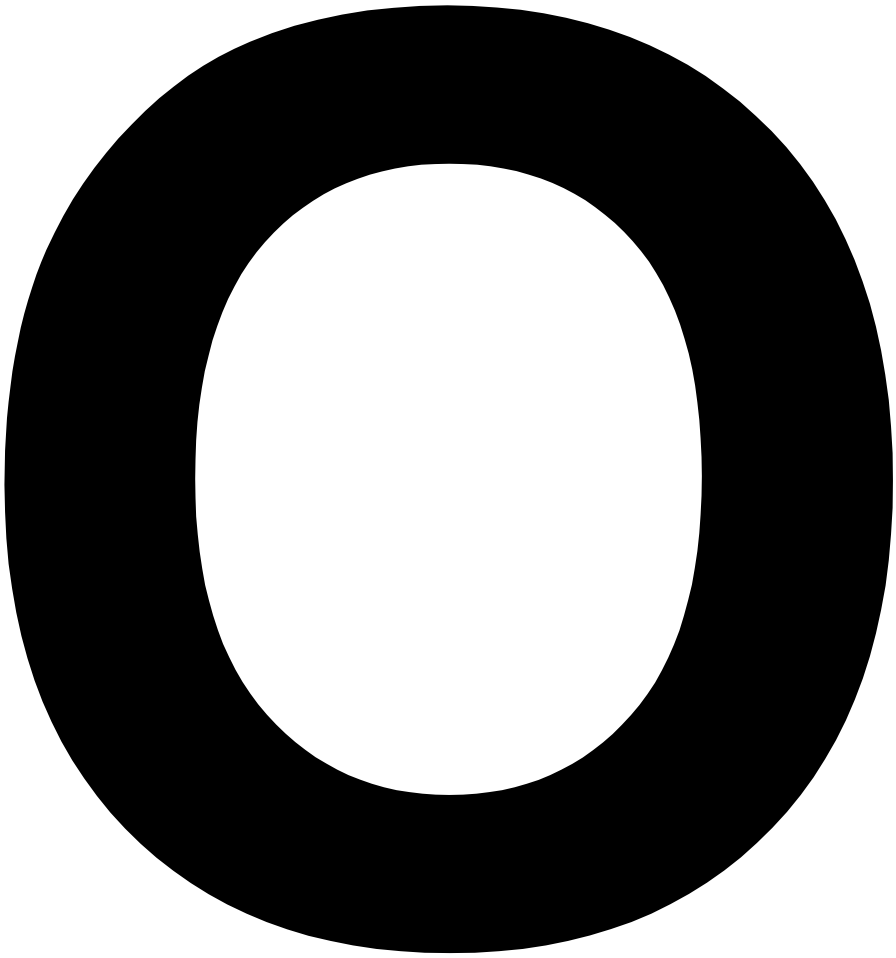
(c) the development of an LLR 5 year Health and Social Care Strategy;

(d) the first UHL Leadership Conference held on 21 May 2014.

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

23rd May 2014



Trust Board Paper O

To:	**Trust Board**
From:	Director of Marketing and Communications
Date:	**29th May 2014**
CQC regulation:	

Title:	**Caring for the Oldest Old**

Author/Responsible Director: Mark Wightman, Director of Marketing and Communications

Supported by: Heather Leatham, Dr Jay Banerjee, Dr Simon Conroy, Dr Kevin Harris, Lara Wealthall, Carole Ribbins and Rachel Overfield.

Purpose of the Report:
A Strategic Direction for Frail and Older People's Services at University Hospitals of Leicester NHS Trust.

The Report is provided to the Board for:

Decision		Discussion	X
Assurance		Endorsement	X

Summary / Key Points:

The NHS in its widest sense and for the purposes of this paper the acute sector specifically, need to recognise that frail older people are no longer a cohort of patients they are THE PATIENT and we should therefore act / plan accordingly. This is the proposed response from Leicester's Hospitals.

Recommendations:
The paper suggests a number of actions designed to…

1. Change culture and practice and recognise that we need to fundamentally up skill our staff to enable them to meet the needs of the oldest old.
2. Change our physical environment so that it is frailty friendly and understand that in doing so we are benefitting all patients.
3. Fix some of the basics which make caring for this cohort of patients harder or less effective.
4. Involve others in the design and planning of services for older people and involve carers in their care.
5. Position care of older people as core business by appointing an Executive and NED Board lead.
6. Create a brand which puts Leicester on the map and in doing so reassures our local population whilst attracting clinical talent and research funding.

… And seeks the Boards support for the strategy and its delivery through the establishment of an Older Peoples Strategy Board as part of 'Delivering Caring at its Best'.

Previously considered at another corporate UHL Committee? Endorsed by the Executive Strategy Board	
Board Assurance Framework: Safe, high quality, patient centred care.	**Performance KPIs year to date:** **To be decided**
Resource Implications (eg Financial, HR): To be determined	
Assurance Implications:	
Patient and Public Involvement (PPI) Implications: Data from patient surveys / feedback /complaints have informed the paper. Patient and carer representation on the Older People's Strategy Board will be essential.	
Stakeholder Engagement Implications: AGE UK (Leicester / Leicestershire) have been consulted and will continue to work with the Trust on this agenda.	
Equality Impact: We know that there are differences between cultures in their response to age and ageing… and as a consequence, different requirements and needs when it comes to the clinical care of older patients from different backgrounds. However, this is not a subject which has had much prominence locally or nationally and will therefore be an important component of the strategy / plan.	
Information exempt from Disclosure: NA	
Requirement for further review? Progress report in 6 months	

Trust Board 29 May 2014

Subject: A Strategic Direction for Frail and Older People's Services at University Hospitals of Leicester NHS Trust.

Title: "Caring for the Oldest Old"

Author: Mark Wightman, Director of Marketing and Communications.

Introduction:

There is no shortage of commentary or evidence that as a consequence of the changing demographic of our nation, there is an equivalent change required in the ways that both public and private sector services for older people are designed.

The subject of frailty and age is so all encompassing, even when it is just considered from an acute hospital's perspective, (where the only two services which are relatively untouched by the demographic changes are maternity and paediatrics), that it is impossible to create in one document a genuine frail older people's strategy which encompasses acute, social, primary, 3rd sector and mental health, care.

Instead, this paper focuses on some key themes, that can be considered to be within our own control and suggests either new or enhanced approaches which build on much of the good work which is already happening in different parts of the Trust. The fact that there are numerous initiatives already in train is a clear indication that many staff and staff groups recognise the importance of this subject. In that sense this Strategic Direction is also an attempt to 'package' existing work to create a unified approach to the care of older people. Finally whilst this paper has been put together by the DM&C the thinking has been largely influenced by discussions with colleagues, particularly, Heather Leatham, Dr Jay Banerjee, Dr Simon Conroy, Dr Kevin Harris, Lara Wealthall and Carole Ribbins and Rachel Overfield.

Definitions:

In discussions with colleagues and in the research underpinning this paper it is clear from the outset that there are cultural issues which impact on any discussion related to the care of frail older people. Foremost is the tendency to discuss the ageing population in pejorative terms, underpinned by the assumption that with age comes frailty. This is not the case. Self-reporting shows that the majority of people aged over 80 are satisfied or very satisfied with their health. (Oliver 2012, Discrimination in Health Services for Older People' International Journal of Medical Ethics).

'Frailty' and 'age' are clearly linked but the assumption that one has to be old to be frail overstates the case and misses the point that there are other causes of frailty. This is important both in terms of acknowledging that whilst our ageing population, undoubtedly

creates new challenges it is also an opportunity in terms of many people living longer, economically productive lives during which they contribute more than ever to the wealth of the nation. One only has to look at the number of older people pushing prams during school half terms to recognise that their contribution to wider society is often overlooked.
Indeed, even the term 'older' can be divisive because it begs the question, at what age does one become an older person? The phrase used by our own clinicians Dr Jay Banerjee and Dr Simon Conroy in their 'Silver Book', ('Quality Care for Older People with Urgent and Emergency Care Needs') is useful here… they refer to the 'oldest old' as those people most in need of a new approach from health services.

Therefore the key principle of this paper is that whilst it will most often link age and frailty, in terms of the patient population, the cohort of people it specifically centres upon is the 'oldest old'.

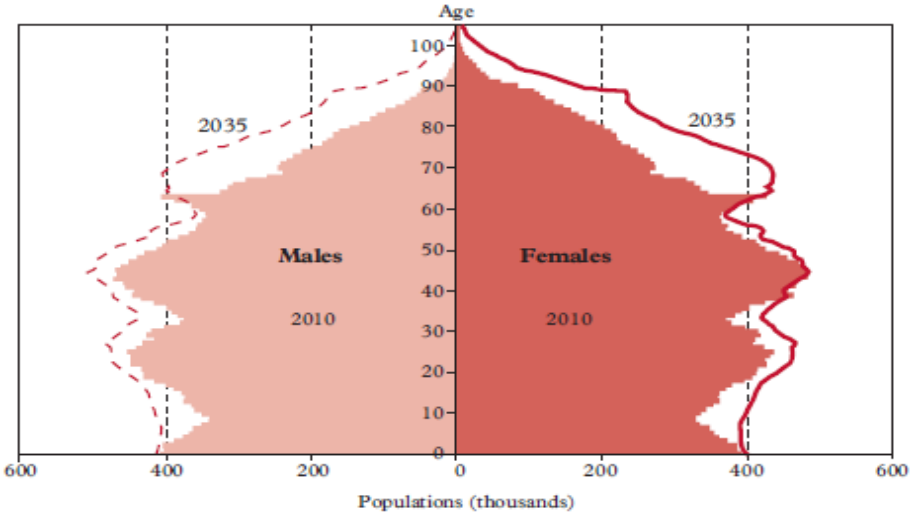
Context:
During the next 16 years we will see…

- 51% more people aged 65 and over in England in 2030 compared to 2010
- 101% more people aged 85 and over in England in 2030 compared to 20102
- Over 50% more people with three or more long-term conditions in England by 2018 compared to 2008
- Over 80% more people aged 65 and over with dementia (moderate or severe cognitive impairment) in England and Wales by 2030 compared to 2010.

(HOUSE OF LORDS Select Committee on Public Service and Demographic Change. Report of Session 2012–13 'Ready for Ageing?'**)**

The increased older population is shown in the 'Christmas tree' diagram (Figure 1) below, with the biggest increase in profile amongst those people aged 70-90.
Figure 1

Estimated and projected age structure of the United Kingdom population, mid-2010 and mid-2035[55]



Locally we are already seeing this impact. Recent reviews have told us that the age related illness has caused a dramatic shift in acuity in many of our inpatient wards and our own data shows that whilst A&E attendances are broadly stable, admission rates continue to increase.

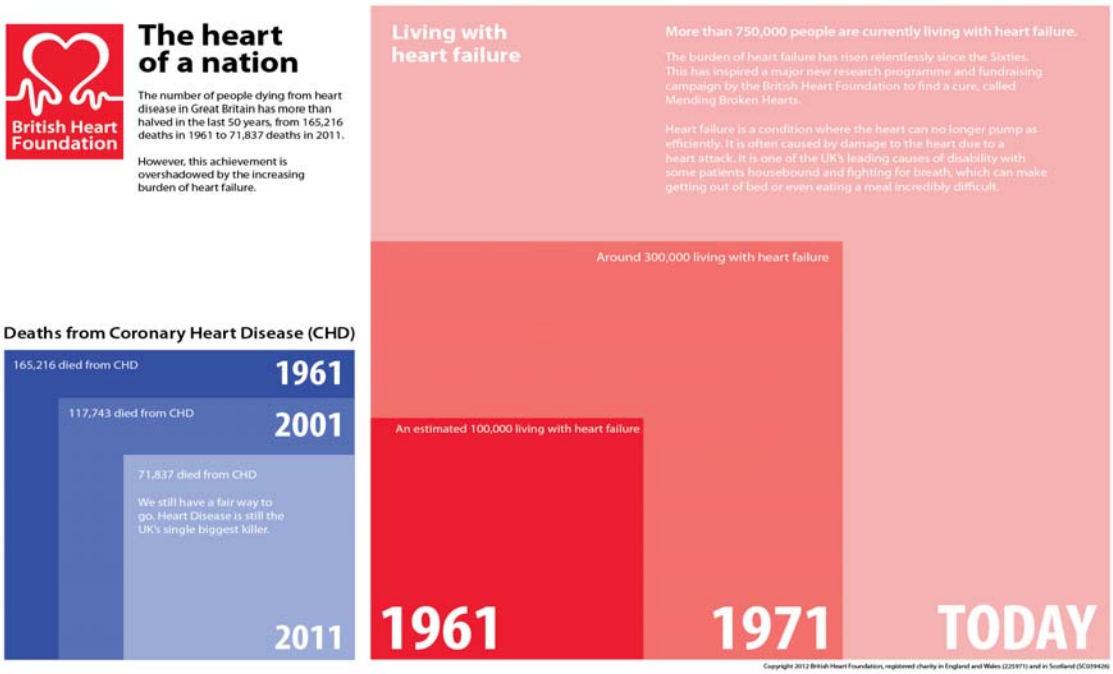
Figures released by the Health and Social Care Information Centre have shown that the number of people aged over 90 who have gone to hospital by ambulance has risen 81 per cent – up from 165,910 in 2009-10 to 300,370 last year.

As stated above an older population is not in itself a problem. The problems occur when the demographic changes are not matched by equivalent changes in service delivery.

Clinically, we know that for a cohort of older patients there is an increased likelihood that they will not only live for longer but will live with illness for longer and for the majority of patients it will not be a single long term condition they live with.

The graphic in Figure 2 (below) speaks to this point. Deaths from coronary heart disease have plummeted over the last 50 years both as result of lifestyle factors but also because surgeons and cardiologist are now able to routinely operate on a cohort of patients who until very recently would not have been able to withstand the hitherto invasive nature of a heart procedure. Now with the advances in technique and technology clinicians can fit new heart valves in a cath' lab, not an operating theatre, non-invasively, meaning that it is common for patients of 75 years and older to have years added to their lives and to be back on their feet within a couple of days.

Figure 3



However as a consequence and as the BHF graphic shows, there has been seven fold increase in those people now living with heart failure.

Again, by 2030…

- People with diabetes: up by over 45%
- People with arthritis, coronary heart disease, stroke: each up by over 50%
- People with dementia (moderate or severe cognitive impairment): up by
- over 80% to 1.96 million
- People with moderate or severe need for social care, up by 90%.

If we then overlay the fact that a majority of older, frail, co-morbid patients also have some kind of brain disease ranging from transitory delirium to dementia, we must ask ourselves… are we properly prepared?

The House of Lords Select Committee on ageing thinks not:

"The National Health Service will have to transform to deal with very large increases in demand for and costs of health and social care. Overall, the quality of healthcare for older people is not good enough now, and older people should be concerned about the quality of care that they may receive in the near future. England has an inappropriate model of health and social care to cope with a changing pattern of ill health from an ageing population".

And the Kings Fund agrees:

"The model of acute care is unsuited to patients with complex needs. The physical environment, working practices and care processes of acute hospitals geared to the model of acute medical care presuppose that the main task of the hospital is treatment and cure. However, care pathways and performance targets for waiting times and access to elective procedures are either irrelevant or actively obstructive to high-quality care for patients with complex conditions".

(KINGS FUND "The care of frail older people with complex needs: time for a revolution". Author: Jocelyn Cornwell March 2012)

Overall the diagnosis appears to be that the NHS in its widest sense and for the purposes of this paper the acute sector specifically, need to recognise that frail older people are no longer a cohort of patients they are THE PATIENT and we should therefore act / plan accordingly.

The rest of this paper looks at some of the specific challenges we face as a result of the context described above and proposes a number of actions to address these challenges.

Challenges and suggested actions

Culture & leadership:

The cultural and language aspects of caring for older people are deeply ingrained. First, at a societal level we recognise that this country's approach to older members of our society differs significantly from that of say, the southern European countries. Moreover in the national discourse around older people's care, phrases like 'perfect storm', 'bed blockers' and 'financial burden' all contribute to the mind-set that older people with health issues are a problem as opposed to a natural consequence of advances in medicine and public health, which could, if we chose to, be celebrated.

The cultural element is also present within the health service itself. The Kings Fund states that, 'Older people's services do not have high societal status and are not generally considered attractive options for professionals'… meaning that there is a shortage of a doctors willing to specialise in geriatric medicine and a perception amongst some staff that the care of older people is somehow less clinically meaningful than for example, nursing in certain surgical specialities.

The reality is that for those who have chosen to specialise in the medical care of older people and for those nursing older people, the job is rewarding whilst, especially for nurse colleagues, tremendously demanding, largely as a result of the historical link between nurse staffing levels and 'acuity' which takes little account of the unique demands placed upon those nursing the oldest old who can often be confused and wandering.

The time is right in a post Francis world to reposition care of older people, especially for nurses, in a way that recognises that it requires levels of compassion, skill and technical ability *at least* equivalent to those healthcare professionals who specialise in paediatric care. The Kings Fund report already referenced above says, "We need to see a revolution in the education and training of current and future staff so that staff are equipped to care for the majority of the patients they are there to serve."

ACTIONS:

1. *We should consider creating a new nursing qualification for those caring for the oldest old.* The cohort of nurses who are supported to seek this qualification will be the 'best of the best', specifically those are already showing the caring and technical skills they will require to become masters in their field of expertise. Ideally the qualification will be co-created with partners at DeMontfort University, and we should explore the potential for central funding for a pilot cohort. Crucially, we must 'brand' these nurses in such a way that once qualified they, stand out in the eyes of their peers, the patients and the public. (Red Uniforms). Given the changes in demography and the required changes in the health services these nurses will ultimately be the Nurse Directors / Chief Nurses of the future… recruited for values and ability and prepared to meet the demands of the NHS in 5-10 years' time.

2. The Trust has previously had a board level Director of Services for Older People, (DSOP). Due to changes in personnel the position was lost when the post holder

changed roles. We should look at this again. However, this time around rather than creating a Director and accompanying directorate, (which has since morphed into the Patient Experience Team) we should look to simply having *a named Director and Non- Executive Director* who have, as a key priority within their portfolio the task of consistently testing / questioning Board decisions in line with this strategy and the ultimate goal described in the Summary / Vision below.

Clinical Specialism:

The rise of clinical specialisms over the years has clearly brought many benefits to patients. However, the role of the specialist is to diagnose, treat and cure in their field of expertise. In the care of the oldest old there is no 'cure' for ageing and as such it requires a different approach and mind set from the clinicians involved in their care. On a number of occasions when researching this paper people mentioned that when it came to the care of the oldest old (especially those with multiple long term conditions), "The consultants did their bit according to their specialism but nobody seemed to be in overall charge of my…" (Father in law / Dad / Mum etc).

As we know increasingly, (outside of paediatrics and obstetrics), the 'average' patient is becoming older and frailer. The current response to this conundrum in most health economies is to hire more geriatricians to work alongside their colleagues as part of the MDT, offering a more holistic view of care plans. However, as a result of the shortage of geriatricians there are more posts than people. This is likely to continue and is linked in part to the cultural aspects of caring for older people discussed above.

ACTIONS:

1. *Improve the trust's ability to recruit and retain geriatricians*, see section on 'brand' below.
2. *Consider the creation of non medical consultant posts specialising in care of older people, (nurse consultants).*
3. *Consider an approach to 'core' training for clinicians which incorporates a module based on care for the 'oldest old'*. In other words if we recognise that care of the oldest old is increasingly likely to be a component of the clinical care of most of our patients, then rather than rely on older people's specialists to compliment the decision making of say a cardiologists, we seek to up skill / educate our other specialists to become more competent in the care of older people. Whether or not this would eventually become a 'mandatory' training module is for discussion but we should perhaps consider that what defines mandatory is at least in part, a result of what is most commonly / urgently required for all clinicians to know.

4. *Consider how we best co-ordinate the care of the oldest old recognising that those with co-morbidities will often cross services and specialities. For example, the creation of a post of patient specific 'care co-ordinator'* within hospital. These people would be tasked with the 'choreography' of care across different disciplines and specialisms.

Fostering research and innovation in the care of older people:

A consistent theme in feedback from colleagues is that when we compare care of older people as a specialism with other clinical specialisms the related research and innovation activities seem relatively underdeveloped.

Whilst many of the strongest research areas in the trust focus on older people with multi-morbidity and/or cancer, the activities are commonly defined by disease area, and the context of the older person is often not emphasised. Currently in UHL there are many examples of care pathway re-design and clinical service developments focused on older people and frailty. Many of these clinical service developments in the care of older people are innovative in themselves, and may be amenable to academic study and evaluation. Therefore we need to increase the profile of research and innovation activities involving older people whilst at the same time creating an environment where the activities can grow and flourish. We need to provide our talented clinical teams with the tools required to initiate and complete research projects involving this group of people and help them obtain funding if required. Furthermore we need to take the opportunity presented by implementation of service changes to facilitate academic evaluation of novel clinical services, and where appropriate disseminate our experiences to the wider health community, especially recognising that there are distinct cultural differences to ageing in the communities we serve.

ACTIONS:

1. Explore with our partners at the University of Leicester the development of an academic post to support research and innovation in the care of older people.
2. The UHL R&D office will provide a 'horizon scanning' function to bring research opportunities to the attention of our researchers in a timely manner.
3. We will support the development within UHL of an Improvement Science and Innovation Unit. This will provide a structure to allow the academic evaluation of service change and ensure that we do not miss opportunities for learning and dissemination.

Environment and facilities:

Patients with frailty and dementia, or other kind of brain diseases require a purpose built or at the very least an adapted environment if they are to feel at their safest, most comfortable and well oriented.

Our children's wards, clinics and A&E are tailored to the requirements of young people in recognition that they are small, fragile, scared, not always able to communicate and of course, ill. We would never contemplate treating a child on an adult ward but we routinely treat older people with similar needs in compromised environments.

Clearly, with over 100 wards across the Trust the notion that we can either afford or continue to operate effectively whilst redesigning them for frailty is beyond us. However, if

we start from the position that our aspiration is to make all appropriate wards frailty friendly over a timescale of say, 10 years, then we might be able to achieve our aspiration with judicious use of capital and even a contribution from a charitable funds campaign.

Action:

1. *Form a task and finish group consisting of nurse / clinician / facilities and PPI to scope and establish what a frailty friendly ward would look like*. (Signage, social space, flooring, acoustics, lighting, bed side furniture etc). This work will be influenced by the information that we already have from the 'Quality Mark for Elder Friendly Wards' scheme. Calculate the cost per ward and work with finance and charitable funds colleagues to devise a programme for implementation.

<u>The first 'Frailty Friendly' A&E :</u>

The rise in attendances and subsequent rise in admissions to adult ED from those people aged over 65 is well known. We have already committed to building a new A&E and Emergency Floor and within that commitment is the desire to create England's first 'frailty friendly' A&E.

However, as there is no current blueprint for what such a facility would look like from a patient or clinical perspective it will be both necessary and an opportunity for the Trust to create the NHS 'industry standard' model for a bespoke emergency / urgent care environment for the oldest old. There is also an opportunity to think about this in terms of brand and potential beneficial endorsement of our new A&E. Specifically, the Trust has built good relations with partners in AGE UK locally and we are already working on a plan to bring an AGE UK advice shop into the Royal Infirmary. There is the potential, if AGE UK colleagues are included in design discussions early enough, for us to seek a unique partnership for the 'UK's first Frailty Friendly ED in association with AGE UK.'

ACTIONS:

1. Form a task and finish group consisting of nurse / clinician / facilities and PPI to scope and establish what a frailty friendly A&E would look like. (Signage, social space, flooring, acoustics, lighting, bed side furniture etc).

2. *Seek agreement in principle for AGE UK endorsement of Leicester's new A&E* subject to necessary assurances and involvement in the design blueprint.

3. Explore the possibility of *securing national funding* (or at the very least national recognition) that the Leicester way is a THE beacon for best practice.

<u>Fixing the basics:</u>

There are some recurrent themes when speaking to nurses or reading patient feedback and complaints which we might class as 'basics'.

For example, we know that hospitals are confusing and often frightening places for older people. Especially for those with dementia or delirium. Just imagine how much more confusing the environment becomes when a hearing aid or patients glasses are lost. Visual

and auditory functions already compromised by age can reduce, meaning that a smile and some reassuring words from the care team are lost on the patient.

Other 'basics' which come up all too often are things like meal portion sizes for older people,(little and often as opposed to 3 x 3 courses a day which can be daunting to people more used to 'grazing').
Patient moves and outlying, especially if this happens in the small hours, which just adds to feelings of confusion and disorientation; standard issue low trolleys which are easier for staff and patients alike to use.

ACTION:

1. *Hold a Listening into Action style event with staff, carers, partners and patients to look at some of the basics and quick wins*. Then take this feedback and commit to addressing the issues within a defined period, (12 months).

<u>Involvement of carers:</u>

In other parts of this paper the comparisons between how we care for the oldest old and some of our youngest patients are discussed in the sense that they share many similar vulnerabilities but do not benefit from the same bespoke approach to service design.

In paediatrics we would not consider carrying out ward rounds without the parents of sick children being present but we do routinely carry out ward rounds without involving an older persons carer.

Research shows that of those older patients who have carers approximately 25% of them are spouses and in the main they are co-habiting with the patient when well. 50% of carers are sons or daughters. The point is that in many cases the carers have unique and rich information about an older persons 'normal' state and as such they are hyper aware of anything 'abnormal'.

How many times have we heard in the media that, "I knew something was wrong with mum, she was going downhill fast but I couldn't get anyone to listen."?

For example, an invented but nonetheless representative scenario; an older patient admitted with a Urinary Tract Infection, who as a result, is at a heightened risk of delirium, which is often mistaken for dementia because the symptoms (acute confusion) are uncannily similar whilst the treatment is vastly different. In this example the carer is crucial to a fast and accurate diagnosis i.e. if they are able to describe their spouse or parent as generally functioning without impairment in their normal state and therefore unusually confused at the time of admission… or subsequent to admission, the nurses and doctors are more able to diagnose effectively.

ACTIONS:

1. We should consider how we can more effectively *use information from carers to improve the quality of care for the oldest of the old.* This might be by inviting carers to take part in a ward based review of the patients progress, and / or…
2. *Invite carers to construct a pen portrait of their relative* which would be included in the patients notes. The point being that if healthcare professionals can appreciate what the person was like before the current symptoms and the current almost inevitable look of vulnerability, they might have a better understanding of what a 'return to form' would look like. For example…

"Mrs MW is 83. Before her admission to hospital she lived alone, was devoted to her small dog, Sally and was active socially, she still maintains and runs her own car. Her hearing and eyesight is good.
She was occasionally unsteady on her feet but showed no signs of confusion.
Before retirement she was a policewoman in the Rutland Constabulary and a radiographer at the Royal Infirmary."

<u>Brand:</u>

As we build upon the Trust's Strategic Direction and start to devise business plans for our Clinical Management Groups we will inevitably begin to discuss brand and specifically how we might differentiate our potential brands to compete for patients and for nurse and clinician talent. 'The East Midlands Heart Centre' / 'The Leicester Respiratory Centre' / 'The Leicester Cancer Centre in Association with CRUK' are all on the table and ripe for marketing, assuming that we can show that there is a return on investment in attracting patients regionally and nationally.

In terms of market positioning there is plenty of competition in many of our specialist markets.

However, thus far no Trust in the country has sought to position itself as excellent in the care of older people. The reason for doing so would be different compared to that of our tertiary markets. We would not be seeking to attract more patients, if anything the opposite would be true BUT in terms of attracting talent and research funding, positioning the Trust as the NHS leader in the care of older people would be attractive. In fact given the predicted growth in this population the premise that caring for the oldest old is beginning to look like our core business, one might ask why wouldn't we seek to make the 'Leicester way' a brand in its own right?

ACTIONS:

1. Given that the integrity / success of a brand is based entirely on whether the product or service it relates to is effective, then the only action is really to decide whether we want to enact some or all of this strategic direction for older people. If we do, then we have the underpinnings of a brand.

Delivering this strategy:

The new 'Delivering Caring at its Best', (DC@iB) project structure will include a dedicated multi-disciplinary board which will drive the Older People's strategy. The board will bring together clinicians, nurses, AHPs under the leadership of the Chief Nurse and Director of Marketing & Communications. The task of the board is twofold first to take each of the strands of this strategy and create the plan to enact them; second to join up the various elements of the Trust's existing work on the care of older people to avoid duplication and to focus attention on the actions which will have the most material benefit for patients.

ACTIONS:

1. Establish the older peoples strategy board, with due consideration to the right clinical input and the patient / carer voice and create the project initiation document, (PID) to plan and execute the strategy.

Summary / vision:

As stated in the introduction this paper does not set out THE strategy for care of the 'oldest old' in Leicester's hospitals. Instead it seeks to propose a strategic direction with examples of actions to be taken and ideas to explore or mainstream in response to some of the current challenges. There is lots of good work already in train, (Dementia champions, Meaningful Activities Co-ordinators etc).

It is also recognised that this paper is silent on matters of integration across primary, social and mental health care. This is not to downplay the pressing need for such services and clinical pathways to be more systematically 'joined up' but is rather, a reflection that those discussions are best held between clinical teams across the various partner agencies.

In talking to the doctors and nurses with specialist knowledge of caring for the oldest old, the consistent theme is that if a hospital designs services, environments and care pathways with this cohort of patients in mind, then ALL patients benefit.

With this in mind the 'lift pitch' for this paper is:

The NHS needs to focus on the care of the oldest old. As far as Leicester's Hospitals are concerned we are already seeing the impact of demographic changes. If we recognise this and think about the requirements of patients who are old and frail we must necessarily see that there is much we could do to improve. This will require us to…

1. Change culture and practice and recognise that we need to fundamentally up skill our staff to enable them to meet the needs of the oldest old.
2. Change our physical environment so that it is frailty friendly and understand that in doing so we are benefitting all patients.
3. Fix some of the basics which simply make caring for this cohort of patients harder or less effective.
4. Involve others in the design and planning of services for older people and involve carers in their care.
5. Position care of older people as core business by appointing an Executive and NED Board lead.

6. Create a brand which puts Leicester on the map and in doing so reassures our local population whilst attracting clinical talent and research funding.

Recommendations:

The Board are invited to discuss the contents of this paper; endorse / support the strategic direction and remit the Older People's Strategy Board to carry this work forward with progress being reported in 6 months.

ENDS

REFERENCES:

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Health and Social Care information Centre, Accident and Emergency Attendances in England - 2012-13 Publication date: January 28, 2014

Oliver 2012, "Discrimination in Health Services for Older People" International Journal of Medical Ethics

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REPORT TO: **Trust Board**
DATE: **29 May 2014**
REPORT BY: **Richard Mitchell, Chief Operating Officer**
SUBJECT: **Modelling the 'right-sizing' of UHL capacity for 2014-15 - update**

Introduction

This paper is an update to the capacity paper brought to Executive Performance Board and Finance and Performance Committee in April 2014.

Agreed capacity increase

The agreed version detailed in table one below reduces the additional bed requirement to 55. Following conversations with respiratory medicine, the CMG has confirmed it plans to utilise their existing beds more effectively negating the need to increase beds by ten. The plan is to increase the bed stock by **45 beds**.

		Current Beds (Dec'13 census)	Bed Increase with no efficiency improvements V1				Bed Increase efficieny improvements in DC rates, Surgery Triage, DTOCs V2				14-15 Bed Base requirements
CMG		TOTAL INPATIENT BEDS	*LRI*	*GH*	*LGH*	*Total*	*LRI*	*GH*	*LGH*	*Total*	1546
CHUGS	Bone Marrow Transplantation	5				0				0	5
	Clinical Haematology	41				0				0	41
	Clinical Oncology	25				0				0	25
	Gastroenterology	58				0				0	58
	General Surgery and Urology	198	6		6	12	2		2	4	202
	Hepatobiliary & Pancreatic Surgery *see General Surgery*					0				0	
	Urology *see General Surgery*					0				0	
Emergency & Specialist Medicine	Accident & Emergency *NB EDU re-classified as ward attender*	8				0				0	8
	Chemical Pathology	0				0				0	0
	Clinical Immunology	0				0				0	0
	Dermatology	0				0				0	0
	Infectious Diseases	18				0				0	18
	Integrated Medicine	370	52			52	37			37	407
	Neurology	42				0				0	42
	Rheumatology	0				0				0	0
ITAPS	Critical Care Medicine *NB apportioned to relevant treatment spec*	33				0				0	33
	Interventional Radiology	0				0				0	0
	Pain Management	0				0				0	0
	Sleep	0				0				0	0
Musculoskeletal and Specialist Surgery	Breast Care	17				0				0	17
	ENT	43	4			4	0			0	43
	Maxillofacial Surgery *see ENT*					0					
	Ophthalmology see ENT					0					
	Plastic Surgery *see ENT*					0					
	Orthopaedic Surgery	57			10	10			4	4	61
	Sports Medicine	0				0				0	0
	Trauma	84				0				0	84
	Vascular Surgery	28				0				0	28
Renal, Respiratory and Cardiac	Cardiac Surgery	48				0				0	48
	Cardiology	153				0				0	153
	End Stage Renal Failure *see Nephrology*	0				0				0	0
	Nephrology	55				0				0	55
	Renal Access Surgery *see Nephrology*	0				0				0	0
	Renal Transplant *see Nephrology*	0				0				0	0
	Respiratory Medicine	153		10		10		10		10	163
	Thoracic Surgery	20				0				0	20
	Gynaecology	35				0				0	35
	ALL SPECIALTIES	1491	62	10	16	88	39	10	6	55	1546

Table one

The modelling is predicated on three elements for improvement:

- Move of all suitable elective work to daycase – fully within UHL's control
- Introduction of surgical triage – fully within UHL's control
- Reduction in DTOCs to 3.5% - requires significant support from partner organisations, see table two below. Since 10 April 2014, DTOCs have been above 5.0% with 82% of the reasons being external or nursing homes. If this does not reduce, the modelling suggests we will not have enough beds at times of peak activity.

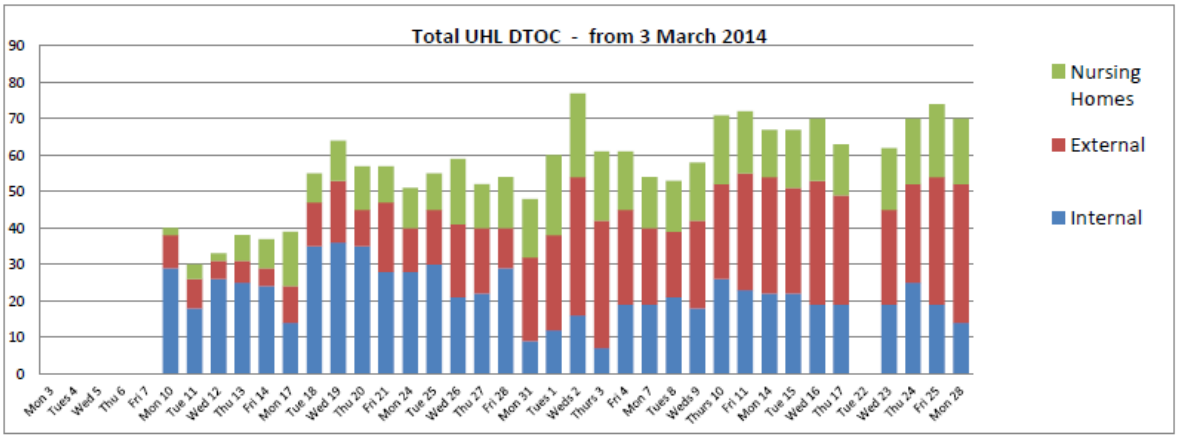


Table two

Location of capacity increase

Recent conversations with the surgical CMGs (in particular Richard Power) have highlighted the importance of providing a ring fenced daycase/ 23 hour facility on the LRI site. Following the last ET meeting on 13 May 2014, a meeting was convened on 20 May 2014 to discuss the proposal for the beds. This meeting was cancelled because of acute operational pressures on the day. Surgery CMGs and the E&SM CMG both have valid reasons for wanting to use the modular facility for their patients. Based on phone conversations on 23 May 2014, the following recommendations are made:

- The modular ward facility is used to provide two wards of medical beds including the re-provision of the Fielding Johnson ward.
- Additional medical beds are provided as detailed in page three of appendix one.
- Existing surgical wards including the daycase facility are ring fenced for elective surgical work, irrespective of acute pressures. The modelling indicates that surgery does not need more beds on the LRI site, it just needs the beds to be ring-fenced. A decision on when the facility can be ring fenced is still to be made. There are three options, all of which will be dependent on staffing numbers:

    - Ring fence from end of September 2014 (see table three below)
    - Ring fence from end of February 2015
    - Two staged approach, daycase facility ring fenced end of September 2014 and other surgical facilities ring fenced from end of February 2015.

- The LRI will not have a decant facility.
- Completion dates may be restricted by our ability to staff the wards.

LRI Modular	End of September	28 Beds
LRI 15 and 16	End of Feb 2015	5 Beds
LRI 33	End of Feb 2015	1 Beds
LRI 37 and 38	End of Feb 2015	10 Beds

Table three

Costs

Capital

Based on a reworking of the original plans, additional funding requirement of £1.75 million is required for the above with all expenditure substantially complete within the 2014 - 2015 financial year. This is a

reduction of £2.25m on the previous value. Revenue consequences of capital costs need to be reviewed.

Actions

- This is a complex change involving strategy, finance, nursing, medical directorate and operations spanning three CMGs. Actions, exec leads and timeframes are below. Dedicated project resource to support this has been identified and Themba Moyo began on 27 May 2014, working with us for three months.
- Increased work to reduce the DTOC rate.
- Continuation of the surgical triage and daycase work both currently picked up through EY supported work streams.

Actions for delivery of the capacity plan		
Quality	Exec lead	Timeframe
Risk assessment including the provision of nurse and medical staff for the additional beds	RO	10/06/2014
Confirmation of nursing assumptions	RO	10/06/2014
Discussion re medical cover for the additional beds	KH with RM	03/06/2014
Sign off of locations by CMG nurse leads	RO	03/06/2014
Finance		
Trust capital plan reviewed and judged against other priorities	PH	Complete
Revenue plan reviewed and method to support agreed	PH	03/06/2014
Review of beds plan and assumptions	RM with JA	03/06/2014
Recurrent revenue impact in respect of opening the additional beds be provided	PH	03/06/2014
Recruitment		
Recruit to nurse vacancies as part of overall plan	KB	Ongoing
Operational		
Short term actions to close the capacity gap	RM	Complete
Confirmation of locations for beds at the General	RKinn	27/05/2014
Discuss with clinical senate	RM	Complete
Appointment of project manager	RM	Complete
Strategy		
Tie in with five year plan	KS	01/06/2014

LRI Beds Executive Summary

FEASIBILITY INTO THE OPPORTUNITY TO CREATE ADDITIONAL BEDS WITHIN THE EXISTING FOOTPRINT OF THE LRI SITE

MAY 2014 VERSION 1.3

Introduction

Two feasibility studies have been carried out at Glenfield in February and then LRI in April to develop solutions to deliver additional beds. The headlines were:

- Glenfield:
  - Quick short term bed wins - £0.15 million (12 Beds)
  - Medium term/cost bed wins - £0.15 million (4 Beds)
  - Longer term and relatively more costly bed wins - £2.55 million (41 Beds)
- LRI:
  - Quick short term bed wins - £3.00 million (33 Beds)
  - Medium term/cost bed wins - £3.75 million (62 Beds)
  - Longer term and relatively more costly bed wins - £3.50 million (38 Beds)

Proposal

Across the two sites a total of 190 Beds (Glenfields 57 and LRI 133) could be created but with varying timescales, costs and cost per bed.

The Trust will therefore have a view on how many beds it wishes to create as a possible first tranche and the split between sites. This report proposes the following schemes with their selection being based on a balance of cost and timescale and CMG buy-in:

▪ Decant ward - LRI Modular Ward (uplift from OPD)	- 28 Beds	- £0.67 million
▪ Medical LRI - Ward 15	- 3 Beds	- £inc below
▪ Medical LRI – Ward 16	- 2 Beds	- £inc below
▪ Medical LRI – Ward 37	- 9 Beds	- £inc below
▪ Medical LRI - Ward 33	- 1 Beds	- £inc below
▪ Medical LRI – Ward 38	- 1 Beds	- £inc below
TOTALS	**44 Beds**	**£1.75m**

Clinical Impact of Delivery

The proposal seeks to deliver the increased Beds incrementally due to decanting etc. Assuming an instruction to proceed in early May then deliver would be broadly as follows:

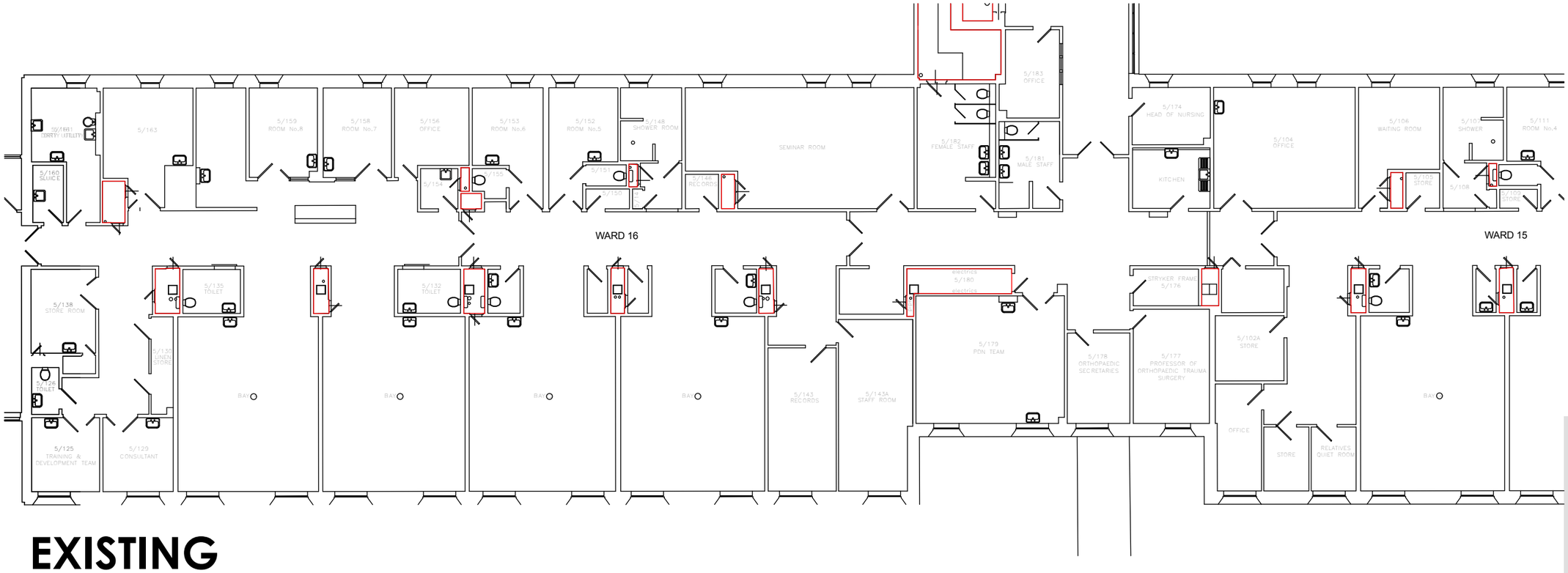
▪ LRI Modular delivered end of September	+ 28 Beds	- gross increase 28 Beds
▪ LRI 15 and 16 end of Feb 2015	+ 5 Beds	- gross increase 33 Beds
▪ LRI 33 end of Feb 2015	+ 1 Beds	- gross increase 35 Beds
▪ LRI 37 and 38 end of Feb 2015	+ 10 Beds	- gross increase 46 Beds

- Net additional funding requirement of £1.75 million with all expenditure substantially complete within 2014/2015 financial year

Way Forward

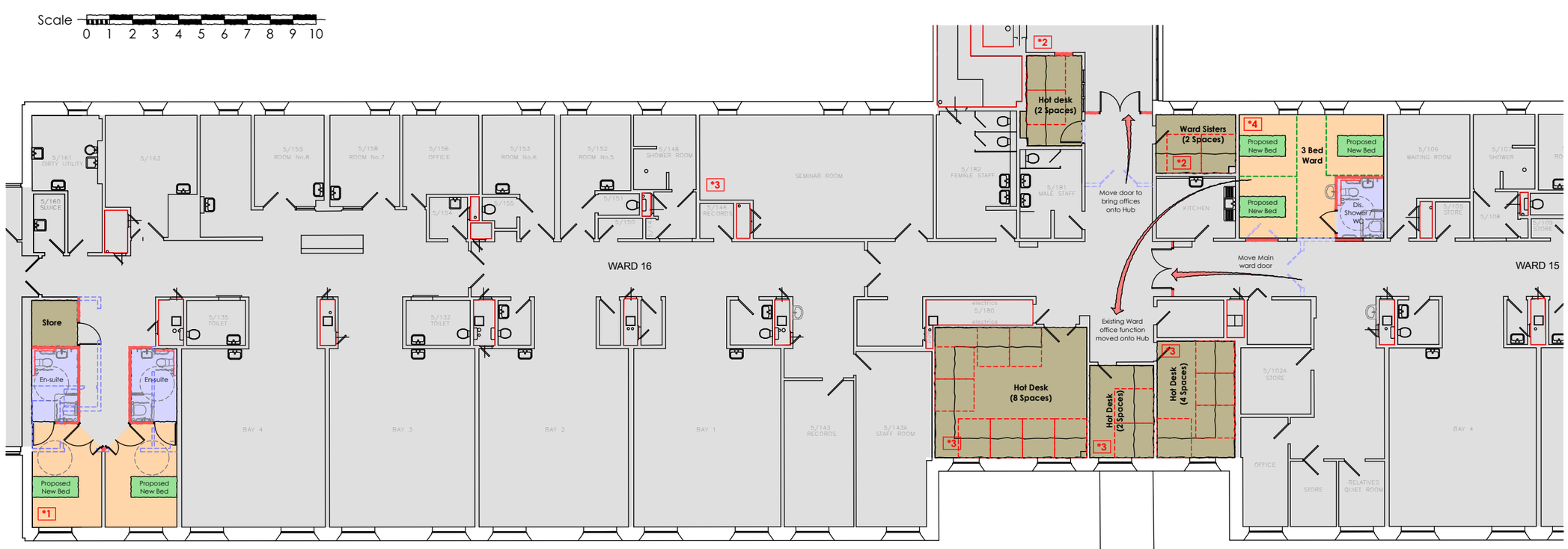
This is an interim report and each of the solutions needs review in more detail particularly around:

- Engineering solutions
- Engineering impact on costs (to include infrastructure)
- Timescales
- Design to tender



EXISTING

Scale
0 1 2 3 4 5 6 7 8 9 10



PROPOSED

Ward 16
2 No. Additional Beds

Ward 15
3No. Additional Beds

Ward 15 & 16 & Hub Planning Assumptions*:

General:

Layouts as shown assume the following concessions regards space / working practice to enble proposals as shown to be implemented:

All Proposed Bed bays as shown based on existing standard of approx. 2.4m x 2.4m

All support facilities as shown are based on existing space standards

Layouts as shown are 'best fit solution' & generally do not conform to current HBN Space Standards

1 - New Side Rooms (Ward 16) - Potential new side room provision assumes relocation 'off ward' of existing training & develoment team & consulant offices or continuous shared used of the hot desk facilities provided in new hub scheme.

2 - Hot desks (Hub) - assumes relocation of existing office uses or continuous shared used of the hot desk facilities provided in new hub scheme.

3 - Ex. Offices (Hub) - Potential new seminar room, Staff facilities, retreat & storea assumes relocation of the following existing functons or continuous shared used of the hot desk facilities provided in new hub scheme:

- PDN Team
- Orthopaedic Secretares
- Professor of Orthopaedic Trauma Surgery

4 - New 3 Bed Ward (Ward 15) - Potential new bed provision assumes relocation 'off ward' of existing office & store or continuous shared used of the hot desk facilities provided in new hub scheme.

EXISTING

PROPOSED

Ward 33

(1No. Additional bed)

Scale 0 1 2 3 4 5 6 7 8 9 10

Planning Assumptions*:

General:

Layouts as shown assume the following concessions regards space / working practice to enble proposals as shown to be implemented:

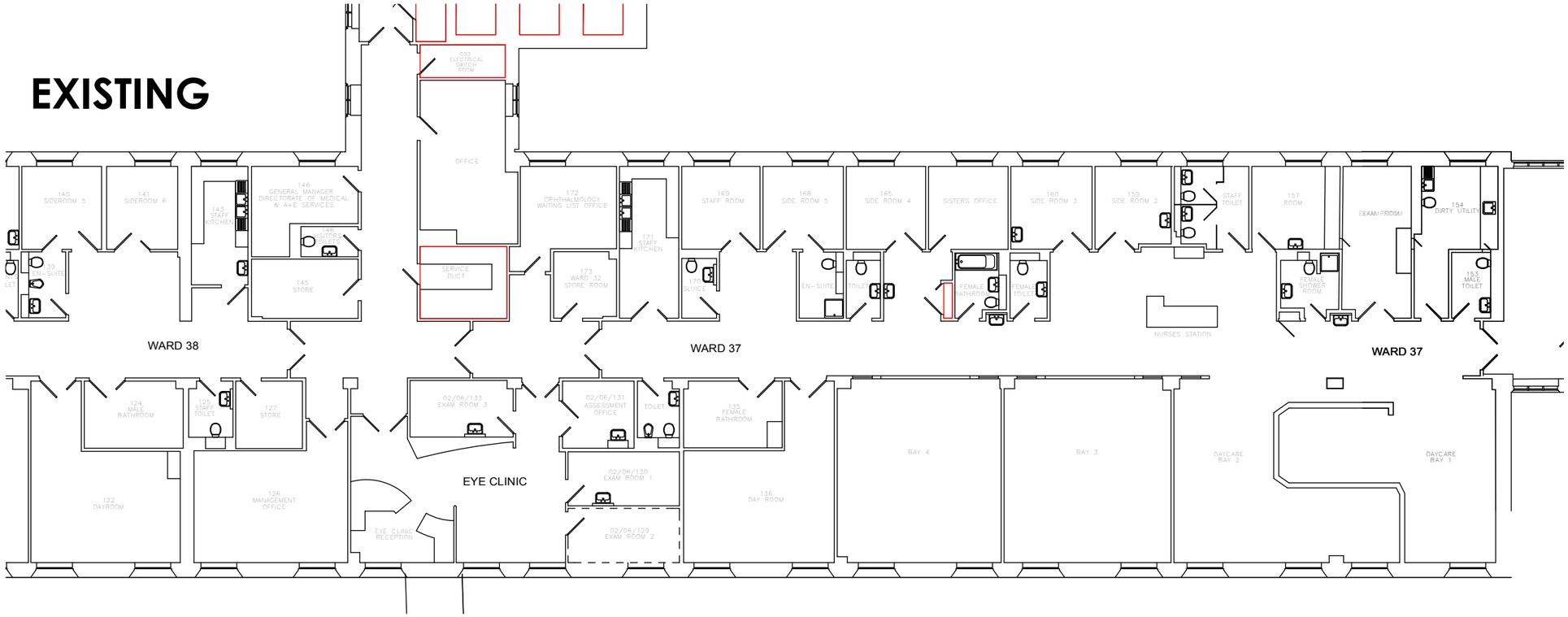
All Proposed Bed bays as shown based on existing standard of approx. 2.4m x 2.4m

All support facilities as shown are based on existing space standards

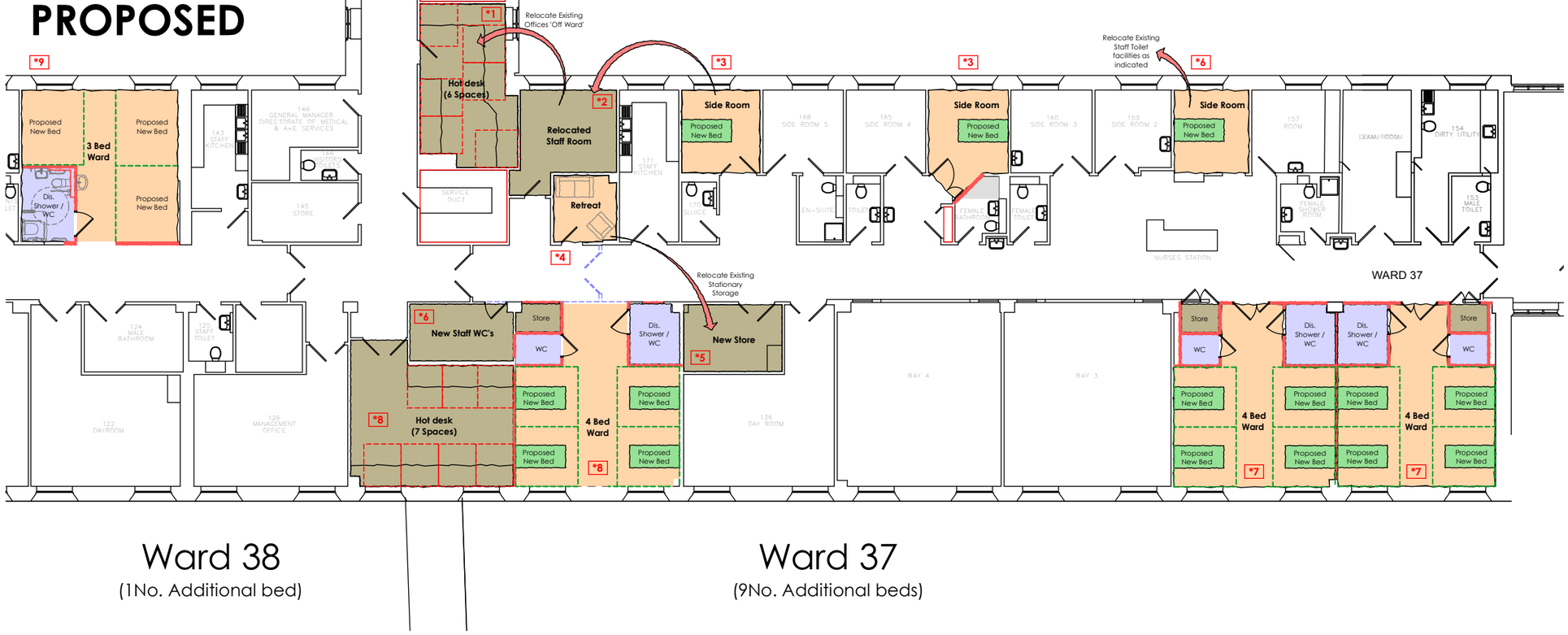
Layouts as shown are 'best fit solution' & generally do not conform to current HBN Space Standards

1 - New 3 Bed Ward (Ward 33) - Assumes conversion of No. side rooms & existig shower room to form 3 bed ward with ensuite facility.

EXISTING



PROPOSED



Ward 38
(1No. Additional bed)

Ward 37
(9No. Additional beds)

Scale 0 1 2 3 4 5 6 7 8 9 10

Planning Assumptions*:

General:

Layouts as shown assume the following concessions regards space / working practice to enble proposals as shown to be implemented:

All Proposed Bed bays as shown based on existing standard of approx. 2.4m x 2.4m

All support facilities as shown are based on existing space standards

Layouts as shown are 'best fit solution' & generally do not conform to current HBN Space Standards

1 - Hub - Convert existing office, general manager of medical and A&E services office and management office to hot desking facility - assumes relocation of existing functions or use of new hot desk facilities

2 - Relocated Staff room (Ward 37) - Potential relocated staff rest facility - assumes relocation 'off-ward' or use of new hot desk facilities

3 - Ex. Sisters Office and Staffroom - Conversion of ex. Sisters office and staff room to Side rooms. Adjacent bathroom to ex. sisters office would require adjustment due to room only having single door.

4 - Ex. Stores - Convert existing stores to retreat rooms - store to be relocated on the ward

5 - Storage / Asst. Bath (Ward 37) - Existing Asst bathroom used as storage

University Hospitals of Leicester NHS
NHS Trust

To:	**Trust Board**
From:	John Adler, Chief Executive
Date:	**29 May 2014**
CQC regulation:	As applicable

Title:	Delivering Care at its Best update

Author/Responsible Director: John Adler, Chief Executive / Kate Shields, Director of Strategy

Purpose of the Report: To provide members of the Trust Board with an update on Delivering Care at its Best.

The Report is provided to the Board for:

Decision		Discussion	X
Assurance	X	Endorsement	

Summary / Key Points:

This paper provides members of the Board with an update on the programmes of work required to deliver Caring at its Best.

Recommendations:

The Trust Board is asked to **seek assurance** from the contents of this paper.

Previously considered at another corporate UHL Committee?

UHL Executive Team meeting - 15th April 2014

UHL Trust Board meeting - 24th April 2014

Board Assurance Framework: N/A	**Performance KPIs year to date:** N/A

Resource Implications (eg Financial, HR): Yes

Assurance Implications: Yes

Patient and Public Involvement (PPI) Implications: Yes

Stakeholder Engagement Implications: Yes

Equality Impact: N/A

Information exempt from Disclosure: No

Requirement for further review? Yes

Trust Board paper Q

REPORT TO: Trust Board

DATE: 29th May 2014

REPORT FROM: John Adler, Chief Executive

SUBJECT: Delivering Caring at its Best update

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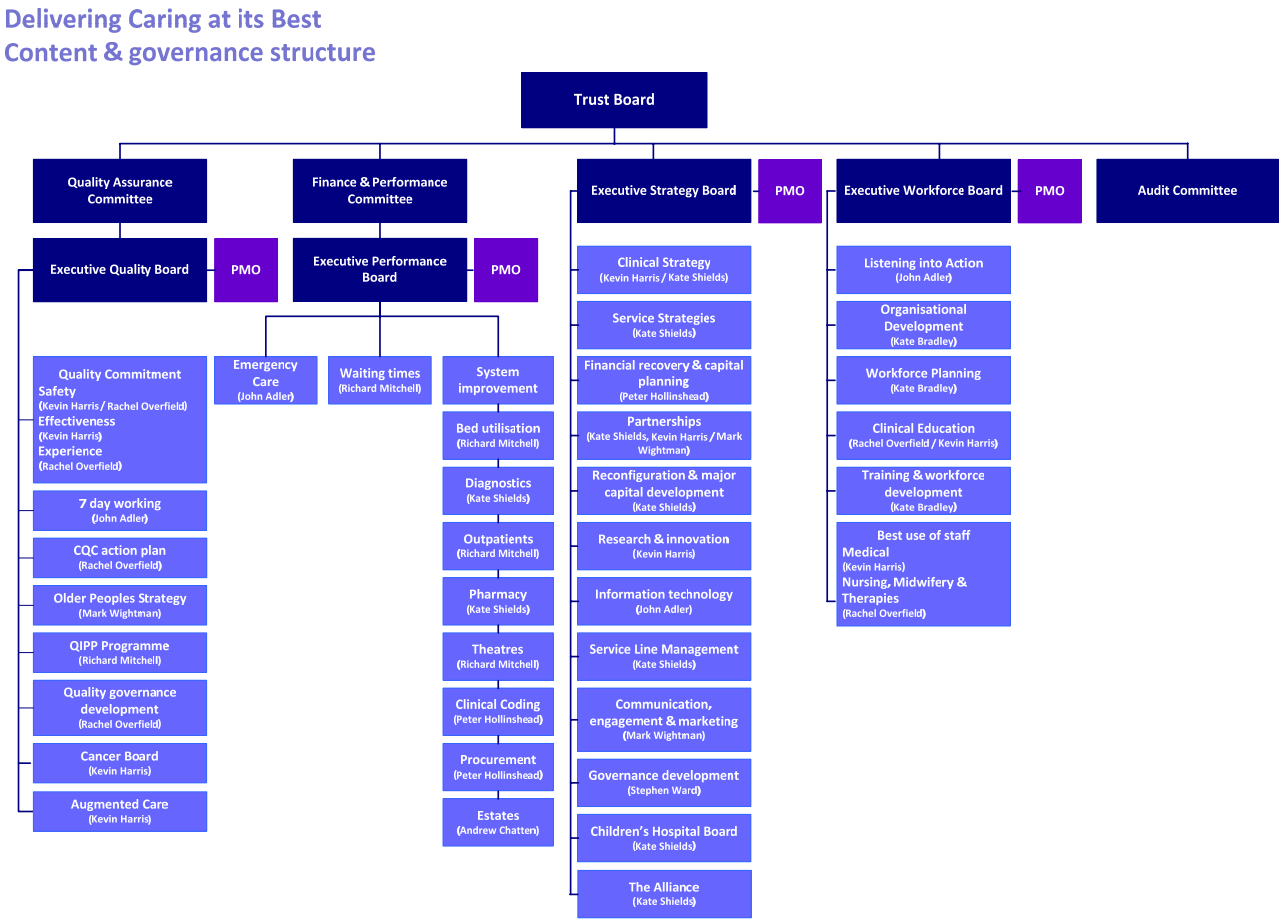
1) Background

This paper provides members of the Board with an update on the programmes of work required to deliver Caring at its Best.

2) Content and governance structure

There have been a number of minor amendments to the Delivering Caring at its Best governance structure, first presented to the Trust Board in April 2014. These include the addition of Augmented Care under the Executive Quality Board and the renaming of the Children's Board to the Children's Hospital Board.

The diagram below shows the Delivering Caring at its Best programmes of work and the Executive Director accountability.



3) Principles and approach

The Executive lead for each Executive Board, (the Executive Quality Board, Executive Performance Board, Executive Strategy Board and Executive Workforce Board) is responsible for

ensuring the appropriate level of rigour and standardisation in terms of Delivering the Caring at its Best delivery work streams.

The Executive and operational lead for each Delivering Caring at its Best programme of work have been asked to complete a standardised Project Initiation Document (PID) setting out their work programmes:

- Objectives
- Scope
- Deliverables
- Risks and issues
- Milestones
- Key Performance Indicators (KPIs)
- Quality Impact Assessment

Completed PIDs are in the process of being reviewed by the relevant Executive Board and once approved will be supplemented by:

- Regular highlight reports from each Executive and operational lead

and

- A delivery dashboard (populated by each Executive Board Programme Management Office (PMO), providing oversight of the key processes and KPIs in relation to the Delivering Caring at its Best programmes of work.

As an example, the reporting timetable for the Executive Strategy Board is set out overleaf along with a draft delivery dashboard for the Strategy Delivering Caring at its Best work programmes. At this stage in the development of the governance of the Delivering Caring at its Best programme, dashboards will focus on tracking the development of Project Initiation Documents and programme key milestones. IN the medium to long term, dashboards will capture KPIs and quality outcomes.

Once each Executive Board delivery dashboard has been populated, an overarching Delivering Caring at its Best delivery dashboard will be populated and maintained by the Trust's Administration service.

Once populated, the overarching Delivering Caring at its Best delivery dashboard will presented at a future Trust Board meeting.

Delivering Caring at its Best – Strategy Project Management Office Reporting Timetable as at 14th May 2014

This month

	May 2014	June 2014	July 2014	August 2014	September 2014	October 2014	November 2014	December 2014	January 2015	February 2015
Trust Board	TB Meeting (29th May 2014)	Extra TB Meeting (16th Jun 2014) TB Meeting (26th Jun 2014)	TB Meeting (31st Jul 2014)	TB Meeting (28th Aug 2014)	TB Meeting (25th Sep 2014)	TB Meeting (30th Oct 2014)	TB Meeting (27th Nov 2014)	TB Meeting (18th Dec 2014)	TB Meeting (29th Jan 2015)	TB Meeting (26th Feb 2015)
Trust Board Development	TB Development Session: Foresight Partnership (15th May 2014)	TB Development Session (12th Jun 2014)	TB Development Session (17th Jul 2014)	TB Development Session (14th Aug 2014)	TB Development Session (18th Sep 2014)	TB Development Session (16th Oct 2014)	TB Development Session (13th Nov 2014)	TB Development Session (11th Dec 2014)	TB Development Session (Jan 2015 tbc)	TB Development Session (Feb 2015 tbc)
Executive Strategy Board	ESB (6th May 2014)	EWB (section of meeting to be dedicated to reviewing outstanding strategy PIDS) (3rd Jun 2014)	ESB: Highlight reports for all strategy programmes Dashboard (process) (1st Jul 2014)	ESB: Dashboard (process) Dashboard (content) Programme Plan (5th Aug 2014)	EWB (2nd Sep 2014)	ESB: Dashboard (content) (7th Oct 2014)	ESB: Dashboard (content) (4th Nov 2014)	EWB (2nd Dec 2014)	ESB: Dashboard (content) (6th Jan 2015)	ESB: Dashboard (content) (3rd Feb 2015)
	ESB papers to PMO (27th May 2014)	ESB papers to PMO (23rd Jun 2014)	ESB papers to PMO (28th Jul 2014)		ESB papers to PMO (29th Sep 2014)	ESB papers to PMO (27th Oct 2014)		ESB papers to PMO (29th Dec 2014)	ESB papers to PMO (26th Jan 2015)	ESB papers to PMO (23rd Feb 2015)
Strategy Senior Management Team meeting (monthly review of DC@IB initiatives)	SMT review all DC@IB initiatives (19th May 2014)	SMT review all DC@IB initiatives (16th Jun 2014)	SMT review all DC@IB initiatives (21st Jul 2014)	SMT review all DC@IB initiatives (18th Aug 2014)	SMT review all DC@IB initiatives (22nd Sep 2014)	SMT review all DC@IB initiatives (20th Oct 2014)	SMT review all DC@IB initiatives (17th Nov 2014)	SMT review all DC@IB initiatives (22nd Dec 2014)	SMT review all DC@IB initiatives (19th Jan 2015)	SMT review all DC@IB initiatives (16th Feb 2015)
	Review ESB action log (12th May 2014)	Review ESB action log (9th Jun 2014)	Review ESB action log (7th Jul 2014)	Review ESB action log (11th Aug 2014)	Review ESB action log (8th Sep 2014)	Review ESB action log (13th Oct 2014)	Review ESB action log (10th Nov 2014)	Review ESB action log (8th Dec 2014)	Review ESB action log (12th Jan 2014)	Review ESB action log (9th Feb 2014)
CMG workshops			(9th Jul 2014)	(13th Aug 2014)	(10th Sep 2014)	(8th Oct 2014)	(12th Nov 2014)	(10th Dec 2014)		
Clinical Strategy (Kevin Harris / Kate Shields)	V7 approved (inc W&Cs changes) at ESB		Highlight Report to be reviewed at ESB							
Service Strategies (Kate Shields)	Draft PID reviewed at ESB		Highlight Report to be reviewed at ESB							
Financial recovery & capital planning (Peter Hollinshead)		Draft PID to be reviewed at ESB	Highlight Report to be reviewed at ESB							
Partnerships: Local (??)	TB paper reviewed at ESB		Highlight Report to be reviewed at ESB							
Partnerships: Regional / national (??)			Highlight Report to be reviewed at ESB							
Partnerships: Academic / commercial (Nigel Brunskill)			Highlight Report to be reviewed at ESB							
Reconfiguration & major capital development (Kate Shields)	Draft PID reviewed at ESB		Highlight Report to be reviewed at ESB							
Research & innovation (Kevin Harris)		Draft PID to be reviewed at ESB	Highlight Report to be reviewed at ESB							
Information technology (John Adler)		Draft PID to be reviewed at ESB	Highlight Report to be reviewed at ESB							
Service Line Management (Kate Shields)	Draft PID reviewed at ESB		Highlight Report to be reviewed at ESB							
Comms, engagement & marketing (Mark Wightman)		Draft PID to be reviewed at ESB	Highlight Report to be reviewed at ESB							
Governance development (Stephen Ward)	Draft PID reviewed at ESB		Highlight Report to be reviewed at ESB							
Children's Hospital Board (Kate Shields)	Draft PID reviewed at ESB		Highlight Report to be reviewed at ESB							
The Alliance (Kate Shields)		Draft PID to be reviewed at ESB	Highlight Report to be reviewed at ESB							

Delivering Caring at its Best - Strategy Delivery Dashboard (as at 20th May 2014)

Process

Programme	Executive Lead	Operational Lead	PID completed ?	PID reviewed at ESB?	Next reporting date		
					PID	Highlight Report	Matters Arising
Clinical Strategy	Kevin Harris / Kate Shields	Helen Seth	N/A	06/05/2013		1/7/2014 ESB	
Service Strategies	Kate Shields	Helen Seth	Y	06/05/2014		1/7/2014 ESB	
Financial Recovery & capital planning	Peter Hollinshead	Paul Gowdridge	y	N	03/06/2014 ESB	1/7/2014 ESB	
Partnerships- wider engagement	Mark Wightman	Mark Wightman	N	N		1/7/2014 ESB	
Partnerships - regional	Kate Shields	Kate Shields	N	N		1/7/2014 ESB	
Partnerships - academic / commercial partnerships	Kevin Harris	Nigel Brunskill	N	N	03/06/2014 ESB	1/7/2014 ESB	
Reconfiguraiton & major capital	Kate Shields	Richard Kinnersley	Y	Y	03/06/2014 ESB	1/7/2014 ESB	
Research & innovaiton	Kevin Harris	Nigel Brunskill	N	N	03/06/2014 ESB	1/7/2014 ESB	
Information Technology	John Adler	John Clarke	N	N	03/06/2014 ESB	1/7/2014 ESB	
Service Line Management	Kate Shields	Helen Harrison	Y	06/05/2014		1/7/2014 ESB	03/06/2014 ESB: Stocktake against SLM domains
Comms, engagement &	Mark Wightman	Mark Wightman	N	N	03/06/2014 ESB	1/7/2014 ESB	
Governance Development	Stephen Ward	Stephen Ward	Y	06/05/2014		1/7/2014 ESB	
Children's Hospital Board	Kate Shields	Alison Poole	Y	06/05/2014		1/7/2014 ESB	
The Alliance	Kate Shields	Debra Mitchell	N	N	03/06/2014 ESB	1/7/2014 ESB	

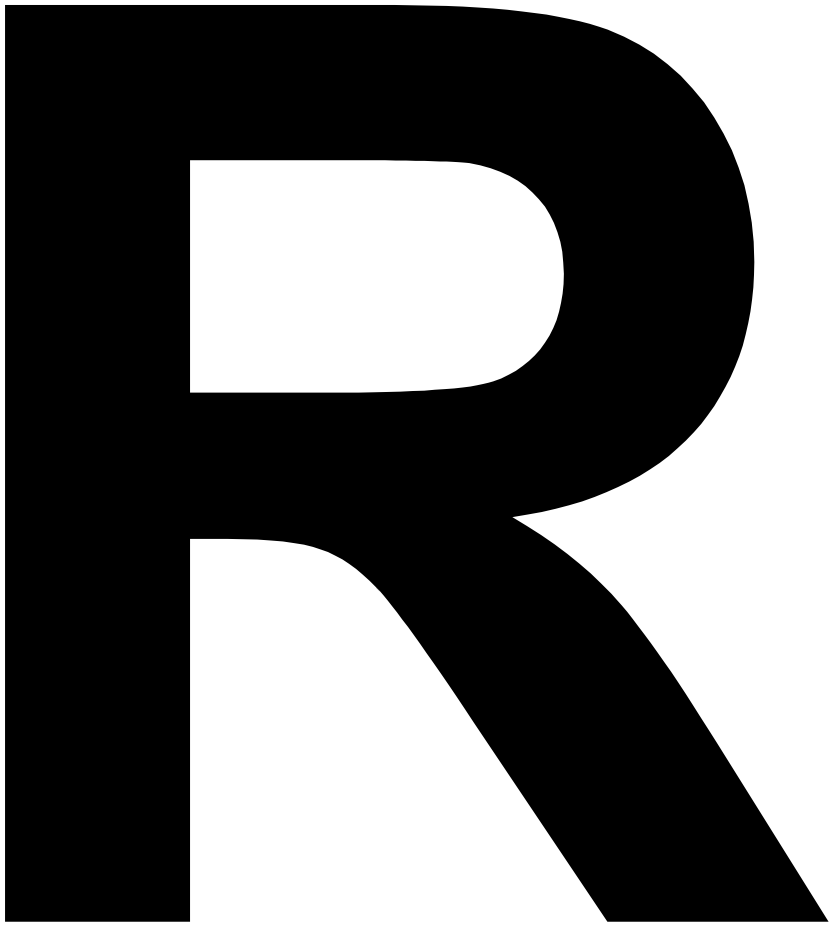
Priorities for 2014/15

	Milestones									
	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15
Development of a 5 year LLR system plan		Submit LLR 5 year plan to NTDA (20th Jun 20214)								
Development of the UHL 5 year plan		Submit IBP / LTFM to NTDA (20th Jun 20214)			Submit Development Support Plans to NTDA (30th Sep 2014)					
Priority capital schemes: Emergency Floor and Vascular move to GH		Vascular OBC to ESB (3rd Jun 2014)	NTDA sign off Emergency Floor OBC (Jul 2014)				Emergency Floor FBC to TB (end Nov 2014)	Emergency Floor FBC to NTDA (early Dec 2014)		NTDA approve Emergency Floor FBC (Feb 2015)
		Vascular OBC to TB (26th Jun 2014)	Vascular OBC to NTDA (w/c 7th Jul 2014)							
Srategy for children's services		OBC for PIC/NIC Transport (30th Jun 2014)	ToR & mentoring strategy for Children's Forum (1st Jul 2014)		Recruit celebrity patron (1st Sep 2014)					
			OBC for EMCHC (25th Jul 2014)		Children's prospectus (1st Sep 2014)					
Procurement of an Electronic Patient Record system		EPR supplier selection Jun 2014)			NTDA approval (Sep 2014)					
					Contract award (Sep 2014)					
Implementation of the CRUK Centre and more patients in clinical trials	Project Initiation Document under development - to be presented at the June 2014 ESB									
New partnerships (incl. Alliance and across East Midlands)	Project Initiation Document under development - to be presented at the June 2014 ESB									

RAG Status Key:	*Complete*	*On Track*	*Some Delay – expected to be completed as planned*	*Significant Delay – unlikely to be completed as planned*

4) Recommendations

The Trust Board is asked to seek assurance from this paper



To:	**Trust Board**
From:	**Rachel Overfield - Chief Nurse**
Date:	**29 May 2014**
CQC regulation:	Outcome 16 – Assessing and Monitoring the Quality of Service Provision

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

Author/Responsible Director: Chief Nurse

Purpose of the Report:
The report provides the Board with an updated BAF and oversight of any new extreme and high risks opened within the Trust during the reporting period. The report includes:-

a) A copy of the BAF as of 30 April 2014.
b) An action tracker to monitor progress of BAF actions
c) New extreme and/ or high risks opened during the reporting period.

The Report is provided to the Board for:

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

Summary :

- This 'interim' 2014/15 BAF provides a continuation of the previous 2013/14 BAF until such time that a full review of the contents is performed.
- The Trust Board is asked to note the following:
  a. The increase in the risk score of risk number five from 16 – 25.
  b. An increase in the risk score of risk number three from 16 – 20.
  c. Significant delay to the completion of action 3.3 due to the staff side intention to ballot members in relation to one element of the proposed pay progression criteria.
  d. In relation to action 11.11, the receipt of a draft business continuity escalation plan from Interserve and subsequent movement from a RAG rating of red to amber.
- The UHL BAF requires review to ensure it aligns with the recently revised and agreed strategic objectives for 2014/15 and following this a fully revised BAF will be submitted for consideration to the TB meeting in June 2014.

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

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

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

(c) identify any areas which it feels that the Trust's controls are inadequate and do

not, therefore, effectively manage the principal risks to the organisation achieving its objectives; (d) identify any gaps in assurances about the effectiveness of the controls in place to manage the principal risks and consider the nature of, and timescale for, any further assurances to be obtained; (e) identify any other actions which it feels need to be taken to address any 'significant control issues' to provide assurance on the Trust meeting its principal objectives.	
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 Board	

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST

REPORT TO: **TRUST BOARD**

DATE: **29th MAY 2014**

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

SUBJECT: **UHL RISK REPORT INCORPORATING THE BOARD ASSURANCE FRAMEWORK (BAF) 2014/15**

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1. INTRODUCTION

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

a) A copy of the BAF as of 30 April 2014.
b) An action tracker to monitor progress of BAF actions.
c) Notification of any new extreme or high risks opened during the reporting period.

2. BAF POSITION AS OF 30 APRIL 2014

2.1 A copy of the 2014/15 'interim' BAF is attached at appendix one with changes since the previous version highlighted in red text. A copy of the action tracker is attached at appendix two. Actions completed prior to April 2014 have been removed from the tracker and a full audit trail of these is available by reference to previous documents.

2.2 The 'interim' 2014/15 BAF provides a continuation of the previous 2013/14 BAF until such time that a full review of the contents is performed.

2.3 The TB is asked to note the following points:

a. After consideration at the previous TB meeting, an increase in the risk score of risk number five from 16 – 25.

b. Following advice from the Director of Human Resources and the Chief Nurse an increase in the risk score of risk number three from 16 – 20 to take account of the staffing required for the additional bed capacity and the difficulties that may be encountered in recruiting to these posts.

c. The significant delay to the completion of action 3.3 due to the staff side's intention to ballot members in relation to one element of the proposed pay progression criteria. It is expected that the ballot will be completed by September 2014.

d. In relation to action 11.11, the receipt of a draft business continuity escalation plan from Interserve and subsequent movement from a RAG rating of red to amber.

e. In instances where action completion dates have slipped there are no associated increases to the current risk scores.

2.4 In order to provide an opportunity for more detailed scrutiny the following three BAF entries are suggested for review against the parameters listed in appendix three.

- Risk 9 – Failure to achieve and maintain high standards of operational performance.
- Risk 10 – Inadequate reconfiguration of buildings and services.
- Risk 11 – Loss of business continuity.

3 REVIEW OF THE 2014/15 BAF

3.1 The UHL BAF requires review to ensure it aligns with the recently revised and agreed strategic objectives for 2014/15 and a fully revised BAF will be submitted for consideration to the TB meeting in June 2014.

4. EXTREME AND HIGH RISK REPORT.

4.1 The TB is asked to note that three new high risks have opened during April 2014 as described below. The details of these risks are included at appendix four.

.

Risk ID	Risk Title	Risk Score	CMG/Corporate Directorate
2236	Risk to patient/staff safety due to security staff not assisting with restraint	25	Corporate Nursing
2333	Risk of increased mortality due to ineffective implementation of best practice for identification and treatment of sepsis	20	Corporate Medical
2234	Lack of paediatric cardiac anaesthetists to maintain a WTD compliant rota leading to service disruption and loss of resilience	20	ITAPS

5. RECOMMENDATIONS

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

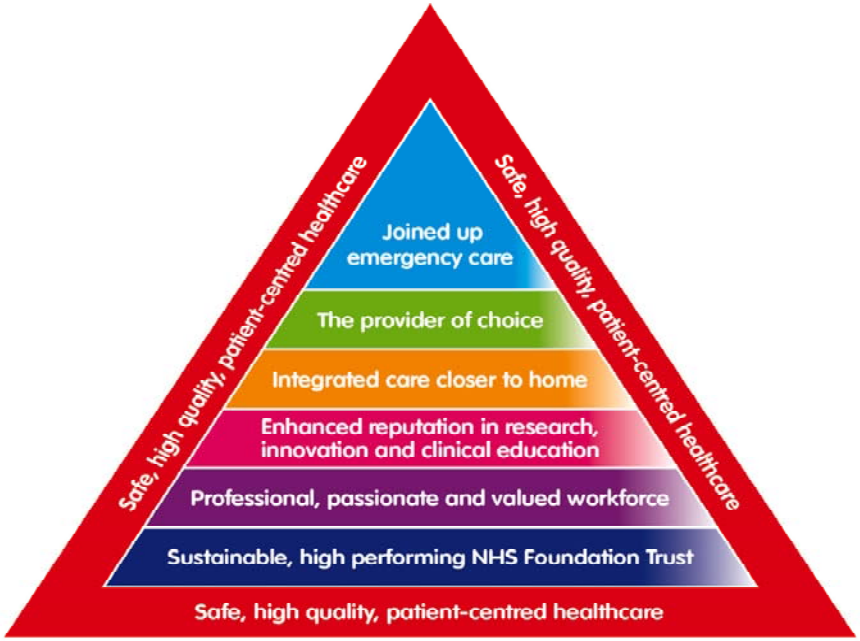
(a) review and comment upon this iteration of the BAF, as it deems appropriate:

(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;


Safe, high quality, patient-centred healthcare
Safe, high quality, patient-centred healthcare
Joined up emergency care
The provider of choice
Integrated care closer to home
Enhanced reputation in research, innovation and clinical education
Professional, passionate and valued workforce
Sustainable, high performing NHS Foundation Trust
Safe, high quality, patient-centred healthcare

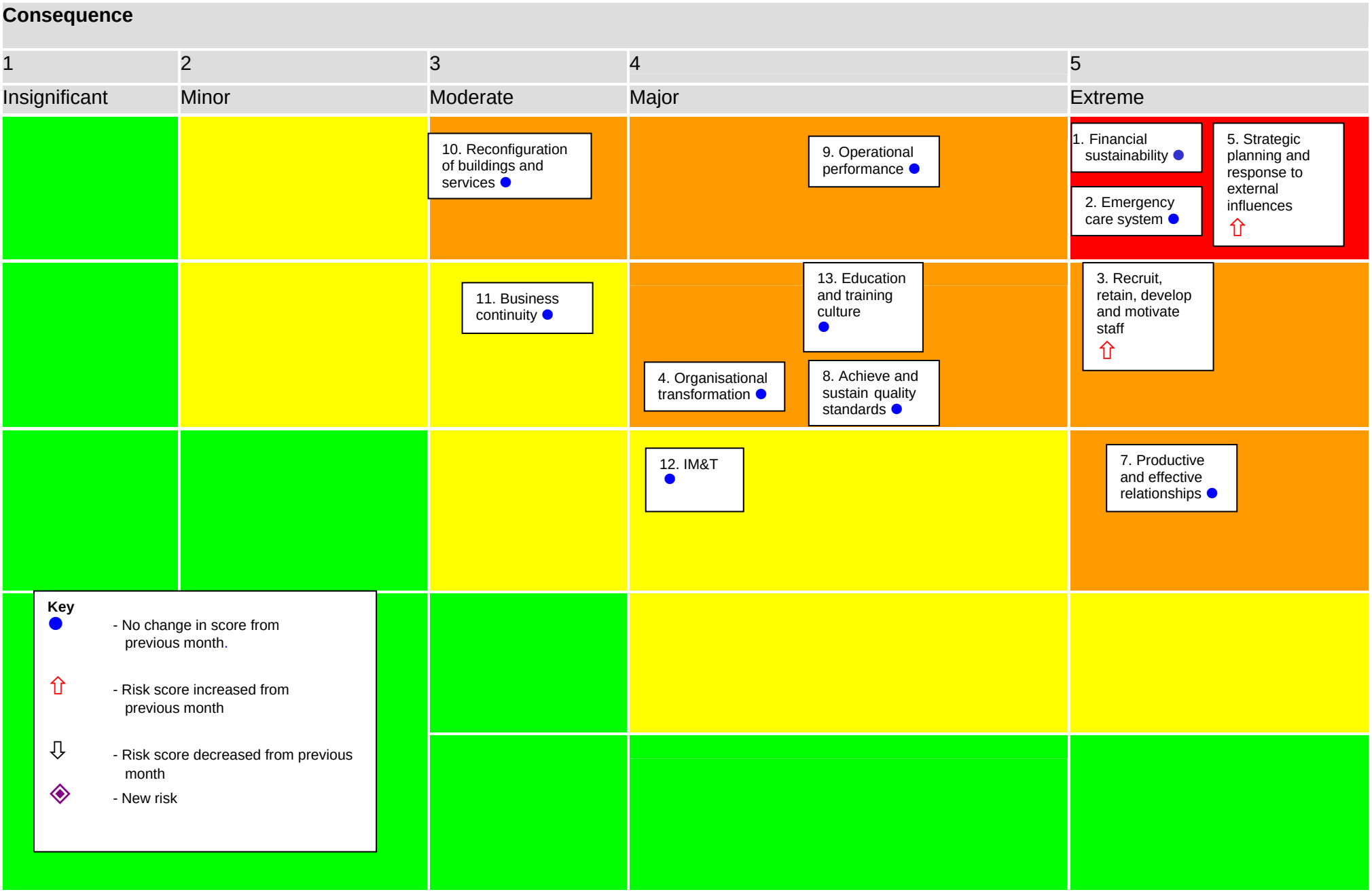
UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST – BOARD ASSURANCE FRAMEWORK (INTERIM) APRIL 2014

PERIOD: APRIL 2014

RISK TITLE	STRATEGIC OBJECTIVE	CURRENT SCORE	TARGET SCORE
Risk 1 – Failure to achieve financial sustainability	g - To be a sustainable, high performing NHS Foundation Trust	25	20
Risk 2 – Failure to transform the emergency care system	b - To enable joined up emergency care	25	12
Risk 3 – Inability to recruit, retain, develop and motivate staff	f - To maintain a professional, passionate and valued workforce e - To enjoy an enhanced reputation in research, innovation and clinical education.	20	12
Risk 4 – Ineffective organisational transformation	a - To provide safe, high quality patient-centred health care c - To be the provider of choice d - To enable integrated care closer to home	16	12
Risk 5 – Ineffective strategic planning and response to external influences	a - To provide safe, high quality patient-centred health care c - To be the provider of choice g - To be a sustainable, high performing NHS Foundation Trust	25	12
Risk 6 – **Risk deleted from BAF following approval of Trust Board**	**Not applicable**	**N/A**	**N/A**
Risk 7 – Failure to maintain productive and effective relationships	c - To be the provider of choice d - To enable integrated care closer to home f - To maintain a professional, passionate and valued workforce	15	10
Risk 8 – Failure to achieve and sustain quality standards	a - To provide safe, high quality patient-centred health care c - To be the provider of choice	16	12
Risk 9 – Failure to achieve and sustain high standards of operational performance	a - To provide safe, high quality patient-centred health care	20	12
Risk 10 – Inadequate reconfiguration of buildings and services	a - To provide safe, high quality patient-centred health care	15	9
Risk 11– Loss of business continuity	g - To be a sustainable, high performing NHS Foundation Trust	12	6
Risk 12 – Failure to exploit the potential of IM&T	a - To provide safe, high quality patient-centred health care d - To enable integrated care closer to home	12	6
Risk 13 - Failure to enhance education and training culture	e – To enjoy an enhanced reputation in research, innovation and clinical education	16	6

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

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST – BOARD ASSURANCE FRAMEWORK (INTERIM) APRIL 2014



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

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST – BOARD ASSURANCE FRAMEWORK (INTERIM) APRIL 2014

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

Principal Risk (What could prevent the objective(s) being achieved)	**What are we doing about it?** **(Key Controls)** What control measures or systems we have in place to assist secure delivery of the objective (describe process rather than management group)	**Current Score I x L**	**How do we know we are doing it?** **(Key Assurances of controls)** Provide examples of recent reports considered by Board or committee where delivery of the objectives is discussed and where the board can gain evidence that controls are effective.	**What are we not doing?** **(Gaps in Controls C) / Assurance (A)** What gaps in systems, controls and assurance have been identified?	**How can we fill the gaps or manage the risk better?** **(Actions to address gaps)**	**Target Score I x L**	**Timescale** When will the action be completed?
Failure to deliver recurrent balance	Standing Financial Instructions & Standing Orders Overarching Financial Governance Processes	5x5=25	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) Varying level of financial understanding/ control within the organisation. (c) Lack of supporting service strategies to deliver recurrent balance	Finance Training Programme (1.21) Production of a FRP to deliver recurrent balance within three years (1.22) Health System External Review to define the scale of the financial challenge and possible solutions (1.23) Production of UHL Service & Financial Strategy including Reconfiguration/SOC (1.24)	5x4=20	Jun 2014 IDFS Jun 2014 IDFS Jun 2014 IDFS Jun 2014 IDFS

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST – BOARD ASSURANCE FRAMEWORK (INTERIM) APRIL 2014

Failure to achieve CIPs	Establishment of Weekly CIP Meetings Executive ownership of cross CIP cutting themes Engagement of Ernst & Young to provide external support to the delivery of the programme Executive Sign off of Plans Establishment of CIP Board Establishment of Project Management Office Short Term Expenditure Reserves CIP Performance Management as part of Integrated Performance Management		Weekly Progress meetings with CEO, COO, FD Monthly Reports to F&P Committee Trust Board Development Sessions Formal sign off documents with CMGs as part of agreement of IBPs Weekly meetings Briefings to Trust Board, F&P Committee, Executive Board regarding establishment of PMO Weekly meeting with Ernst & Young to formalise progress	(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 (1.25) PMO Arrangements need to be finalised (1.26)		May 2014 IDFS May 2014 IDFS
Failure to effectively manage financial performance	Establishment of Weekly CIP Meetings Executive ownership of cross CIP cutting themes Engagement of Ernst & Young to provide external support to the delivery of the programme Executive Sign off of Plans Establishment of CIP Board Establishment of Project Management Office Short Term Expenditure Reserves CIP Performance Management as part of Integrated Performance Management Sign-off' 'of local finance plans		Formal documentation for sign off Report to Trust Board, F&P Committee and Executive Board Formal approval of process by Executive Board Agenda, action notes and supporting papers for meetings Schedule of meetings	(c) The organisation has not effectively identified its service model. (c) Varying level of financial understanding/ control within the organisation. (c) Finance department having difficulties in recruiting to finance posts leading to temporary staff being employed. (	Production of Integrated Business Plan (Activity, Capacity, Operational Targets, Workforce, CIPS, Budgets, Capital & Risks) (1.27) Finance Training Programme (1.21) Restructuring of financial management via MoC (1.28)		Jun 2014 IDFS Jun 2014 Jul 2014

Failure to agree financially and operationally deliverable contracts	Contract Arbitration & TDA Mediation Internal Contracts Group -		Agreed contracts document through the dispute resolution process/arbitration Regular updates to F&P Committee, Executive Board, Escalation meeting between CEOs/CCG Accountable Officers	(c) Failure to agree appropriate levels of financial impact for QIPP, fines and penalties and MRET. (c) Failure to agree levels of operational performance in relation to the above.	Negotiate realistic contracts with CCGs and Specialised Commissioning - QIPP - Fines & Penalties - MRET rebase - Counting & Coding - CCG Non Recurring Funding (1.30)		May 2014 IDFS
Failure to receive capital funding	Capital Group Established TDA Monthly IDM Meeting IBM Commercial Sub Group to Joint Governance Board Link to Strategy & SOC Assessment of affordability of Business Cases and consistency with financial recovery Link to Health Systems Review and Service Strategy		UHL Programme Board, Trust Board, F&P Committee and Capital Group Agreement through Commercial Executive (or it's replacement), F&P Committee and Trust Board Health Economy Steering Group, FD's Sub-Group Regular reports to F&P Committee, Trust Board and Executive Board	(c) Lack of clear strategy for reconfiguration of services.	Production of Business Cases to support Reconfiguration and Service Strategy (1.31)		Jun 2014 IDFS

Failure to obtain sufficient cash resources	Agreeing short term borrowing requirements with TDA Short Term borrowing applications Formalised arrangements with TDA/CCGS Escalation to TDA Rolling cash-flow forecasts Cash-flow Monitoring/Reporting		Board reporting and F&P Committee review of cash flow Integral to Service & Financial Strategy UHL Programme Board, F&P Committee, Executive Board and Trust Board Reports to F&P Committee Trust Board and F&P Committee reporting	**(c)** Lack of service strategy to deliver recurrent balance	Agreeing long term loans as part of June Service & Financial Plan		Jun 2014 IDFS

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST – BOARD ASSURANCE FRAMEWORK (INTERIM) APRIL 2014

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

Principal Risk (What could prevent the objective(s) being achieved)	**What are we doing about it?** **(Key Controls)** What control measures or systems we have in place to assist secure delivery of the objective (describe process rather than management group)	**Current Score I x L**	**How do we know we are doing it?** **(Key Assurances of controls)** Provide examples of recent reports considered by Board or committee where delivery of the objectives is discussed and where the board can gain evidence that controls are effective.	**What are we not doing?** **(Gaps in Controls C) / Assurance (A)** What gaps in systems, controls and assurance have been identified?	**How can we fill the gaps or manage the risk better?** **(Actions to address gaps)**	**Target Score I x L**	**Timescale** When will the action be completed?
Failure to transform emergency care system leading to demands on ED and admissions units continuing to exceed capacity.	Health Economy has submitted response plan to NHSE requirements for an Emergency Care system under the A&E Performance Gateway Reference 00062.	5x5=25	Once plan agreed with NTDA, it will be circulated to the Board.	No gaps	No actions	4x3=12	
	Emergency Care Action Team formed. Chaired by Chief executive to ensure Emergency Care Pathway Programme actions are being undertaken in line with NHSE action plan and any blockages to improvement removed. Development of action plan to address key issues.		Action Plan circulated to the Board on a monthly basis as part of the Report on the Emergency Access Target within the Quality and Performance Report.	Gaps described below	Actions described below		
	A new plan has been submitted detailing a clear trajectory for performance improvement and includes key themes from plan: Single front door.		Project plan developed by CCG project manager Risks from 'single front door' to be escalated via ECAT and raised with CCG Managing Director as required.	No gaps	No actions		
	ED assessment process is being operated.		Forms part of Quality Metrics for ED reported daily update and part of monthly board performance report.	No gaps	No actions		
	Recruitment campaign for continued recruitment of ED medical and nursing staff including fortnightly meetings with HR to highlight delays and solutions in the recruitment process.		Vacancy rates and bank/agency usage reported to Trust Board on a monthly basis. Recruitment plan being led by HR and monitored as part of ECAT.	(c) Difficulties are being encountered in filling vacancies within the emergency care pathway. Agency and bank requests continue to increase in response to increasing sickness rates, additional capacity, and vacancies. (c) Staffing vacancies for medical and nursing staff remain high.	Continue with substantive appts until funded establishment is achieved. (2.7)		Review Jun 2014 COO

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

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST – BOARD ASSURANCE FRAMEWORK (INTERIM) APRIL 2014

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

Principal Risk (What could prevent the objective(s) being achieved)	**What are we doing about it?** **(Key Controls)** What control measures or systems we have in place to assist secure delivery of the objective (describe process rather than management group)	**Current Score I x L**	**How do we know we are doing it?** **(Key Assurances of controls)** Provide examples of recent reports considered by Board or committee where delivery of the objectives is discussed and where the board can gain evidence that controls are effective.	**What are we not doing?** **(Gaps in Controls C) / Assurance (A)** What gaps in systems, controls and assurance have been identified?	**How can we fill the gaps or manage the risk better?** **(Actions to address gaps)**	**Target Score I x L**	**Timescale** When will the action be completed?
Inability to recruit, retain, develop and motivate suitably qualified staff leading to inadequate organisational capacity and development.	Leadership and talent management programmes to identify and develop 'leaders' within UHL.	4x5=20	Development of UHL talent profiles.	No gaps identified.	No actions required.	4x3=12	
			Talent profile update reports to Remuneration Committee.	No gaps identified.	No actions required.		
	Substantial work program to strengthen leadership contained within OD Plan.			No gaps identified.	No actions required.		
	Organisational Development (OD) plan.		A central enabler of delivering against the OD Plan work streams will be adopting, 'Listening into Action' (LiA) and progress reports on the LiA will be presented to the Trust Board on a quarterly basis.	No gaps identified.	No actions required.		
	A central enabler of delivering against the OD Plan work streams will be adopting, 'Listening into Action (LiA). A Sponsor Group personally led by our Chief Executive and including, Executive Leads and other key clinical influencers has been established.		Progress reports on the LiA will be presented to the Trust Board on a quarterly basis.	No gaps identified. No gaps identified.	No actions required. No actions required.		
	Staff engagement action plan encompassing six integrated elements that shape and enable successful and measurable staff engagement.		Results of National staff survey and local patient polling reported to Board on a six monthly basis. Improving staff satisfaction position.	No gaps identified.	No actions required.		
			Staff sickness levels may also provide an indicator of staff satisfaction and performance and are reported monthly to Board via Quality and Performance report	No gaps identified	No actions required.		

	Appraisal and objective setting in line with UHL strategic direction. Local actions and appraisal performance recovery plans/ trajectories agreed with CMGs and Directorates Boards.		Appraisal rates reported monthly to Board via Quality and Performance report. Appraisal performance features on CMG / Directorate Board Meetings to monitor the implementation of agreed local actions.				
	Summary of quality findings communicated across the Trust; to identify how to improve the quality of the appraisal experience for the individual and the quality of appraisal meeting recording.		Results of quality audits to ensure adequacy of appraisals reported to the Board via the quarterly workforce and OD report.	No gaps identified.	No actions required.		
			Appraisal Quality Assurance Findings reported to Trust Board via OD Update Report June 2013 Quality Assurance Framework to monitor appraisals on an annual cycle (next due March 2014).	No gaps identified.	No actions required.		
	Workforce plans to identify effective methods to recruit to 'difficult to fill areas). CMG and Directorates 2013/14 Workforce Plans. Active recruitment strategy including implementation of a dedicated nursing recruitment team. Programme of induction and adaptation for international pool of nurses.		Nursing Workforce Plan reported to the Board in September 2013 highlighting demand and initiatives to reduce gap between supply and demand. The use of locum staff in 'difficult to fill' areas is reported to the Board on a monthly basis via the Q&P report. Reduction in the use of such staff would be an assurance of our success in recruiting substantive staff.	(c) Risks with employing high number from an International Pool in terms of ensuring competence	Develop an employer brand and maximise use of social media (3.9).		Jul 2014 DHR
	Reward /recognition strategy and programmes (e.g. salary sacrifice, staff awards, etc). Recruitment and Retention Premia for ED medical and nursing staff.				Development of Pay Progression Policy for Agenda for Change staff (3.3).		Sep 2014 DHR
	UHL Branding – to attract a wider and more capable workforce. Includes development of recruitment literature and website, recruitment events, international recruitment. Recruitment progress is measured now there is a structured plan for bulk recruitment. Leads have been identified to develop and encourage the production of fresh and up to date recruitment material. Reporting and monitoring of posts with 5 or less applicants.		Evaluate recruitment events and numbers of applicants. Reports issued to Nursing Workforce Group. Reporting will be to the Board via the quarterly workforce an OD report. Quarterly report to senior HR team and to Board via quarterly workforce and OD report.	(a) Better baselining of information to be able to measure improvement. (c) Lack of engagement in production of website material.			

	Statutory and mandatory training programme (e-learning) for 10 key subject areas in line with National Core Skills Framework.		Monthly monitoring of statutory and mandatory training attendance data from e-UHL via reports to TB and ESB against 9 key subject areas (				

RISK NUMBER/ TITLE:	**RISK 4 – INEFFECTIVE ORGANISATIONAL TRANSFORMATION**						
LINK TO STRATEGIC OBJECTIVE(S)	**a. - To provide safe, high quality patient-centred health care.** **c. - To be the provider of choice.** **d. - To enable integrated care closer to home**						
EXECUTIVE LEAD:	Director of Strategy						
Principal Risk (What could prevent the objective(s) being achieved)	**What are we doing about it?** **(Key Controls)** What control measures or systems we have in place to assist secure delivery of the objective (describe process rather than management group)	**Current Score I x L**	**How do we know we are doing it?** **(Key Assurances of controls)** Provide examples of recent reports considered by Board or committee where delivery of the objectives is discussed and where the board can gain evidence that controls are effective.	**What are we not doing?** **(Gaps in Controls C) / Assurance (A)** What gaps in systems, controls and assurance have been identified?	**How can we fill the gaps or manage the risk better?** **(Actions to address gaps)**	**Target Score I x L**	**Timescale** When will the action be completed?

Failure to put in place a robust approach to organisational transformation, adequately linked to related initiatives and financial planning/outputs.	Developing an integrated business plan based upon an overarching strategy for UHL supported by service based strategies. Ensuring that the 2 year operating plan and the 5 year strategy describe the outputs of the clinical strategy and workforce strategy and reflect the estates and financial consequences Engaging in the BCT 2014 programme to ensure cross LLR alignment and ensuring that, allowing for appropriate transition our 2 year and 5 year plans reflect direction of travel in respect of system wide clinical service (and wider social care transformation e.g. more care, closer to home where it is safe and cost effective to do so. Implementing the 'Delivering Caring at its Best' work programmes and put the clear governance arrangements in place Cross LLR capacity and activity plan.	4x4=16	Delivery of 'Delivering Caring at its Best' work programmes will be formally reported through sub-committees of the Board. This requires alignment with the whole local Health Economy change programme Better Care Together 2014 Track delivery against key programme metrics and CMG based delivery targets through ESB, EPB and Trust Board Monitored through the LLR Better Care Together 2014 programme	(c) Gaps are evident in the alignment of transformational process between UHL and principle partners – this is being raised through the Better Care Together Programme structures. (c) Gaps are evident in medium term capacity planning across the Trust and LLR	Review outputs from Chief Officers Group and strategic Planning Group to ensure gaps in current processes are being addressed (4.1). Capacity planning workshop with all CMGs in April/May to build internal capacity and capability and to scope and develop our internal planning assumptions (4.2) The LLR BCT 2014 planning process will support and facilitate the development and agreement of an LLR wide capacity plan in May/June 2014 (4.3)	4x3=12	May 2014 DS May 2014 DS May/ Jun 2014 DS

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

Principal Risk (What could prevent the objective(s) being achieved)	**What are we doing about it?** **(Key Controls)** What control measures or systems we have in place to assist secure delivery of the objective (describe process rather than management group)	Current Score I x L	**How do we know we are doing it?** **(Key assurances of controls)** Provide examples of recent reports considered by Board or committee where delivery of the objectives is discussed and where the board can gain evidence that controls are effective.	**What are we not doing?** **(Gaps in Controls C) / Assurance (A)** What gaps in systems, controls and assurance have been identified?	**How can we fill the gaps or manage the risk better?** **(Actions to address gaps)**	Target Score I x L	**Timescale** When will the action be completed?

Failure to put in place appropriate systems to horizon scan and respond appropriately to external drivers. Failure to proactively develop whole organisation and service line clinical strategies.	Integrated business planning processes in place across CMGs. Forward programme developed. CMG Strategy Leads now engaged in the Business and Strategy Support Teams (BSST) meetings to improve engagement, alignment and teamwork. ESB forward plan to reflect a 12 month programme aligned with: • the development of the IBP/LTFM • the reconfiguration programme • the development of the next AOP • The TB Development Programme. The TB formal agenda Processes now in place to deliver a rolling 2 year operational plan based upon a 5 year strategic plan.	5x5=25	Weekly strategic planning meetings in place – cross CMG and corporate team attendance with delivery led through the Strategy Directorate. Progress reported through reports to ESB and Trust Board Development of a clear, clinically based 5 year strategic for Trust Board sign off in June 2014 and subsequent TDA sign off by the TDA will provide assurance that strategic planning is taking place. Reports to ESB. Regular reports to TB reflecting progress against 12 month rolling programme.	.(c) No high level plan yet developed	High level plan for the Trust to be developed. (5.16)	4x3=12	Jun 2014

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

Principal Risk (What could prevent the objective(s) being achieved)	**What are we doing about it?** **(Key Controls)** What control measures or systems we have in place to assist secure delivery of the objective (describe process rather than management group)	**Current Score I x L**	**How do we know we are doing it?** **(Key Assurances of controls)** Provide examples of recent reports considered by Board or committee where delivery of the objectives is discussed and where the board can gain evidence that controls are effective.	**What are we not doing?** **(Gaps in Controls C) / Assurance (A)** What gaps in systems, controls and assurance have been identified?	**How can we fill the gaps or manage the risk better?** **(Actions to address gaps)**	**Target Score I x L**	**Timescale** When will the action be completed?

Failure to maintain productive relationships with external partners/ stakeholders leading to potential loss of activity and income, poor reputation and failure to retain/ reconfigure clinical services.	Stakeholder Engagement Strategy including engagement with the Trust's Commissioners	5X3=15	Twice yearly GP surveys with results reported to UHL Executive Team. Latest survey results discussed at the April 2013 Board and showed increasing levels of satisfaction… a trend which has now continued for 18 months. Annual Reputation / Relationship survey to key professional and public stakeholders Nov 13.	(c) No external and 'dispassionate' professional view of stakeholder / relationship management activity.	Invite PWC (Trust's Auditors) to offer opinion on the plan / talk to a selection of stakeholders. (7.3)	5X2=10	May 2014 DCM
	Regular meetings with external stakeholders and Director of Communications and member of Executive Team to identify and resolve concerns.						
	Regular stakeholder briefing provided by an e-newsletter to inform stakeholders of UHL news.						
	Leicester, Leicestershire and Rutland (LLR) health and social care partners have committed to a collaborative programme of change ('Better Care Together').						
	The Board to meet 3 times per year in external venues hosted by stakeholders						
	The Chairman, with CCG colleagues hosts regular meetings with CCG lay members to improve dialogue and understanding and foster a culture of teamwork between providers and commissioners.						
	A joint report by local Healthwatch organisations to be included in Trust Board papers as a means of bringing community and stakeholder views to the Board's attention.						

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

Principal Risk (What could prevent the objective(s) being achieved)	**What are we doing about it?** **(Key Controls)** What control measures or systems we have in place to assist secure delivery of the objective (describe process rather than management group)	Current Score I x L	**How do we know we are doing it?** **(Key Assurances of controls)** Provide examples of recent reports considered by Board or committee where delivery of the objectives is discussed and where the board can gain evidence that controls are effective.	**What are we not doing?** **(Gaps in Controls C) / Assurance (A)** What gaps in systems, controls and assurance have been identified?	**How can we fill the gaps or manage the risk better?** **(Actions to address gaps)**	Target Score I x L	**Timescale** When will the action be completed?

Failure to achieve and sustain quality standards leading to failure to reduce patient harm with subsequent deterioration in patient experience/ satisfaction/ outcomes, loss of reputation and deterioration of 'friends and family test' score.	Standardised M&M meetings in each speciality.	4x4=16	Routine analysis and monitoring of out of hours/weekend mortality at CMG Boards.	No gaps.	No action needed.	4x3=12	
	Systematic speciality review of "alerts" of deterioration to address cause and agree remedial action by Mortality Review Committee. All deaths in low risk groups identified. Working with DFI to ensure data has been recorded accurately.		Quality and Performance Report and National Quality dashboard presented to ET and TB. Currently SMHI "within expected" (i.e. 107 based on HSCIC data from July 12 to June 13). UHL subscribes to the Hospital Evaluation Dataset (HED) which is similar to the Dr Foster Intelligence clinical benchmarking system but also includes a 'SHMI analysis tool'. Independent analysis of mortality review performed by Public Health. Results reported at November 2013 TB meeting.	(a) UHL risk adjusted perinatal mortality rate above regional and national average.			
	Agreed patient centred care priorities for 2013-14: - Older people's care - Dementia care - Discharge Planning		Quality Action Group meets monthly. Achievement against key objectives and milestones report to Trust board on a monthly basis. A moderate improvement in the older people survey scores has been recorded.	No gaps identified.	No action needed.		
	Multi-professional training in older peoples care and dementia care in line with LLR dementia strategy.		Quality Action Group monitoring of training numbers and location.	No gaps identified.	No action needed.		
	Protected time for matrons and ward sisters to lead on key outcomes.		CMG/ specialty reporting on matron activity and implementation or supervisory practice.	(c) Present vacancy levels prevent adoption of supervisory practice.	Active recruitment to ward nursing establishment so releasing ward sister –for supervisory practice (8.5).		Sep 2014 CN
	Promote and support older people's champion's network and new dementia champion's network.		Monthly monitoring of numbers and activity.	No gaps identified.	No action needed.		
	Targeted development activities for key performance indicators - answering call bells - assistance to toilet - involved in care - discharge information		Monthly monitoring and tracking of patient feedback results. Monthly monitoring of Friends and Family Test reported to the Board				

	Quality Commitment 2013 – 2016: • Save 1000 extra lives • Avoid 5000 harm events • Provide patient centred care so that we consistently achieve a 75 point patient recommendation score.		Quality Action Groups monitoring action plans and progress against annual priority improvements. A Quality Commitment dashboard has been developed to present updates to the TB on the 3 core metrics for tracking performance against our 3 goals. These metrics will be tracked up to 2015. Impressive drops in fall numbers have been observed in Datix reports and in the Safety Thermometer audit. Quality commitment has been refreshed and aligned with the components of quality (experience, safety, effectiveness) that the Trust is undertaking				
	Relentless attention to 5 Critical Safety Actions (CSA) initiatives to lower mortality.		Q&P report to TB showing outcomes for 5 CSAs. 4CSAs form part of local CQUIN monitoring and there is full compliance against agreed action plans. Full CQUIN funding received	(c) Lack of a unified IT system in relation to ordering and receiving results means that many differing processes are being used to acknowledge/respond to results. Potential risk of results not being acted upon in a timely fashion.	Implementation of Electronic Patient Record (EPR). (8.10)		2015 CIO

	NHS Safety thermometer utilised to measure the prevalence of harm and how many patients remain 'harm free' (Monthly point prevalence for '4 Harms'). Monthly meetings with operational/clinical and managerial leads for each harm in place.		Monthly outcome report of '4 Harms' is reported to Trust board via Q&P report. There are no areas of concern in relation to the prevalence of New Harms.	(a) There is some concern that the revised DH monitoring tool is still not an effective measure to produce accurate information. Local actions to resolve this are not practicable.			

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

Principal Risk (What could prevent the objective(s) being achieved)	**What are we doing about it?** **(Key Controls)** What control measures or systems we have in place to assist secure delivery of the objective (describe process rather than management group)	**Current Score I x L**	**How do we know we are doing it?** **(Key Assurances of controls)** Provide examples of recent reports considered by Board or committee where delivery of the objectives is discussed and where the board can gain evidence that controls are effective.	**What are we not doing?** **(Gaps in Controls C) / Assurance (A)** What gaps in systems, controls and assurance have been identified?	**How can we fill the gaps or manage the risk better?** **(Actions to address gaps)**	**Target Score I x L**	**Timescale** When will the action be completed?
Failure to achieve and sustain operational targets leading to contractual penalties, patient dissatisfaction and poor reputation.	Referral to treatment (RTT) backlog plans (patients over 18 weeks) and operational performance of 90% (for admitted) and 95 % (for non-admitted). Further recovery plans for RTT performance agreed by Commissioners Use of independent sector for key specialties. Reissue across UHL of cancelled operations policy UHL action plan signed off by Commissioners (to reduce cancellations on the day for non-clinical reasons to <0.8%and rebook within 28days)	4x5=20	Key specialities in weekly performance meetings with COO to implement plans. Monthly monitoring of RTT performance recovery plans Daily RTT performance and prospective reports to inform decision making. Weekly patient level reporting meeting for all key specialties. Monthly Q&P report to Trust Board showing 18 week RTT performance. Operational group meeting alternate weeks Operational improvement plan in place Weekly monitoring and actioning 28 day rebooking via access meeting Monthly report to Trust Board and commissioners	(c) Inadequate elective capacity. (c) Not creating ring-fenced elective capacity to prevent cancellations due to no beds on the day	To open an additional 55 beds iteratively until February 2015 (9.15)	4x3=12	COO Feb 2015
	Transformational theatre project to improve theatre efficiency to 80 -90%.		Monthly theatre utilisation rates. Theatre Transformation monthly meeting. Transformation update to Board.	No gaps identified.	No actions required.		

	Emergency Care process redesign (phase 1) implemented 18 February 2013 to improve and sustain ED performance.		Monthly report to Trust Board in relation to Emergency Dept (ED) flow (including 4 hour breaches).	See risk number 2.	See risk number 2.		
	Cancer 62 day performance - Tumour site improvement trajectory agreed and each tumour site has developed action plans to achieve targets. Senior Cancer Manager appointed. Lead Cancer Clinician appointed. Action plan to resolve Imaging issues implemented.		Cancer action board established and weekly meetings with all tumour sites represented. Monthly trajectory agreed and Cancer action plan agreed with CCGs and reported and monitored at Executive Performance board. Chief Operating Officer receives reports from Cancer Manager and 62 day performance included within Monthly Q&P report to Trust Board. The ongoing management of cancer performance is carried out by a weekly cancer action board to provide operational assurance. Performance against 62 day standard has been achieved for the past 6 months. Commissioners have formally removed the contract performance notice in relation to 62 day standard.	No gaps identified.	No actions required.		

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

Principal Risk (What could prevent the objective(s) being achieved)	**What are we doing about it?** **(Key Controls)** What control measures or systems we have in place to assist secure delivery of the objective (describe process rather than management group)	**Current Score I x L**	**How do we know we are doing it?** **(Key Assurances of controls)** Provide examples of recent reports considered by Board or committee where delivery of the objectives is discussed and where the board can gain evidence that controls are effective.	**What are we not doing?** **(Gaps in Controls C) / Assurance (A)** What gaps in systems, controls and assurance have been identified?	**How can we fill the gaps or manage the risk better?** **(Actions to address gaps)**	**Target Score I x L**	**Timescale** When will the action be completed?
Inadequate reconfiguration of buildings and services leading to less effective use of estate and services.	Reviewing and refreshing our Clinical Strategy. LLR Better Care Together 2014 Strategy	3x5=15	Trust Board development session on development of approach to strategic planning and development of strategic case for change. On-going monitoring of service outcomes by MRC to ensure outcomes improve. Improvement in health outcomes and effective Infection Prevention and Control practices monitored by Executive Quality Board (Q+P report) with escalation to ET, QAC and TB as required.	(a) Service specific KPIs not yet identified for all services.	Iterative development of operational and strategic plans (10.5)	3X3=9	Jun 2014 DS
	Review and refresh of our current Estates Strategy to ensure that it will support the delivery of an Estates solution that will be a key enabler for our clinical strategy. Reconfiguration Programme working with clinicians to develop a 'preferred' way forward' completed.		Trust Board development sessions and Board reports in respect of estate related developments over a 2 year and 5 year time horizon. Facilities Management Collaborative (FMC) monitors operational estate delivery against agreed KPIs to provide assurance of successful outsourced service.	(c) Estates plans not fully developed to achieve the strategy. The success of the plans will be dependent upon capital funding beyond our own capital resources and successful approval by the NTDA. Access to discretionary capital will be dependent on delivery of our agreed financial plan	Reconfiguration programme to develop a strategic outline case which will inform the future estate strategy (10.6) Deliver our financial plan, activity plans (10.7) Secure capital funding (10.3).		Jun 2014 DS Jun 2014 IDFS/COO Jun 2014 IDFS/COO

	CMG service development strategies and plans to deliver key developments.		Progress on CMG development plans reported to Development Meetings with execs	No gaps identified.	No actions required.		
	Executive Strategy Board - Reconfiguration		Monthly ESB to provide oversight of reconfiguration.	No gaps identified.	No actions required.		Jun 2014 DS
	Capital expenditure programme to fund developments. Capital Board to oversee in year performance management		Capital expenditure reports reported to the Board via F&P Committee. Capital Board re-established	Require financial strategy by the end of Q1 to reflect how the Trust anticipates sourcing external capital for strategic business cases.	Develop and secure TDA approval for access to strategic capital. (10.8)		Jun 2014 IDFS
	Managed Business Partner for IM&T services to deliver IT that will be a key enabler for our clinical strategy. IM&T incorporated into Improvement and Innovation Framework.		IM&T Board in place.	No gaps identified.	No actions required.		

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

Principal Risk (What could prevent the objective(s) being achieved)	**What are we doing about it?** **(Key Controls)** What control measures or systems we have in place to assist secure delivery of the objective (describe process rather than management group)	**Current Score I x L**	**How do we know we are doing it?** **(Key Assurances of controls)** Provide examples of recent reports considered by Board or committee where delivery of the objectives is discussed and where the board can gain evidence that controls are effective.	**What are we not doing?** **(Gaps in Controls C) / Assurance (A)** What gaps in systems, controls and assurance have been identified?	**How can we fill the gaps or manage the risk better?** **(Actions to address gaps)**	**Target Score I x L**	**Timescale** When will the action be completed?
Inability to react /recover from events that threaten business continuity leading to sustained downtime and inability to provide full range of services.	Major incident/business continuity/ disaster recovery and Pandemic plans developed and tested for UHL/ wider health community. This includes UHL staff training in major incident planning/ coordination and multi agency involvement across Leicestershire to effectively manage and recover from any event threatening business continuity. Tailored training packages for service area based staff. Contingency plans developed to manage loss of critical supplier and how we will monitor and respond to incidents affecting delivery of critical supplies.	3x4=12	Annual Emergency planning Report Training Needs Analysis developed to identify training requirements for staff External auditing and assurances to SHA, Business Continuity Self-Assessment, Completion of the National Capabilities Survey, November 2013 Results included in the annual report on Emergency Planning and Business Continuity to the QAC. Audit by PwC Jan 2013. Completed Jan 2014. Documented evidence from key critical suppliers has been collected to ensure that contracts include business continuity arrangements.	(c) On-going continual training of staff to deal with an incident. (a) Lack of coordination of plans between different service areas and across the specialties. c) Not all the critical suppliers questioned provided responses. (c) Contracts aren't assessed for their potential BC risk on the Trust.	Training and Exercising events to involve multiple specialties/CMGs to validate plans to ensure consistency and coordination (11.13). Finance and procurement staff to be trained how to assess the BC risk to a contract and utilise the tools developed. (11.14)	2x3=6	Aug 2014 COO May 2014 COO

	Emergency Planning Officer appointed to oversee the development of business continuity within the Trust.		Outcomes from PwC LLP audit identified that there is a programme management system in place through the Emergency Planning Officer to oversee. A year plan for Emergency Planning developed and updated annually. Production/updates of documents/plans relating to Emergency Planning and Business Continuity aligned with national guidance have begun. Including Business Impact Assessments for all specialties. Plan templates for specialties now include details/input from Interserve. 2014/2015 work plan based on priority tasks to undertake and plans to review	(c) Local plans for loss of critical services not completed due to change over of facilities provider. (c) Plans have not been provided by Interserve as to how they would respond or escalate issues to the Trust. (c) A number of plans are out of date and risk being inadequate for a response due to operational changes. (c)Call out system designed to notify staff of a major incident and activate the plan is not suitable.	Further work required to develop escalation plans and response plans for Interserve. (11.11) Review and consider options for an automated system to reduce time and resources required to initiate a staff call out (11.16).		May 2014 COO Jun 2014 COO
			Minutes/action plans from Emergency Planning and Business Continuity Committee. Any outstanding risks/issues will be raised through the COO.	No gaps identified.	No actions required.		
			New Policy on InSite Emergency Planning and Business Continuity Committee ensures that processes outlined in the Policy are followed, including the production of documents relating to business continuity within the service areas. Incidents within the Trust are investigated and debrief reports written, which include recommendations and actions to consider. Issues/lessons feed into the development of local plans and training and exercising events.	No gaps identified.	No actions required.		

			Head of Operations and Emergency Planning Officer are consulted on the implementation of new IM&T projects that will disrupt user's access to IM&T systems.	(c) Do not always consider the impact on business continuity and resilience when implementing new systems and processes. (c) End users aren't always consulted adequately prior to downtime of a system.	Further processes require development, particularly with the new Facilities and IM&T providers to ensure resilience is considered/ developed when implementing new systems, infrastructure and processes. (11.8)		Review Jun 2014 COO
	All priority IT systems have disaster recovery testing completed as part of the change approvals for major upgrades or at least once per year if no upgrade is planned within a financial year.			(a) Lack of clarity around how the trust receives assurance that disaster recovery testing for IT systems takes place	Develop an assurance process (11.17)		May 2014 CIO

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST – BOARD ASSURANCE FRAMEWORK (INTERIM) APRIL 2014

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

Principal Risk (What could prevent the objective(s) being achieved)	**What are we doing about it?** **(Key Controls)** What control measures or systems we have in place to assist secure delivery of the objective (describe process rather than management group)	**Current Score I x L**	**How do we know we are doing it?** **(Key Assurances of controls)** Provide examples of recent reports considered by Board or committee where delivery of the objectives is discussed and where the board can gain evidence that controls are effective.	**What are we not doing?** **(Gaps in Controls C) / Assurance (A)** What gaps in systems, controls and assurance have been identified?	**How can we fill the gaps or manage the risk better?** **(Actions to address gaps)**	**Target Score I x L**	**Timescale** When will the action be completed?
Failure to integrate the IM&T programme into mainstream activities.	IM&T is required to be part of the short/medium and long term planning processes	4x3=12	Strategic IM&T Board in place. Quarterly reports to Trust Board IM&T represented on key groups such as ESB, capital planning etc…	(c) late notice of significant changes that have a material impact on M&T provision (c) lack of uptake of IM&T opportunities within the planning processes	Ensure that there is further integration of IM&T within planning groups (12.9) Ensure that there are no unforeseen IM&T requirements coming out of the 2014-2016 planning phase. (12.10)	3x2=6	May 2014 CIO Review Jun 2014 CIO
	Creation of an exciting portfolio of opportunities for UHL to use within its delivery and reporting activities		A clear plan for 2014/15 exists, within the IM&T strategic framework. Work with directly affected areas has commenced	(c) lack of a fully signed off five year plan for IMT (c) a clear communications and engagement plan to inform all stakeholders of these opportunities	Work with the DOF and the capital group to ensure a coherent 5 year plan is in place for the delivery of the core IM&T components (12.11) Work with specialists from UHL and IBM to better define the communications and engagement strategy. (12.12) Review and reissue the IM&T strategy (12.13)		May 2014 CIO May 2014 CIO Jun 2014 CIO
	Engagement with the wider clinical communities (internal) including formal meetings of the newly created advisory groups/ clinical IT. Improved communications plan incorporating process for feedback of information.		CMIO(s) now in place, and active members of the IM&T meetings The joint governance board monitors the level of communications with the organisation.				

	Engagement with the wider clinical communities (External). UHL CMIOs are added as invitees to the meetings, as are the clinical (IM&T) leads from each of the CCGs.		UHL membership of the wider LLR IM&T board	(c) no involvement of external stakeholders on our significant internal projects	Review any relevant groups and engage our external stakeholders for membership (12.15)		May 2014 CIO/CMIO
Benefits are not well defined or delivered	Appointment of IBM to assist in the development of an incentivised, benefit driven, programme of activities to get the most out of our existing and future IM&T investments. Initial engagement with key members of the TDA to ensure there is sufficient understanding of technology roadmap and their involvement. The development of a strategy to ensure we have a consistent approach to delivering benefits. Increased engagement and communications with departments to ensure that we capture requirements and communicate benefits. Standard benefits reporting methodology in line with trust expectations. Paperwork and processes have be re-modelled and issued to all IM&T project staff to ensure they work to required standards.		Minutes of the joint governance board, the transformation board and the service delivery board. Benefits are part of all the projects that are signed off by the relevant groups.	. (c) Ownership of benefits delivery is being overlooked when a project, from IM&T's perspective, is finished. (c) Requirements within projects are moving significantly from the time a project specification is signed off.	Post project benefit realisation plans and ownership is identified at pre-commencement phase to ensure the total work is identified. (12.17) Requirements and benefits are fully signed off prior to any work commencing (12.18)		Jul 2014 CIO Jul 2014 CIO
Major programmes of work do not deliver on time and budget	A joint Programme and project methodology is in place between UHL and IBM for managing and tracking activities. Monthly meetings with a nominated lead to discuss projects and overall performance with the CMGs. Enhanced communications with the CMGs to include new opportunities that they could consider within their planning processes going forward		Weekly and Monthly reports are in place to track both at a programme level and at an individual project level	(c) sufficient feedback to individual CMGs on both the progress, benefits and further opportunities from their IM&T projects	Monitor the meetings and review for effectiveness (12.23)		Jul 14 CIO

	External factors such as CCG alignment and NTDA approval are in place to ensure smooth passage of approvals		Bi monthly LLR meetings are in place to ensure alignment across all healthcare stakeholders in Leicestershire	(c) Agree LLR joint priorities for 2014	Invite key external parties to be part of the significant projects. The first of these will be the EPR project (12.24) Further work through the IM&T strategy board is required to refine the large set of requirements into a realistic deliverable plan (12.22)		Jul 14 CIO May 2014 CIO

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

Principal Risk (What could prevent the objective(s) being achieved)	**What are we doing about it?** **(Key Controls)** What control measures or systems we have in place to assist secure delivery of the objective (describe process rather than management group)	**Current Score I x L**	**How do we know we are doing it?** **(Key Assurances of controls)** Provide examples of recent reports considered by Board or committee where delivery of the objectives is discussed and where the board can gain evidence that controls are effective.	**What are we not doing?** **(Gaps in Controls C) / Assurance (A)** What gaps in systems, controls and assurance have been identified?	**How can we fill the gaps or manage the risk better?** **(Actions to address gaps)**	**Target Score I x L**	**Timescale** When will the action be completed?
Failure to implement and embed an effective medical training and education culture with subsequent critical reports from commissioners, loss of medical students and junior doctors, impact on reputation and potential loss of teaching status.	Medical Education Strategy and Action Plan.	4x4=16	Strategy approved by the Trust Board. Strategy monitored by Operations Manager and reviewed monthly in Full team Meetings. Favourable Deanery visit in relation to ED Drs training.	(c) Lack of engagement/awareness of the Strategy with CMGs.	Meetings to discuss strategy with CMGs (13.1).	3x2 = 6	Jun 2014 MD
	UHL Education Committee. 'Doctors in Training' Committee established. Education and Patient Safety. Links with LEG/ QAC and EQB		Professor Carr reports to the Trust Board. Reports submitted to the Education Committee. Terms of reference and minutes of meetings.	(c) Attendance at the Committee could be improved. (c) Improved trainee representation on Trust wide committees. (c) Improve engagement with other patient safety activities/groups.	Relevance of the committee to be discussed at specialty/ CMG meetings (13.2).		Jun 2014 MD
	Quality Monitoring. Engagement with specialties to share findings from education and training dashboards		Quality dashboard for education and training (including feedback from GMC and LETB visits) monitored monthly by Operations Manager, Quality Manager and Education Committee. Education Quality Visits to specialties. Exit surveys for trainees. Monitor progress against the Education Strategy and GMC Training Survey results.	(a) Do not currently ensure progress against strategic and national benchmarks. (c) Inadequate educational resources.	Monitor UHL position against other trusts nationally. (13.7) New Library/learning facilities to be developed at the LRI .(13.8)		Review Jun 2014 MD Oct 2014 MD

	Educational project teams to lead on education transformation projects.		Project team meets monthly. Favourable outcome from Deanery visit in relation to ED Drs training.				
	Financial Monitoring.		SIFT monitoring plan in place.	(c) Poor engagement with specialties in relation to implication of SIFT.	Need to engage with the specialties to help them understand the implication of SIFT and their funding streams. (13.10)		Jun 2014 MD

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST
ACTION TRACKER FOR THE 2013/14 BOARD ASSURANCE FRAMEWORK (BAF)

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

REF	ACTION	SENIOR LEAD	OPS LEAD	COMPLETION DATE	PROGRESS UPDATE	STATUS
1	**Failure to achieve financial sustainability**					
1.21	Implementation of financial training programme to address variability of financial knowledge and control across UHL.	IDFS		June 2014	On track	4
1.22	Production of a FRP to deliver recurrent balance within three years.	IDFS		June 2014	On track, but reliant on and overlap with the delivery of outputs from the Challenged Health Economy work	4
1.23	Health System External Review to define the scale of the financial challenge and possible solutions.	IDFS		June 2014	On track	4
1.24	Production of UHL Service & Financial Strategy including Reconfiguration/SOC.	IDFS		June 2014	On track	4
1.25	Expedite agreement of CIP quality impact assessments both internally and with CCGs.	IDFS		~~April~~ May 2014	On track Meeting with CCG arranged for 29/04/14 but this will only cover the evaluated 'green' schemes. The balance of the Q&A cannot be completed until red CIP schemes have been defined.	4
1.26	PMO Arrangements need to be finalised to ensure continuity following departure of Ernst & Young.	IDFS		May 2014	On track	4
1.27	Production of Integrated Business Plan (Activity, Capacity, Operational Targets, Workforce, CIPS, Budgets, Capital & Risks).	IDFS		June 2014	On track	4
1.28	Restructuring of financial management	IDFS		July 2014	On track	4

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

	via MoC.					
1.29	'Sign-off' 'of local finance plans.	IDFS		April 2014	**Complete.**	5
1.30	Negotiate realistic contracts with CCGs and Specialised Commissioning	IDFS		~~April~~ May 2014	On track. Discussions at CEO level continue but the Trust is unable to reach agreement on the consequences of fines and penalties. The Specialised services contract is ready to sign but national issues prevent progress. Situation is being escalated with TDA and NHSE	4
2	**Failure to transform the emergency care system**					
2.7	Continue with substantive appts until funded establishment within ED is achieved.	COO	HO	Review ~~Sept~~ ~~Nov 2013~~ ~~Jan 2014~~ June 2014	Still on track to recruit to funded establishment. International recruitment has been successful. Continued review of progress.	4
3	**Inability to recruit, retain, develop and motivate staff**					
3.3	Development of Pay Progression Policy for Agenda for Change staff.	DHR	DDHR	~~October~~ ~~November~~ ~~December 2013~~ ~~February 2014~~ Review ~~April~~ September 2014	At the JSCNC on 12.03.14, staff side indicated their intention to ballot members in relation to one element of the proposed pay progression criteria. A formal intention to ballot was received on 30.04.14 with indicative timescales that this will be completed by September 2014. Timescale for action completion adjusted to reflect this	3
3.7	Update e-UHL records to ensure accuracy of reporting on a real time basis	DHR	ADLOD	Review April ~~March~~ 2014	**Complete.** System interface issues resolved to ensure accuracy in reporting Statutory and Mandatory Training completion real time. OCB Media currently working on putting together a detailed specification that will meet business requirements set out in the Project Specification document	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

3.9	Develop an employer brand and maximise use of social media to describe benefits of working at UHL	DHR		~~April~~ July 2014	Action plan in development, focused on three elements of employment cycle – attraction, retaining existing staff and understanding why individuals exit. A focused piece of work will take place on the development of the work for us area. Best nursing practice in relation to values based recruitment will be shared with other staff groups. Linkedin to be used to promote upcoming recruitment campaigns. There has been an extension to timescales for completion due as UHL needs to acquire a credit card in order to register for Linkedin for advertising and we need to find a way to progress this	4
4	**Ineffective organisational transformation**					
4.1	Review outputs from Chief Officers Group and strategic Planning Group to ensure gaps in current processes are being addressed	DS		~~Review February~~ May 2014	This hasn't been done yet as we now have E&Y in across the health community to test and support the development of our LLR plans for transformation over the medium term (5 years)	3
4.2	Capacity planning workshop with all CMGs in April/May to build internal capacity and capability and to scope and develop our internal planning assumptions	DS		May 2014	On track	4
4.3	The LLR BCT 2014 planning process will support and facilitate the development and agreement of an LLR wide capacity plan in May/June			May/ June 2014	On track	4

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

5	**Ineffective strategic planning and response to external influences**					
5.16	High level plan for the Trust to be developed	DS		June 2014	CMG planning and strategy workshops undertaken January – June 2014. Forward programme developed.	4
7	**Failure to maintain productive and effective relationships**					
7.3	Invite PWC (Trust's Auditors) to offer opinion on the plan / talk to a selection of stakeholders.	DMC		~~January 2014~~ ~~March~~ May 2014	Meeting held to scope the work, however delays in sending the raw data to PWC have delayed this action. Timescale for completion adjusted to reflect this.	3
8	**Failure to achieve and sustain quality standards**					
8.5	Active recruitment to ward nursing establishment so releasing ward sister for supervisory practice.	CN		September 2014	On going recruitment process in place and is likely to take 12 -18months. Deadline extended to reflect this.	4
8.10	Implementation of Electronic Patient Record (EPR)	CIO		2015	Currently developing the procurement strategy for the EPR solution	4
9	**Failure to achieve and sustain high standards of operational performance**					
9.14	UHL Exec Team to discuss and consider implementing ring-fenced facilities to avoid cancellation of operations on the day due to lack of beds	COO		April 2014	**Complete.** ET agreement to open additional 55 beds iteratively until February 2015	5
9.15	To open an additional 55 beds iteratively until February 2015	COO		Feb 2015	On track	4
10	**Inadequate reconfiguration of buildings and services**					
10.3	Secure capital funding to implement Estates Strategy.	IDFS		~~May 2013~~ ~~December 2013~~ ~~March~~ ~~Review April~~ June 2014	Capital funding requirements will be reflected in the LTFM for additional PDC as part of the Service and Financial plan (see 1.24)	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

10.5	Iterative development of operational and strategic plans with specialities.	MD		~~March~~ June 2014	Iterative development of operational and strategic plans with specialities to be reflected in our 5 year Integrated Business Plan by June 2014 – including proposed configuration to best meet the clinical and financial sustainability challenges faced by the Trust and the local health and care community. This is monitored by CMG and Executive Boards. Operational plans due April 2014 and strategic plans by June 2014	3
10.6	Reconfiguration programme to develop a strategic outline case which will inform the future estate strategy	DS		June 2014	A decision was made at the Reconfiguration Board of 12th February that, to ensure that we place the activities to progress the SOC in the correct sequence and develop a robust plan, we need to refresh the programme structure, work stream ownership and governance arrangements. We are developing clinical and service based strategies that will inform all aspects of our Integrated Business Plan and reflect model of care change and required estate configuration. This will inform the future estate strategy and associated reconfiguration programme. New timescale.	4
10.7	Deliver our financial plan, activity plans	IDFS/ COO		June 2014	On track.	4
10.8	Develop and secure TDA approval for access to strategic capital.	IDFS		June 2014	On track. Capital funding requirements will be reflected in the LTFM for additional PDC as part of the Service and Financial plan (see 1.24)	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

11	**Loss of business continuity**					
11.8	Further processes require development, particularly with the new Facilities and IM&T providers to ensure resilience is considered/ developed when implementing new systems, infrastructure and processes.	COO	EPO	~~July~~ ~~August~~ Review ~~October~~ ~~November 2013~~ ~~December 2013~~ ~~March~~ June 2014	Lack of progress with Interserve escalated via Chief Nurse and NHS Horizons; however still no formal assurance from Interserve of the BCM policy/process/plans. Meeting scheduled (19/05/2014) to review process and determine an appropriate process. Deadline extended to reflect this.	3
11.11	Further work required to develop escalation plans and response plans for Interserve.	COO	EPO	~~October~~ ~~December 2013~~ ~~March~~ ~~April~~ May 2014	Draft escalation plan received 1st May. To be reviewed and implemented. Deadline extended to reflect this.	3
11.13	Training and Exercising events to involve multiple CMGs/ specialties to validate plans to ensure consistency and coordination	COO	EPO	August 2014	BCM training and exercising programme has been developed. Training sessions for bleep holders in cardiology and MSK and Specialist Surgery undertaken with more to be planned. New exercises planned for May and July with more to follow.	4
11.14	Finance and procurement staff to be trained how to assess the BC risk to a contract and utilise the tools developed.	COO	EPO	~~March~~ May 2014	Materials developed awaiting availability to run training session.	3
11.16	Review and consider options for an automated system to reduce time and resources required to initiate a staff call out	COO	EPO	~~April~~ June 2014	A number of solutions considered but high costs and integration with current trust systems are not ideal. Awaiting consideration from IBM to develop an in house option.	3
11.17	Develop an assurance process for IT disaster recovery testing in order to provide the Trust with confidence that testing is being performed.	CIO		May 2014	We have achieved the ISO 27001 accreditation which has been externally validated.	4
12	**Failure to exploit the potential of IM&T**					

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

12.9	Ensure that there is further integration of IM&T within planning groups (12.9)	CIO		May 2014	On track	4
12.10	Ensure that there are no unforeseen IM&T requirements coming out of the 2014-2016 planning phase.	CIO		Review June 2014	Significant work still needed to assess the 2016 planning horizon and what all the elements of UH:\CMG\LLR plans mean with regards to IM&T	2
12.11	Work with the DOF and the capital group to ensure a coherent 5 year plan is in place for the delivery of the core IM&T components	CIO		May 2014	On track	4
12.12	Work with specialists from UHL and IBM to better define the communications and engagement strategy.	CIO		May 2014	On track	4
12.13	Review and reissue the IM&T strategy	CIO		June 2014	On track	4
12.14	To review the means by which we communicate to clinical teams, including reviewing working models from successful organisations.	CMIO		April 2014	**Complete.** CMIOs have reviewed their current engagement activities and feel that they have the appropriate mechanisms in place.	5
12.15	Review any relevant groups and engage our external stakeholders for membership	CIO/ CMIO		May 2014	On track	4
12.16	Ensure that all teams working on IM&T projects work to the required standards.	CIO		April 2014	**Complete.** Paperwork and processes have be re-modelled and issued to all IM&T project staff	5
12.17	Post project benefit realisation plans and ownership is identified at pre-commencement phase to ensure the total work is identified.	CIO		July 2014	Paperwork and processes have be re-modelled and issued to all IM&T project staff. Further work required to test the output from this work	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

12.18	Requirements and benefits are fully signed off prior to any work commencing	CIO		July 2014	Paperwork and processes have be re-modelled and issued to all IM&T project staff. Further work required to test the output from this work	4
12.19	Re-establish monthly meetings with a nominated lead to discuss projects and overall performance with the CMGs	CIO		April 2014	**Complete.** Meetings have been established. A further review of the effectiveness is planned	5
12.20	Enhance the communications with the CMGs to include new opportunities that they could consider within their planning processes going forward	CIO		April 2014	**Complete.** Senior IM&T and IBM staff have met with all CMGs to discuss planning and opportunities from IM&T investments.	5
12.21	To provide a plan/dates to the relevant NTDA bodies of the expected business case release plan	CIO		March 2014	**Complete.** Planned dates were submitted to the NTDA.	5
12.22	Further work through the IM&T strategy board is required to refine the large set of requirements into a realistic deliverable plan	CIO		May 2014	On track.	4
12.23	Monitor the monthly meetings with nominated leadss and review for effectiveness	CIO		July 2014	On track	4
12.24	Invite key external parties to be part of the significant projects. The first of these will be the EPR project	CIO		July 2014	On track	4
13	**Failure to enhance education and training culture**					
13.1	To improve CMG engagement facilitate meetings to discuss Medical Education Strategy and Action Plans with CMGs.	MD	AMD	~~December 2013/January 2014~~ ~~March~~ ~~April~~ June 2014	Meetings held with – ES Medicine, O&G, MSS, ITAPS, and discussion with CMG Leads from CHUGS and CSI Meeting with RRC tbc. Previous meeting with Cardiac Services had to be postponed. New meeting date 6/6/14.	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

13.2	Relevance of the UHL Education Committee to be discussed at CMG Meetings in an effort to improve attendance.	MD	AMD	~~December 2013/January 2014~~ ~~March~~ ~~April~~ June 2014	Meetings held with – ES Medicine, O&G, MSS, ITAPS, and discussion with CMG Leads from CHUGS and CSI Meeting with RRC tbc. . Previous meeting with Cardiac Services had to be postponed. New meeting date 6/6/14.	3
13.7	Monitor UHL position against other trusts nationally to ensure progress against strategic and national benchmarks.	MD	AMD	Review ~~October 2013~~ ~~March~~ June 2014	Following further discussions with the LETB this data is not readily available. LETB to investigate how we can acquire this data.	2
13.8	New Library/learning facilities to be developed at the LRI to help resolve inadequate educational resources.	MD	AMD	~~October 2013~~ ~~April~~ October 2014	Odames Ward due be handed over on 1st February for work to start on 1st April 2014. However during April there was a delay as there was the possibility that the ward may potentially be used for patients. This is now deemed not feasible and therefore a start date for work to convert to a library will begin on 23/6/14 with a completion date of October 2014. Completion date extended to reflect this.	3
13.10	Need to engage with the CMGs to help them understand the implication of SIFT and their funding streams.	MD	AMD	~~December 2013/January 2014~~ ~~March~~ ~~April~~ June 2014	Meetings held with – ES Medicine, O&G, MSS, ITAPS, and discussion with CMG Leads from CHUGS and CSI Meeting with RRC tbc. Previous meeting with Cardiac Services had to be postponed. New meeting date 6/6/14.	3

Key

CEO	Chief Executive Officer
IDFBS	Interim Director of Financial Strategy
MD	Medical Director
AMD	Assistant Medical Director

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

COO	Chief Operating Officer
DHR	Director of Human Resources
DDHR	Deputy Director of Human Resources
DS	Director of Strategy
ADLOD	Asst Director of Learning and Organisational Development
DMC	Director of Marketing and Communications
CIO	Chief Information Officer
CMIO	Chief Medical Information Officer
EPO	Emergency Planning Officer
HPO	Head of Performance Improvement
HO	Head of Operations
CD	Clinical Director
CMGM	Clinical Management Group Manager
DDF&P	Deputy Director Finance and Procurement
FTPM	Foundation Trust Programme Manager
HTCIP	Head of Trust Cost Improvement Programme
ADI	Assistant Director of Information
FC	Financial Controller
ADP&S	Assistant Director of Procurement and Supplies
HoN	Head of Nursing
TT	Transformation Team
CN	Chief Nurse

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

Appendix three

University Hospitals of Leicester NHS Trust

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

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

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

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

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

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

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

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

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

8) Are the assigned risk scores realistic?

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

Appendix - Risk Scoring 15 or above opened during April 2014

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
2325	Nursing	Nursing	Risk to patient/staff safety due to security staff not assisting with restraint	03/04/2014	17/04/2014	Causes Interserve refusal to provide trained staff to carry out non-harmful physical intervention, holding and restraint skills, where patient control is necessary to deliver essential critical care to patients lacking capacity to consent to treatment. Insufficient UHL staff trained in use of non-harmful physical intervention and restraint skills to carry out patient control. Termination of Physical skills training contract with LPT provider in January 2014. Consequence Inability to deliver safe clinical interventions for patients lacking capacity who resist treatment and/or examination. Increased risk of Life threatening or serious harm to patients resisting clinical intervention Increased risk of injuries to patients due to physical interventions by inexperienced/untrained staff. Increased risk of injuries to untrained staff carrying out physical interventions. Increased risk of injuries to staff carrying out clinical procedures Requirement for increased staffing presence to carry out safe procedures Reduced quality of service due to diverted staff resources Increased risk of sick absence due to staff injury. Increased risk of complaints from patients and visitors Increased risk of failure to meet targets Adverse publicity	Patients	UHL Nursing and Horizons colleagues have met with Interserve 12/03/14 and UHL have agreed to issue a temporary indemnity notice that will provide vicarious liability cover for Interserve staff in these situations (supported by our legal team). This was rejected by Interserve Management Cover with more UHL employed staff where there may be patients requiring this type of restraint; Staff must take risk assessed decisions about the use of restraint and ensure incidents are reported using the Trust's incident reporting database. In extreme cases staff should be aware that the police should be called Continue to communicate with all staff about the current position.	Extreme	Almost certain	25	Communication circular to senior managers to advise of current position and interim measures (to be cascaded to staff) - ASAP Staff to apply reasonable use of force as appropriate until trained in non-harmful physical skills - Immediate Identification of clinical staff trained in physical skills - as first call for situations requiring intervention - 26/3/2014 Series of management briefings on Lawful use of Force 18/4/14 Provision of guidance note on 'Lawful use of Force' for staff familiarisation 28/2/14 Request police presence where possible due to level of patient resistance/arousal if violent. - Immediate Clear documentation of instances where physical intervention is necessary - Immediate High priority recruitment of physical skills trainer - 2/5/14 Task and Finish group to review physical skills requirement , arrangements and training needs analysis - 20/4/14 Development and delivery of training programme in Physical Skills for clinical staff - 30/5/14 Interserve staff assistance to be requested where patient becomes violent and aggressive. This is an ex	5	DLO

2234	Emergency and Specialist Medicine	ED	There is a medical staffing shortfall resulting in a risk of an understaffed Emergency Department impacting on patient care	10/04/2013	31/03/2014	Causes: Consultant vacancies. Middle grade vacancies. Risk of losing trainees due to incorrect service/training balance. Trainee attrition. Trainees not wanting to apply for consultant positions. Reduced cohesiveness as a trainee group. Junior grade vacancies. Juniors defecting to other specialties. Poorer quality of training resulting in poor deanery reports. Non ED medical consultants. Locums. Increased consultant workload. Lack of uniformity. Paediatric medical staffing. Poorer quality care for paediatric population. Consequences: Poor quality care. Lack of retention. Stress, poor morale and burnout. Increased sickness. Increased incidents (SUI's), claims and complaints. Inability to do the general work of the department, including breaches of 4 hour target. Financial impacts. Reduced ability to maintain CPD commitments for consultants/medical staff with subspecialty interest. Reduced ability to train and supervise junior doctors. Deskilling of consultants without subspecialty interest. Suboptimal training.	Patients	Chief executive and medical director have met with senior trainees in Leicester ED to invite them to apply for consultant positions. The East Midlands Local Education and training board has recognised middle grade shortages and set up several projects aiming to attract and retain emergency medicine trainees and consultants. Advanced nurse practitioners and non-training CT1 grades employed in order to backfill the shortage of SHO grade doctors. Shared teaching sessions in which non ED consultants and ED consultants share skills. The non ED consultants have a specific mailing list so that new developments and departmental 'mini-teaches' can be shared. Only approved locum agencies are used and CVs are checked for suitability prior to appointment. Locums receive a brief shop floor induction on arrival and also must sign the green locum induction book, which introduces trust policies . Locums work only in a supervised environment. There is a specific consultant who is concerned with locum issues. Poorly performing locums are not permitted to continue working and this is fed back to their agencies Locum doctors are only placed in paeds ED in excepti Grid paediatric trainees shift pattern has altered, allow ED employs medical registrars to work night shifts in E ED consultants have extended their shop-floor hours	Extreme	Likely	20	Review of shift vs rota and the required number of juniors per shift - 01/03/14	6	BTD
2333	ITAPS	Anaesthesia	Lack of paediatric cardiac anaesthetists to maintain a WTD compliant rota leading to service disruption and loss of resilience	17/04/2014	16/05/2014	Causes: 1. Retirement of previous consultants 2. Ill health of consultant 3.lack of applicants to replace substantively Consequence: 4.need for remaining paeds anaesthetists to work a 1:2 rota on call 5.Lack of resilience puts cardiac workload at risk 6. May adversely affect the national reputation of GGH as a centre of excellence 7.current rota non complaint WTD 8. patients requiring urgent paeds surgery may be at risk of having to be transferred to other centres 9. Income stream relating to paeds cardiac surgery may be subsequently affected 10. risk of suboptimal treatment	Quality	1. 1:2 rota covered by experience colleagues 2. 12 month locum appointed	Major	Almost certain	20	1. Continue with substantive recruitment strategy and planning - 16/05/14 2. Further training to Consultant returning from maternity leave - 31/05/14 3. Explore "acting" roles for trainee to second in to rota gaps - 01/05/2014	8	DTR

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To:	Trust Board
From:	Rachel Overfield, Chief Nurse
Date:	29th May 2014
CQC regulation:	Outcome 1, 2, 14 and 16

Title:	Patient Experience Story – Labelled An Anxious patient

Author/Responsible Director:
Ben Hyde, Matron
Khazeh Fananapazir, Associate Specialist

Purpose of the Report: To describe for Trust Board the experience of care a patient received following cardiac surgery.

The Report is provided to the Board for: time

Decision		Discussion	X
Assurance		Endorsement	

Summary / Key Points:

Introduction

The Cardiac surgery team has embraced feedback from patients and confidently responds to negative patient feedback regarding care following their cardiac surgery, to ensure service and care developments are in line with patient opinions.

The Friends and Family Test

In April 2014 40% of patients completed the Friends and Family Test on ward 31 at the Glenfield. Of these:

Promoters	Passives	Detractors	FFT Score
13	3	0	81.3

Experience of Care Following Cardiac Surgery

A patient whom had cardiac surgery is captured using audio feedback about their experience at this time:

- Clinical staff put symptoms of high blood pressure and pain down to anxiety
- Labelled as anxious patient
- Did not feel listened to and felt that care could have been compromised.
- Loss of self-esteem & confidence

The Future

The team have shared and discussed this patient feedback; reinforcing those individual needs of patients must be addressed with sensitivity. Observation of patients whilst respecting their dignity and to avoid labelling of patients as anxious without exploring their concerns.

Patients should be sensitively made aware that it is normal to feel low, worried and anxious after heart surgery or being told about a heart condition and that this may occur immediately or

months later and directed to counselling services as appropriate. Staff have been encouraged and supported to ensure a high level of care is provided at all times whilst meeting physical needs and psychological support of cardiac patients. By alleviating concerns this will empower patients to be in control of choices and on-going life decisions.

Current practice to be reviewed to whether the use of anti-anxiety medication is required in some cases.

Care taken with communication for all team members to avoid patient's feelings of not being listened to and inappropriate labelling which may compromise care.

Recommendations:
The Trust Board is asked to:

- Receive and listen to the patient's story
- Support the improvements instigated in response to this feedback.

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): None

Assurance Implications: This paper provides assurance that the Cardiology teams are listening and acting upon patient feedback to improve patient's experience of care.

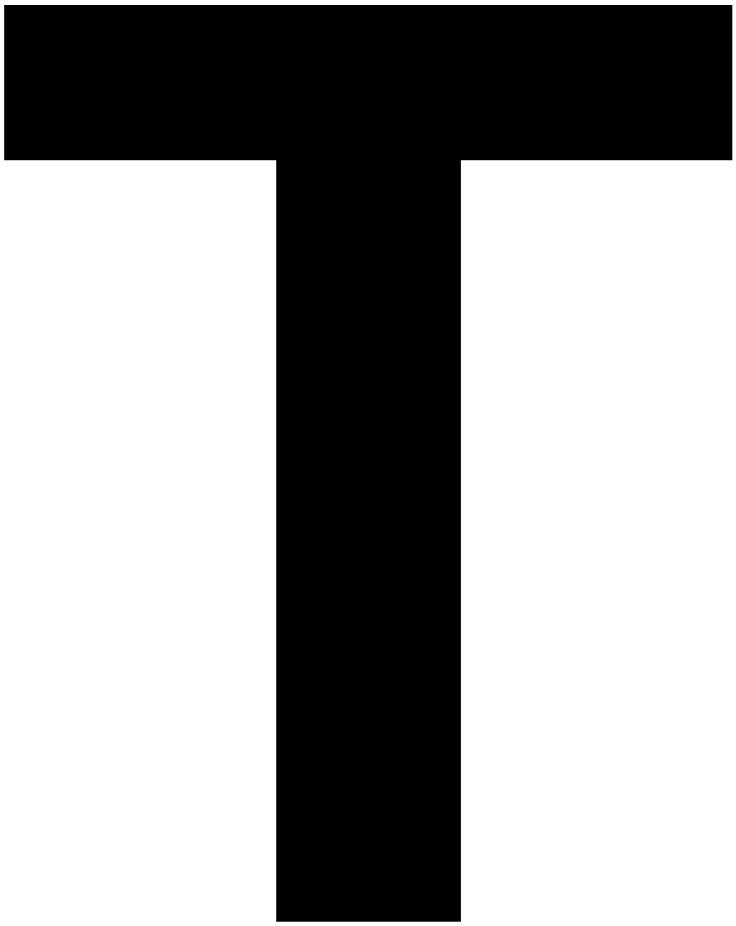
Patient and Public Involvement (PPI) Implications: Patients are encouraged to share their stories of care within the trust.

Stakeholder Engagement Implications: None

Equality Impact: None

Information exempt from Disclosure: N/A

Requirement for further review? No requirement for further review



To:	Trust Board
From:	Peter Hollinshead – Interim Director of Financial Strategy
Date:	29th May 2014
CQC regulation:	

Title:	**Annual Accounts 2013-14**

Author/Responsible Director:
Peter Hollinshead – Interim Director of Financial Strategy

Purpose of the Report:
To present the annual accounts 2013-14 and the process for adoption by the Trust Board

The Report is provided to the Board for:

Decision	√	Discussion	
Assurance		Endorsement	

Summary : The report covers the following:
The Trust's performance against its statutory and administrative targets:

- Break-even - £39.7m deficit.
- External Financing Limit - A permissible undershoot of £1,265k.
- Capital Resource Limit - A permissible undershoot of £52k.
- Better Payments Practice Code - *Non-NHS:* value 69%; volume 46%; *NHS:* value 82%; volume 55%. The target of 95% was not met due to actions agreed within the Trust's liquidity plan.

Key points from the accounts:

- The Trust's income has risen by 1.5% to £770.4 million.
- The Trust's expenditure has increased by 6.9% to £809.9 million.

Recommendations:
The Trust Board is asked to:

- Approve the accounts and Letter of Representation.
- Note the management responses to the recommendations made by External Audit in their ISA 260 report.
- Note that the Annual Governance Statement, which is a key element of the Annual Accounts, is presented separately for review by the Director of Corporate & Legal Affairs.

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

Resource Implications (eg Financial, HR)
N/A

Assurance Implications
To provide assurance on the Trust's 2013-14 annual accounts

Patient and Public Involvement (PPI) Implications
N/A

Equality Impact
N/A

Information exempt from Disclosure
N/A

Requirement for further review?
N/A

Peter Hollinshead – Interim Director of Financial Strategy

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST

REPORT TO: **TRUST BOARD**

FROM: **PETER HOLLINSHEAD, INTERIM DIRECTOR OF FINANCIAL SERVICES**

DATE: **29th MAY 2014**

SUBJECT: **ANNUAL ACCOUNTS 2013-14**

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1. INTRODUCTION

1.1 The Trust is required to produce annual statutory accounts for the year ending 31st March which are required to be approved by the Trust Board. The accounts for the year ending 31st March 2014 are attached (Appendix 1).

1.2 These accounts have been subject to external audit by KPMG, who will report as a separate agenda item to the Trust Board.

2. STATUTORY & ADMINISTRATIVE TARGETS 2013-14

TARGET	ACHIEVED	NOTES
STATUTORY TARGETS		
Break-even – to generate a surplus of income over spending comparing one year with another	**X**	£39.7m retained deficit
External Financing Limit – to control cash within the financing limit	√	A permissible undershoot of £1,265k
Capital Resource Limit – to contain capital spending within an agreed limit	√	A permissible undershoot of £52k
ADMINISTRATIVE TARGET		
Better Payments Practice Code – to pay all valid invoices within 30 days of receipt	**X**	*Non-NHS* value 69%; volume 46% *NHS* value 82%; volume 55%

3. KEY POINTS TO NOTE

3.1 The Trust delivered a year end I&E deficit of £39.7m.

3.2 The Trust's income has risen by 1.5% to £770.4m. The key components of this increase of £11.7m are:

- £19.3m increase in revenue from patient care activities via the CCGs and NHS England, including increases due to the sexual health service being commissioned via Local Authorities in 2013-14. The Trust has seen a significant increase in activity particularly in inpatients and critical care.

- (£1.3m) reduction in private patient and overseas visitors income. This is due to activity levels which have fallen from 1,101 in 2012/13 to 902 in 2013/14.
- (£4.9m) reduction in education, training and research income due to:
    - SIFT - £2.6m reduction reflecting the implementation of the national review of the payment mechanism. This is now based on an average tariff per student week.
    - MADEL - £1.5m reduction driven by reduce training doctors plus non recurrent income received in 2012/13.
    - CEA - £0.3m reduction due to the reduction in the number of Doctors receiving the national CEA awards.

3.3 The Trust's expenditure has increased by 6.9% to £809.9m This £38.5m increase reflects:

- An increase in pay spend of £18.9m. This is primarily due to:
    - Transfer of staff (over 300 WTE) from Facilities and IMT to Interserve and IBM respectively. These costs were treated as pay in 2012/13 but are now recharge to the Trust within non pay.
    - Significant increase in nursing and midwifery staffing numbers on the back of the ward staffing acuity review.
    - Increases in the Consultant workforce across many specialties including the Emergency Department and the Medical areas.
    - Increases in premium staffing costs (agency, locums, bank, overtime and WLI) to ensure clinical areas are safely staffed.
- An increase in non-pay spend of £34.5m (11.9%) predominantly due to:
    - £15m increase in clinical supplies and services costs (10.4%). This category includes a number of areas including drugs, dressings, medical and surgical equipment, appliances and diagnostic costs.
        - Drugs: increase of £7.9m reflecting activity increases particularly around NICE and High Cost Therapies.
        - Dressings and Medical and surgical supplies increases of £4.3m reflecting the marginal cost volume increases in activity.
        - Other clinical supplies increase of £3.3m.
    - The premises category has seen the most significant change in year. This category includes the utilities (gas, electricity, and water), business rates, and external contracts. The £8.9m increase, 33%, is as a consequence of;
        - £1.0m increase in electricity prices.
        - £0.3m decrease in gas.
        - £4.2m in general contracts for the Interserve contract.
        - £3.9m due to the managed business partner with IBM.

- Supplies and services – general, have increased by £3.2m (13%). The significant movement £3.4m in this category is the contracting out of the facilities contract and associated staffing to Interserve.

- Consultancy costs have increased by £1.1m reflecting the increased support within the Trust for a number of Trust wide projects including the reconfiguration programme, the CIP programme, Trust Board review and quality reviews.

3.4 Material current asset and liability changes are as shown below:

Description	Increase/Decrease	Reason
Cash	Decreased £19.5m to £0.5m.	This was a planned decrease in line with our reset External Financing Limit to ensure that we reduced our backlog of creditor payments at the year end.
Receivables	Increase of £4.2m to £49.9m	The increase includes £9m in relation to winter pressures funding billed at the year end and the prior year contained some large performance related invoices.
Payables	Increase of £32.5m to £109.1m	The increase in total payables can be attributed to an increase in capital payables of £7.5m; an increase in deferred income of £5.5m due to the change in the way maternity pathways are funded; and a general increase in the backlog of supplier invoices that remained unpaid at the year end due to the low levels of cash resulting from the Trust's financial performance.

3.5 Under the Better Payments Practice Code (BPPC), the Trust is required to pay 95% (value and volume) of NHS and non NHS invoices within 30 days of receipt. The target was not met, due to actions agreed within the Trust's liquidity plan. Pressure on cash throughout 2013-14 meant that the Trust had to actively manage its cash levels, including the value of payment runs to suppliers. Supplier payment terms were also reviewed and the Trust ensured that cash levels were maintained above the minimum target level of £2 million at all times.

3.6 The year end cash balance was reduced to £0.5m following agreement with the NTDA to reset our External Financing Limit (EFL). This enabled us to minimise the backlog of creditor invoices that were outstanding at the year-end although a significant amount of overdue and unpaid invoices were carried forward into 2014-15.

4. OUTCOMES FROM THE FINAL ACCOUNTS AUDIT

4.1 KPMG have completed the audit of the accounts and have issued their 'ISA260 Audit Highlights Memorandum', in which they conclude that there were no material adjusted or unadjusted audit differences.

4.2 Agreed management responses have been incorporated into KPMG's memorandum, and are included in Appendix 2. KPMG are satisfied with the responses.

5. LETTER OF REPRESENTATION AND ANNUAL GOVERNANCE STATEMENT

5.1 Auditing standards require written representations from management in respect of the following issues:

- related party disclosures;
- compliance with laws and regulations;
- accuracy of the financial statements;
- unadjusted audit differences;
- fraud;
- fair value measurements & disclosures;
- going concern; and
- post balance sheets & contingent liabilities.

5.2 The Trust is also providing specific representations on the significant contracts that the Trust has in place; income recognition; and the agreement of NHS balances exercise.

5.4 The Annual Governance Statement is a key element of the accounts and is presented as a separate agenda item by the Director of Corporate & Legal Affairs.

6. RECOMMENDATIONS

6.1 The Trust Board is asked to:

- Approve the accounts and Letter of Representation (to be tabled at the Trust Board on 29 May 2014).

- Note the management responses to the recommendations made by External Audit in their ISA 260 report (Appendix 2).

- Note that the Annual Governance Statement, which is a key element of the Annual Accounts, is presented separately for review by the Director of Corporate & Legal Affairs.

PETER HOLLINSHEAD
INTERIM DIRECTOR OF FINANCIAL STRATEGY
29th MAY 2014

Data entered below will be used throughout the workbook:

Trust name	University Hospitals of Leicester NHS Trust
This year	2013-14
Last year	2012-13
This year ended	31 March 2014
Last year ended	31 March 2013
This year commencing:	1 April 2013
Last year commencing:	1 April 2012

Accounts 2013-14

Statement of Comprehensive Income for year ended 31 March 2014

	NOTE	**2013-14 £000s**	2012-13 £000s
Gross employee benefits	10.1	**(474,090)**	(455,142)
Other operating costs	8	**(325,181)**	(290,721)
Revenue from patient care activities	5	**675,045**	649,145
Other Operating revenue	6	**95,348**	109,520
Operating surplus/(deficit)		**(28,878)**	12,802
Investment revenue	12	**66**	77
Other gains and (losses)	13	**(51)**	0
Finance costs	14	**(263)**	(612)
Surplus/(deficit) for the financial year		**(29,126)**	12,267
Public dividend capital dividends payable		**(10,388)**	(11,090)
Retained surplus/(deficit) for the year		**(39,514)**	1,177
Total Comprehensive Income for the year		**(39,514)**	1,177

Financial performance for the year

Retained surplus/(deficit) for the year	**(39,514)**	1,177
Adjustments in respect of donated gov't grant asset reserve elimination	**(141)**	(1,086)
Adjusted retained surplus/(deficit)	**(39,655)**	91

Total Comprehensive Income of (£39,514k) includes £141k relating to the receipt of donated assets (net of donated asset depreciation). This figure is removed from the final retained surplus/(deficit) figure in accordance with Department of Health Accounting guidance. This removes the effect on the Trust's financial performance of no longer having a donated asset or government granted asset reserve and ensures that performance can be measured consistently.

The Trust delivered a £39.7m deficit for the year against a planned surplus of £3.7m. Total income of £770.4m was £25.1m above the plan of £745.3m and expenditure of £809.9m was £68.3m above the plan of £741.6m. The principal drivers for the Trust's deficit were:

- The Trust did not receive £15m strategic transitional support which was expected at the 2013-14 planning stage.
- £5.3m less non-recurrent transformation funding was received from commissioners than expected.
- £14.3m relating to in year operating cost pressures and a deliberate investment in nurse staffing to sustain quality of care and patient safety standards.
- Contractual penalties and deductions of £5.2m, including a £3.4m increase in MRET deductions.

Note 26 details the impact of the Trust's deficit on its cash position and Note 28 details the impact on Trade and Other Payables.

Details of the impact of the Trust's deficit on its breakeven requirement, and future plans are included in note 43.1

Statement of Financial Position as at 31 March 2014

		31 March 2014	31 March 2013
	NOTE	£000s	£000s
Non-current assets:			
Property, plant and equipment	15	**362,465**	354,658
Intangible assets	16	**8,019**	5,308
Trade and other receivables	22.1	**3,123**	3,155
Total non-current assets		**373,607**	363,121
Current assets:			
Inventories	21	**13,937**	13,064
Trade and other receivables	22.1	**49,892**	45,649
Other current assets	25	**0**	40
Cash and cash equivalents	26	**515**	19,986
Total current assets		**64,344**	78,739
Non-current assets held for sale	27	**0**	0
Total current assets		**64,344**	78,739
Total assets		**437,951**	441,860
Current liabilities			
Trade and other payables	28	**(109,135)**	(76,594)
Provisions	35	**(1,585)**	(1,906)
Borrowings	30	**(6,590)**	(2,727)
Total current liabilities		**(117,310)**	(81,227)
Net current liabilities		**(52,966)**	(2,488)
Total non-current assets less net current liabilities		**320,641**	360,633
Non-current liabilities			
Provisions	35	**(2,070)**	(2,406)
Borrowings	31	**(5,890)**	(10,906)
Total non-current liabilities		**(7,960)**	(13,312)
Total Assets Employed:		**312,681**	347,321
FINANCED BY:			
TAXPAYERS' EQUITY			
Public Dividend Capital		**282,625**	277,733
Retained earnings		**(34,542)**	4,960
Revaluation reserve		**64,598**	64,628
Total Taxpayers' Equity:		**312,681**	347,321

The notes on pages 16 to 40 form part of this account.

The financial statements on pages 1 to 40 were approved by the Board on 29th May and signed on its behalf by

Chief Executive: Date:

Statement of Changes in Taxpayers' Equity for the year ended 31 March 2014

	2013-14			
	Public Dividend capital £000s	Retained earnings £000s	Revaluation reserve £000s	Total reserves £000s
Balance at 1 April 2013	**277,733**	**4,960**	**64,628**	**347,321**
Changes in taxpayers' equity for the year ended 31 March 2014				
Retained deficit for the year	0	(39,514)	**0**	**(39,514)**
Transfers between reserves	0	30	(30)	**0**
Transfers under Modified Absorption Accounting - PCTs & SHAs	0	(18)	**0**	**(18)**
New PDC Received - Cash	5,219	0	0	**5,219**
New PDC Received - PCT Legacy items paid for by Department of Health	50	0	0	**50**
PDC Repaid In Year	(377)	0	0	**(377)**
Net recognised revenue/(expense) for the year	**4,892**	**(39,502)**	**(30)**	**(34,640)**
Balance at 31 March 2014	**282,625**	**(34,542)**	**64,598**	**312,681**

The new Public Dividend Capital (PDC) received in 2013-14 relates to the following schemes:

	£000s
Safer Hospitals Technology Fund	2,350
Improving Maternity Care Settings	100
Nursing Technology Fund	622
Energy Efficiency Schemes	1,770
	4,842

	2012-13			
	Public Dividend capital	Retained earnings	Revaluation reserve	Total reserves
Balance at 1 April 2012	**277,487**	**3,705**	**64,706**	**345,898**
Changes in taxpayers' equity for the year ended 31 March 2013				
Retained surplus for the year	0	1,177	0	1,177
Transfers between reserves	0	78	(78)	0
New PDC Received	246	0	0	246
Net recognised revenue/(expense) for the year	**246**	**1,255**	**(78)**	**1,423**
Balance at 31 March 2013	**277,733**	**4,960**	**64,628**	**347,321**

STATEMENT OF CASH FLOWS FOR THE YEAR ENDED 31 MARCH 2014

	2013-14	2012-13
	£000s	£000s
Cash Flows from Operating Activities		
Operating Surplus/(Deficit)	**(28,878)**	12,802
Depreciation and Amortisation	**31,245**	32,097
Donated Assets received credited to revenue but non-cash	**(765)**	(1,617)
Interest Paid	**(468)**	(540)
Dividend paid	**(10,232)**	(10,030)
(Increase)/Decrease in Inventories	**(873)**	(802)
(Increase)/Decrease in Trade and Other Receivables	**(4,211)**	(18,283)
(Increase)/Decrease in Other Current Assets	**40**	0
Increase/(Decrease) in Trade and Other Payables	**24,835**	11,289
Provisions Utilised	**(1,229)**	(667)
Increase/(Decrease) in Provisions	**458**	2,069
Net Cash Inflow/(Outflow) from Operating Activities	**9,922**	26,318
CASH FLOWS FROM INVESTING ACTIVITIES		
Interest Received	**66**	77
(Payments) for Property, Plant and Equipment	**(25,691)**	(18,838)
(Payments) for Intangible Assets	**(3,503)**	(1,938)
Net Cash Inflow/(Outflow) from Investing Activities	**(29,128)**	(20,699)
NET CASH INFLOW/(OUTFLOW) BEFORE FINANCING	**(19,206)**	5,619
CASH FLOWS FROM FINANCING ACTIVITIES		
Public Dividend Capital Received	**5,269**	246
Public Dividend Capital Repaid	**(377)**	0
Capital Element of Payments in Respect of Finance Leases and On-SoFP PFI and LIFT	**(5,157)**	(4,248)
Net Cash Inflow/(Outflow) from Financing Activities	**(265)**	(4,002)
NET INCREASE/(DECREASE) IN CASH AND CASH EQUIVALENTS	**(19,471)**	1,617
Cash and Cash Equivalents (and Bank Overdraft) at Beginning of the Period	**19,986**	18,369
Cash and Cash Equivalents (and Bank Overdraft) at year end	**515**	19,986

NOTES TO THE ACCOUNTS

1. Accounting Policies

The Secretary of State for Health has directed that the financial statements of NHS Trusts shall meet the accounting requirements of the NHS Trusts Manual for Accounts, which shall be agreed with HM Treasury. Consequently, the following financial statements have been prepared in accordance with the 2013-14 NHS Manual for Accounts issued by the Department of Health. The accounting policies contained in that manual follow International Financial Reporting Standards to the extent that they are meaningful and appropriate to the NHS, as determined by HM Treasury, which is advised by the Financial Reporting Advisory Board. Where the NHS Trusts Manual for Accounts permits a choice of accounting policy, the accounting policy which is judged to be most appropriate to the particular circumstances of the Trust for the purpose of giving a true and fair view has been selected. The particular policies adopted by the Trust are described below. They have been applied consistently in dealing with items considered material in relation to the accounts.

1.1 Accounting convention

These accounts have been prepared under the historical cost convention modified to account for the revaluation of property, plant and equipment, intangible assets, inventories and certain financial assets and financial liabilities.

1.2 Acquisitions and discontinued operations

Activities are considered to be 'acquired' only if they are taken on from outside the public sector. Activities are considered to be 'discontinued' only if they cease entirely. They are not considered to be 'discontinued' if they transfer from one public sector body to another.

1.3 Movement of assets within the DH Group

Transfers as part of reorganisation fall to be accounted for by use of absorption accounting in line with the Treasury FReM. The FReM does not require retrospective adoption, so prior year transactions (which have been accounted for under merger accounting) have not been restated. Absorption accounting requires that entities account for their transactions in the period in which they took place, with no restatement of performance required when functions transfer within the public sector. Where assets and liabilities transfer, the gain or loss resulting is recognised in the SOCNE/SOCNI, and is disclosed separately from operating costs.

Other transfers of assets and liabilities within the Group are accounted for in line with IAS20 and similarly give rise to income and expenditure entries.

For transfers of assets and liabilities from those NHS bodies that closed on 1 April 2013, Treasury has agreed that a modified absorption approach should be applied. For these transactions only, gains and losses are recognised in reserves rather than the SOCNE/SOCNI.

1.4 Charitable Funds

For 2013-14, the divergence from the FReM that NHS Charitable Funds are not consolidated with NHS Trust's own returns is removed. Under the provisions of IAS 27 *Consolidated and Separate Financial Statements*, those Charitable Funds that fall under common control with NHS bodies are consolidated within the entity's financial statements. In accordance with IAS 1 *Presentation of Financial Statements*, restated prior period accounts are presented where the adoption of the new policy has a material impact.

Following Treasury's agreement to apply IAS 27 to NHS Charities from 1 April 2013, the Trust has established that as the Trust is the Corporate Trustee of the linked NHS Charity (Leicester Hospitals Charity), it effectively has the power to exercise control so as to obtain economic benefits. However the transactions are immaterial in the context of the group and transactions have not been consolidated. Details of the transactions with the Charity are included in the related parties' notes.

1.5 Pooled Budgets

The Trust has no pooled budget arrangements.

Notes to the Accounts - 1. Accounting Policies (Continued)

1.6 Critical accounting judgements and key sources of estimation uncertainty

In the application of the Trust's accounting policies, management is required to make judgements, estimates and assumptions about the carrying amounts of assets and liabilities that are not readily apparent from other sources. The estimates and associated assumptions are based on historical experience and other factors that are considered to be relevant. Actual results may differ from those estimates and the estimates and underlying assumptions are continually reviewed. Revisions to accounting estimates are recognised in the period in which the estimate is revised if the revision affects only that period or in the period of the revision and future periods if the revision affects both current and future periods.

In the preparation of these Financial Statements, judgements, estimates and assumptions have been made by the Trust's management concerning the selection of useful lives of fixed assets, provisions necessary for certain liabilities and other similar evaluations. Actual amounts could differ from those estimates.

Deferred income
The value of deferred income included in the Statement Of Financial Position is based on management's judgement around the deferability of income at the Statement Of Financial Position date. More detail is provided in note 32.

Provisions

Provisions included in the Statement Of Financial Position are estimated using appropriate professional advice and are based on circumstances prevailing at the Statement Of Financial Position date.

Valuation of assets
There are judgements around the valuation of assets, of which more detail is provided in note 1.10.

1.7 Revenue

Revenue in respect of services provided is recognised when, and to the extent that, performance occurs, and is measured at the fair value of the consideration receivable. The main source of revenue for the Trust is from commissioners for healthcare services.

Revenue relating to patient care spells that are part-completed at the year end are apportioned across the financial years on the basis of length of stay at the Statement Of Financial Position date compared to expected total length of stay.

Revenue from education, training and research is recognised in the period in which services are provided.
Interest revenue is accrued on a time basis, by reference to the principal outstanding and interest rate applicable.

Where income is received for a specific activity that is to be delivered in the following year, that income is deferred.

The Trust receives income under the NHS Injury Cost Recovery Scheme, designed to reclaim the cost of treating injured individuals to whom personal injury compensation has subsequently been paid e.g. by an insurer. The Trust recognises the income when it receives notification from the Department of Work and Pension's Compensation Recovery Unit that the individual has lodged a compensation claim. The income is measured at the agreed tariff for the treatments provided to the injured individual, less a provision for unsuccessful compensation claims and doubtful debts.

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Notes to the Accounts - 1. Accounting Policies (Continued)

Revaluations are performed with sufficient regularity to ensure that carrying amounts are not materially different from those that would be determined at the end of the reporting period. Fair values are determined as follows:

- Land and non-specialised buildings – market value for existing use
- Specialised buildings – depreciated replacement cost

HM Treasury has adopted a standard approach to depreciated replacement cost valuations based on modern equivalent assets and, where it would meet the location requirements of the service being provided, an alternative site can be valued.

Properties in the course of construction for service or administration purposes are carried at cost, less any impairment loss. Cost includes professional fees but not borrowing costs, which are recognised as expenses immediately, as allowed by IAS 23 for assets held at fair value. Assets are revalued and depreciation commences when they are brought into use.

Fixtures and equipment are carried at depreciated historic cost as this is not considered to be materially different from fair value.

An increase arising on revaluation is taken to the revaluation reserve except when it reverses an impairment for the same asset previously recognised in expenditure, in which case it is credited to expenditure to the extent of the decrease previously charged there. A revaluation decrease that does not result from a loss of economic value or service potential is recognised as an impairment charged to the revaluation reserve to the extent that there is a balance on the reserve for the asset and, thereafter, to expenditure. Impairment losses that arise from a clear consumption of economic benefit should be taken to expenditure. Gains and losses recognised in the revaluation reserve are reported as other comprehensive income in the Statement of Comprehensive Income.

Subsequent expenditure
Where subsequent expenditure enhances an asset beyond its original specification, the directly attributable cost is capitalised. Where subsequent expenditure restores the asset to its original specification, the expenditure is capitalised and any existing carrying value of the item replaced is written-out and charged to operating expenses.

1.11 Intangible assets

Recognition

Intangible assets are non-monetary assets without physical substance, which are capable of sale separately from the rest of the Trust's business or which arise from contractual or other legal rights. They are recognised only when it is probable that future economic benefits will flow to, or service potential be provided to, the trust; where the cost of the asset can be measured reliably, and where the cost is at least £5,000.

Intangible assets acquired separately are initially recognised at fair value. Software that is integral to the operating of hardware, for example an operating system, is capitalised as part of the relevant item of property, plant and equipment. Software that is not integral to the operation of hardware, for example application software, is capitalised as an intangible asset. Expenditure on research is not capitalised: it is recognised as an operating expense in the period in which it is incurred. Internally-generated assets are recognised if, and only if, all of the following have been demonstrated:

- the technical feasibility of completing the intangible asset so that it will be available for use
- the intention to complete the intangible asset and use it
- the ability to sell or use the intangible asset
- how the intangible asset will generate probable future economic benefits or service potential
- the availability of adequate technical, financial and other resources to complete the intangible asset and sell or use it
- the ability to measure reliably the expenditure attributable to the intangible asset during its development

Notes to the Accounts - 1. Accounting Policies (Continued)

Measurement
The amount initially recognised for internally-generated intangible assets is the sum of the expenditure incurred from the date when the criteria above are initially met. Where no internally-generated intangible asset can be recognised, the expenditure is recognised in the period in which it is incurred.

Following initial recognition, intangible assets are carried at fair value by reference to an active market, or, where no active market exists, at amortised replacement cost (modern equivalent assets basis), indexed for relevant price increases, as a proxy for fair value. Internally-developed software is held at historic cost to reflect the opposing effects of increases in development costs and technological advances.

1.12 Depreciation, amortisation and impairments
Freehold land, properties under construction, and assets held for sale are not depreciated.

Otherwise, depreciation and amortisation are charged to write off the costs or valuation of property, plant and equipment and intangible non-current assets, less any residual value, over their estimated useful lives, in a manner that reflects the consumption of economic benefits or service potential of the assets. The estimated useful life of an asset is the period over which the University Hospitals of Leicester NHS Trust expects to obtain economic benefits or service potential from the asset. This is specific to the University Hospitals of Leicester NHS Trust and may be shorter than the physical life of the asset itself. Estimated useful lives and residual values are reviewed each year end, with the effect of any changes recognised on a prospective basis. Assets held under finance leases are depreciated over their estimated useful lives

At each reporting period end, the University Hospitals of Leicester NHS Trust checks whether there is any indication that any of its tangible or intangible non-current assets have suffered an impairment loss. If there is indication of an impairment loss, the recoverable amount of the asset is estimated to determine whether there has been a loss and, if so, its amount. Intangible assets not yet available for use are tested for impairment annually.

A revaluation decrease that does not result from a loss of economic value or service potential is recognised as an impairment charged to the revaluation reserve to the extent that there is a balance on the reserve for the asset and, thereafter, to expenditure. Impairment losses that arise from a clear consumption of economic benefit should be taken to expenditure. Where an impairment loss subsequently reverses, the carrying amount of the asset is increased to the revised estimate of the recoverable amount but capped at the amount that would have been determined had there been no initial impairment loss. The reversal of the impairment loss is credited to expenditure to the extent of the decrease previously charged there and thereafter to the revaluation reserve.

Impairments are analysed between Departmental Expenditure Limits (DEL) and Annually Managed Expenditure (AME). This is necessary to comply with Treasury's budgeting guidance. DEL limits are set in the Spending Review and Departments may not exceed the limits that they have been set.
AME budgets are set by the Treasury and may be reviewed with departments in the run-up to the Budget. Departments need to monitor AME closely and inform Treasury if they expect AME spending to rise above forecast. Whilst Treasury accepts that in some areas of AME inherent volatility may mean departments do not have the ability to manage the spending within budgets in that financial year, any expected increases in AME require Treasury approval.

1.13 Donated assets
Donated non-current assets are capitalised at their fair value on receipt, with a matching credit to Income. They are valued, depreciated and impaired as described above for purchased assets. Gains and losses on revaluations, impairments and sales are as described above for purchased assets. Deferred income is recognised only where conditions attached to the donation preclude immediate recognition of the gain.

1.14 Government grants

The value of assets received by means of a government grant are credited directly to income. Deferred income is recognised only where conditions attached to the grant preclude immediate recognition of the gain.

Notes to the Accounts - 1. Accounting Policies (Continued)

1.15 Non-current assets held for sale

Non-current assets are classified as held for sale if their carrying amount will be recovered principally through a sale transaction rather than through continuing use. This condition is regarded as met when the sale is highly probable, the asset is available for immediate sale in its present condition and management is committed to the sale, which is expected to qualify for recognition as a completed sale within one year from the date of classification. Non-current assets held for sale are measured at the lower of their previous carrying amount and fair value less costs to sell. Fair value is open market value including alternative uses.

The profit or loss arising on disposal of an asset is the difference between the sale proceeds and the carrying amount and is recognised in the Statement of Comprehensive Income. On disposal, the balance for the asset on the revaluation reserve is transferred to retained earnings.

Property, plant and equipment that is to be scrapped or demolished does not qualify for recognition as held for sale. Instead, it is retained as an operational asset and its economic life is adjusted. The asset is de-recognised when it is scrapped or demolished.

1.16 Leases

Leases are classified as finance leases when substantially all the risks and rewards of ownership are transferred to the lessee. All other leases are classified as operating leases.

The University Hospitals of Leicester NHS Trust as lessee

Property, plant and equipment held under finance leases are initially recognised, at the inception of the lease, at fair value or, if lower, at the present value of the minimum lease payments, with a matching liability for the lease obligation to the lessor. Lease payments are apportioned between finance charges and reduction of the lease obligation so as to achieve a constant rate on interest on the remaining balance of the liability. Finance charges are recognised in calculating the Trust's surplus/deficit.

Operating lease payments are recognised as an expense on a straight-line basis over the lease term. Lease incentives are recognised initially as a liability and subsequently as a reduction of rentals on a straight-line basis over the lease term.

Contingent rentals are recognised as an expense in the period in which they are incurred.

Where a lease is for land and buildings, the land and building components are separated and individually assessed as to whether they are operating or finance leases.

The University Hospitals of Leicester NHS Trust as lessor

The University Hospitals of Leicester NHS Trust has no income from finance leases.

Rental income from operating leases is recognised on a straight-line basis over the term of the lease. Initial direct costs incurred in negotiating and arranging an operating lease are added to the carrying amount of the leased asset and recognised on a straight-line basis over the lease term.

1.17 Private Finance Initiative (PFI) transactions

The Trust has no PFI schemes

Notes to the Accounts - 1. Accounting Policies (Continued)

1.18 Inventories

Inventories are valued at the lower of cost and net realisable value using the weighted average cost formula. This is considered to be a reasonable approximation to fair value due to the high turnover of stocks.

1.19 Cash and cash equivalents

Cash is cash in hand and deposits with any financial institution repayable without penalty on notice of not more than 24 hours. Cash equivalents are investments that mature in 3 months or less from the date of acquisition and that are readily convertible to known amounts of cash with insignificant risk of change in value.

In the Statement of Cash Flows, cash and cash equivalents are shown net of bank overdrafts that are repayable on demand and that form an integral part of the Trust's cash management.

1.20 Provisions

Provisions are recognised when the University Hospitals of Leicester NHS Trust has a present legal or constructive obligation as a result of a past event, it is probable that the University Hospitals of Leicester NHS Trust will be required to settle the obligation, and a reliable estimate can be made of the amount of the obligation. The amount recognised as a provision is the best estimate of the expenditure required to settle the obligation at the end of the reporting period, taking into account the risks and uncertainties. Where a provision is measured using the cash flows estimated to settle the obligation, its carrying amount is the present value of those cash flows using HM Treasury's discount rate of 1.8% and 2.7% for inflation.

When some or all of the economic benefits required to settle a provision are expected to be recovered from a third party, the receivable is recognised as an asset if it is virtually certain that reimbursements will be received and the amount of the receivable can be measured reliably.

A restructuring provision is recognised when the Trust has developed a detailed formal plan for the restructuring and has raised a valid expectation in those affected that it will carry out the restructuring by starting to implement the plan or announcing its main features to those affected by it. The measurement of a restructuring provision includes only the direct expenditures arising from the restructuring, which are those amounts that are both necessarily entailed by the restructuring and not associated with ongoing activities of the entity.

1.21 Clinical negligence costs

The NHS Litigation Authority (NHSLA) operates a risk pooling scheme under which the trust pays an annual contribution to the NHSLA which in return settles all clinical negligence claims. The contribution is charged to expenditure. Although the NHSLA is administratively responsible for all clinical negligence cases the legal liability remains with the Trust. The total value of clinical negligence provisions carried by the NHSLA on behalf of the Trust is disclosed at note 35.

Notes to the Accounts - 1. Accounting Policies (Continued)

1.22 Non-clinical risk pooling

The University Hospitals of Leicester NHS Trust participates in the Property Expenses Scheme and the Liabilities to Third Parties Scheme. Both are risk pooling schemes under which the Trust pays an annual contribution to the NHS Litigation Authority and, in return, receives assistance with the costs of claims arising. The annual membership contributions, and any excesses payable in respect of particular claims are charged to operating expenses as and when they become due.

1.23 Carbon Reduction Commitment Scheme (CRC)

CRC and similar allowances are accounted for as government grant funded intangible assets if they are not expected to be realised within twelve months, and otherwise as other current assets. They are valued at open market value. As the NHS body makes emissions, a provision is recognised with an offsetting transfer from deferred income. The provision is settled on surrender of the allowances. The asset, provision and deferred income amounts are valued at fair value at the end of the reporting period.

1.24 Contingencies

A contingent liability is a possible obligation that arises from past events and whose existence will be confirmed only by the occurrence or non-occurrence of one or more uncertain future events not wholly within the control of the Trust, or a present obligation that is not recognised because it is not probable that a payment will be required to settle the obligation or the amount of the obligation cannot be measured sufficiently reliably. A contingent liability is disclosed unless the possibility of a payment is remote.

A contingent asset is a possible asset that arises from past events and whose existence will be confirmed by the occurrence or non-occurrence of one or more uncertain future events not wholly within the control of the Trust. A contingent asset is disclosed where an inflow of economic benefits is probable.

Where the time value of money is material, contingencies are disclosed at their present value.

1.25 Financial assets

Financial assets are recognised when the Trust becomes party to the financial instrument contract or, in the case of trade receivables, when the goods or services have been delivered. Financial assets are derecognised when the contractual rights have expired or the asset has been transferred.

Financial assets are classified into the following categories: financial assets at fair value through profit and loss; held to maturity investments; available for sale financial assets, and loans and receivables. The classification depends on the nature and purpose of the financial assets and is determined at the time of initial recognition.

Financial assets at fair value through profit and loss

Embedded derivatives that have different risks and characteristics to their host contracts, and contracts with embedded derivatives whose separate value cannot be ascertained, are treated as financial assets at fair value through profit and loss. They are held at fair value, with any resultant gain or loss recognised in calculating the Trust's surplus or deficit for the year. The net gain or loss incorporates any interest earned on the financial asset.

Held to maturity investments

Held to maturity investments are non-derivative financial assets with fixed or determinable payments and fixed maturity, and there is a positive intention and ability to hold to maturity. After initial recognition, they are held at amortised cost using the effective interest method, less any impairment. Interest is recognised using the effective interest method.

Available for sale financial assets

Available for sale financial assets are non-derivative financial assets that are designated as available for sale or that do not fall within any of the other three financial asset classifications. They are measured at fair value with changes in value taken to the revaluation reserve, with the exception of impairment losses. Accumulated gains or losses are recycled to surplus/deficit on de-recognition.

Notes to the Accounts - 1. Accounting Policies (Continued)

Loans and receivables
Loans and receivables are non-derivative financial assets with fixed or determinable payments which are not quoted in an active market. After initial recognition, they are measured at amortised cost using the effective interest method, less any impairment. Interest is recognised using the effective interest method.

Fair value is determined by reference to quoted market prices where possible, otherwise by valuation techniques

The effective interest rate is the rate that exactly discounts estimated future cash receipts through the expected life of the financial asset, to the initial fair value of the financial asset.

At the end of the reporting period, the Trust assesses whether any financial assets, other than those held at 'fair value through profit and loss' are impaired. Financial assets are impaired and impairment losses recognised if there is objective evidence of impairment as a result of one or more events which occurred after the initial recognition of the asset and which has an impact on the estimated future cash flows of the asset.

For financial assets carried at amortised cost, the amount of the impairment loss is measured as the difference between the asset's carrying amount and the present value of the revised future cash flows discounted at the asset's original effective interest rate. The loss is recognised in expenditure and the carrying amount of the asset is reduced directly.

If, in a subsequent period, the amount of the impairment loss decreases and the decrease can be related objectively to an event occurring after the impairment was recognised, the previously recognised impairment loss is reversed through expenditure to the extent that the carrying amount of the receivable at the date of the impairment is reversed does not exceed what the amortised cost would have been had the impairment not been recognised.

1.26 Financial liabilities
Financial liabilities are recognised on the statement of financial position when the Trust becomes party to the contractual provisions of the financial instrument or, in the case of trade payables, when the goods or services have been received. Financial liabilities are de-recognised when the liability has been discharged, that is, the liability has been paid or has expired.

Loans from the Department of Health are recognised at historical cost. Otherwise, financial liabilities are initially recognised at fair value.

Financial guarantee contract liabilities
Financial guarantee contract liabilities are subsequently measured at the higher of:

The premium received (or imputed) for entering into the guarantee less cumulative amortisation.

The amount of the obligation under the contract, as determined in accordance with IAS 37 *Provisions, Contingent Liabilities and Contingent Assets.*

Other financial liabilities

After initial recognition, all other financial liabilities are measured at amortised cost using the effective interest method, except for loans from Department of Health, which are carried at historic cost. The effective interest rate is the rate that exactly discounts estimated future cash payments through the life of the asset, to the net carrying amount of the financial liability. Interest is recognised using the effective interest method.

Notes to the Accounts - 1. Accounting Policies (Continued)

1.27 Value Added Tax

Most of the activities of the Trust are outside the scope of VAT and, in general, output tax does not apply and input tax on purchases is not recoverable. Irrecoverable VAT is charged to the relevant expenditure category or included in the capitalised purchase cost of fixed assets. Where output tax is charged or input VAT is recoverable, the amounts are stated net of VAT.

1.28 Foreign currencies

The Trust's functional currency and presentational currency is sterling. Transactions denominated in a foreign currency are translated into sterling at the exchange rate ruling on the dates of the transactions. At the end of the reporting period, monetary items denominated in foreign currencies are retranslated at the spot exchange rate on 31 March. Resulting exchange gains and losses for either of these are recognised in the trust's surplus/deficit in the period in which they arise.

1.29 Third party assets

Assets belonging to third parties (such as money held on behalf of patients) are not recognised in the accounts since the trust has no beneficial interest in them. Details of third party assets are given in Note 44 to the accounts.

1.30 Public Dividend Capital (PDC) and PDC dividend

Public dividend capital represents taxpayers' equity in the NHS trust. At any time the Secretary of State can issue new PDC to, and require repayments of PDC from, the trust. PDC is recorded at the value received. As PDC is issued under legislation rather than under contract, it is not treated as an equity financial instrument.

An annual charge, reflecting the cost of capital utilised by the Trust, is payable to the Department of Health as public dividend capital dividend. The charge is calculated at the real rate set by HM Treasury (currently 3.5%) on the average carrying amount of all assets less liabilities (except for donated assets, net assets transferred from NHS bodies dissolved on 1 April 2013 and cash balances with the Government Banking Service). The average carrying amount of assets is calculated as a simple average of opening and closing relevant net assets.

1.31 Losses and Special Payments

Losses and special payments are items that Parliament would not have contemplated when it agreed funds for the health service or passed legislation. By their nature they are items that ideally should not arise. They are therefore subject to special control procedures compared with the generality of payments. They are divided into different categories, which govern the way that individual cases are handled.

Losses and special payments are charged to the relevant functional headings in expenditure on an accruals basis, including losses which would have been made good through insurance cover had Trusts not been bearing their own risks (with insurance premiums then being included as normal revenue expenditure).

1.32 Subsidiaries

Material entities over which the Trust has the power to exercise control so as to obtain economic or other benefits are classified as subsidiaries and are consolidated. Their income and expenses; gains and losses; assets, liabilities and reserves; and cash flows are consolidated in full into the appropriate financial statement lines. Appropriate adjustments are made on consolidation where the subsidiary's accounting policies are not aligned with the Trust or where the subsidiary's accounting date is not co-terminus.

Subsidiaries that are classified as 'held for sale' are measured at the lower of their carrying amount or 'fair value less costs to sell'

Notes to the Accounts - 1. Accounting Policies (Continued)

1.33 Associates

Material entities over which the University Hospitals of Leicester NHS Trust has the power to exercise significant influence so as to obtain economic or other benefits are classified as associates and are recognised in the University Hospitals of Leicester NHS Trust's accounts using the equity method. The investment is recognised initially at cost and is adjusted subsequently to reflect the University Hospitals of Leicester NHS Trust's share of the entity's profit/loss and other gains/losses. It is also reduced when any distribution is received by the Trust from the entity.

Associates that are classified as 'held for sale' are measured at the lower of their carrying amount or 'fair value less costs to sell'

The University Hospitals of Leicester NHS Trust had no Associates in 2013-14.

1.34 Joint ventures

Material entities over which the University Hospitals of Leicester NHS Trust has joint control with one or more other parties so as to obtain economic or other benefits are classified as joint ventures.

The University Hospitals of Leicester NHS Trust had no Joint Ventures in 2013-14.

1.35 Joint operations

Joint operations are activities undertaken by the Trust in conjunction with one or more other parties but which are not performed through a separate entity. The Trust records its share of the income and expenditure; gains and losses; assets and liabilities; and cashflows.

The University Hospitals of Leicester NHS Trust had no Joint Operations in 2013-14.

1.36 Research and Development

Research and development expenditure is charged against income in the year in which it is incurred, except insofar as development expenditure relates to a clearly defined project and the benefits of it can reasonably be regarded as assured. Expenditure so deferred is limited to the value of future benefits expected and is amortised through the SOCNE/SOCI on a systematic basis over the period expected to benefit from the project. It should be revalued on the basis of current cost. The amortisation is calculated on the same basis as depreciation, on a quarterly basis.

1.37 Accounting Standards that have been issued but have not yet been adopted

The Treasury FReM does not require the following Standards and Interpretations to be applied in 2013-14. The application of the Standards as revised would not have a material impact on the accounts for 2013-14, were they applied in that year.

IAS 27 Separate Financial Statements - subject to consultation
IAS 28 Investments in Associates and Joint Ventures - subject to consultation
IFRS 9 Financial Instruments - subject to consultation - subject to consultation
IFRS 10 Consolidated Financial Statements - subject to consultation
IFRS 11 Joint Arrangements - subject to consultation
IFRS 12 Disclosure of Interests in Other Entities - subject to consultation
IFRS 13 Fair Value Measurement - subject to consultation
IPSAS 32 - Service Concession Arrangement - subject to consultation

2. Pooled budget

The Trust does not participate in any pooled budgets.

3. Operating segments

The core principle of IFRS 8 *Operating Segments* is that information should be disclosed to enable users of an organisation's Financial Statements to evaluate the nature and financial effects of the types of business activities in which it engages and the economic environments in which it operates. IFRS 8 also requires that the amounts reported for each operating segment should be the amounts reported to the Board.

The Trust operates in one material segment, which is the provision of healthcare services and the reporting to the Board is at a total Trust level. The provision of healthcare (including medical treatment, research and education) is within one main geographical segment, the United Kingdom.

4. Income generation activities

The Trust does not undertake any income generation activities which meet the conditions set by the Department of Health for income generation. The Trust does not run any commercial schemes with a view to achieving a profit, and does not market commercial goods or services outside of the NHS.

5. Revenue from patient care activities

	2013-14	2012-13
	£000s	£000s
NHS:		
NHS Trusts	**7,948**	631
NHS England	**222,614**	0
Clinical Commissioning Groups	**431,416**	0
Primary Care Trusts	**0**	629,861
Strategic Health Authorities	**0**	8,446
NHS Foundation Trusts	**2,659**	621
NHS Other	**509**	0
Non-NHS:		
Local Authorities	**3,547**	0
Private patients	**3,002**	3,883
Overseas patients (non-reciprocal)	**975**	1,362
Injury costs recovery	**1,271**	2,725
Other	**1,104**	1,616
Total Revenue from patient care activities	**675,045**	649,145

Non-NHS: Other includes £726k income from health bodies in Wales, Scotland and Northern Ireland (2012-13 - £1,436k).

Primary Care Trusts and Strategic Health Authorities no longer exist. The income that was received from these organisations in 2012-13 is now received from NHS England, Clinical Commissioning Groups, NHS Trust's and Local Authorities.

6. Other operating revenue

	2013-14	2012-13
	£000s	£000s
Recoveries in respect of employee benefits	**6,595**	6,214
Education, training and research	**71,502**	76,436
Receipt of donations for capital acquisitions - NHS Charity	**765**	1,617
Non-patient care services to other bodies	**3,481**	3,194
Rental revenue from operating leases	**8,857**	1,427
Other revenue	**4,148**	20,632
Total Other Operating Revenue	**95,348**	109,520
Total operating revenue	**770,393**	758,665

Other revenue includes all other income which does not fall within the specific categories listed above, including staff car parking £1.0m (2012-13: £1.0m) and accommodation £1.6m (2012-13: £1.4m).

Rental revenue from operating leases includes £7.4m of income from our facilities management service provider in relation to car parking and catering. This arrangement commenced in March 2013 and, in accordance with International Financial Reporting Standards, we classify these income elements as operating lease income.

7. Revenue

Revenue is almost totally from the supply of services. Revenue from the sale of goods is immaterial.

8. Operating expenses

	2013-14	2012-13 (restated)
	£000s	£000s
Services from other NHS Trusts	**4,353**	3,977
Services from other NHS bodies	**833**	295
Services from NHS Foundation Trusts	**2,002**	2,419
Services from Primary Care Trusts	0	1,972
Total Services from NHS bodies	**7,188**	8,663
Purchase of healthcare from non-NHS bodies	**7,678**	7,006
Trust Chair and Non-executive Directors	**73**	68
Supplies and services - clinical	**164,900**	149,374
Supplies and services - general	**27,288**	24,116
Consultancy services	**2,439**	1,304
Establishment	**5,812**	4,969
Transport	**2,626**	2,118
Premises	**35,308**	26,412
Insurance**	**38**	36
Legal Fees***	**500**	681
Impairments and Reversals of Receivables	**1,135**	259
Depreciation	**29,484**	30,025
Amortisation	**1,761**	2,072
Audit fees	**209**	209
Other auditor's remuneration	**0**	174
Clinical negligence	**17,733**	17,545
Research and development (excluding staff costs)	**14,340**	12,356
Education and Training	**1,084**	1,099
Other	**5,585**	2,235
Total Operating expenses (excluding employee benefits)	**325,181**	290,721

*Services from NHS bodies does not include expenditure which falls into any other category.

**Insurance and ***Legal Fees are new categories for 2013-14. 2012-13 totals have been restated to include these amounts.

Supplies and services - clinical includes £73,601k expenditure on drugs (2012-13 - £65,653k). There were no impairments of property, plant and equipment in 2013-14.

A change in accounts coding structure for research and development in 2013-14 has enabled an improved identification of these costs. 2012-13 comparatives have been restated.

	2013-14	2012-13
	£000s	£000s
Employee Benefits		
Employee benefits excluding Board members	**473,222**	454,237
Board members	**868**	905
Total Employee Benefits	**474,090**	455,142
Total Operating Expenses	**799,271**	745,863

9 Operating Leases

9.1 University Hospitals of Leicester NHS Trust as lessee

	2013-14				2012-13
	Land	**Buildings**	**Other**	**Total**	Total
	£000s	**£000s**	**£000s**	**£000s**	£000s
Payments recognised as an expense					
Minimum lease payments				**5,391**	5,044
Total				**5,391**	5,044
Payable:					
No later than one year	0	0	4,433	**4,433**	3,950
Between one and five years	0	0	12,164	**12,164**	10,692
After five years	0	0	689	**689**	1,235
Total	**0**	**0**	**17,286**	**17,286**	15,877

Of the total minimum lease payments for 2013-14, £4,333k (£3,950k in 2012-13) relates to three contracts for the provision of haemodialysis services as defined under IAS 17 *Leases.* The Trust is provided with haemodialysis services from private sector suppliers from sites at Boston, Leicester and Corby.

9.2 University Hospitals of Leicester NHS Trust as lessor

The Trust leases two properties to a local NHS Trust following the exchange of land and buildings with that Trust.

The Trust also receives lease income from its facilities managed service provider in relation to catering and car parking.

	2013-14	2012-13
	£000	£000s
Recognised as revenue		
Rental revenue	8,857	1,427
Total	**8,857**	1,427
Receivable:		
No later than one year	7,999	1,340
Between one and five years	37,185	2,389
After five years	0	0
Total	**45,184**	3,729

10 Employee benefits and staff numbers

10.1 Employee benefits

	2013-14		
	Total £000s	**Permanently employed £000s**	**Other £000s**
Employee Benefits - Gross Expenditure			
Salaries and wages	**403,871**	373,199	30,672
Social security costs	**29,137**	29,137	0
Employer Contributions to NHS BSA - Pensions Division	**42,133**	42,133	0
Termination benefits	**182**	182	0
Total employee benefits	**475,323**	**444,651**	**30,672**
Employee costs capitalised	**1,233**	703	530
Gross Employee Benefits excluding capitalised costs	**474,090**	**443,948**	**30,142**

	2012-13		
Employee Benefits - Gross Expenditure 2012-13	**Total £000s**	**Permanently employed £000s**	**Other £000s**
Salaries and wages	387,483	364,001	23,482
Social security costs	28,186	28,186	0
Employer Contributions to NHS BSA - Pensions Division	40,452	40,452	0
Termination benefits	27	27	0
TOTAL - including capitalised costs	456,148	432,666	23,482
Employee costs capitalised	1,006	797	209
Gross Employee Benefits excluding capitalised costs	455,142	431,869	23,273

In 2012-13 there were rows for 'other post-employment benefits' and 'other employment benefits'. These are now included within the 'Salaries and wages' row.

10.2 Staff Numbers

	2013-14			2012-13
	Permanently employed Number	**Other Number**	**Total Number**	Total Number
Average Staff Numbers				
Medical and dental	1,092	491	**1,583**	1,461
Administration and estates	1,608	59	**1,667**	1,781
Healthcare assistants and other support staff	598	36	**634**	866
Nursing, midwifery and health visiting staff	3,141	170	**3,311**	3,173
Nursing, midwifery and health visiting learners	1,304	59	**1,363**	1,212
Scientific, therapeutic and technical staff	1,260	281	**1,541**	1,268
Other	268	33	**301**	241
TOTAL	**9,271**	**1,129**	**10,400**	10,002
Of the above - staff engaged on capital projects	14	4	**18**	22

10.3 Staff Sickness absence and ill health retirements

	2013-14	2012-13
	Number	Number
Total Days Lost	73,616	75,560
Total Staff Years	9,966	9,928
Average working Days Lost	7.39	7.61
	Number	Number
Number of persons retired early on ill health grounds	**14**	16
	£000s	£000s
Total additional pensions liabilities accrued in the year	**748**	989

10.4 Exit Packages agreed in 2013-14

	2013-14							
Exit package cost band (including any special payment element)	*Number of compulsory redundancies	Cost of compulsory redundancies	Number of other departures agreed	Cost of other departures agreed	Total number of exit packages	Total cost of exit packages	Number of departures where special payments have been made	Cost of special payment element included in exit packages
	Number	£'s	Number	Number	Number	£'s	Number	£'s
Less than £10,000	0	0	0	0	0	0	0	0
£10,000-£25,000	2	44,652	0	2	2	44,652	0	0
£25,001-£50,000	1	47,087	0	1	1	47,087	0	0
£50,001-£100,000	1	90,252	0	1	1	90,252	0	0
£100,001 - £150,000	0	0	0	0	0	0	0	0
£150,001 - £200,000	0	0	0	0	0	0	0	0
>£200,000	0	0	0	0	0	0	0	0
Totals	4	181,991	0	4	4	181,991	0	0

	2012-13							
Exit package cost band (including any special payment element)	*Number of compulsory redundancies	Cost of compulsory redundancies	Number of other departures agreed	Cost of other departures agreed	Total number of exit packages	Total cost of exit packages	Number of departures where special payments have been made	Cost of special payment element included in exit packages
	Number	£'s	Number	Number	Number	£'s	Number	£'s
Less than £10,000	0	0	0	0	0	0	0	0
£10,000-£25,000	0	0	0	0	0	0	0	0
£25,001-£50,000	1	26,771	0	0	1	26,771	0	0
£50,001-£100,000	0	0	0	0	0	0	0	0
£100,001 - £150,000	0	0	0	0	0	0	0	0
£150,001 - £200,000	0	0	0	0	0	0	0	0
>£200,000	0	0	0	0	0	0	0	0
Totals	1	26,771	0	0	1	26,771	0	0

Redundancy and other departure costs have been paid in accordance with the provisions of the NHS Scheme. Exit costs in this note are accounted for in full in the

This disclosure reports the number and value of exit packages taken by staff leaving in the year.

10.5 Exit packages - Other Departures analysis

There were none of the following other departures in the year within the Trust:

- Voluntary redundancies including early retirement contractual costs
- Mutually agreed resignations (MARS) contractual costs
- Early retirements in the efficiency of the service contractual costs
- Contractual payments in lieu of notice
- Exit payments following Employment Tribunals or court orders
- Non-contractual payments requiring HMT approval

10.6 Pension costs

Past and present employees are covered by the provisions of the NHS Pensions Scheme. Details of the benefits payable under these provisions can be found on the NHS Pensions website at www.nhsbsa.nhs.uk/pensions. The scheme is an unfunded, defined benefit scheme that covers NHS employers, GP practices and other bodies, allowed under the direction of the Secretary of State, in England and Wales. The scheme is not designed to be run in a way that would enable NHS bodies to identify their share of the underlying scheme assets and liabilities. Therefore, the scheme is accounted for as if it were a defined contribution scheme: the cost to the NHS Body of participating in the scheme is taken as equal to the contributions payable to the scheme for the accounting period.

The scheme is subject to a full actuarial valuation every four years (until 2004, every five years) and an accounting valuation every year. An outline of these follows:

a) Full actuarial (funding) valuation

The purpose of this valuation is to assess the level of liability in respect of the benefits due under the scheme (taking into account its recent demographic experience), and to recommend the contribution rates to be paid by employers and scheme members. The last such valuation, which determined current contribution rates was undertaken as at 31 March 2004 and covered the period from 1 April 1999 to that date. The conclusion from the 2004 valuation was that the scheme had accumulated a notional deficit of £3.3 billion against the notional assets as at 31 March 2004.

In order to defray the costs of benefits, employers pay contributions at 14% of pensionable pay and most employees had up to April 2008 paid 6%, with manual staff paying 5%.

Following the full actuarial review by the Government Actuary undertaken as at 31 March 2004, and after consideration of changes to the NHS Pension Scheme taking effect from 1 April 2008, his Valuation report recommended that employer contributions could continue at the existing rate of 14% of pensionable pay, from 1 April 2008, following the introduction of employee contributions on a tiered scale from 5% up to 8.5% of their pensionable pay depending on total earnings.

On advice from the scheme actuary, scheme contributions may be varied from time to time to reflect changes in the scheme's liabilities.

b) Accounting valuation

A valuation of the scheme liability is carried out annually by the scheme actuary as at the end of the reporting period by updating the results of the full actuarial valuation.

Between the full actuarial valuations at a two-year midpoint, a full and detailed member data-set is provided to the scheme actuary. At this point the assumptions regarding the composition of the scheme membership are updated to allow the scheme liability to be valued.

The valuation of the scheme liability as at 31 March 2011, is based on detailed membership data as at 31 March 2008 (the latest midpoint) updated to 31 March 2011 with summary global member and accounting data.

The latest assessment of the liabilities of the scheme is contained in the scheme actuary report, which forms part of the annual NHS Pension Scheme (England and Wales) Resource Account, published annually. These accounts can be viewed on the NHS Pensions website. Copies can also be obtained from The Stationery Office.

c) Scheme provisions

The NHS Pension Scheme provided defined benefits, which are summarised below. This list is an illustrative guide only, and is not intended to detail all the benefits provided by the Scheme or the specific conditions that must be met before these benefits can be obtained:

The Scheme is a "final salary" scheme. Annual pensions are normally based on 1/80th for the 1995 section and of the best of the last three years pensionable pay for each year of service, and 1/60th for the 2008 section of reckonable pay per year of membership. Members who are practitioners as defined by the Scheme Regulations have their annual pensions based upon total pensionable earnings over the relevant pensionable service.

With effect from 1 April 2008 members can choose to give up some of their annual pension for an additional tax free lump sum, up to a maximum amount permitted under HMRC rules. This new provision is known as "pension commutation".

Annual increases are applied to pension payments at rates defined by the Pensions (Increase) Act 1971, and are based on changes in retail prices in the twelve months ending 30 September in the previous calendar year.

Early payment of a pension, with enhancement, is available to members of the scheme who are permanently incapable of fulfilling their duties effectively through illness or infirmity. A death gratuity of twice final year's pensionable pay for death in service, and five times their annual pension for death after retirement is payable

For early retirements other than those due to ill health the additional pension liabilities are not funded by the scheme. The full amount of the liability for the additional costs is charged to the statement of comprehensive income at the time the Trust commits itself to the retirement, regardless of the method of payment.

Members can purchase additional service in the NHS Scheme and contribute to money purchase AVC's run by the Scheme's approved providers or by other Free Standing Additional Voluntary Contributions (FSAVC) providers.

11 Better Payment Practice Code

11.1 Measure of compliance

	2013-14		2012-13	
	Number	**£000s**	Number	£000s
Non-NHS Payables				
Total Non-NHS Trade Invoices Paid in the Year	**128,364**	**396,204**	123,289	364,150
Total Non-NHS Trade Invoices Paid Within Target	**59,150**	**271,621**	104,995	307,704
Percentage of NHS Trade Invoices Paid Within Target	**46.08%**	**68.56%**	85.16%	84.50%
NHS Payables				
Total NHS Trade Invoices Paid in the Year	**4,654**	**163,108**	4,857	**147,687**
Total NHS Trade Invoices Paid Within Target	**2,549**	**133,356**	3,320	**132,473**
Percentage of NHS Trade Invoices Paid Within Target	**54.77%**	**81.76%**	68.35%	89.70%

The Better Payment Practice Code requires the NHS body to aim to pay all valid invoices by the due date or within 30 days of receipt of a valid invoice, whichever is later. The Trust has not complied with this requirement for 2013-14 as its adverse financial performance reduced the cash available to make timely payments to all suppliers during the year.

The Trust will improve its performance against the Better Payment Practice Code (BPPC) in 2014-15 as a result of the cash financing outlined in note 26 The financing solutions will give us sufficient cash to ensure all invoices can be paid within the 30 day payment terms within 2014-15.

11.2 The Late Payment of Commercial Debts (Interest) Act 1998

	2013-14	2012-13
	£000s	£000s
Amounts included in finance costs from claims made under this legislation	**0**	0
Compensation paid to cover debt recovery costs under this legislation	**0**	0
Total	**0**	0

12 Investment Revenue

	2013-14	2012-13
	£000s	£000s
Bank interest	**66**	77
Total investment revenue	**66**	77

13 Other Gains and Losses

	2013-14	2012-13
	£000s	£000s
Gain/(Loss) on disposal of assets other than by sale (PPE)	**(51)**	0
Total	**(51)**	0

14 Finance Costs

	2013-14	2012-13
	£000s	£000s
Interest		
Interest on obligations under finance leases	**109**	553
Total interest expense	**109**	553
Other finance costs	**0**	0
Provisions - unwinding of discount	**154**	59
Total	**263**	612

The reduction in finance lease interest from the prior year is due to a reprofiling by the service provider of the interest chargeable for the finance lease across the full lease term.

15.1 Property, plant and equipment

2013-14	Land	Buildings excluding dwellings	Dwellings	Assets under construction & payments on account	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000's	£000's	£000's	£000's	£000's	£000's	£000's	£000's	£000's
Cost or valuation:									
At 1 April 2013	**52,734**	**277,502**	**8,723**	**5,896**	**138,448**	**137**	**52,245**	**1,923**	**537,608**
Transfers under Modified Absorption Accounting - PCTs & SHAs	**0**	**0**	**0**	**0**	**0**	**0**	**2**	**0**	**2**
Additions of Assets Under Construction				**7,243**					**7,243**
Additions Purchased	0	14,888	81		6,285	0	3,538	191	**24,983**
Additions Donated	0	0	0	0	114	0	7	0	**121**
Additions Government Granted	0	313	0	0	320	11	0	0	**644**
Additions Leased	0	0	0		4,353	0	0	0	**4,353**
Reclassifications	0	5,517	0	(5,597)	22	0	41	13	**(4)**
Disposals other than for sale	0	0	0	0	(7,602)	0	(552)	(154)	**(8,308)**
At 31 March 2014	**52,734**	**298,220**	**8,804**	**7,542**	**141,940**	**148**	**55,281**	**1,973**	**566,642**
Depreciation									
At 1 April 2013	**5,612**	**39,735**	**885**	**129**	**91,397**	**82**	**43,340**	**1,770**	**182,950**
Disposals other than for sale	0	0	0		(7,551)	0	(552)	(154)	**(8,257)**
Charged During the Year	0	15,366	424		9,538	14	4,117	25	**29,484**
At 31 March 2014	**5,612**	**55,101**	**1,309**	**129**	**93,384**	**96**	**46,905**	**1,641**	**204,177**
Net Book Value at 31 March 2014	**47,122**	**243,119**	**7,495**	**7,413**	**48,556**	**52**	**8,376**	**332**	**362,465**
Asset financing:									
Owned - Purchased	47,122	236,450	7,495	7,413	25,410	26	6,792	245	**330,953**
Owned - Donated	0	5,870	0	0	1,107	26	41	87	**7,131**
Owned - Government Granted	0	799	0	0	0	0	0	0	**799**
Held on finance lease	0	0	0	0	22,039	0	1,543	0	**23,582**
Total at 31 March 2014	**47,122**	**243,119**	**7,495**	**7,413**	**48,556**	**52**	**8,376**	**332**	**362,465**

Revaluation Reserve Balance for Property, Plant & Equipment

At 1 April 2013	Land £000's	Buildings £000's	Dwellings £000's	Assets under construction & payments on account £000's	Plant & machinery £000's	Transport equipment £000's	Information technology £000's	Furniture & fittings £000's	Total £000's
Movements	12,633	45,630	6,316	0	49	0	0	0	**64,628**
At 31 March 2014	0	0	0	0	(9)	0	0	0	**(9)**
	12,633	**45,630**	**6,316**	**0**	**40**	**0**	**0**	**0**	**64,619**

Additions to Assets Under Construction in 2013/14

	£000's
Buildings excl Dwellings	6,191
Plant & Machinery	1,052
Balance as at YTD	**7,243**

15.2 Property, plant and equipment prior-year

2012-13	Land	Buildings excluding dwellings	Dwellings	Assets under construction & payments on account	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000s	£000s	£000s	£000s	£000s	£000s	£000s	£000s	£000s
Cost or valuation:									
At 1 April 2012	52,490	266,172	8,664	1,430	132,226	536	48,687	2,089	512,294
Additions - Assets Under Construction				5,691					5,691
Additions - purchased	244	8,688	56		5,236	22	1,674	55	15,975
Additions - donated	0	1,291	0	0	282	13	30	0	1,616
Additions Leased	0	0	0	0	9,893	0	2,523	0	**12,416**
Reclassifications	0	1,351	3	(1,354)	0	0	0	0	0
Disposals other than by sale	0	0	0	0	(9,189)	(434)	(669)	(221)	(10,513)
At 31 March 2013	**52,734**	**277,502**	**8,723**	**5,767**	**138,448**	**137**	**52,245**	**1,923**	**537,479**
Depreciation									
At 1 April 2012	5,612	25,422	463	0	90,147	421	38,900	1,966	162,931
Disposals other than for sale	0	0	0		(8,879)	(366)	(669)	(221)	(10,135)
Charged During the Year	0	14,313	422		10,129	27	5,109	25	30,025
At 31 March 2013	**5,612**	**39,735**	**885**	**0**	**91,397**	**82**	**43,340**	**1,770**	**182,821**
Net book value at 31 March 2013	**47,122**	**237,767**	**7,838**	**5,767**	**47,051**	**55**	**8,905**	**153**	**354,658**
Asset financing:									
Owned	47,122	237,767	7,838	5,767	26,623	55	6,677	153	332,002
Held on finance lease	0	0	0	0	20,428	0	2,228	0	22,656
On-SOFP PFI contracts	0	0	0	0	0	0	0	0	0
PFI residual: interests	0	0	0	0	0	0	0	0	0
Total at 31 March 2013	**47,122**	**237,767**	**7,838**	**5,767**	**47,051**	**55**	**8,905**	**153**	**354,658**

15.3 (cont). Property, plant and equipment

15.3.1 Donated assets

The majority of donated assets have been purchased on behalf of the Trust by the Leicester Hospitals Charity.

The most notable donated additions from the Leicester Hospitals Charity have included:

- £246K of building works including £78k works to improve the environment on Childrens Ward 27 and £32k refurbishment of the parent rooms.
- £303k for medical and dental equipment including £102k for scalp cooling equipment and £95k for an ultrasound machine for the breast care centre.

15.3.2 Revaluation

The Trust re-values its assets every three years.

The Trust's freehold and leasehold properties were valued as at the 31 March 2012 by an external valuer, Gerald Eve LLP, a regulated firm of chartered surveyors. The valuation was prepared in accordance with the requirements of the RICS Valuation Standards, Eighth Edition, March 2012, the International Valuation Standards and IFRS. The valuation of each property was on the basis of Fair Value, equivalent to Market Value, subject to the following assumptions:

- for owner occupied property: the property would be valued as part of the continuing business; and
- for surplus property and property held for development: the property would be valued with vacant possession in its existing condition.

The valuer's opinion of Fair Value was primarily derived using the Depreciated Replacement Cost approach, because the specialised nature of the assets means that there are no market transactions of this type of asset except as part of the business or entity. For non-specialised assets regard has been had to comparable recent market transactions and/or an estimate of the future potential net income generated by the use of the property.

The valuations have been prepared in accordance with the Government Financial Reporting Manual 2012-2013 (FReM) to comply with IFRS, specifically with regard to IAS 16 'Property, Plant and Equipment' and IAS 40 'Investment Properties'.

15.3.3 Property plant and equipment

The accounting policies in relation to depreciation, amortisation and impairments are included in accounting policies note 1.10.

15.3.4 Temporarily idle asset values

The Trust does not hold any temporarily idle assets.

15.3.5 Gross carrying value of fully depreciated assets in use at the balance sheet date

The following totals represent total gross carrying value of all assets which have been fully depreciated.

	31 March 2014	31 March 2013
	£000	£000
Plant & Machinery (Purchased)	**40,921**	47,082
Plant & Machinery (Donated)	**5,593**	6,648
Transport Equipment (Purchased)	**39**	39
Tangible IM&T (Purchased)	**38,716**	32,334
Tangible IM&T (Donated)	**106**	157
Intangible IM&T (Purchased)	**4,085**	3,302
Furniture & Fittings (Purchased)	**1,520**	1,634
Furniture & Fittings (Donated)	**73**	114
	91,053	**91,310**

15.3.6 Compensation for assets impaired, lost or given up

The Trust has no compensation from third parties for assets impaired, lost or given up, which it needs to include in its surplus.

16.1 Intangible non-current assets

	2013-14	
	Computer Licenses £000's	**Total £000's**
At 1 April 2013	**11,754**	**11,754**
Additions - purchased	4,468	**4,468**
Reclassifications	4	**4**
Disposals other than by sale	(125)	**(125)**
At 31 March 2014	**16,101**	**16,101**
Amortisation		
At 1 April 2013	**6,446**	**6,446**
Disposals other than by sale	(125)	**(125)**
Charged during the year	1,761	**1,761**
At 31 March 2014	**8,082**	**8,082**
Net Book Value at 31 March 2014	**8,019**	**8,019**
Asset Financing: Net book value at 31 March 2014 comprises:		
Purchased	8,018	**8,018**
Donated	1	**1**
Total at 31 March 2014	**8,019**	**8,019**

16.2 Intangible non-current assets prior year

	2012-13	
	Computer Licenses £000s	Total £000s
Cost or valuation:		
At 1 April 2012	9,616	9,616
Additions - purchased	2,138	2,138
At 31 March 2013	11,754	11,754
Amortisation		
At 1 April 2012	4,374	4,374
Charged during the year	2,072	2,072
At 31 March 2013	6,446	6,446
Net book value at 31 March 2013	5,308	5,308
Asset Financing: Net book value at 31 March 2013 comprises:		
Purchased	5,308	5,308
Donated	0	0
Government Granted	0	0
Total at 31 March 2013	5,308	5,308

16.3 Intangible non-current assets

The accounting policies in relation to intangible assets are included in note 1.11.

16.3.1 Internally generated assets

Expenditure on research activities is recognised as an expense in the period in which it is incurred.

All of the Trust's intangible assets are either purchased or donated, and none have been internally generated.

16.3.2 Amortisation

All of the Trust's intangible assets are amortised up to a maximum of 5 years and are not subject to revaluation.

16.3.3 Acquisition

None of the Trust's intangible assets have been acquired by government grant.

16.3.4 Fully amortised assets

The Trust has £4.1m of fully amortised intangible assets still in use.

16.3.5 Recognition

The Trust has no significant intangible assets which it does not recognise as assets under IAS 38 *Intangible Assets*.

16.3.6 Revaluation reserve balance for intangible assets

The Trust has no revaluation reserve balances for intangible assets.

16.3.7 Impairments

The Trust has no material impairments for any individual intangible assets.

17 Analysis of impairments and reversals recognised in 2013-14

The Trust has not impaired any assets during 2013-14.

18 Investment property

The Trust has no investment property.

19 Commitments

19.1 Capital commitments

Contracted capital commitments at 31 March not otherwise included in these financial statements:

	31 March 2014	31 March 2013
	£000s	£000s
Property, plant and equipment	**7,812**	8,970
Total	**7,812**	8,970

19.2 Other financial commitments

The Trust has no other financial commitments such as non-cancellable contracts (which are not leases or PFI contracts or other service concession arrangements).

20 Intra-Government and other balances

	Current receivables £000s	**Non-current receivables £000s**	**Current payables £000s**	**Non-current payables £000s**
Balances with other Central Government Bodies	35,968	0	23,023	0
Balances with Local Authorities	76	0	237	0
Balances with NHS Trusts and Foundation Trusts	3,116	0	4,492	0
Balances with bodies external to government	10,682	3,123	86,968	0
At 31 March 2014	**49,842**	**3,123**	**114,720**	**0**
prior period:				
Balances with other Central Government Bodies	33,908	0	16,628	0
Balances with Local Authorities	14	0	30	0
Balances with NHS Trusts and Foundation Trusts	1,576	0	2,549	0
At 31 March 2013	**35,498**	**0**	**19,207**	**0**

21 Inventories

	Drugs	Consumables	Energy	Total	Of which held at NRV
	£000s	£000s	£000s	£000s	£000s
Balance at 1 April 2013	**3,126**	**9,659**	**279**	**13,064**	**9,659**
Additions	73,600	64,214	46	**137,860**	64,214
Inventories recognised as an expense in the period	(73,401)	(63,485)	(101)	**(136,987)**	(63,485)
Balance at 31 March 2014	**3,325**	**10,388**	**224**	**13,937**	**10,388**

22.1 Trade and other receivables

	Current		Non-current	
	31 March 2014	31 March 2013	**31 March 2014**	31 March 2013
	£000s	£000s	**£000s**	£000s
NHS receivables - revenue	**37,320**	33,679	**0**	0
Non-NHS receivables - revenue	**10,758**	9,819	**3,148**	3,180
Non-NHS prepayments and accrued income	**1,660**	2,327	**372**	372
Provision for the impairment of receivables	**(1,408)**	(1,123)	**(397)**	(397)
VAT	**1,265**	748	**0**	0
Other receivables	**297**	199	**0**	0
Total	**49,892**	45,649	**3,123**	3,155
Total current and non current	**53,015**	48,804		

The great majority of trade is with CCGs, as commissioners for NHS patient care services. As CCGs are funded by Government to buy NHS patient care services, no credit scoring of them is considered necessary.

Other receivables are amounts owing to the Trust in relation to dividends paid on our Public Dividend Capital (PDC) balances in the year. We calculate the final total PDC dividends payable for the year at the year end, and we can therefore have an amount either owing to or from the Trust depending whether we have actually over or under paid in the year.

22.2 Receivables past their due date but not impaired

	31 March 2014	31 March 2013
	£000s	£000s
By up to three months	**2,162**	1,586
By three to six months	**441**	520
By more than six months	**476**	109
Total	**3,079**	2,215

22.3 Provision for impairment of receivables

	2013-14	2012-13
	£000s	£000s
Balance at 1 April 2013	**(1,520)**	(1,402)
Amount written off during the year	**850**	141
Amount recovered during the year	**241**	321
(Increase)/decrease in receivables impaired	**(1,376)**	(580)
Balance at 31 March 2014	**(1,805)**	**(1,520)**

The Trust makes a general provision on non NHS debts over 90 days old, increasing from 25% at 90 days to 100% for debts over a year old. Certain debts incur a higher or lower provision dependent on a risk assessment approved by the Trust. The Trust provides for 12.6% of injury cost recovery debts based on Department of Health guidance. The total injury cost recovery provision is £484k (2012-13: £397k).

23 NHS LIFT investments

The Trust has no NHS LIFT investments.

24.1 Other Financial Assets - Current

The Trust has no other financial assets.

24.2 Other Financial Assets - Non Current

The Trust has no other financial assets.

25 Other current assets

	31 March 2014 £000s	31 March 2013 £000s
EU Emissions Trading Scheme Allowance	**0**	40
Total	**0**	40

26 Cash and Cash Equivalents

	31 March 2014 £000s	31 March 2013 £000s
Opening balance	**19,986**	18,369
Net change in year	**(19,471)**	1,617
Closing balance	**515**	19,986
Made up of		
Cash with Government Banking Service	**503**	19,974
Commercial banks	**0**	12
Cash in hand	**12**	0
Cash and cash equivalents as in statement of financial position	**515**	19,986
Bank overdraft - Government Banking Service	**0**	0
Bank overdraft - Commercial banks	**0**	0
Cash and cash equivalents as in statement of cash flows	**515**	19,986
Patients' money held by the Trust	**2**	4

The Trust's closing cash balance of £0.5m was £18.5m below the planned value of £19m. Following an agreed reset of its External Financing Limit (EFL) by the NTDA, the Trust was able to reduce its cash balances significantly from plan at the year end. This enabled the Trust to maximise its creditor payments at the year end and reduce the backlog of unpaid and overdue supplier invoices which arose due to the Trust's adverse financial position. The Trust achieved met its revised EFL target as shown in Note 43.3.

The financial plan for 2014-15 forecasts that the Trust will require both temporary borrowing and permanent financing as follows:

- £78m permanent PDC financing is required to fund the £40.7m deficit plan for the full year; cover the outstanding creditors brought forward at the start of the year; and provide funding for the capital programme; and

- Temporary borrowing will be drawn down from April to clear the outstanding creditor payments and to fund the deficit plan until permanent PDC financing is received later in the year.

This has been discussed with the NTDA and the Trust received the first tranche of its temporary borrowing (£15.5m) in April 2014. Sufficient liquidity therefore will exist or can be made available to support the operations of the Trust in the coming twelve months from the date of annual accounts.

27 Non-current assets held for sale

The Trust has no non-current assets held for sale.

28 Trade and other payables

	Current	
	31 March 2014	31 March 2013
	£000s	£000s
NHS payables - revenue	**6,419**	3,517
NHS accruals and deferred income	**5,517**	875
Non-NHS payables - revenue	**36,227**	29,325
Non-NHS payables - capital	**12,907**	5,407
Non-NHS accruals and deferred income	**30,053**	21,516
Social security costs	**4,458**	4,324
Tax	**4,951**	4,991
Other	**8,603**	6,639
Total payables (current and non-current)	**109,135**	**76,594**
Included above:		
Outstanding Pension Contributions at the year end	**5,898**	5,404

The increase in total payables can be attributed to an increase in capital payables of £7.5m; an increase in deferred income of £5.5m due to the change in the way maternity pathways are funded; and a general increase in the backlog of supplier invoices that remained unpaid at the year end due to the low levels of cash resulting from the Trust's financial performance.

29 Other liabilities

The Trust has no other liabilities.

30 Borrowings

	Current		Non-current	
	31 March 2014	31 March 2013	**31 March 2014**	31 March 2013
	£000s	£000s	**£000s**	£000s
Finance lease liabilities	**6,590**	2,727	**5,890**	10,906
Total other liabilities (current and non-current)	**12,480**	**13,633**		

Finance leases - payment of principal falling due in:

	31 March 2014		
	DH	**Other**	**Total**
	£000s	**£000s**	**£000s**
0-1 Years	0	6,590	**6,590**
1 - 2 Years	0	5,890	**5,890**
TOTAL	**0**	**12,480**	**12,480**

31 Other financial liabilities

The Trust has no other financial liabilities.

32 Deferred revenue

	Current		Non-current	
	31 March 2014	31 March 2013	**31 March 2014**	31 March 2013
	£000s	£000s	**£000s**	£000s
Opening balance at 1 April 2013	**6,442**	7,657	**0**	0
Deferred revenue addition	**7,941**	1,348	**0**	0
Transfer of deferred revenue	**(477)**	(2,563)	**0**	0
Current deferred Income at 31 March 2014	**13,906**	6,442	**0**	0
Total deferred income	**13,906**	6,442		

33 Finance lease obligations as lessee

Managed Equipment Service (MES) finance lease

The Trust has a finance lease in relation to its managed equipment service as defined by IAS 17*Leases.*

Commencement date: 2007
End date: 2026

Picture Archiving and Communications Service (PACS)

The Trust has a finance lease in relation to its PACS system as defined by IAS 17*Leases.*

Commencement date: 2012
End date: 2017

Payment for the fair value of the services received

The annual unitary payment is applied to meet the annual finance cost and to repay the lease liability over the contract term.

Interest costs charged to revenue

An annual finance cost is calculated by applying the implicit interest rate in the lease to the opening lease liability for the period, and is charged to 'Finance Costs' within the Statement of Comprehensive Income.

Property plant and equipment assets recognised on the balance sheet

The finance lease assets are recognised as property, plant and equipment. The asset values, life and depreciation for the MES scheme are provided to the Trust by the Lessor. The asset lives for the PACS system are calculated by the Trust.

Depreciation on the property, plant and equipment is charged to revenue.

Liability

A liability is recognised at the same time as the assets are recognised. It is measured initially at the same amount as the fair value of the assets and is subsequently measured as a finance lease liability in accordance with IAS 17*Leases.*

Asset replacement

Any assets, or asset components replaced by the operator during the contract are capitalised where they meet the Trust's criteria for capital expenditure. They are capitalised at the time they are provided by the operator and are measured initially at their fair value.

Assets contributed by the Trust to the operator for use in the scheme (MES only).

Assets contributed for use in the scheme are recognised as items of property, plant and equipment in the Trust's Statement of Financial Position.

Amounts payable under finance leases (Other)	**Minimum lease payments**		**Present value of minimum lease payments**	
	31 March 2014	31 March 2013	**31 March 2014**	31 March 2013
	£000s	£000s	**£000s**	£000s
Within one year	**6,590**	2,727	**6,590**	2,727
Between one and five years	**7,680**	11,952	**5,890**	10,906
Less future finance charges	(1,790)	(1,046)		
Minimum Lease Payments / Present value of minimum lease payments	**12,480**	13,633	**12,480**	13,633
Included in:				
Current borrowings			**6,590**	2,727
Non-current borrowings			**5,890**	10,906
			12,480	13,633

34 Finance lease receivables as lessor

The Trust has no finance lease receivables.

35 Provisions

		Comprising:		
	Total	**Early Departure Costs**	**Other**	**Redundancy**
	£000s	**£000s**	**£000s**	**£000s**
Balance at 1 April 2013	**4,312**	1,658	918	1,736
Arising During the Year	**447**	40	329	78
Utilised During the Year	**(1,229)**	(215)	(212)	(802)
Reversed Unused	**(29)**	0	0	(29)
Unwinding of Discount	**154**	26	128	0
Balance at 31 March 2014	**3,655**	**1,509**	**1,163**	**983**
Expected Timing of Cash Flows:				
No Later than One Year	**1,585**	212	390	983
Later than One Year and not later than Five Years	**933**	676	257	0
Later than Five Years	**1,137**	621	516	0

Amount Included in the Provisions of the NHS Litigation Authority in Respect of Clinical Negligence Liabilities:

	£000s
As at 31 March 2014	123,061
As at 31 March 2013	115,991

Early departure costs include pensions payable to former directors and other staff.

Other provisions includes £200k for employer and public liability cases as notified to us by the NHS Litigation Authority; £687k permanent injury benefits and £276k for potential litigation or employment tribunals.

36 Contingencies

	31 March 2014	31 March 2013
	£000s	£000s
Contingent liabilities		
Other	**(147)**	(101)
Net Value of Contingent Liabilities	**(147)**	(101)

The Trust's contingent liabilities relate to property, employer and public liability cases. All of these are administered by the NHS Litigation Authority and are expected to be resolved in 2014-15. Provisions for these are also included at note 35.

The Trust has a contingent asset in relation to assets which will be transferred from Interserve to UHL at the completion of the facilities management contract, or at any point the contract is terminated. We have not disclosed a value for these assets as we will not know the net book value of these assets until the point of transfer but the value is not expected to be material.

37 PFI and LIFT - additional information

The Trust has no PFI or LIFT contracts.

38 Impact of IFRS treatment - current year

The Trust is fully compliant with IFRS and therefore there are no transitional impacts under IFRIC12.

39 Financial Instruments

39.1 Financial risk management

Financial reporting standard IFRS 7 requires disclosure of the role that financial instruments have had during the period in creating or changing the risks a body faces in undertaking its activities. Because of the continuing service provider relationship that the Trust has with commissioners and the way those commissioners are financed, the NHS trust is not exposed to the degree of financial risk faced by business entities. Also financial instruments play a much more limited role in creating or changing risk than would be typical of listed companies, to which the financial reporting standards mainly apply. The Trust has limited powers to borrow or invest surplus funds and financial assets and liabilities are generated by day-to-day operational activities rather than being held to change the risks facing the Trust in undertaking its activities.

The Trust's treasury management operations are carried out by the finance department, within parameters defined formally within the Trust's standing financial instructions and policies agreed by the board of directors. Trust treasury activity is subject to review by the Trust's internal auditors.

Currency risk

The Trust is principally a domestic organisation with the great majority of transactions, assets and liabilities being in the UK and sterling based. The trust has no overseas operations. The Trust therefore has low exposure to currency rate fluctuations.

Interest rate risk

The Trust borrows from government for capital expenditure, subject to affordability as confirmed by the strategic health authority. The borrowings are for 1 – 25 years, in line with the life of the associated assets, and interest is charged at the National Loans Fund rate, fixed for the life of the loan. The Trust therefore has low exposure to interest rate fluctuations.

Credit risk

Because the majority of the rust's income comes from contracts with other public sector bodies, the Trust has low exposure to credit risk. The maximum exposures as at the 31st March 2014 are in receivables from customers, as disclosed in the trade and other receivables note.

Liquidity risk

The Trust's operating costs are incurred under contracts with Clinical Commissioning Groups, which are financed from resources voted annually by Parliament. The Trust funds its capital expenditure from funds obtained within its prudential borrowing limit. The Trust is not, therefore, exposed to significant liquidity risks.

39.2 Financial Assets

	Loans and receivables £000s	Total £000s
Receivables - NHS	18,952	**18,952**
Receivables - non-NHS	7,881	**7,881**
Cash at bank and in hand	515	**515**
Total at 31 March 2014	**27,348**	**27,348**
Cash at bank and in hand	19,986	19,986
Total at 31 March 2013	19,986	19,986

39.3 Financial Liabilities

	Other £000s	Total £000s
NHS payables	429	**429**
Non-NHS payables	16,961	**16,961**
Finance lease obligations	12,480	**12,480**
Total at 31 March 2014	**29,870**	**29,870**
Finance lease obligations	13,633	13,633
Total at 31 March 2013	13,633	13,633

40 Events after the end of the reporting period

There are no material adjusting post balance sheet events arising subsequent to the date of these financial statements.

41 Related party transactions

During the year none of the Department of Health Ministers, Trust Board members or members of the key management staff, or parties related to any of them, has undertaken any material transactions with the University Hospitals of Leicester NHS Trust.

Material Department of Health entities

The Department of Health is regarded as a related party. During the year the University Hospitals of Leicester NHS Trust has had a significant number of material transactions with the Department, and with other entities for which the Department is regarded as the parent Department. These entities are listed below:

Cambridgeshire And Peterborough CCG
Community Health Partnerships
Corby CCG
Coventry And Rugby CCG
Derbyshire Community Health Services NHS Trust
Derbyshire and Nottinghamshire
East Leicestershire and Rutland CCG
East Staffordshire CCG
George Eliot Hospital NHS Trust
Health Education England
HM Revenue and Customs
Kettering General Hospital NHS Foundation Trust
Leicester City CCG
Leicestershire County Council
Leicestershire and Lincolnshire Area Team
Leicestershire Partnership NHS Trust
Lincolnshire East CCG
Lincolnshire West CCG
National Insurance Fund
Nene CCG
Newark & Sherwood CCG
NHS Blood & Transplant
NHS England
NHS Litigation Authority
NHS Pension Scheme
NHS Supply Chain
Northampton General Hospital NHS Trust
Northamptonshire Healthcare NHS Foundation Trust
Northern Lincolnshire and Goole NHS Foundation Trust
Nottingham City CCG
Nottingham University Hospitals NHS Trust
Oxford Health NHS Foundation Trust
Peterborough & Stamford Hospitals NHS Foundation Trust
Rushcliffe CCG
Sherwood Forest Hospitals NHS Foundation Trust
South East Staffs And Seisdon Peninsular CCG
South Lincolnshire CCG
Southern Derbyshire CCG
South West Lincolnshire CCG
Staffordshire and Stoke on Trent Partnership NHS Trust
United Lincolnshire Hospitals NHS Trust
University Hospitals Coventry and Warwickshire NHS Trust
Warwickshire North CCG
West Leicestershire CCG
Department of Energy and Climate Change
Public Health England
Welsh Assembly Government

University of Leicester:

One of the Trust's Non-Executive Directors is Dean of the University of Leicester's Medical School an organisation with which the Trust has had a number of material transactions during the year. The Director has been excluded from any discussions or negotiations relating to the transactions which have all been conducted at arms length on normal commercial terms.

During the reporting year, the Trust made payments to the University of Leicester amounting to £9,006k. The majority of these payments relate to the provision of services to the Trust by medical staff employed by the University of Leicester, and research payments. As at 31st March 2014 a sum of £425k is included in creditors in respect of the University of Leicester. The University Paid us £6,264k in the year, relating primarily to research work, and £1,363k was included within debtors at the year end

Leicester Hospitals Charity

The Trust is the Corporate Trustee for Leicester Hospitals Charity which is an independent charity registered with the Charity Commission. In 2013-14 the Trust received total asset donations of £1,423k (£1,497k in 2012-13). Full details will be included in the Charity's accounts as submitted to the Charity Commission.

42 Losses and special payments

The total number of losses cases in 2013-14 and their total value was as follows:

	Total value of cases £000s	Total number of cases Number
Losses		
Bad debts and claims abandoned -		
Private patients	13	66
Overseas visitors	660	249
Other	162	299
Total losses	**835**	**614**
Special payments		
Ex gratia payments -		
Loss of personal effects	38	128
Personal injury with advice	129	25
Maladministration, no financial loss	1	20
Other payments	15	1
Total special payments	**183**	**174**
Total losses and special payments	**1,018**	**788**

Bad debts and claims abandonded are debts written off during 2013-14 and where the original invoice may have been raised in previous periods. The increase in the level of debts written off in 2013-14 over 2012-13 is due to the timing of the write off exercise. An example of this is shown in the table below for overseas debts.

	Financial year invoices were raised				
	2013-14 £000s	2012-13 £000s	2011-12 £000s	2010-11 £000s	pre 2010 £000s
Overseas visitors debt written off in 2013-14	164	314	148	24	10

The Trust makes appropriate provision for doubtful debts in its accounts and has made and has taken a consistent approach to this in 2012-13 and 2013-14.

There were no individual cases over £250,000.

The total number of losses cases in 2012-13 and their total value was as follows:

	Total value of cases £000s	Total number of cases Number
Losses		
Losses of Cash Due to -		
Theft, Fraud etc	0	1
Bad debts and claims abandoned -		
Private patients	84	58
Overseas visitors	78	135
Other	33	178
Total losses	**195**	**372**
Special payments		
Ex Gratia Payments -		
Loss of personal effects	24	90
Personal injury with advice	130	23
Other negligence and injury	3	11
Total special payments	**157**	**124**
Total losses and special payments	**352**	**496**

There were no individual cases over £250,000.

43. Financial performance targets

The figures given for periods prior to 2009-10 are on a UK GAAP basis as that is the basis on which the targets were set for those years.

43.1 Breakeven performance	**2005-06**	**2006-07**	**2007-08**	**2008-09**	**2009-10**	**2010-11**	**2011-12**	**2012-13**	**2013-14**
	£000s	**£000s**	**£000s**	**£000s**	**£000s**	**£000s**	**£000s**	**£000s**	**£000s**
Turnover	556,656	588,666	615,155	652,159	697,692	696,257	719,154	758,665	**770,393**
Retained surplus/(deficit) for the year	60	61	577	3,018	(3,992)	(2,542)	(27,985)	1,177	**(39,514)**
Adjustment for:									
Adjustments for Impairments				0	4,043	3,555	28,073	0	**0**
Adjustments for impact of policy change re donated/government grants assets							0	(1,086)	**(141)**
Break-even in-year position	**60**	**61**	**577**	**3,018**	**51**	**1,013**	**88**	**91**	**(39,655)**
Break-even cumulative position	**254**	**315**	**892**	**3,910**	**3,961**	**4,974**	**5,062**	**5,153**	**(34,502)**

Due to the introduction of International Financial Reporting Standards (IFRS) accounting in 2009-10, the Trust's financial performance measurement needs to be aligned with the guidance issued by HM Treasury measuring Departmental expenditure. Therefore, the incremental revenue expenditure resulting from the application of IFRS to IFRIC 12 schemes (which would include PFI schemes), which has no cash impact and is not chargeable for overall budgeting purposes, is excluded when measuring Breakeven performance. Other adjustments are made in respect of accounting policy changes (impairments and the removal of the donated asset and government grant reserves) to maintain comparability year to year.

	2005-06	**2006-07**	**2007-08**	**2008-09**	**2009-10**	**2010-11**	**2011-12**	**2012-13**	**2012-13**
	%	**%**	**%**	**%**	**%**	**%**	**%**	**%**	**%**
Materiality test (I.e. is it equal to or less than 0.5%):									
Break-even in-year position as a percentage of turnover	0.01	0.01	0.09	0.46	0.01	0.15	0.01	0.01	-5.15
Break-even cumulative position as a percentage of turnover	0.05	0.05	0.15	0.60	0.57	0.71	0.70	0.68	-4.48

The amounts in the above tables in respect of financial years 2005/06 to 2008/09 inclusive have **not** been restated to IFRS and remain on a UK GAAP basis.

The Trust has submitted the final version of its two year plan to the NTDA. The key details relating to the plan for 2014-15 are as follows:

- An adjusted retained deficit of £40.7m for the year.
- A major CIP plan of £45m.
- A capital expenditure plan of £63.3m, including the Emergency Floor development and vascular services move.
- Permanent PDC funding of £78m to fund the deficit plan; £12m of brought forward creditors; and to part fund the capital programme. The Trust is planning to apply for temporary borrowing at regular stages during the year until the PDC application is submitted.
- A Financial Risk Rating (FRR) of 4 (calculated in accordance with the TDA planning submission guidelines).

The Trust has agreed with the NTDA that a financial recovery plan will be produced by the end of Q1 for the Trust to achieve a recurrent balanced financial position within three years. This will be linked to our 5 year plan and Service Strategy.

The financial recovery plan will be considered in the wider context of the Leicester, Leicestershire and Rutland (LLR) health economy position. The quantum of the Trust's 2013-14 deficit, and the increase in the in-year deficit has increased the need for a joined up approach to planning for the Trust and for the LLR Health Economy. 2013-14 will be the first year that the LLR health economy has not delivered a balanced financial position.

The overall financial plan and resulting deficit position is driven by the Trust's activity and income assumptions, workforce implications and the Cost Improvement Programme (CIP). The Trust has a clear process for deliveri

The Trust does not expect to breakeven on a cumulative basis for several years after 2017-18 and this detail will also be included in the 5 Year Plan.

43.3 External financing

The Trust is given an external financing limit which it is permitted to undershoot.

	2013-14	2012-13
	£000s	£000s
External financing limit (EFL)	**20,655**	(4,185)
External financing requirement:		
Cash flow financing	**19,156**	(5,619)
Unwinding of Discount Adjustment	**154**	0
Total external financing requirement	**19,310**	(5,619)
Under/(Over) Spend against EFL	**1,345**	1,434

During the year our EFL was adjusted by the Department of Health from a negative (£1,417k) up to £20,655k. We requested an adjustment of £19m to enable us to minimise our cash balances and thereby repay a large backlog of creditor payments that had accumulated due to the Trust's adverse financial performance. The EFL was also adjusted due to the increase in new PDC received in the year, as detailed in the Statement of Changes in Taxpayers' Equity.

43.4 Capital resource limit

The Trust is given a capital resource limit which it is not permitted to exceed.

	2013-14	2012-13
	£000s	£000s
Gross capital expenditure	**37,459**	25,421
Less: book value of assets disposed of	**(46)**	(378)
Less: donations towards the acquisition of non-current assets	**(765)**	(1,617)
Charge against the capital resource limit	**36,648**	23,426
Capital resource limit	**36,700**	31,746
(Over)/underspend against the capital resource limit	**52**	8,320

During the year our CRL was reduced by £6m due to the forecast underspend on our capital programme and our underspend against this revised limit was not material.

44 Third party assets

The Trust held cash and cash equivalents which relate to monies held by the Trust on behalf of patients or other parties. This has been excluded from the cash and cash equivalents figure reported in the accounts.

	31 March	31 March
	£000s	£000s
Third party assets held by the Trust	**2**	4

Appendix 2: Management responses to KPMG ISA260 recommendations

This appendix summarises the recommendations that we have identified from our work. We have given each of our recommendations a risk rating (as explained below) and agreed with management what action you will need to take.

Priority rating for recommendations		
1 ***Priority one***: issues that are fundamental and material to your system of internal control. We believe that these issues might mean that you do not meet a system objective or reduce (mitigate) a risk.	2 ***Priority two***: issues that have an important effect on internal controls but do not need immediate action. You may still meet a system objective in full or in part or reduce (mitigate) a risk adequately but the weakness remains in the system.	3 ***Priority three***: issues that would, if corrected, improve the internal control in general but are not vital to the overall system. These are generally issues of best practice that we feel would benefit you if you introduced them.

#	Risk	Issue, Impact and Recommendation	Management Response/ Responsible Officer/Due Date
1	1	**Valuations** The Trust should strengthen the quality assurance procedures in relation to valuation of its land and building asset to ensure that sufficient evidence is provided to support values as per the balance sheet on an annual basis, especially in years when no formal external valuation is received. This should include review of relevant indices, benchmarking and comparison against other NHS and public sector bodies, as well as a detailed review of possible impairments against IAS 36. When valuations are received, these are fully suitable for its needs, and that unusual movements are investigated. This should include a review of: ■ The valuers' methodologies and assumptions, and how these compare to those previously used; ■ The accuracy of property data provided by the Trust; and ■ The appropriateness of accounting transactions in prior periods. The Trust transferred £5.6m of Assets Under Construction during the 2013/14 financial year into operation categories such as buildings, plant and machinery, and IT. The Trust's policy states that *"Assets are revalued and depreciation commences when they are brought into use."* These assets were not revalued during the year, contrary to accounting policy requirements. The Trust should ensure that its capital accounting policies are fully complied with each year.	Agreed We will have a full revaluation of our land and buildings in 2014-15 and agree a policy for gaining assurance on the valuation of our assets in years where no formal revaluation takes place. Nick Sone – Financial Controller Darren Stell – Capital Accountant Due date: November 2014

Appendix 2: Management responses to KPMG ISA260 recommendations

#	Risk	Issue, Impact and Recommendation	Management Response/ Responsible Officer/Due Date
2	1	**Executive Director Contracts** During the financial year, an Executive Director of the Trust resigned from employment. Through reviewing the arrangements regarding this departure, it was discovered that the Trust did not hold a signed contract for the individual in question. The discovery of unsigned contracts for any member of staff is a control weakness, this is even more so when in relation to an Executive Director. The Trust have undertaken a review of the remaining Directors to provide assurance this was an isolated incident. The Trust should review its policies and procedures with regards to ensuring signed copies of contracts for all members of staff are received prior to the commencement of employment.	Agreed We will review our policies and procedures relating to staff contracts of employment. Kate Bradley – Director of Human Resources Due date: Immediate
3	2	**Outsourcing Contracts** The two new major contracts entered into in 2012-13 by the Trust, IBM and Interserve, were signed in December 2012, and commenced during the final quarter of the 2012/13 financial year. As a result both contracts operated under a 'steady state' / 'business as usual' basis until the year end. During 2013/14 the contracts have remain 'business as usual'. The accounting and disclosure requirements have therefore remained minimal during the financial year. However, we continue to note that additional areas within these contracts, such as potential sub-leases and capital spend, may be activated in the forthcoming financial year. Furthermore, as part of the Trust's contractual arrangements with Interserve to provide facilities management, on termination of the contract the Trust is entitled to receive all assets being used in provision of the various services. The Trust is over a year into the contract but currently does not have a list of what these assets will be, nor the value expected to be attached to them. The Trust should ensure that all relevant information pertaining to outsourcing contracts is obtained and reviewed on a timely basis to ensure that the accounting treatment and disclosures remain appropriate;	Agreed We will remain engaged with the Trust's major contracts including IBM and Interserve and review any developments against appropriate accounting standards. Nick Sone – Financial Controller Due Date: Ongoing We will discuss with Interserve the assets that will be transfer back to the Trust at completion of the contract in order to determine the likely value of these assets. Nick Sone – Financial Controller Due date: September 2014

Appendix 2: Management responses to KPMG ISA260 recommendations

#	Risk	Issue, Impact and Recommendation	Management Response/ Responsible Officer/Due Date
4	2	**Annual Report** As part of our Prepared By Client (PBC) list issued in January 2014 we requested that the Trust provide us with the annual report during our audit so that we could undertake our required review, including audit of the remuneration contained within. We also requested that the annual report be cross referenced to the requirements in the Manual for Accounts, and provided a schedule to help with this. We commenced our audit on 24 April 2014 and received an initial draft of the annual report, however the completed final draft was not provided until 22 May 2014. This is required so that we can review the full report to identify material inconsistencies with the audited financial statements and to identify any information that is apparently materially incorrect based on, or materially inconsistent with, the knowledge acquired by us in the course of performing the audit. If we become aware of any apparent material misstatements or inconsistencies we consider the implications for our report. The Trust should ensure that all working papers, reports and supporting documentation requested are made available to a high standard and quality by the start of the onsite audit. These should be in line with agreed requests as per our Prepared by Client requirements to enable us to utilise these fully in support of our audit work and conclusion.	Agreed Whilst the final draft version of the Annual Report was provided to audit on the 22nd May, a substantially complete version was provided on the 24th April. We consider that many of the mandatory elements of the report, including the OFR and remuneration report, were included in the 24th April version. However at that stage some content was outstanding from several contributors and this was clearly marked up in the report. There is also some specific content (such as complaints data) that is not available until mid to late May so it is not possible to have a fully completed report by the Audit commencement date. We had a timetable at the end of 2013-14 for the submission of Annual Report content to the Communications team. In light of the issue raised we will review this timetable for 2014-15. If necessary we will bring forward the report's production date, taking into account such factors as the audit date and the Easter holiday period. We will communicate this to all contributors in sufficient time to allow for the Annual Report's completion. Mark Wightman - Director of Communications March 2015

University Hospitals of Leicester NHS
NHS Trust

To:	**Trust Board**
From:	**CHIEF EXECUTIVE**
Date:	**29 May 2014**
CQC regulation:	N/A

Title:	**ANNUAL GOVERNANCE STATEMENT 2013/14**

Author/Responsible Director: Director of Corporate and Legal Affairs

Purpose of the Report: To invite the Trust Board to adopt the attached Annual Governance Statement 2013/14.

The Report is provided to the Committee for:

Decision	√	Discussion	
Assurance		Endorsement	√

Summary / Key Points: The Audit Committee is to review the Annual Governance Statement 2013/14 at its meeting on 27 May 2014 and an oral update will be reported at the Trust Board meeting.

Recommendations: To invite the Trust Board to adopt the attached Annual Governance Statement 2013/14.

Previously considered at another corporate UHL Committee? Audit Committee – 27 May 2014

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

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

Assurance Implications: The draft Annual Governance Statement is to be reviewed by the Audit Committee on 27 May 2014, ahead of its consideration by the Board.

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

Stakeholder Engagement Implications: N/A

Equality Impact: N/A

Information exempt from Disclosure: N/A

Requirement for further review? N/A

DRAFT :

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST

ANNUAL GOVERNANCE STATEMENT 2013/14

Scope of Responsibility

As Accountable Officer, I have responsibility for maintaining a sound system of internal control that supports adherence to the Trust's policies and achievement of its aims and objectives, whilst safeguarding the public funds and departmental assets for which I am personally responsible, in accordance with the responsibilities assigned to me. I am also responsible for ensuring that the NHS Trust is administered prudently and economically and that resources are applied efficiently and effectively. I also acknowledge my responsibilities as set out in the NHS Trust Accountable Officer Memorandum.

The Governance Framework of the Organisation

Trust Board Composition and Membership

The Trust Board comprises 13 members: a Chairman, seven Non-Executive Directors and five Executive Directors. There have been a number of changes in the composition of the Board during 2013/14. Mr Martin Hindle stood down as Trust Chairman on 30 September 2013. One of the Trust's Non-Executive Directors, Mr Richard Kilner was appointed by the Trust Board to serve as Acting Chairman pending the appointment of a substantive Chairman by the NHS Trust Development Authority and continues to serve in this capacity. Until such time as the post is filled substantively, a post of Non-Executive Director remains open.

Col. (Retd) Ian Crowe joined the Board as a Non-Executive Director on 1 July 2013 and Dr Sarah Dauncey resumed her position as a Non-Executive Director on 27 January 2014, having earlier served in this capacity between 1 May and 17 June 2013. Messrs Ian Reid and Ian Sadd stood down as Non-Executive Directors on 30 June and 31 December 2013, respectively.

Mr Richard Mitchell joined the Trust as Chief Operating Officer on 1 July 2013 and Ms Rachel Overfield commenced her role as Chief Nurse on 9 September 2013.

Mr P Hollinshead joined the Trust as Interim Director of Financial Strategy in January 2014. The Trust is to make a substantive appointment to the post of Director of Finance following the departure of Mr A Seddon in April 2014.

The Board is supported in its work by the Director of Human Resources, Director of Marketing and Communications , Director of Corporate and Legal Affairs and Director of Strategy. Ms Kate Shields joined the Trust as Director of Strategy on 4 November 2013.

Performance Management Reporting Framework

To ensure that the Board is aware to a sufficient degree of granularity of what is happening in the hospitals, a comprehensive quality and performance report is reviewed at each monthly public Board meeting.

The monthly report:

- is structured across several domains: quality and patient safety; patient experience; operational performance; human resources; facilities management; information management and technology service delivery; and financial performance;

- includes information on the Trust's performance against the NHS Trust Development Authority outcome and quality governance measures;

- includes performance indicators rated red, amber or green;

- includes data quality indicators, measured against six key data quality components to assist the Board in gaining assurance;

- is complemented by commentaries from the accountable Executive Directors identifying key issues to the Board and, where necessary, corrective actions to bring performance back on track.

Importantly, the quality and performance report includes information on 'never events' and the Trust Board receives information on follow-up action.

This formal Board performance management reporting framework is accompanied by a series of measures to achieve a more interactive style of governance, moving beyond paper reporting. Examples include:

- patient stories, which are presented in public at each Board meeting quarter. These shine a light on individual experiences of care provided by the Trust and act as a catalyst for improvement; and

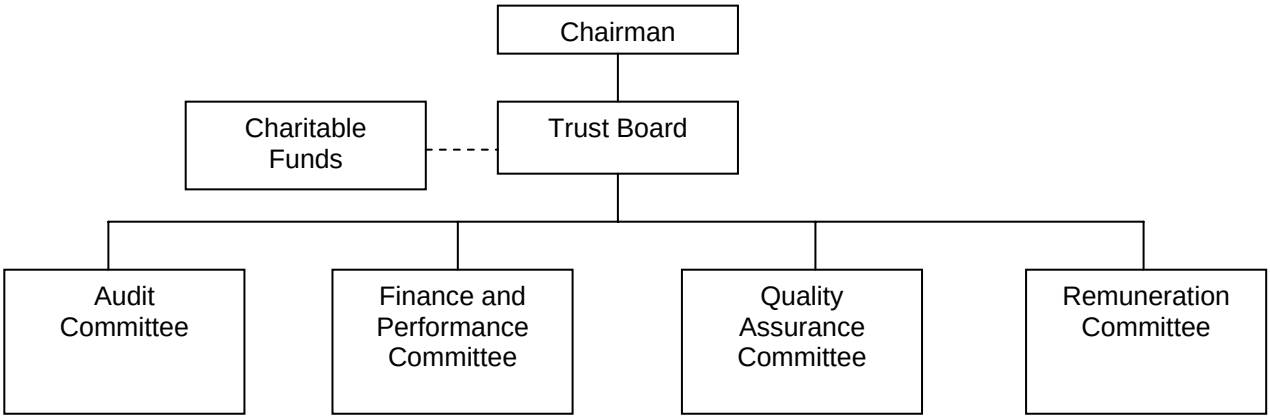
- Board members undertake patient safety walkabouts regularly.

These arrangements allow Board members to help model the Trust's values through direct engagement, as well as ensuring that Board members take back to the boardroom an enriched understanding of the lived reality for staff, public and patients.

Committee Structure

The Trust has operated a well-established committee structure to strengthen its focus on quality governance. finance and performance, and risk management. The structure has been designed to provide effective governance over, and challenge to,

the Trust's patient care and other business activities. The committees carry out detailed work of assurance on behalf of the Board. A diagram illustrating the Board committee structure is set out below.



All of the Board committees are chaired by a Non-Executive Director and comprise a mixture of both Non-Executive and Executive Directors within their memberships. The exceptions to this are the Audit Committee and the Remuneration Committee, which (in accordance with NHS guidance) comprise Non-Executive Directors exclusively.

The Audit Committee is established under powers delegated by the Trust Board with approved terms of reference that are aligned with the NHS Audit Committee Handbook. The Committee consists of three Non-Executive Directors, has met on five occasions throughout the 2013/14 financial year and has discharged its responsibilities for scrutinising the risks and controls which affect all aspects of the organisation's business. The Audit Committee receives a report at each of its meetings from the External Auditor,Internal Audit and the Local Counter-Fraud Specialist, the latter providing the Committee with an assurance on the Trust's work programme to deter fraud.

The Finance and Performance Committee meets monthly and oversees the effective management of the Trust's financial resources and operational performance across a range of measures.The Quality Assurance Committee also meets monthly and seeks assurances that there are effective arrangements in place for monitoring and continually improving the quality of healthcare provided to patients.

The Minutes of each meeting of the Board's committees are submitted to the next available Board meeting for consideration. Recommendations made by the Committees to the Trust Board are clearly identified in a cover sheet accompanying the submission of the Minutes to the Board; and the Chairman of each Committee personally presents the Minutes at the Board meeting and highlights material issues arising from the work of the Committee to Board members. In particular, the Chairs provide feedback to the Trust Board on their committees' scrutiny of that month's quality and performance report, thereby complementing the commentaries of the Executive Directors.

Each meeting of each Board Committee was quorate during 2013/14.

Attendance at Board and committee Meetings

The attendance of the Chairman, individual Non-Executive Directors, Executive Directors and Corporate Directors at Board and committee meetings during 2013/14 is set out in an appendix to this Statement. The table reflects instances of attendances for either the whole or part of the meeting, and applies to formal members and/or regular attenders as detailed in the terms of reference for each committee.

Board Effectiveness

On joining the Board, Non-Executive Directors are given background information describing the Trust and its activities. A full induction programme is arranged.

The Board recognises the importance of effectively gauging its own performance so that it can draw conclusions about its strengths and weaknesses, and take steps to improve. The Board therefore undergoes regular assessment using third party external advisers to ensure that it is:

- operating at maximum efficiency and effectiveness;
- adding value; and
- providing a yardstick by which it can both prioritise its activities for the future and measure itself.

During 2013/14, the Trust Board commissioned The Foresight Partnership to undertake a review of Board effectiveness. The review will culminate with the Trust Board agreeing an updated Board development programme during quarter 1, 2014/15. Board members have received feedback from Foresight on their individual 360 degree reviews.

Outside of its formal meetings, the Board has held development sessions throughout 2013/14. Amongst the topics considered were quality governance; the development of the Trust's 2 year operational plan 2014/15 – 2015/16; refreshing the Trust's quality and safety commitment; and stakeholder engagement.

The Trust Chairman set objectives for the Chief Executive and Non-Executive Directors for 2013/14. In turn, the Chief Executive set objectives for the Executive Directors and Corporate Directors in relation to the delivery of the Annual Plan for 2013/14. Performance against objectives is reviewed formally on an annual basis by the Chairman and Chief Executive, respectively.

Corporate Governance

In managing the affairs of the Trust, the Trust Board is committed to achieving high standards of integrity, ethics and professionalism across all areas of activity. As a fundamental part of this commitment, the Board supports the highest standards of corporate governance within the statutory framework.

The Trust has in place a suite of corporate governance policies which are reviewed annually and updated as required. These include standing orders, standing financial instructions, a scheme of delegation, policy on fraud and code of business conduct.

The Trust Board subscribes to the HM Treasury/Cabinet Office Corporate Governance Code, the NHS Code of Conduct and Code of Accountability and has adopted the Nolan Principles, 'the seven principles of public life'. The Trust Board has adopted a Code of Conduct : "Standards for NHS Board members and members of Clinical Commissioning Group governing bodies in the NHS in England" (Professional Standards Authority : November 2012).

Risk Assessment

The Trust operates a risk management process which enables the identification and control of risks at both a strategic and operational level. Central to this is the Trust's Risk Assessment Policy which sets out details of the risk assessment methodology used across the Trust. This methodology enables a suitable, trained and competent member of staff to identify and quantify risks in their respective area and to decide what action, if any, needs to be taken to reduce or eliminate risks. All risk assessments must be scored and recorded in line with the procedure set out in the Risk Assessment Policy. Completed risk assessments are held at Clinical Management Group and Corporate Directorate level and when they give rise to a significant residual risk must be linked to the Trust's risk register.

A common risk-scoring matrix is used by the Trust to quantify and prioritise risks identified through the risk assessment procedure. It is based on the frequency or likelihood of the harm combined with the possible severity or impact of that harm. The arrangement determines at what level in the organisation a risk should be managed and who needs to be assured management arrangements are in place.

The Trust recognises the importance of robust information governance. During 2013/14, the Director of Finance and Business Services led on information governance issues as the Trust's Senior Information Risk Owner, supported by a Privacy Manager. The Director of Corporate and Legal Affairs has assumed the role of Senior Information Risk Owner from 24 April 2014. The Medical Director continued as the Trust's Caldicott Guardian during 2013/14.

The Trust took further actions during 2013/14 to secure improvement in its information governance arrangements. A Privacy and Information Governance Board monitors and oversees compliance with information governance requirements. The Trust has fully supported the former NHS Midlands and East Strategic Health Authority's information governance awareness campaign to promote secure handling of personal data ('NHS Confidential').

All NHS Trusts are required annually to undertake an information governance self-assessment using the NHS Information Governance Toolkit. This contains 45 standards of good practice. UHL's overall percentage score for 2013/14 was 83%, compared to 82% in 2012/13. This score is deemed to be a 'satisfactory – minimum level 2' standard across all of the information governance standards.

There were no serious untoward incidents involving lapses of data security which were required to be reported to the Information Commissioner's Office in 2013/14. In respect of other personal data related incidents experienced during 2013/14, the Trust has undertaken investigations to ensure that the root causes are properly understood and addressed; in addition, patients have been contacted to inform them of the lapses and to provide them with assurance about the actions taken by the Trust to prevent recurrence.

The Risk and Control Framework

The Trust's Board-approved Risk Management Strategy describes an organisation-wide approach to risk management supported by effective and efficient systems and processes. The Strategy clearly describes the Trust's approach to risk management and the roles and responsibilities of the Trust Board, management and all staff.

Key strategic risks are documented in the Trust's Board Assurance Framework. Each strategic risk is assigned to an Executive Director as the risk owner and the Executive Team and Trust Board review the Framework on a monthly basis to identify and review the Trust's principal objectives, clinical, financial and generic. Key risks to the achievement of these objectives, controls in place and assurance sources, along with any gaps in assurance, are identified and reviewed.

The Trust's Annual Operational Plan 2014/15 responds to and addresses the strategic risks facing the Trust. The current Board Assurance Framework is being updated to reflect risks in the 2014/15 Plan and will continue to be reviewed at regular intervals by both the Executive Team and Trust Board.

During January 2014, the Care Quality Commission (CQC) inspected the Trust's hospitals to judge the quality of care. The overall ratings for the Glenfield Hospital and St Mary's Birth Centre, Melton Mowbray were 'good'; the overall ratings for the Leicester Royal Infirmary and Leicester General Hospital were 'requires improvement'. Overall, the CQC assigned a rating of 'requires improvement' to the Trust, while concluding that the Trust was providing services that were safe, effective, responsive, caring and well-led.

The Trust Board has approved a formal action plan to address the findings of the CQC : progress against this plan will be monitored by the Quality Assurance Committee on behalf of the Trust Board during 2014/15.

Annual Quality Account

The Trust Board is required under the Health Act 2009 and the National Health Service (Quality Accounts) Regulations 2010 (as amended) to prepare Quality Accounts for each financial year. The Department of Health has issued guidance to NHS Trusts on the form and content of annual Quality Accounts which incorporates the above-mentioned legal guidance.

The Director of Clinical Quality, on behalf of the Chief Nurse co-ordinates the preparation of the Trust's Annual Quality Account. This is reviewed in draft form by the Trust's Quality Assurance Committee, ahead of its eventual submission to the Trust Board for final review and adoption. In reviewing the draft Quality Account 2013/14, the Quality Assurance Committee has noted the Trust's internal controls and standards which underpin the Statement of Directors' responsibilities in respect of the Quality Account – which Statement is to be reviewed and signed by the Chairman and Chief Executive on behalf of the Board on 26 June 2014.

Review of the Effectiveness of Risk Management and Internal Control

As Accountable Officer, I have responsibility for reviewing the effectiveness of the system of internal control. My review of the effectiveness of the system of internal control is informed by the work of the Internal Auditors, Clinical Audit and the Executive Managers and clinical leads within the Trust who have responsibility for the development and maintenance of the internal control framework. I have drawn on the content of the draft Quality Account 2013/14 and other performance information available to me. My review is also informed by comments made by the External Auditors in their management letter and other reports. I have been advised on the implications of the results of my review of the effectiveness of the system of internal control by the Board, the Audit Committee, Finance and Performance Committee and Quality Assurance Committee. During 2013/14, each of these bodies has been involved in a series of processes that, individually and collectively, has contributed to the review of the effectiveness of the system of internal control.

In the draft Head of Internal Audit Opinion 2013/14, the Head of Internal Audit notes that Internal Audit's work (to date) has identified low, medium and two high risk rated findings. Based on the work completed, the Head of Internal Audit believes that there is some risk that management's objectives may not be fully achieved and that improvements are required in those areas to enhance the adequacy and/or effectiveness of governance, risk management and control.

As Accountable Officer, I accept this view and note in particular that two of the (eight) reviews carried out by Internal Audit during 2013/14 have resulted in high-risk rated reports, namely, Estates and Facilities Management, and Bank and Agency Usage. In each case, the Trust has agreed action plans to meet Internal Audit's recommendations and to strengthen internal control.

In December 2012, the Trust, together with its Framework Partners, namely, Leicestershire Partnership NHS Trust and NHS Property Services ('the Framework Partners') entered into an agreement with Interserve FM Limited for the delivery of estates and facilities management services to the Leicester, Leicestershire and Rutland Health Community. The Framework is managed by NHS Horizons on behalf of the Framework Partners and is hosted by UHL.

In the case of the Estates and Facilities Management review, the Trust has taken action to address the high risk findings of Internal Audit as follows:

(a) the Trust has formalised performance monitoring mechanisms with NHS Horizons;

(b) the Trust has retained appropriate facilities management expertise to provide the appropriate level of independent challenge around the service level agreements with Interserve (the Trust's facilities management provider); and

(c) the respective roles and responsibilities of the Trust and NHS Horizons in all areas of the contract have been clarified.

In respect of the Bank and Agency review, the Trust has taken action to demonstrate appropriate authorisation for bank and agency usage; to ensure that reasons for requests are documented in sufficient detail; and to report on trends in reasons for requests.

Internal Audit also re-raised one high risk issue relating to a review of Business Continuity on IT Disaster Recovery. In this case, the Chief Information Officer has provided assurance to the Audit Committee (on 15 April 2014) on the planned completion of business impact assessments for all areas of the Trust which are part of critical activities; and the development of business recovery plans for the failure of key third party suppliers.

The Head of Internal Audit's Opinion 2013/14 (which, using the terminology set out in the Department of Health guidance to Heads of Internal Audit, equates to "significant assurance") has taken into account the relative materiality of these areas and management's progress in respect of addressing control weaknesses.

Using its Board Assurance Framework, which it reviews at each of its monthly public meetings, the Trust Board has also identified actions to mitigate other risks in 2014/15 in relation to:

(a) failure to transform the emergency care system;

(b) inability to recruit, retain, develop and motivate staff;

(c) ineffective organisational transformation;

(d) ineffective strategic planning and response to external influences;

(e) failure to maintain productive and effective relationships;

(f) failure to achieve and sustain quality standards;

(g) failure to achieve and sustain high standards of operational performance;

(h) inadequate reconfiguration of buildings and services;

(i) loss of business continuity;

(j) failure to exploit the potential of information management and technology;

(k) failure to enhance education and training culture.

It is important to note that, during 2013/14, Internal Audit did not carry out specific work on the matters identified at (a) and (b) above, nor on the subject of patient experience/satisfaction. Instead, the Trust Board received management assurances on each of these matters at each of its monthly public Board meetings via the quality and performance report, a separate report on emergency care performance and the Board Assurance Framework. In addition, during 2013/14 the Quality Assurance Committee received reports at regular intervals from the Chief Nurse and Director of Nursing on patient experience/satisfaction.

Any changes in the current or target risk scores are highlighted to the Trust Board, and the Board also reviews and seeks assurances on the management actions in place to mitigate the identified risks.

Significant Issues

In respect of performance in 2013/14 against the key financial duties, the Trust :

(a) failed to deliver its planned surplus, did not meet its breakeven duty and incurred a deficit of £39.7M;

(b) achieved the External Financing Limit (£20.2M against a target of £20.7M), noting that the limit was adjusted in year by the Department of Health at the request of the Trust;

(c) achieved the (revised) Capital Resource Limit of £36.7M.

At its meeting on 27 March 2014, the Trust Board assessed the 'going concern' position of the Trust in the light of performance in 2013/14. In making this assessment, the Board received advice from the Executive Directors about the future prospects of the Trust (for a minimum of twelve months), driven by the historical financial position of the organisation and knowledge of the challenges faced by the Trust.

The assessment covered :

(i) an overview of the 2013/14 financial year;

(ii) the Trust's financial plan for 2014/15;

(iii) consideration of each of the following issues in order to determine the appropriateness of the Trust preparing its accounts as a going concern:

- ability to generate an operating surplus
- statutory break-even duty

- cash flow impact on net current assets and meeting liabilities as they fall due;
- use and/or breach of borrowing facilities;
- adverse operating conditions;
- loss of key management positions;
- compliance with statutory requirements;
- pending or on-going legal action;
- potential changes in legislation or government policy;
- other liabilities.

The following risks to the ongoing concern assessment were also considered by the Trust Board :

(1) failure to receive permanent financing;

(2) failure to deliver the planned deficit in 2014/15;

(3) failure to manage working capital.

Having undertaken a robust assessment, the Trust Board concluded that the Trust should prepare its financial statements for 2013/14 on a going concern basis and accepted that steps would be taken to ensure that this remained the case for at least 12 months from the date of the preparation of the annual accounts.

In reaching this decision, the Trust Board noted in particular that provisional agreement had been reached with the NHS Trust Development Authority that the Trust would produce a financial recovery plan by the end of quarter 1 2014/15 with the aim of returning to a recurrent balanced financial position within three years. The financial recovery plan will form an integral component of the Trust's five-year plan, due to be submitted to the NHS Trust Development Authority by 20 June 2014.This will in turn be derived from the Leicester,Leicestershire and Rutland health and social care system's five year strategy which is required to be produced to the same timescale.

Emergency Care

The Trust failed to meet the A&E 4 hour standard in 2013/14. As a member of the Leicester, Leicestershire and Rutland Urgent Care Working Group, the Trust is committed to working with its partners to improve performance against this standard in 2014/15, and has approved an action plan which includes components relating to :

(a) demand management
(b) patient flow within A&E
(c) hospital bed flow
(d) delayed transfers of care.

Referral to Treatment Times (RTT)

The Trust failed to meet the Referral to Treatment (RTT) standards in 2013/14. A RTT recovery plan has been approved by the Trust Board and agreed with Commissioners.

During 2014/15, the Trust Board shall continue to monitor performance against the A&E 4 hour standard and RTT standards at each of its monthly public Board meetings.

In addition to the issues identified above, further work will be undertaken in 2014/15 to review and strengthen the Trust's governance, risk management and internal control systems, policies and procedures. This work will contribute to the Trust's aim of submitting its application for authorisation as an NHS Foundation Trust.

I am of the opinion that the implementation of the actions described above will strengthen the Trust's system of internal control in 2014/15 and beyond.

My review confirms that the Trust has a generally sound system of internal control that supports the achievement of its policies, aims and objectives.

Signed……

Chief Executive (on behalf of the Trust Board)

Date ……

Committee attendance 2013-14

Name	**Trust Board** maximum - 14	**Audit Committee** maximum - 5	**Finance and Performance Committee** maximum - 12	**Quality Assurance Committee** maximum - 11	**Remuneration Committee** maximum – 9
Martin Hindle – Chairman **(1)**	7	N/A	N/A	N/A	4
Richard Kilner – Acting Chairman **(2)**	14	2	12	N/A	8
Ian Crowe – Non-Executive Director **(3)**	9	1	9	N/A	7
Sarah Dauncey – Non-Executive Director **(4)**	4		N/A	1	2
Kiran Jenkins – Non-Executive Director	13	5	N/A	1	8
Prakash Panchal – Non-Executive Director **(5)**	12	2	2	7	8
Ian Reid – Non-Executive Director **(6)**	4	2	3	N/A	2
Ian Sadd – Non-Executive Director **(7)**	2	1	1	N/A	1
Jane Wilson – Non-Executive Director	13	N/A	10	10	7
David Wynford-Thomas – Non-Executive Director	8	N/A	N/A	8	4
John Adler – Chief Executive	13	N/A	10	7	N/A
Kate Bradley – Director of Human Resources	13	N/A	N/A	1	N/A
Kevin Harris – Medical Director	13	N/A	4	8	N/A

Suzanne Hinchliffe – Chief Nurse/Deputy Chief Executive **(8)**	2	N/A	5	N/A	N/A
Peter Hollinshead – Interim Director of Financial Strategy **(9)**	3	N/A	3	N/A	N/A
Richard Mitchell – Chief Operating Officer **(10)**	10	N/A	8	N/A	N/A
Rachel Overfield – Chief Nurse **(11)**	7	N/A	N/A	4	N/A
Carole Ribbins – Acting Chief Nurse **(12)**	4	N/A	N/A	3	N/A
Andrew Seddon – Director of Finance and Business Services	11	N/A	9	N/A	N/A
Kate Shields – Director of Strategy **(13)**	5	N/A	N/A	N/A	N/A
Jez Tozer – Interim Director of Operations **(14)**	2	N/A	2	N/A	N/A
Stephen Ward – Director of Corporate and Legal Affairs	14	N/A	N/A	N/A	N/A
Mark Wightman – Director of Marketing and Communications	13	N/A	N/A	N/A	N/A

Notes:-

(1) Trust Chairman until 30 September 2013
(2) Acting Trust Chairman from mid-October 2013 (stepped down from Audit Committee at that point)
(3) Non-Executive Director from 1 July 2013. Audit Committee member from 30 January 2014
(4) Non-Executive Director from 1 May 2013 – 17 June 2013 and then from 27 January 2014

(5) Audit Committee member from September 2013. Finance and Performance Committee member from August 2013 – end October 2013
(6) Non-Executive Director until 30 June 2013
(7) Non-Executive Director from October 2013 until 31 December 2013
(8) Left the Trust on 19 May 2013
(9) Interim Director of Financial Strategy from 20 January 2014
(10) Chief Operating Officer from 10 July 2013
(11) Chief Nurse from 9 September 2013
(12) Acting Chief Nurse May – September 2013
(13) Director of Strategy from November 2013
(14) Interim Director of Operations from October 2012 – 7 June 2013