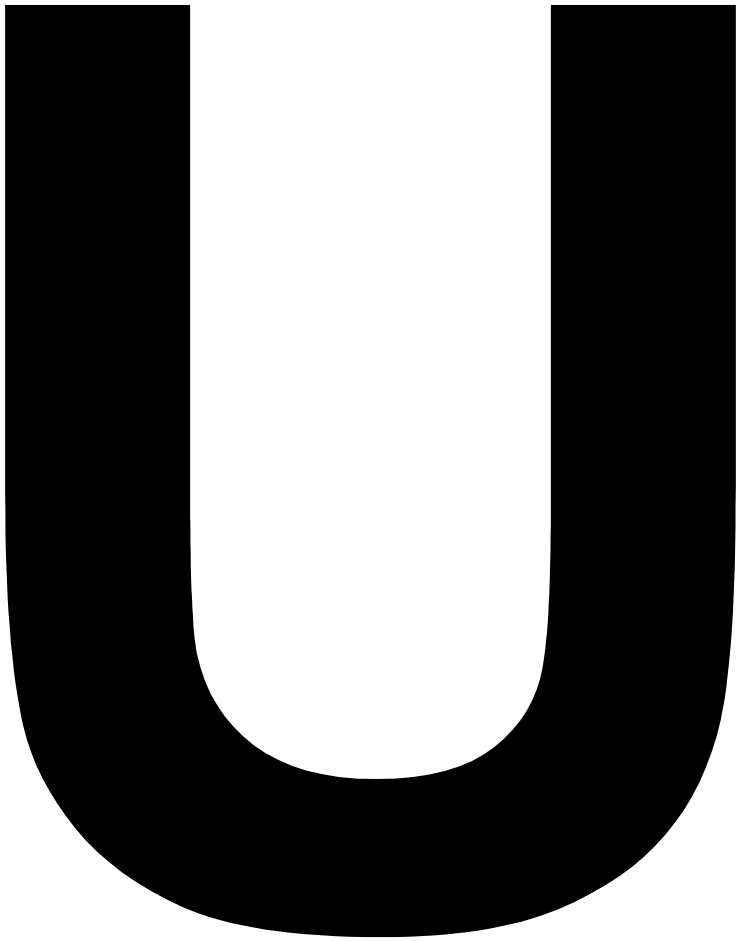


University Hospitals of Leicester NHS
NHS Trust

	TRUST BOARD
From:	Rachel Overfield, Kevin Harris, Richard Mitchell Kate Bradley Peter Hollinshead
Date:	**29th May 2014**
CQC regulation	All

Title:	**Quality & Performance Report**

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

Purpose of the Report:
To provide members with an overview of UHL quality and safety, patient experience, operational and finance performance against national and local indicators for the month of April.

The Report is provided to the Board for:

Decision		Discussion	√
Assurance	√	Endorsement	

Summary / Key Points:

Compliant

- C Difficile – 4 cases reported for the year against a month target of 7.
- Pressure ulcers - With 6 grade 2 pressure ulcers and 4 grade 3 pressure ulcers report for April, all trajectories for pressure ulcers have been achieved.
- Inpatient Friends and Family Test - performance for April is 69.6.
- VTE - The VTE risk assessment within 24 hours of admission threshold of 95% has been achieved since July 2013.
- Theatres – 100% WHO compliant for since January 2013.
- All cancer targets delivered including the 62 day cancer with performance for March at 92.4% and full year performance at 86.7%.
- The percentage of stoke patients spending 90% of their stay on a stroke ward year target is 82.5%, performance for the year is 83.2% (target 80%).

Areas to watch:-

- Diagnostic waiting times– although the target was achieved with performance at 0.8%, the target was missed in Qtr 4.
- C&B – performance similar to this time last year and target is still not delivered.
- #NoF to theatre within 36hrs below target with performance at 56.9% during April.

Exceptions/Contractual Queries:-

- ED 4hr target - Performance for emergency care 4hr wait in April was 86.9%.
- RTT admitted and non-admitted – Trust level compliant non admitted performance is expected in August 2014 and trust level compliant admitted performance is expected in November 2014.
- Cancelled Operations – % of short notice cancellations in April was 1.1%.

Finance key issues:

- The Trust does not have an agreed contract and as such there is a significant risk to the reported income position as this does not account for CCG proposed local fines and penalties.
- Shortfall of £6.6m on the forecast CIP delivery against the £45m target.
- The Capital Plan is currently over-committed and is predicated on Emergency Floor external funding, the commitments may be in advance of the receipt of funding.

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

University Hospitals of Leicester NHS
NHS Trust

Caring at its best

Quality and Performance – April 2014

Trust Board

Thursday 29th May 2014

One team shared values

CONTENTS

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST

REPORT TO: **TRUST BOARD**

DATE: **29th MAY 2014**

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

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

1.0 INTRODUCTION

The following paper provides an overview of the April 2014 Quality & Performance report highlighting key metrics and areas of escalation or further development where required.

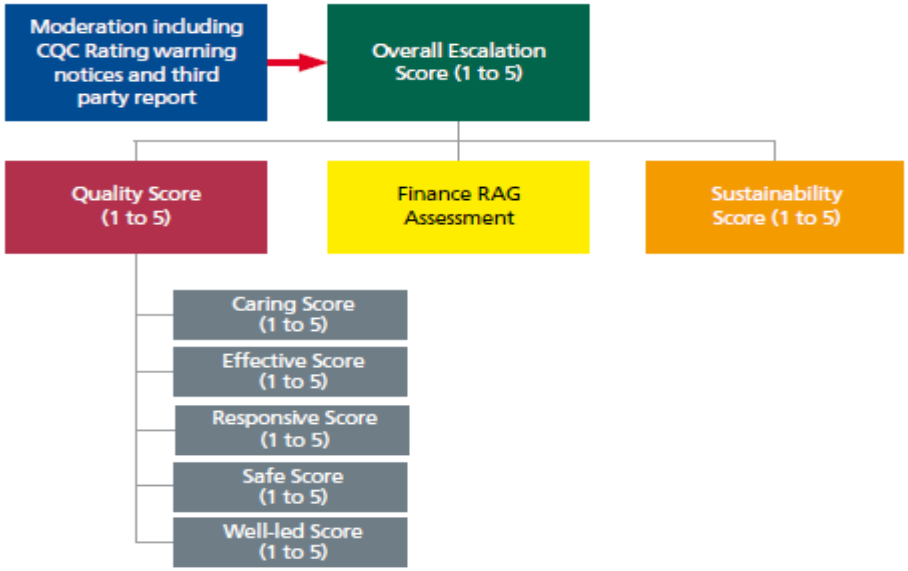
2.0 2014/15 NTDA Oversight and Escalation Level

2.1 NTDA 2014/15 Indicators

On 31st March 2014 the NHS Trust Development Authority (NTDA) published an updated version of the Accountability Framework, now called *'Delivering for Patients: the 2014/15 Accountability Framework for NHS trust boards'*.

The oversight process sets out what the NTDA will measure and how it will hold trusts to account for delivering high quality services and effective financial management.

For 2014/15, the NTDA's quality metrics have been adjusted to improve alignment and ensure consistency with the CQC's *Intelligent Monitoring* process. For 2014/15 NHS trusts will be scored using escalation levels 1 to 5, as it was last year, but the key change will be that escalation level 1 will now be the highest risk rating with level 5 the lowest.



The oversight process also sets out how the NTDA will score and categorise NHS trusts with a clearer approach to both intervention and support for organisations at different levels of escalation. Further supporting documentation which contains the detailed information about the scoring methodology are due to made available to all Trusts by the NTDA.

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

- Caring
- Effective
- Safe
- Well Led
- Responsive
- Finance

Caring	Target	2013/14	Apr-13	May-13	Jun-13	Jul-13	Aug-13	Sep-13	Oct-13	Nov-13	Dec-13	Jan-14	Feb-14	Mar-14	Apr-14
Inpatient scores from Friends and Family Test	TBC	68.8	66.4	73.9	64.9	66.0	69.6	67.6	66.2	70.3	68.7	71.8	69.0	69.9	69.6
A&E scores from Friends and Family Test	TBC	59.5	43.3	47.3	60.6	57.0	59.6	57.6	58.8	58.6	67.4	67.6	58.7	65.5	69.4
Complaints - rate per bed day	TBC	2014-15 New Indicator													2.2
Inpatient Survey: Q68 Overall I had a very poor/good experience	TBC	2014/15 New Indicator - awaiting further NTDA guidance													
Mixed Sex Accommodation Breaches	0	2	0	0	0	0	0	0	0	2	0	0	0	0	4

Effective	Target	2013/14	Apr-13	May-13	Jun-13	Jul-13	Aug-13	Sep-13	Oct-13	Nov-13	Dec-13	Jan-14	Feb-14	Mar-14	Apr-14
Summary Hospital Mortality Indicator	TBC		104.5	104.5	104.5	104.9	104.9	104.9	106.4	106.4	106.4	107.1	107.1	107.1	106.0
Hospital Standardised Mortality Ratio (DFI Quarterly)	TBC	92.4	93.5			94.6			89.5			Awaiting DFI Update			
Hospital Standardised Mortality Ratio - weekend (DFI Quarterly)	TBC	96.0	100.9			99.4			88.9			Awaiting DFI Update			
Hospital Standardised Mortality Ratio - weekday (DFI Quarterly)	TBC	90.8	91.0			93.0			88.1			Awaiting DFI Update			
Deaths in low risk conditions (DFI Quarterly)	TBC	88.6	104.7			71.3			89.5			Awaiting DFI Update			
Emergency re-admissions within 30 days following and elective or emergency spell at the trust	TBC	7.9%	7.6%	7.8%	7.7%	7.5%	7.6%	7.8%	7.9%	7.8%	8.0%	8.7%	9.0%	8.7%	

Safe	Target	2013/14	Apr-13	May-13	Jun-13	Jul-13	Aug-13	Sep-13	Oct-13	Nov-13	Dec-13	Jan-14	Feb-14	Mar-14	Apr-14
CDIFF	67	66	6	7	2	6	5	9	6	6	5	10	0	4	4
MRSA	0	1	0	0	0	0	0	1	0	0	0	0	0	0	0
Never events	0	3	1	0	0	0	0	1	0	0	0	0	1	0	0
Medication errors causing serious harm	TBC	2014/15 New Indicator - awaiting further NTDA guidance													
Incidence of MSSA	TBC	30	5	2	5	1	4	3	1	1	1	3	2	2	2
Percentage of Harm Free Care	TBC	93.6%	92.1%	93.7%	93.6%	93.8%	93.5%	93.1%	94.7%	93.9%	94.0%	93.8%	94.8%	93.6%	94.6%
Maternal deaths	0	3	0	0	0	0	0	0	0	0	0	1	2	0	0
Proportion of patients risk assessed for VTE	95%	95.3%	94.1%	94.5%	93.1%	95.9%	95.2%	95.4%	95.5%	96.7%	96.1%	95.6%	95.0%	95.6%	95.7%
Serious Incidents	TBC	2014-15 New Indicator													12
Proportion of reported safety incidents that are harmful	TBC	2014/15 New Indicator - awaiting further NTDA guidance													
CAS alerts	TBC	20	14	9	15	36	10	10	14	15	12	11	14	20	11
Admissions to adult facilities of patients who are under 16 years of age (Number)	TBC	2014/15 New Indicator - awaiting further NTDA guidance													

Well-Led	Target	2013/14	Apr-13	May-13	Jun-13	Jul-13	Aug-13	Sep-13	Oct-13	Nov-13	Dec-13	Jan-14	Feb-14	Mar-14	Apr-14
Inpatient response rate from Friends and Family Test	15.0%	24.3%	19.4%	21.4%	25.3%	24.8%	22.0%	25.8%	21.7%	25.4%	23.3%	24.5%	28.2%	28.8%	36.8%
A&E response rate from Friends and Family Test	15.0%	14.9%	5.7%	14.2%	16.6%	14.6%	16.1%	11.1%	16.3%	18.4%	16.4%	15.6%	18.4%	16.1%	15.2%
Data Quality of trust returns to HSCIC	TBC	2014/15 New Indicator - awaiting further NTDA guidance													
NHS Staff Survey: Percentage of staff who would recommend the trust as a place to work	TBC	2014/15 New Indicator - awaiting further NTDA guidance													
NHS Staff Survey: Percentage of staff who would recommend the trust as place to receive treatment	TBC	2014/15 New Indicator - awaiting further NTDA guidance													
Trust Turnover	10.0%	10.0%	8.8%	8.9%	9.2%	9.5%	9.3%	9.7%	9.6%	9.7%	10.2%	10.6%	10.4%	10.0%	9.9%
Trust level total sickness (Reported One Month in Arrears)	3.0%	3.4%	3.3%	3.1%	3.0%	3.2%	3.1%	3.1%	3.3%	3.5%	3.8%	3.9%	3.9%	3.8%	
Total trust vacancy rate	TBC	2014/15 New Indicator - awaiting further NTDA guidance													
Temporary costs and overtime as % total paybill	TBC		6.0%	6.5%	6.6%	6.2%	5.4%	5.6%	6.0%	6.1%	6.3%	6.6%	6.6%	6.9%	5.8%
Percentage of staff with annual appraisal	95%	91.3%	90.9%	90.2%	90.7%	92.4%	92.7%	91.9%	91.0%	91.8%	92.4%	91.9%	92.3%	91.3%	91.8%

2.2 UHL 2013/14 NTDA Escalation Level

The 2013/14 Accountability Framework set out five different categories by which Trust's are defined, depending on key quality, delivery and finance standards.

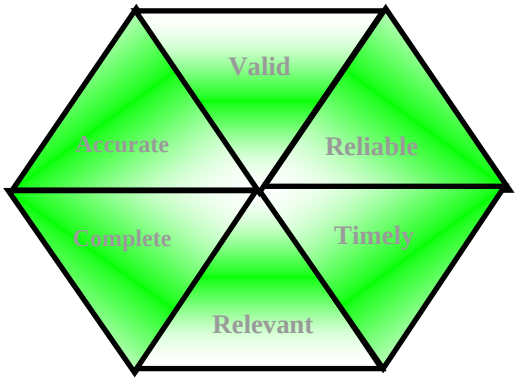
The five categories are (figures in brackets are number of non FT Trusts in each category as at July 2013):

1) No identified concerns (18 Trusts)
2) Emerging concerns (27 Trusts)

3) Concerns requiring investigation (21 Trusts)
4) Material issue (29 Trusts)
5) Formal action required (5 Trusts)

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

3.0 DATA QUALITY DIAMOND



The UHL Quality Diamond has been developed as an assessment of data quality for high-level key performance indicators. It provides a level of assurance that the data reported can be relied upon to accurately describe the Trust's performance. It will eventually apply to each indicator in the Quality and Performance Reports. The process was reviewed by the Trust internal auditors who considered it 'a logical and comprehensive approach'. Full details of the process are available in the Trust Information Quality Policy.

The diamond is based on the 6 dimensions of data quality as identified by the Audit Commission:

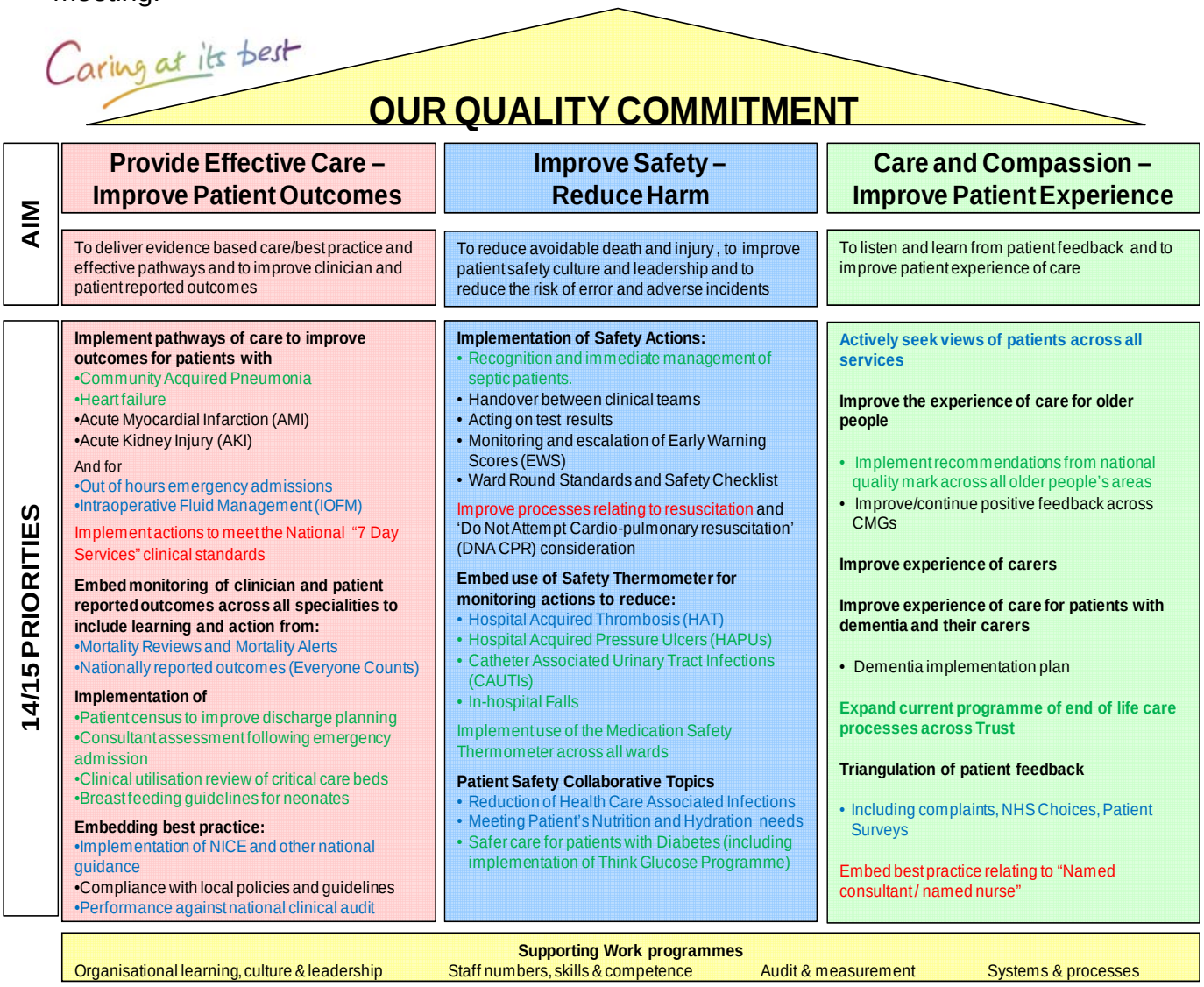
- **Accuracy** – Is the data sufficiently accurate for the intended purposes?
- **Validity** – is the data recorded and used in compliance with relevant requirements?
- **Reliability** – Does the data reflect stable and consistent collection processes across collection points and over time?
- **Timeliness** – is the data up to date and has it been captured as quickly as possible after the event or activity?
- **Relevance** – Is the data captured applicable to the purposes for which they are used?
- **Completeness** – Is all the relevant data included?

The data quality diamond assessment is included in the Quality and Performance report against indicators that have been assessed.

4.0 QUALITY AND PATIENT SAFETY – KEVIN HARRIS/RACHEL OVERFIELD

4.1 Quality Commitment

The Trust Board agreed the following 'extended' Quality Commitment in the April Board meeting.



Performance against each of the 2014/15 priorities will be monitored at the Executive Quality Board (EQB). Reporting frequency against the priorities varies from monthly to quarterly, with the first reports due to be received at the June meeting of the EQB.

4.2 Mortality Rates

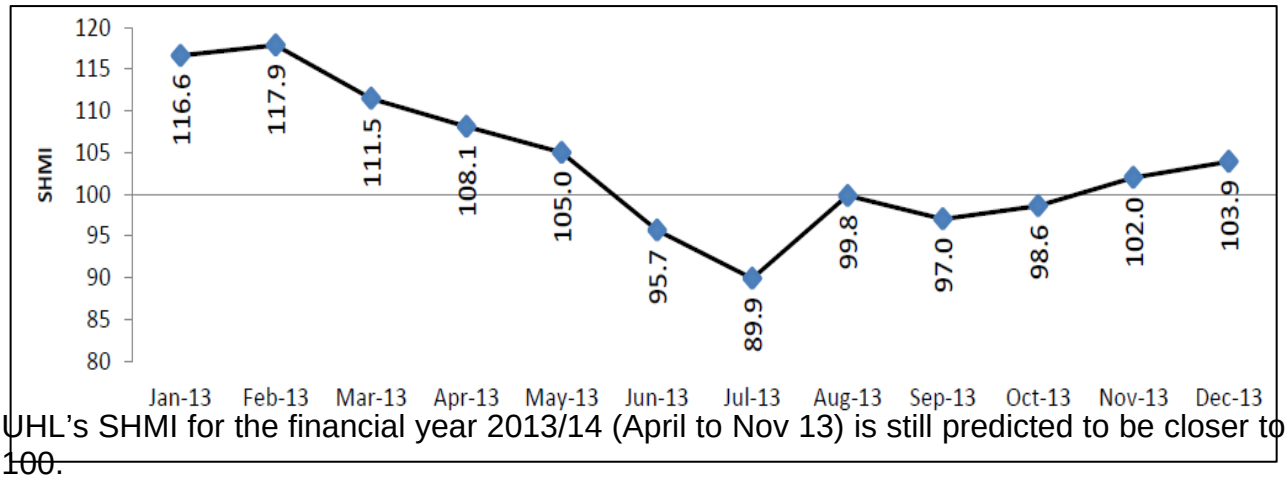
2013/14 | Mth

SUMMARY HOSPITAL MORTALITY INDEX (SHMI)

The SHMI is published as a rolling 12 month figure and the latest SHMI by the Health and Social Care Information Centre (HSCIC) published at the end of April covers the 12 month period Oct 12 to Sept 13. UHL's SHMI has gone back down from 107 to 106 and remains in Band 2 (i.e. within expected).

UHL is now able to use the Hospital Evaluation Dataset tool (HED) to internally monitor our SHMI on a monthly basis using more recent data.

For the most recent 12 months (Jan to Dec 13) UHL's SHMI is 103.9 (this still includes the January to March 13 period).



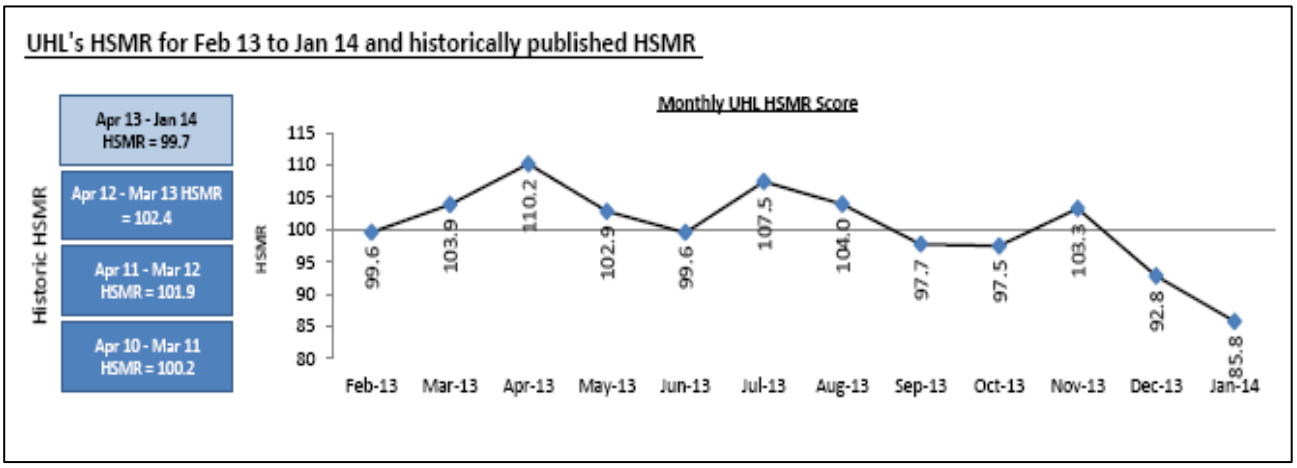
UHL's SHMI for the financial year 2013/14 (April to Nov 13) is still predicted to be closer to 100.

However, due to the published SHMI being based on a '12 month rolling figure', the trust's published SHMI is likely to remain above 100 until the Jan to April 13 period is not included in the '12 months'.

HOSPITAL STANDARDISED MORTALITY RATIO (HSMR)

UHL's HSMR (as reported by HED) for the rolling 12 months Feb 13 to Jan 14 is 100.1 and for the financial year (Apr 13 to Jan 14) it is 99.7 which is below the national average.

It should be noted that although UHL's HSMR has been below 100 for Sept, Oct, Dec and Jan and HED rebase monthly, there may be an increase for these months as Trusts resubmit their coded data.



CRUDE MORTALITY

UHL's crude mortality rates are also monitored as these are available for the more recent time periods.

As can be seen from the table below, whilst there is 'month on month' variation, the overall rate for 13/14 is slightly lower than in 12/13.

Discharge Month	Dec-13	Apr-13	May-13	Jun-13	Jul-13	Aug-13	Sep-13	Oct-13	Nov-13	Dec-13	Jan-14	Feb-14	Mar-14	13/14
No of Admissions	221,146	17,872	18,693	17,736	19,136	17,893	18,199	19,676	18,688	17,903	19,615	18,014	19,458	222,883
No of In-hospital Deaths	3,177	277	254	229	229	233	218	253	251	267	245	262	242	2,960
In-hospital Crude Mortality	1.40%	1.50%	1.40%	1.30%	1.20%	1.30%	1.20%	1.30%	1.30%	1.50%	1.20%	1.50%	1.20%	1.30%

DR FOSTER MORTALITY BY DIAGNOSIS & PROCEDURAL GROUP

In addition to providing an overall HSMR figure, the Dr Fosters Intelligence 'Quality Investigator' tool also reports HSMR for individual diagnosis and procedural groups and highlights where the mortality rate is 'higher than expected' in their monthly 'Performance Summary'.

There are two new 'alerts' in the December Performance Summary:

Excision of Thyroid Gland

The alert was caused by one death following thyroid surgery (none were expected). It has been confirmed that this patient's surgery was for palliative reasons.

Aortic and Peripheral Arterial Embolism

This alert was triggered by an increase in the number of deaths for the 3 months October to December last year. A review by the Vascular Surgery M&M lead has identified that most deaths were expected due to the patients' presenting severity of illness. Further review is being undertaken for 3 patients to confirm if there were any delays in the Emergency Department.

CQC INTELLIGENT MONITORING REPORT (IMR)

The latest CQC IMR has two areas of 'elevated risk' relating to mortality and both are based upon the Dr Foster Intelligence risk adjusted mortality data:

Low Risk Diagnosis Groups

The Dr Fosters Intelligence (DFI) "Deaths in Low Risk Diagnosis Groups" is a 'composite mortality indicator' which benchmarks the combined mortality rate of several diagnosis groups, which individually have a low risk of mortality.

This latest IMR report covers Jul 12 to June 13 and UHL's mortality rate for the Deaths in Low Risk Diagnosis Groups' is 'above the expected' for this time frame and specifically relates to the 3 months Oct to Dec 12 (all other months are 'within expected).

Following the first 'elevated risk' a case note review has been undertaken of the patients contributing to this 'higher than expected' mortality for Oct to Dec 12. For the majority of patients, their death was expected and appropriate care was given. The findings of the review have been reported to the Mortality Review Committee.

CABG +Other

Within this composite indicator there is one procedural group which has a 'higher than expected mortality' – CABG +Other. Clinically "CABG +Other" is considered to be when a Coronary Artery Bypass Graft is undertaken plus a valve repair and "CABG Isolated" is for CABG without any valve repair and is a first time CABG..

However it appears that in the DFI 'risk adjustment tool', they have included 'first time CABG without valve repair procedures' in the 'CABG +Other' because additional codes were recorded relating to monitoring aspects of the procedure. This is then skewing both

the denominator and numerator for both procedures. This information has been fed back to the CQC.

Whilst it would seem that the reason for the alerts is purely due to an interpretation of procedural codes, a retrospective case note review has been undertaken to confirm patients' care was appropriate. All reviews undertaken to date have found both 'case selection' and management was appropriate.

4.3 Maternal Deaths

There were no maternal deaths reported in April. The World Health Organisation (WHO 2014), defines maternal death as the death of a woman while pregnant or within 42 days of termination of pregnancy (giving birth) , irrespective of the duration and site of the pregnancy, from any cause related to or aggravated by the pregnancy or its management but not from accidental or incidental causes.

4.4 Patient Safety

2013/14 | Mth

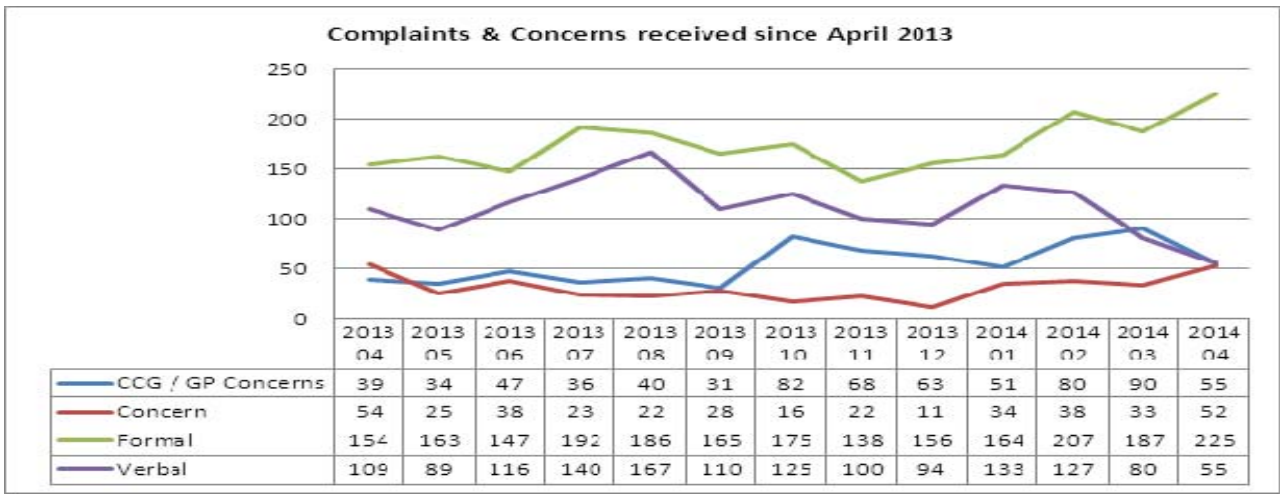
In April a total of 12 new Serious Untoward Incidents (SUIs) were escalated within the Trust. Four of these were patient safety incidents, eight related to Hospital Acquired Pressure Ulcers and no Healthcare Acquired Infections were reported for this month. No Never Events were reported in April and there were no medication errors reported which caused severe harm. Of the 4 patient safety SUIs, one related to a no harm 10 times medication incident, one to no harm following an unintentionally retained vaginal swab. One SUI suggests an avoidable death due to a delay in the diagnosis and treatment of sepsis and one SUI details permanent harm as a failure to recall the patient for a follow-up appointment. Four patient safety root cause analysis investigation reports were completed and signed off last month, the actions and learning of which have been shared internally. These will be further reviewed at the Trust's 'Learning from Experience Group'.

In April three calls were made to the 3636 Staff Concerns Reporting Line, one relating to the a charge nurse in theatres being unable to contact a duty manager, a further concern relating to the signing of a new employment contract and the third concern related to a computer in Theatre 3 that determined right site surgery was not working. All concerns have been fully investigated by a director and appropriate actions taken. All 3636 concerns are presented at the Executive Quality Board and the Quality Assurance Committee in the monthly Patient Safety report. Pleasingly the very high level of compliance with deadlines for external CAS alerts has been maintained (99% over a rolling 12 months) but the NPSA alert 'Right Blood' remains open.

April continued to see high complaints activity with a total of 225 formal written complaints received. The top 5 themes have changed slightly to:-

- Medical Care
- Waiting Times
- Cancellations
- Staff attitude
- Communication

CMGs continue to review their complaints monthly and take actions for improvement but these complaints show the tremendous strain on the emergency system and the increased activity leading to further increases in waiting times and operation and procedure cancellations. The rate of complaints per 1000 bed days for April is 2.2, with the 2014 total being 1.9. Below is the trend graph which shows complaints activity over the past 10 months.



	2013 04	2013 05	2013 06	2013 07	2013 08	2013 09	2013 10	2013 11	2013 12	2014 01	2014 02	2014 03	2014 04
CCG / GP Concerns	39	34	47	36	40	31	82	68	63	51	80	90	55
Concern	54	25	38	23	22	28	16	22	11	34	38	33	52
Formal	154	163	147	192	186	165	175	138	156	164	207	187	225
Verbal	109	89	116	140	167	110	125	100	94	133	127	80	55

4.5 Critical Safety Actions

2013/14 | Mth

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

1. **Improving Clinical Handover**.

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

Actions:-

- Nervecentre handover training for nursing staff completed and Go Live successful on 15th and 23rd April across LRI site in medicine, MSK and oncology/haematology wards. Training commenced at GH site ready for Go Live on 20th May 2014.
- Plan for roll out to medical staff to be confirmed.

2. Relentless attention to Early Warning Score triggers and actions

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

Actions:-

- Appointment of Dr.Rajani Annamaneni as the new Trust lead for EWS.
- The focus of the work for 14-15 will be working with the electronic observation project to implement NEWS simultaneously with electronic observations.

3. Acting on Results

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

Actions:-

- Have received signed off processes for managing diagnostic tests for 89% of specialities now. The four outstanding specialities are obstetrics, gynaecology,

metabolic medicine and immunology despite several chase email and meetings and meetings with heads of service.

4. Senior Clinical Review, Ward Rounds and Notation

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

Actions:-

.

- ❖ Meeting has taken place with medical education simulation training lead to incorporate the ward round safety checklist into existing training on an on-going basis.
- ❖ This work will now collaborate with the 7 Day Working work stream.

For the year 2013-14, the CSA programme has seen a reduction in Serious Untoward Incidents (SUIs) related to the CSAs of 25%. Over the 2 year programme so far, CSA related incidents have been reduced by half.

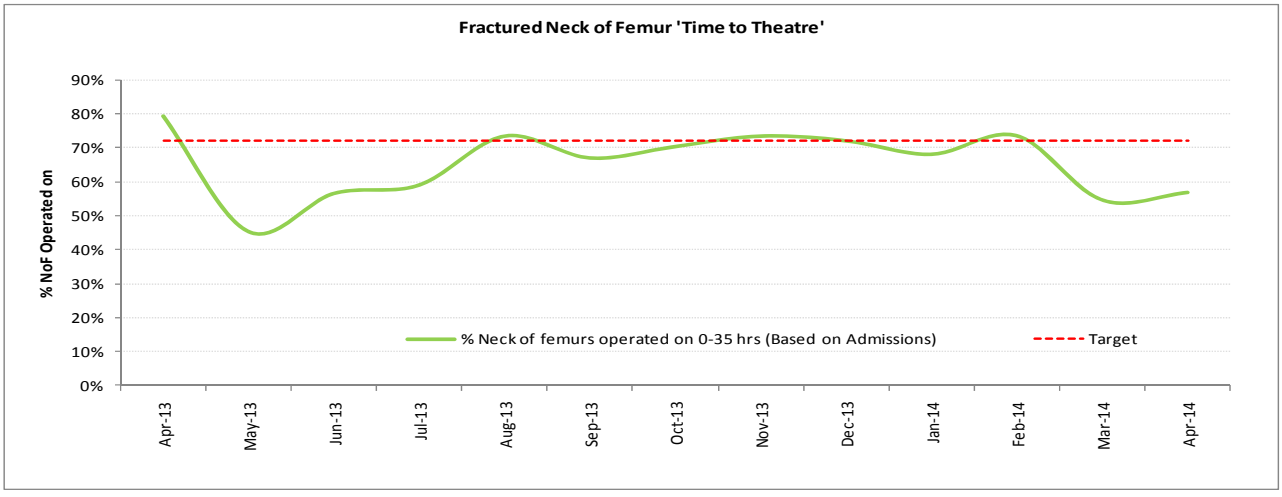
The Q4 CSA CQUIN commissioner visit took place on 29th April 2014. The visit was at the LGH site and observed the following;

- Nurse handover in gynaecology
- Doctors handover in general surgery
- Ward round in urology
- EWS practice on Brain Injuries Unit
- Acting on Results processes in renal

Formal feedback will be received at CQRG on 22nd May 2014.

4.6 Fractured Neck of Femur 'Time to Theatre'

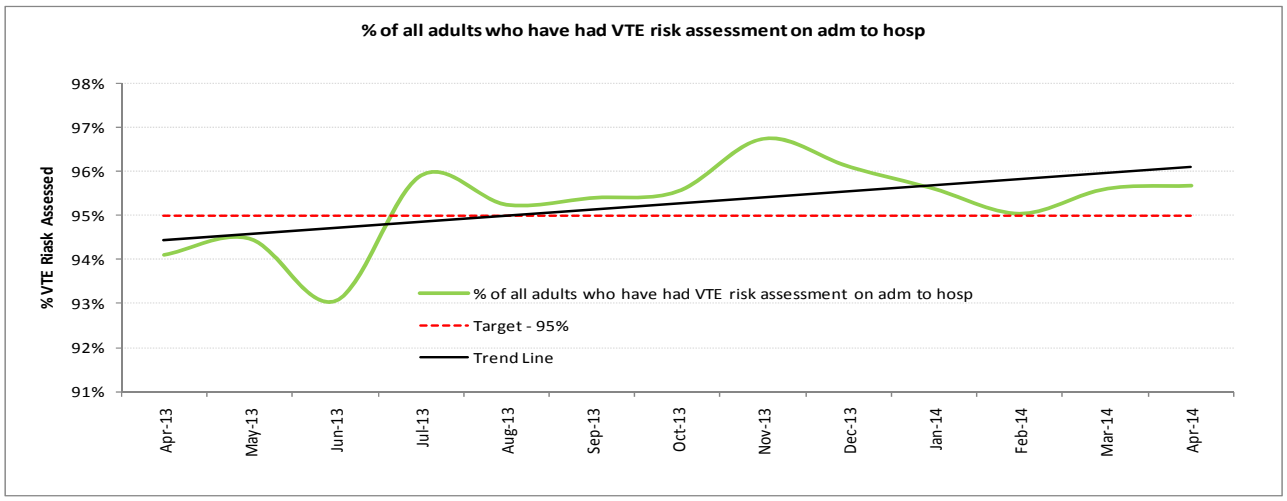
2013/14 Mth



The percentage of patients admitted with fractured neck of femur during April who were operated on within 36hrs was 56.9% (33 out of 58 #NOF patients) against a target of 72%.

4.7 Venous Thrombo-embolism (VTE) Risk Assessment

2013/14 Mth



The 95% threshold for VTE risk assessment within 24 hours of admission was 95.7% in April.

4.8 Quality Schedule and CQUIN Schemes

At the CQRG meeting on 22nd May, CCG Commissioners have agreed to full payment for all but one of the National CQUINs which relates to Dementia Training. This 'Amber RAG' will equate to a loss of approximately £20,000.

Specialised Services Commissioners have confirmed that UHL met the Quarter 4 thresholds for all their CQUIN schemes.

In respect of the CCG Quality Schedule, there were 25 'baskets' of indicators due for reporting - 13 were given a Green RAG, 9 Amber and 3 Red.

Details of the rationale for the RAGs are given in the table below.

Both the CCG Quality Schedule and CQUIN indicators for 2014/15 have been agreed. Details of the Specialised Services CQUINs are still being finalised.

Schedule Ref	Indicator Title and Detail	Q4 RAG	Comments re 2013/14 Performance
	QUALITY SCHEDULE INDICATORS		
IP1a-e	MRSA bacteraemias C Diff Numbers MRSA screens (Emergency & Elective admissions) MSSA bacteraemias E Coli bacteraemias Infection Prevention Annual Programme	G	0 MRSAs reported for Jan to Mar 14. (1 for 13/14) C Diff trajectory met (66/67) (94 in 12/13) 100% pts screened. 30 MSSA (46 in 12/13) 514 E Coli (524 in 12/13)
IP2a	Surgical Wound Surveillance - Caesarean Section	G	Reduction in C Section wound infection rate since 11/12 baseline.
IP2b	Improved compliance with Surgical Wound, Peripheral Canula and Urinary Cathether HIIs across UHL	A	Although achieved 90% at a Trust level, <90% for individual areas. Agreed to discontinue indicator in 14/15 and to focus on Vascular Access monitoring as part of the Safety Thermometer audit days.
PS1b	Never Events	R	NE reported for February relating to retained vaginal swab.

Schedule Ref	Indicator Title and Detail	Q4 RAG	Comments re 2013/14 Performance
PS2a	Risk register - Board Assurance Framework report	G	Further assurance provided about 'suspended' Risk and progress with actions.
PS2b	Central Alerting System Patient Safety Alerts and Rapid Response Reports (NPSA PSA and RRR)	A	Dependent upon actions agreed necessary for the Blood Transfusion NPSA alert
PS3	Safe Guarding for Adults and Children	G	
PS4	Ward Health Check Proactive oversight and scrutiny of ward level data (staffing and nursing metrics) to ensure safety care delivery	G	Noted increase in vacancies for March.
PS6	Eliminating "avoidable" Grade 2, 3 and 4 Hospital Acquired Pressure Ulcers	G	Above threshold in January but below for both February and March
WF1	Organisational Development Plan Update and Workforce Metrics	A	Reflects UHL's internal RAG rating for sickness, appraisal, corporate induction.
MM1a-g	Medicines Code Audit Controlled Drugs Audit Non compliance with Traffic Light Policy Compliance with LLR Formulary for prescribing Medication errors causing serious harm	G	Improvement seen across all sections of Medicines Code and Controlled Drugs Storage audits. Evidence of actions being taken to reduce harm.
PE1a	SSA Breaches Monthly Compliance	G	No non clinically justified breach for March but one in April affecting 4 patients. Root cause analysis to be reported to the June EQB.
PE2a & b	Number of Formal Written Complaints and Rates against Activity Response to complainants within agreed timescales	tbc	To be reported in June but anticipate Amber RAG due to delays in response times.
PE3a-c	Progress in respect of Quality Commitment of the Patient Centred Care Priorities for 2013: Improvement in National Patient Survey Results	G	Improvements in F&FT scores and in the Quality Commitment related patient experience scores. Good progress made with actions
	Improvement in National Patient Survey Results for 'Responsiveness to Needs' Composite score	A	No improvement in either 'Responsiveness to Needs' or 'Overall Score' in the National Patient Survey.
PE4	ED service experience.	G	End of year improvement in F&FT score. (39 in Apr 13 to 59 in Mar 14). Actions taken to improve privacy and dignity of patients whilst in ED.
PE5	Improve staff engagement	G	
PE6	Implementation of the Trust's Equality high level plan.	N/A	
CE1	Maternity Dashboard	A	Caesarean Section Rates overall within agreed limits. Increase in Em Section Rates for Q4. Agreed with Commissioners to review Emergency Section thresholds to reflect changes made to the overall threshold.
CE2	Children's Services Dashboard	A	Deterioration in training numbers and audit results. Actions taken to address both areas of performance.
CE3a	PROMS Participation for patients undergoing Groin Hernia Surgery Varicose Vein Repair	G	Latest Groin Hernia PROMs show improvement in outcomes from Q2
CE4	Fractured Neck of Femur Dashboard	A	'Time to theatre within 36 hrs' not met in Jan or March. Most non clinically related breaches in March were related to a high number of admissions over one weekend. Actions being taken to improve co-ordination of pre-op patient pathway. Ortho-geriatrician related indicators anticipated to improve from June with increase in Consultant Sessions.

Schedule Ref	Indicator Title and Detail	Q4 RAG	Comments re 2013/14 Performance
CE5a)	Improve performance with the Stroke Dashboard Indicators	**A**	High risk patients seen in TIA clinic within 24 hrs = 64% for 13/14 as a whole and for each CCG. All stroke inpatient indicators achieved except 'time to stroke unit' and 'review by all members of the multi-disciplinary team'.
CE6	Mortality Dashboard to include: SHMI HSMR	**A**	RAG reflects UHL's internal RAG rating as our SHMI remains 'within expected' but is above 100.
CE7a-c	Compliance with NICE Technology Appraisals published in 13/14 and all NICE Guidance Clinical Audit 13/14 programme progress	**A**	Some delays with confirming compliance against NICE guidelines. Anticipated to be back on track by end of Q1.
CE8	Francis Report and 'Transforming Care' Recommendations	**G**	
CE9	National Quality Dashboard	**N/A**	National Dashboard closed down.
CE10	Consultant level survival rates as stated on the 'Everyone Counts' document	**G**	Bariatric surgery outcomes not submitted in time for 13/14 publication. On track for 14/15
PR1.1	Use of Digital First to reduce inappropriate face-to-face contacts	**A**	Not all areas of work on track – incorporated into the SDIP for 14/15.
PR1.2	Use of Intra-Operative Fluid Management	**R**	End of year threshold not achieved and delays in actions to improve performance. Work-stream agreed for 14/15.
PR1.3	Carers of patients with dementia receive advice	**G**	Improved results in the carers' surveys.
	CCG CQUIN SCHEMES		
Nat 1.	Implementation of Friends and Family Test: 1.2 Increased Response Rate	**G**	Although not achieved 20% in both ED and Inpatients, overall UHL F&FT participation is 22.3%.
	1.3 Improved F&FT score in Staff Survey	**G**	Slight improvement for both aspects of the Staff Survey relating to 'F&FT' question.
Nat 2.	2.1. To collect NHS Safety Thermometer data: pressure ulcers, falls, CAUTIs and VTE	**G**	Data submitted for all 4 harms
	2. 2a Reduction in the prevalence of CAUTI	**G**	Reduction in CAUTI prevalence as recorded on ST. Some actions being carried forward into 14/15 as part of the IP Annual Programme.
	2. 2b Reduction in the prevalence of Falls	**G**	Continued reduction in number of Falls and good progress with actions.
Nat 3	3. Dementia Screening, Risk Assessment and Referral of Patients aged over 75 yrs	**G**	90% performance for January and just achieved for February. Already met '3 consecutive month threshold' earlier in the year.
	3.2 Training of staff – Category A, B C	**A**	Although increase in number of staff undertaking Cat A & Cat B Training, little progress with the Cat C training. To be taken forward in 14/15.
	3.3. Ensuring carers of people with dementia feel adequately supported	**G**	
Nat 4	Reduce Venous thromboembolism(VTE) 1. VTE risk assessment	**G**	95% performance for Q2-Q4.
	2. Hospital Acquired Thrombosis RCAs	**G**	RCAs undertaken and reviewed by the Thrombosis Cttee.
Loc 1.1	MECC - Increase in number of referrals to Smoking Cessation Services (STOP), Alcohol Liaison, Healthy Eating	**G**	Increased number of staff trained and referrals to Alcohol Liaison and Community Healthy Eating services. Referrals to STOP smoking service slightly less than in 12/13 and thought to be related to the e-cigarette.
Loc 2	Implementation of the AMBER care bundle to ensure patients and carers will	**G**	Implementation of AMBER on 23 wards as per plan.

Schedule Ref	Indicator Title and Detail	Q4 RAG	Comments re 2013/14 Performance
	receive the highest possible standards of end of life care		
Loc 3	Improve care pathway and discharge for patients with Pneumonia	G	Improved compliance with guidelines and patient outcomes
Loc 4	Improving care pathway and discharge for patients with Heart Failure - Implementation of Care Bundle and discharge Check List and piloting of 'virtual ward'	G	Virtual ward piloted and 41% of patients receiving the Heart Failure care bundle of care.
Loc 5	Critical Safety Actions: Clinical Handover, Acting on Results, Senior Clinical Review, Ward Round and Notation standards and Early Warning Scores (EWS)	G	Evidence of progress made across all Safety Actions. Further work to be done in 14/15, specifically in respect of embedding the Ward Round Safety Check List.
Loc 6	Implementation of DoH Quality Mark with specific focus on Dignity Aspects	G	Good progress made. Delay in funding being agreed for environmental works – to be carried forward to 14/15
	SPECIALISED CQUIN SCHEMES		
SS1	Implementation of Specialised Service Quality Dashboards	G	
SS2	Bone Marrow Transplant (BMT) – Donor acquisition measures	G	
SS3	Fetal Medicine – Rapidity of obtaining a tertiary level fetal medicine opinion	G	90% threshold achieved for January
SS4	Joint scoring for patients with Haemophilia	G	50% threshold achieved.
SS5	Discharge planning in NICU	G	Quarter 4 performance was 85% which was above the 70% target
SS6	Radiotherapy – Improving the proportion of radical Intensity modulated radiotherapy with level 2 imaging – image guided radiotherapy (IGRT)	G	The target of >30% of IMRT patients receiving level 2 IGRT was exceeded – Performance for Q4 = 51%
SS7	Acute Kidney Injury	G	Automated Alert System in place and Outreach team now reviewing patients.
SS8	PICU - . To prevent and reduce unplanned readmissions to PICU within 48 hours	G	Readmissions remains stable at around 2%, in line with the national rate. All Q4 readmissions were post cardiac surgery.

4.9 Theatres – 100% WHO compliance

2013/14 Mth

The theatres checklist has been fully compliant since January 2012.

4.10 C-sections rate

2013/14 Mth

The C-section rate for April is 27.3% against a target of 25%.

4.11 Safety Thermometer

Areas to note for the April 2014 Safety Thermometer:-

- UHL reported 95% Harm Free Care for April 2014
- The Trust is not an outlier in the prevalence of falls and pressure ulcers in all ages of patients
- The total of newly acquired harms has reduced (but noting that harm cannot always be attributed to an organisation). The reduction appears to be a result of a reduction in the prevalence of new pressure ulcers

- ❖ The prevalence of new falls with a harm remains the same.
- ❖ The prevalence of VTEs in April remained the same including the number of Hospital Acquired Thrombosis (HAT)

Chart One – UHL Percentage of Harm Free Care March 2014 to April 2014

	Number of patients on ward	1635	1573
All Harms	Total No of Harms - Old (Community) and Newly Acquired (UHL)	109	88
	No of patients with no Harms	1531	1488
	% Harm Free	93.64%	94.60%
New	Total No of Newly Acquired (UHL) Harms	50	39
Harms	No of Patients with no Newly Acquired Harms	1587	1536
	% of UHL Patients with No Newly Acquired Harms	97.06%	97.65%
Harm One	No of Patients with an OLD or NEWLY Acquired Grade 2, 3 or 4 PU	69	58
	No of Newly Acquired Grade 2, 3 or 4 PUs	25	20
Harm Two	No of Patients with falls in a care setting in previous 72 hrs resulting in harm	5	5
	No of patients with falls in UHL in previous 72 hrs resulting in harm	3	3
Harm Three	No of Patients with Urinary Catheter and Urine Infection (prior to or post admission)	22	12
	Number of New Catheter Associated UTIs	7	1
Harm Four	Newly Acquired community or hospital acquired VTE (DVT, PE or Other)	13	13
	Hospital Acquired Thrombosis (HAT)	6	6

DETAILED ANALYSIS OF FOUR HARMS

a) Falls Prevalence

The UHL falls ST data for April 2014 does not indicate any areas of concern. UHL reported five falls on the safety thermometer for April. This figure has now been sustained for the last four months. Of the five falls reported in April, three occurred within UHL. Two patients sustained a level two harm and had a head laceration and skin tear to the elbow. The third patient who fell in UHL sustained a level three harm and had a fractured femur. The first patient that fell prior to hospital admission fell at their residential home and had a head laceration. The second patient has a package of care and fell at home, they sustained bruising. UHL continues to analysis the falls that occur to identify interventions that will prevent avoidable falls and reduce harms

b) Pressure Ulcer Prevalence

New Pressure Ulcer prevalence decreased in April. The Trust also achieved the threshold for pressure ulcer incidence for this month and the outstanding contract query has been removed.

c) VTE Prevalence

The ST VTE data for April 2014 confirmed the following:

- ❖ 36 VTEs reported on ST from the Wards.
- ❖ 13 cases excluded from the data as no diagnosis of VTE present

Of the remaining 23;

- ❖ 10 were 'old'.
- ❖ 7 patients were admitted with VTE

Of the remaining 6 cases that have been confirmed a new VTEs / HAT:

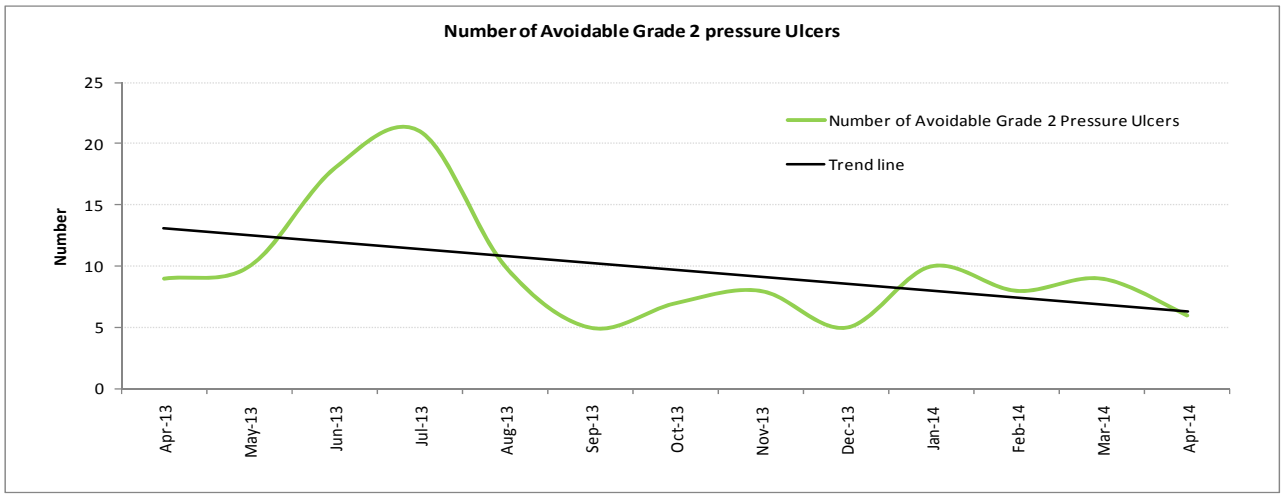
- ❖ Two cases are the same patients who have been reported each month since October and November 2013 as both have remained in-patients from during this time.

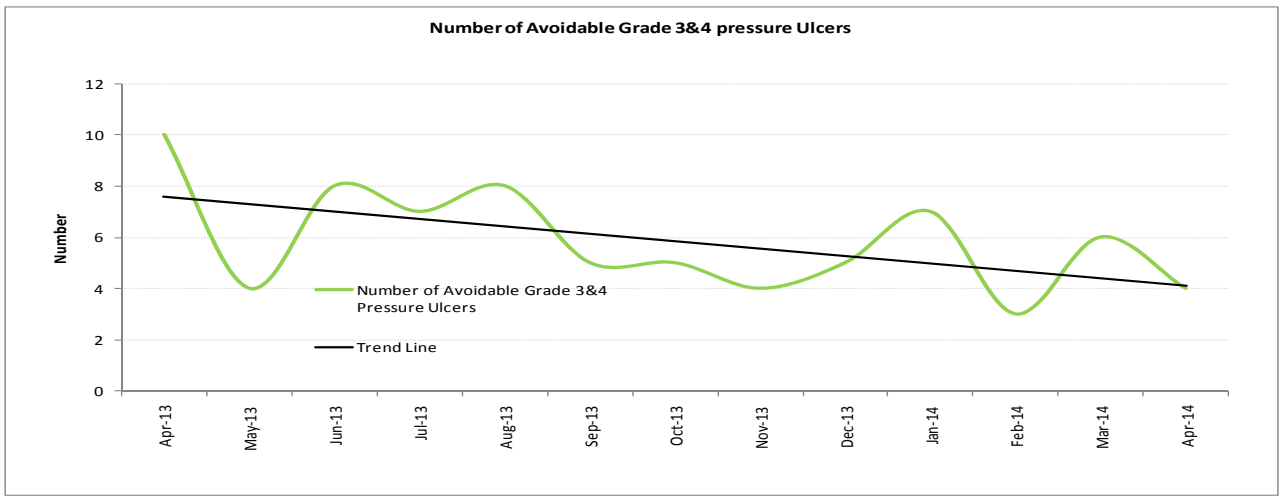
d) CAUTI Prevalence

The prevalence of CAUTIs has reduced significantly. However, it is noted that from April 2014, the UHL classification of a CAUTI for the purposes of the Safety Thermometer has changed in that only laboratory confirmed UTIs are being used. Lead Nurse for IPC to confirm if the Commissioners are aware of this change.

PRESSURE ULCER INCIDENCE

Zero Grade 4 pressure ulcers have been reported for this month. With 6 grade 2 pressure ulcers and 4 grade 3 pressure ulcers report for April, all trajectories for pressure ulcers have been achieved.





Themes for avoidable Grade 2 and 3 pressure ulcers included:-

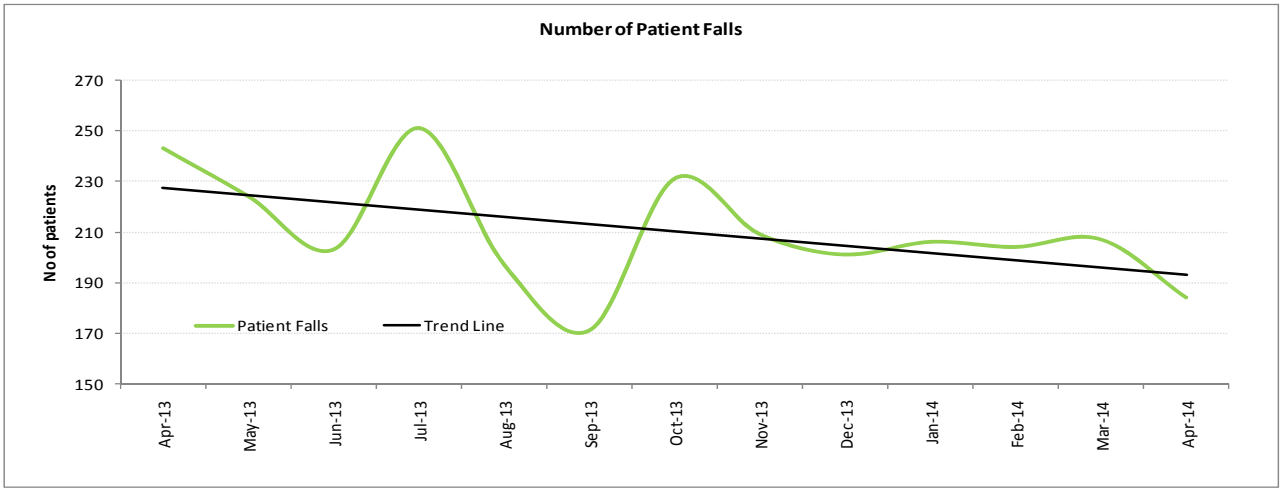
- Insufficient use of protective measures; Repose boots and Silltape and positioning of catheter tubing
- Plaster of Paris – application and continuing care including patient or carer education.
- Gaps in re-positioning and the documentation of repositioning

An LLR Strategic Pressure Ulcer Group will meet for the first time on June 25th 2014 to meet the requirements of the new Pressure Ulcer CQUIN. The Chief Nurse for LPT (Adrian Childs) will chair the first meeting. A new action plan that will focus on pressure

ulcer reduction strategies across the healthcare community will be developed with the UHL lead being the Assistant Director of Nursing.

At the end of May 2014, presentation of certificates to those areas that have achieved 100 / 200 and 300 pressure ulcer free days needs to take place. Heads of Nursing of Nursing and CMG Director to award the 100 PU day certificates, Chief Nurse to give 200 PU days certificates and Chief Executive or Chairman to award the 300 PU free days certificates.

Patient Falls (Incidence via Datix)



Falls incidence for April 2014 was 184. This may be subject to change due to outstanding Datix incidents being closed by ward managers.

5.0 PATIENT EXPERIENCE – RACHEL OVERFIELD

5.1 Infection Prevention

a) MRSA

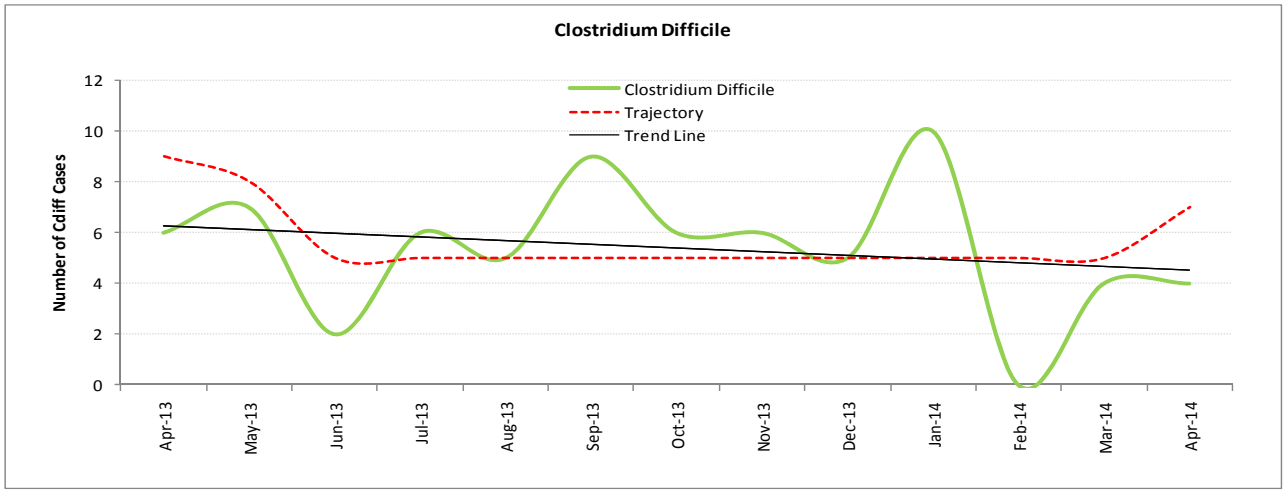
2013/14 | Mth

There were no avoidable MRSA cases reported in April.

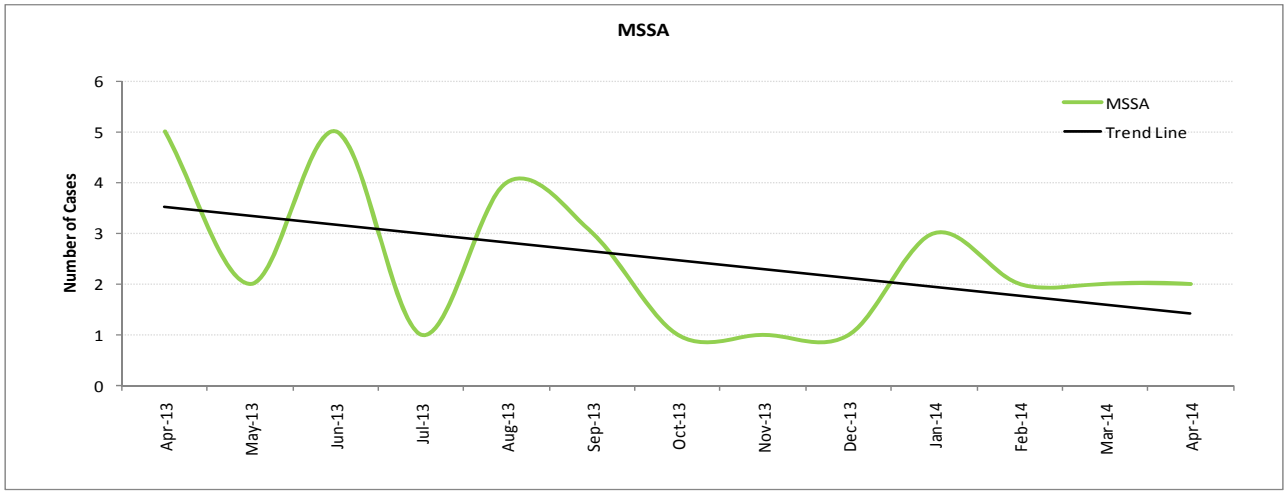
b) Clostridium Difficile

2013/14 | Mth

There were 4 cases reported in April against a monthly trajectory of 7. The full year target is 81.



c) The number of MSSA cases reported during April was 2.



5.2 Patient Experience

Patient Experience Surveys are offered to patients, carers, relatives and friends across the trust in the form of four paper surveys for adult inpatient, children's inpatient, adult day case and intensive care settings and eleven electronic surveys identified in the table below.

In April 2014, 5,002 Patient Experience Surveys were returned this is broken down to:

- 3,401 paper inpatient/day case surveys
- 968 electronic surveys
- 610 ED paper surveys
- 23 maternity paper surveys

Share Your Experience – Electronic Feedback Platform
In April 2014, a total of 968 electronic surveys were completed via email, touch screen, SMS Text, our Leicester's Hospitals web site or handheld devices.

A total of 189 emails were sent to patients inviting them to complete a survey. The table below shows how this breaks down across the trust

SHARE YOUR EXPERIENCE SURVEY	Email	Touch Screen	Sms	Tablet	Web	Total Completions	Emails sent
A&E Department	0	2	0	0	5	7	0
Carers Survey	0	0	0	0	1	1	0
Childrens Urgent and ED Care	0	19	0	0	0	19	0
FFT Eye Casualty	0	17	0	167	0	184	0
Glenfield CDU	0	0	0	0	0	0	0
Glenfield Radiology	0	0	0	0	0	0	2
Hope Clinical Trials Unit	0	0	0	7	0	7	0
IP, Daycase and Childrens IP Wards	0	0	42	0	15	57	0
Maternity Survey	0	0	0	485	4	489	0
Neonatal Unit Survey	0	0	0	0	23	23	0
Outpatient Survey	38	2	1	133	3	177	187
Windsor Eye Clinic	0	2	0	2	0	4	0
Total	38	42	43	794	51	968	189

Treated with Respect and Dignity

2013/14 Mth

This month has been rated GREEN for the question 'Overall do you think you were treated with dignity and respect while in hospital' based on the Patient Experience Survey trust wide scores for the last 12 months.

This new threshold scheme will be refreshed on a quarterly basis. A green score at trust level will mean that a new high score (based on the previous 12 months) and an improvement has been achieved. Conversely a red score will mean a new low score has been given by patients. The amber score has been replaced by blue and reflects 'an expected score' as scores will not be outside this blue range unless there is a significant improvement / deterioration.

Friends and Family Test

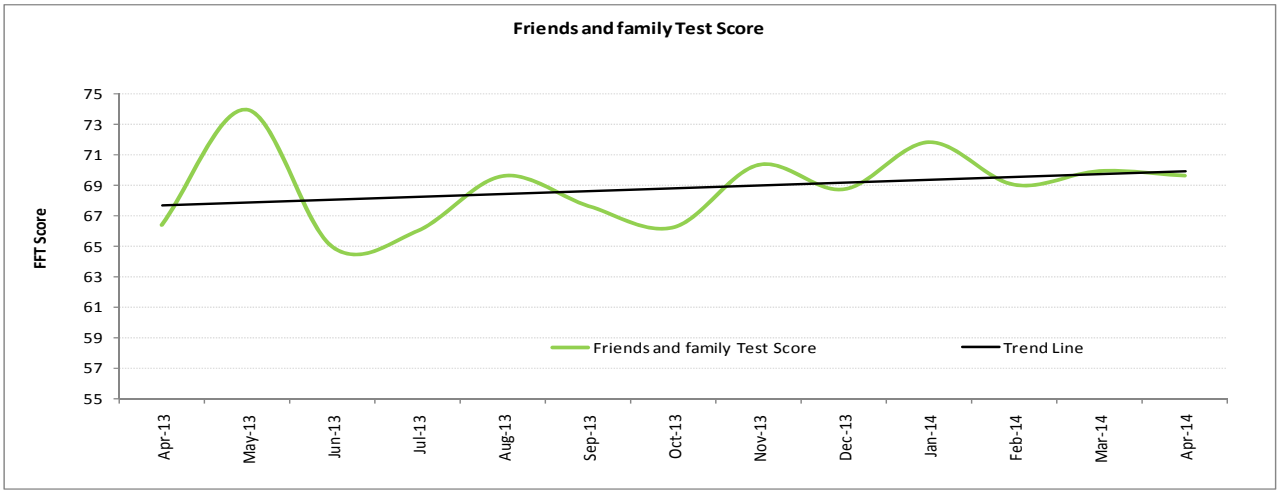
Inpatient

The inpatient surveys include the Friends and Family Test question; **How likely are you to recommend this ward to friends and family if they needed similar care or treatment?'** Of all the surveys received in April, 2,391 surveys included a response to this question and were considered inpatient activity (excluding day case / outpatients) and therefore were included in the Friends and Family Test score for NHS England.

Overall there were 6,489 patients in the relevant areas within the month of April 2014. The Trust easily met the 25% target achieving coverage of 36.8**%.**

The Friends & Family Test responses broken down to:

Extremely likely:	1,742
Likely:	546
Neither likely nor unlikely:	67
Unlikely	13
Extremely unlikely	8
Don't know:	15
Overall Friends & Family Test Score	**69.6**



March 2014 Data Published Nationally

The National Table reports the scores and responses for 170 Trusts

If we filter out the Private and Single Speciality Trusts, and those that achieved less than 20% footfall, the UHL score of **70** ranks 88th out of **139** Trusts.

The overall National Inpatient Score (not including independent sector Trusts) was **72**.

CMG Performance Changes

The FFT score for Renal, Respiratory and Cardiac rose this month to 79, and they also achieved a record number of responses this month. Renal, Respiratory and Cardiac overall performance on the FFT score is strong and their score has consistently been above the UHL level FFT performance.

Emergency and Specialist Medicine showed a drop in their FFT score from 68 in March to 63 in April. This was due to a reduction in promoters as they switched to being passive.

CHUGS showed a 5 percentage point improvement on their FFT score in April, with a decrease in detractor respondents, and an increase in promoters. CHUGS obtained responses from 628 patients, a large increase on previous months so the improvement in their score is particularly notable given the larger survey base.

Musculoskeletal and Specialist Surgery also obtained the highest level of responses to date, but their FFT score fell in April compared to March performance. Promoters switched to being passive respondents this month, and there was also a one percentage point increase in the proportion of detractor responses.

Whilst the FFT score for Women's and Children's fell from 79 to 70 this month, performance is still strong for this CMG. As Women's and Children's has a fairly small number of responses compared to other CMGs, and from a smaller ward base, the score is more likely to fluctuate month on month.

The FFT score for the Emergency Department rose again this month by 3 percentage points, and ED also reached their highest FFT score to date. Detractors fell and both passive and promoter responses increased.

	Mar-14	Apr-14	Point Change in FFT Score (Mar - Apr 14)
UHL Trust Level Totals	**69.9**	**69.6**	**-0.3**
Renal, Respiratory and Cardiac	76	79	**3**
Emergency and Specialist Medicine	68	63	**-5**
CHUGS	57	62	**5**
Musculoskeletal and Specialist Surgery	78	74	**-4**
Women's and Children's	79	70	**-9**
Emergency Department	66	69	**3**

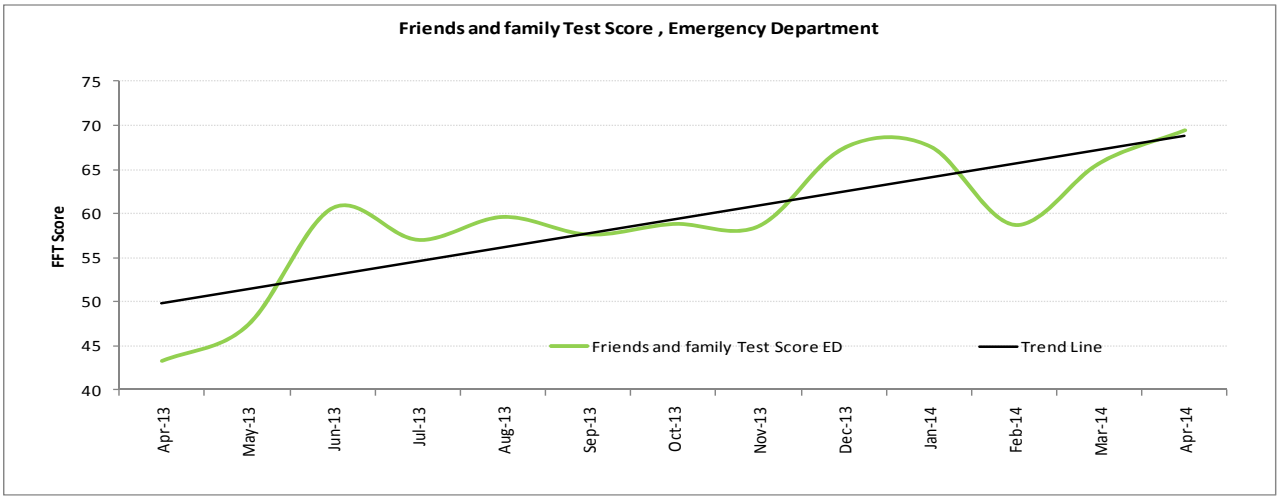
Details at hospital and ward level for those wards included in the Friends and Family Test Score are included in Appendix 1.

Emergency Department & Eye Casualty

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

Overall there were 5,966 patients who were seen in A&E and then discharged home within the month of April 2014. The Trust surveyed 904 eligible patients meeting **15.2%** of the footfall. The Friends & Family test responses break down to:

Extremely likely:	650
Likely:	223
Neither likely nor unlikely:	16
Unlikely	5
Extremely unlikely	5
Don't know:	5
Overall Friends & Family Test Score	**69.4**



Breakdown by department	No. of responses	FFT Score	Total no. of patients eligible to respond
Emergency Dept Majors	156	64.7	1,325
Emergency Dept Minors	398	68.3	2,565
Emergency Dept – not stated	53	54.7	-
Emergency Decisions Unit	121	54.2	723
Eye Casualty	176	90.9	1353

March 2014 Data Published Nationally

The National Table reports the scores and responses for 143 Trusts

If we filter out the Trusts that achieved less than 15% footfall, the UHL score of **66** ranks 21st out of the remaining 98 Trusts

The overall National Accident & Emergency Score was **54**.

(NB previously only trusts that met 20% were included in the A&E ranking – however the CQUIN 2014/15 national target for A&E has been reset to 15% Q1-3 and will increase to 20% only in Q4).

Maternity Services

Electronic and paper surveys are used to offer the Friends and Family Test question to ladies at different stages of their Maternity journey. A slight variation on the standard question: **How likely are you to recommend our <service> to friends and family if they needed similar care or treatment?** is posed to patients in antenatal clinics following 36 week appointments, labour wards or birthing centres at discharge, postnatal wards at discharge and postnatal community follow-up at 10 days after birth.

Overall there were 3,277 patients in total who were eligible within the month of April 2014. The Trust surveyed 890 eligible patients meeting **27.2%** of the footfall. The Friends & Family test responses break down to:

Extremely likely:	577
Likely:	269
Neither likely nor unlikely:	23
Unlikely	7
Extremely unlikely	7
Don't know:	7

Overall Maternity Friends & Family Test Score 61.2

Breakdown by maternity journey stage	No. of responses	FFT Score	Total no. of patients eligible to respond
Antenatal following 36 week appointment	51	47.1	865
Labour Ward/Birthing centre following delivery	448	65.8	820
Postnatal Ward at discharge	381	57.1	677
Postnatal community – 10 days after birth	10	80.0	915

March 2014 Data Published Nationally

Maternity

NHS England has begun publishing all trust's Maternity Friends and Family Test scores and the results are split into each of the four Maternity Care Stages. February data was published at the beginning of April.

Antenatal

The average Friend and Family Test score for England (excluding independent sector providers) was **67**.

If we filter out the Trusts that are single speciality or achieved less than 20% footfall, the UHL score of **71** ranks 22nd out of the remaining 44 Trusts.

Birth

The average Friend and Family Test score for England (excluding independent sector providers) was **77**.

With single speciality and Trusts that achieved less than a 20% footfall excluded, the UHL Friends and Family Test score of **68** ranks the Trust 60th out of the remaining 77 Trusts.

Postnatal Ward

The average Friend and Family Test score for England (excluding independent sector providers) was **64**.

With single speciality and Trusts that achieved less than a 20% footfall excluded, the UHL Friends and Family Test score of **60** ranks the Trust 64th out of the remaining 91 Trusts.

Postnatal Community Provision

The average Friend and Family Test score for England (excluding independent sector providers) was **74**.

If we filter out the Trusts that are single speciality or achieved less than 20% footfall, then we are left with 36 Trusts. However our UHL Score of **82** does not feature among these as the 20% footfall was not achieved.

5.3 Nursing workforce

5.3.1 Vacancies

There are 230 WTE vacancies – 192 wte RN vacancies and 38 wte HCA

The sum of budgeted WTE's in April 2014 is reported as	4,916wte
The sum of nurses in post in April 2014 is reported as	4,554wte
The sum of nurses waiting to start in April is reported as	219wte
The sum of nurses waiting to leave in April is reported as	87wte
Therefore the sum of total reported vacancies for April is	230wte

5.3.2 Real Time Staffing

Future workforce reports will detail real time staffing for the previous month, how many shifts have been made red, and whether there is any trending with this in relation to wards and CMG's and days of the week.

The report will also detail the compliancy in relation to completion of the information per ward area/CMG.

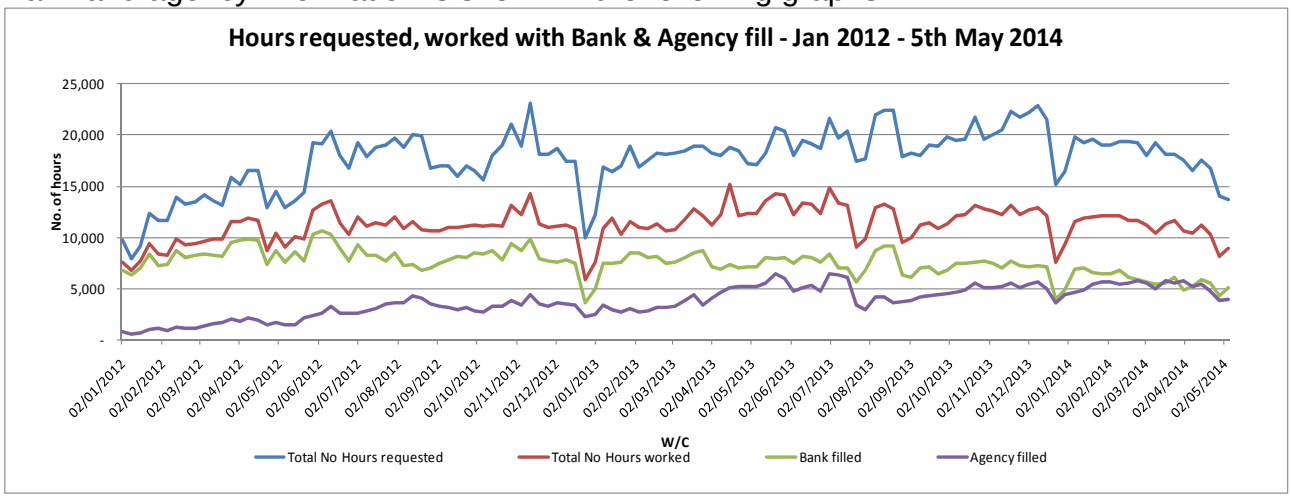
This will form the basis of UHL's reporting in relation to NHS England's, 'Hard Truths Commitments Regarding the Publishing of Staffing Data'. The Board will receive a monthly update containing the details and summary of planned and actual staffing on a daily basis. Therefore we will be reporting the gap.

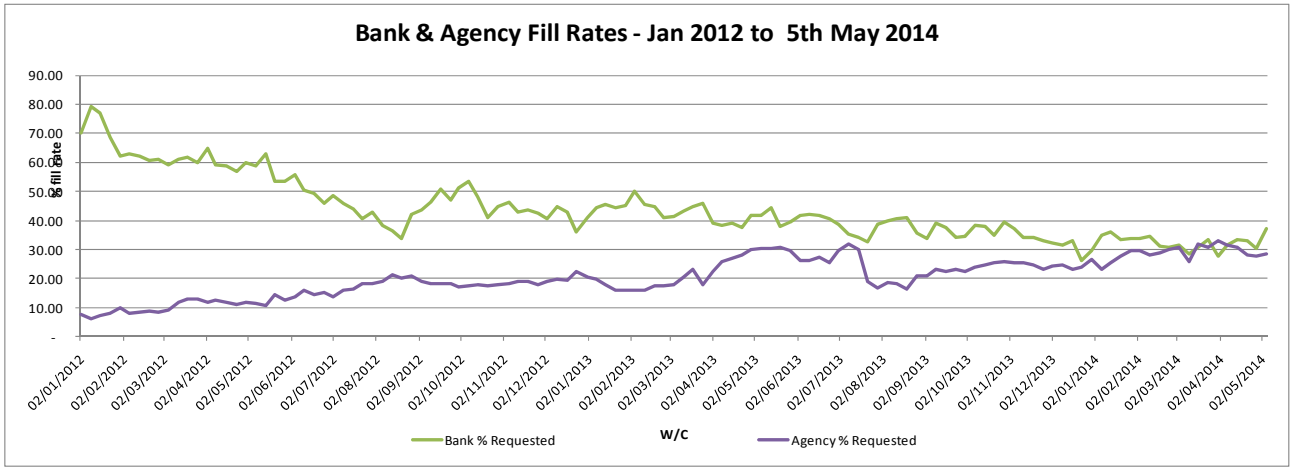
The Board will be advised about wards where staffing falls below the requirements, the reason for the gap, with the impact and actions taken to address the gap, therefore completion of Real Time Staffing is even more essential.

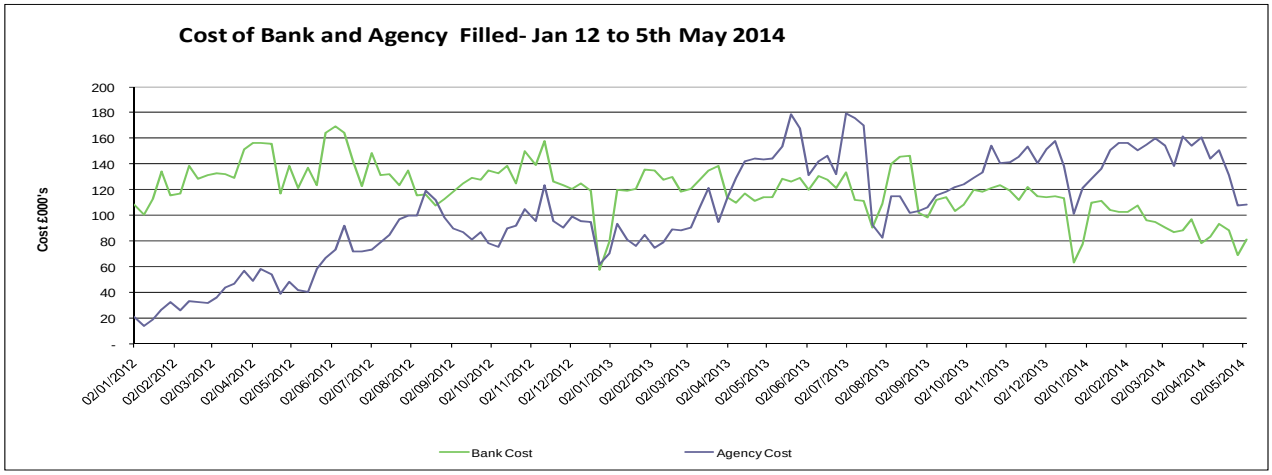
Assurances are needed in relation to contingency plans in place and incident reporting, and the report will be published in a form accessible to patients on the Trusts website.

5.3.3 Bank and Agency

Bank and agency information is shown in the following graphs.







5.4 Ward Performance

The ward quality dashboard for April information is included in Appendix 2.

5.5 Same Sex Accommodation

2013/14 Mth

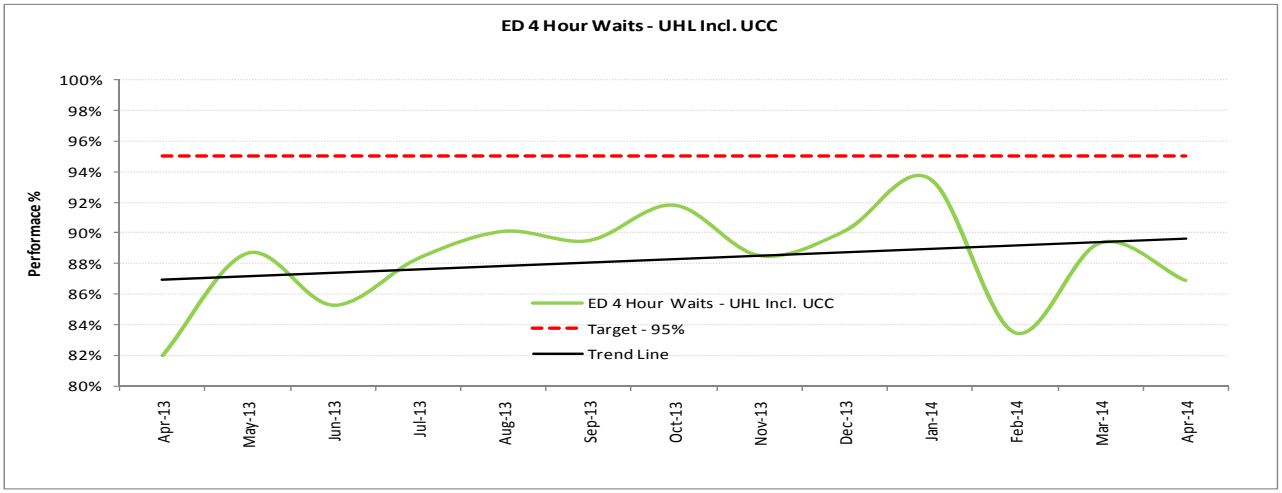
There was 1 not clinically justified same sex accommodation breach during April affecting 4 patients. A root cause analysis is to be reported to the June EQB.

6 OPERATIONAL PERFORMANCE – RICHARD MITCHELL

Responsive	Target	2013/14	Apr-13	May-13	Jun-13	Jul-13	Aug-13	Sep-13	Oct-13	Nov-13	Dec-13	Jan-14	Feb-14	Mar-14	Apr-14
A&E - Total Time in A&E (UHL+UCC)	95%	88.4%	82.0%	88.7%	85.3%	88.3%	90.1%	89.5%	91.8%	88.5%	90.1%	93.6%	83.5%	89.3%	86.9%
12 hour trolley waits in A&E	0	5	2	0	1	0	0	1	0	1	0	0	0	0	0
RTT waiting times – admitted	90%	76.7%	88.2%	91.3%	85.6%	89.1%	85.7%	81.8%	83.5%	83.2%	82.0%	81.8%	79.1%	76.7%	78.9%
RTT waiting times – non-admitted	95%	93.9%	97.0%	95.9%	96.0%	96.4%	95.5%	92.0%	92.8%	91.9%	92.8%	93.4%	93.5%	93.9%	94.3%
RTT - incomplete 92% in 18 weeks	92%	92.1%	92.9%	93.4%	93.8%	93.1%	92.9%	93.8%	92.8%	92.4%	91.8%	92.0%	92.6%	92.1%	93.9%
RTT - 52+ week waits	0	0	0	0	0	0	0	0	0	0	1	1	0	0	3
Diagnostic Test Waiting Times	<1%	1.9%	1.6%	0.6%	0.6%	0.6%	0.8%	0.7%	1.0%	0.8%	1.4%	5.3%	1.9%	1.9%	0.8%
2 week wait - all cancers	93%	94.8%	93.0%	95.2%	94.8%	94.2%	94.6%	93.0%	94.9%	95.7%	94.9%	95.3%	95.9%	95.3%	
2 week wait - for symptomatic breast patients	93%	94.0%	94.0%	94.8%	93.2%	93.6%	92.0%	95.2%	93.0%	91.3%	95.5%	96.8%	93.4%	94.3%	
31-day for first treatment	96%	98.1%	97.5%	97.0%	99.0%	98.3%	99.7%	99.1%	98.9%	96.2%	97.4%	97.2%	98.5%	98.2%	
31-day for subsequent treatment - drugs	98%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	
31-day wait for subsequent treatment - surgery	94%	96.0%	97.2%	94.4%	97.5%	100.0%	98.4%	88.6%	96.4%	97.1%	92.3%	94.8%	96.4%	98.6%	
31-day wait subsequent treatment - radiotherapy	94%	98.2%	100.0%	97.8%	99.1%	100.0%	100.0%	97.7%	97.5%	98.5%	98.1%	94.8%	96.3%	99.1%	
62-day wait for treatment	85%	86.7%	80.9%	80.3%	85.9%	85.8%	88.2%	87.4%	86.4%	85.7%	89.4%	89.1%	89.1%	92.4%	
62-day wait for screening	90%	95.6%	98.6%	94.3%	95.0%	90.6%	97.2%	96.2%	100.0%	97.0%	96.6%	97.1%	95.1%	91.7%	
Urgent operation being cancelled for the second time	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Cancelled operations re-booked within 28 days	100%	95.1%	90.4%	91.0%	86.4%	99.1%	96.0%	98.6%	94.2%	97.7%	94.3%	94.1%	98.9%	94.2%	90.6%
Cancelled operations on the day (%)	0.8%	1.6%	1.5%	1.5%	1.0%	1.2%	1.4%	2.3%	1.7%	1.8%	1.7%	1.6%	2.1%	1.5%	1.1%
Cancelled operations on the day (vol)		1739	125	134	81	114	124	208	171	172	141	152	178	139	106
Stroke - 90% of Stay on a Stroke Unit	80%	83.1%	77.4%	80.7%	78.0%	87.1%	88.5%	89.1%	83.7%	78.0%	81.8%	89.3%	83.7%	82.5%	
Stroke - TIA Clinic within 24 Hours (Suspected TIA)	60%	64.2%	51.1%	69.2%	72.0%	60.5%	73.6%	64.6%	62.4%	76.8%	65.7%	60.5%	40.7%	77.9%	79.7%
Choose and Book Slot Unavailability	4%	13%	7%	9%	13%	15%	14%	11%	16%	17%	14%	10%	16%	19%	22%
Delayed transfers of care	3.5%	3.6%	3.7%	3.9%	3.1%	3.6%	3.1%	3.9%	3.1%	4.6%	2.8%	3.6%	4.5%	3.4%	3.7%

6.3 Emergency Care 4hr Wait Performance

2013/14 Mth



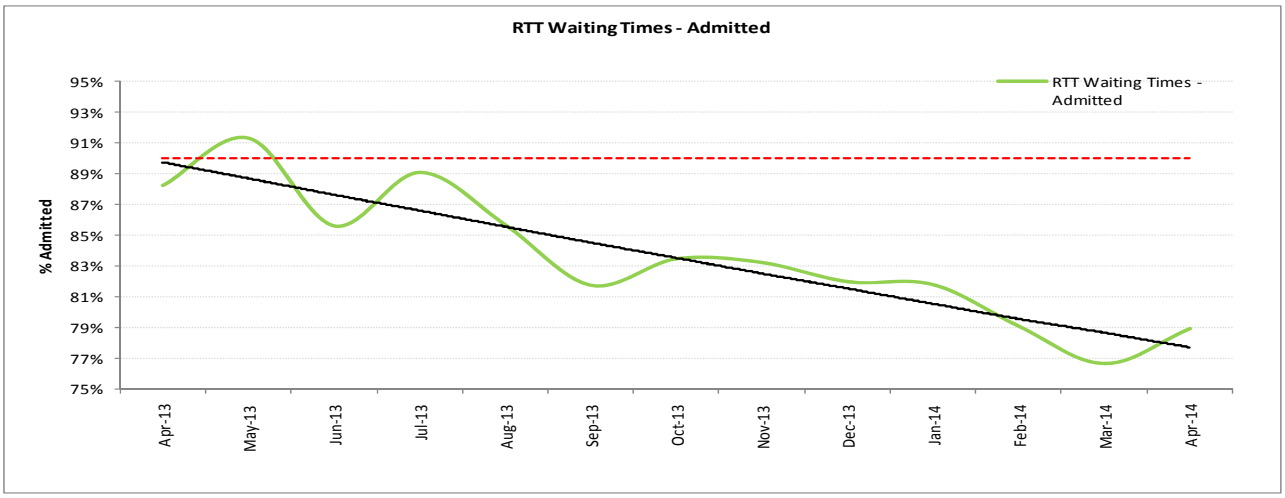
Performance for emergency care 4hr wait in April submitted via the weekly SITREP was 86.9%. Actions relating to the emergency care performance are included in the ED exception report.

UHL was ranked 140 out of 144 Trusts with Type 1 Emergency Departments in England for the four weeks up to 11th May 2014. Over the same period 79 out of 144 Acute Trusts delivered the 95% target.

6.4 RTT – 18 week performance including Alliance performance

a) RTT Admitted performance

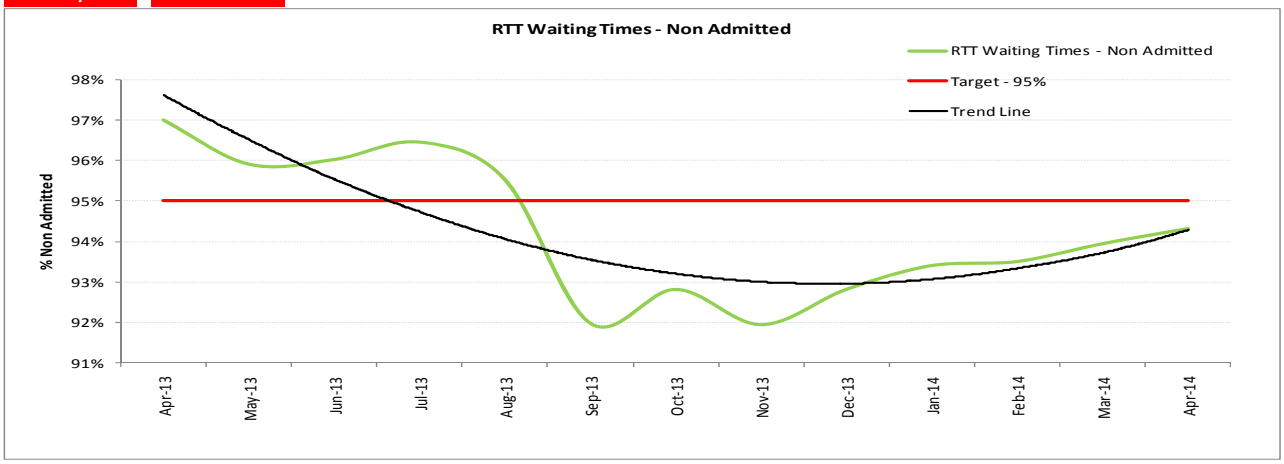
2013/14 Mth



RTT admitted performance (UHL and Alliance) for April was 78.9% with significant speciality level failures in ENT, General Surgery, Ophthalmology and Orthopaedics. Further details can be found in the RTT Improvement Report – Appendix 3.

a) RTT Non Admitted performance

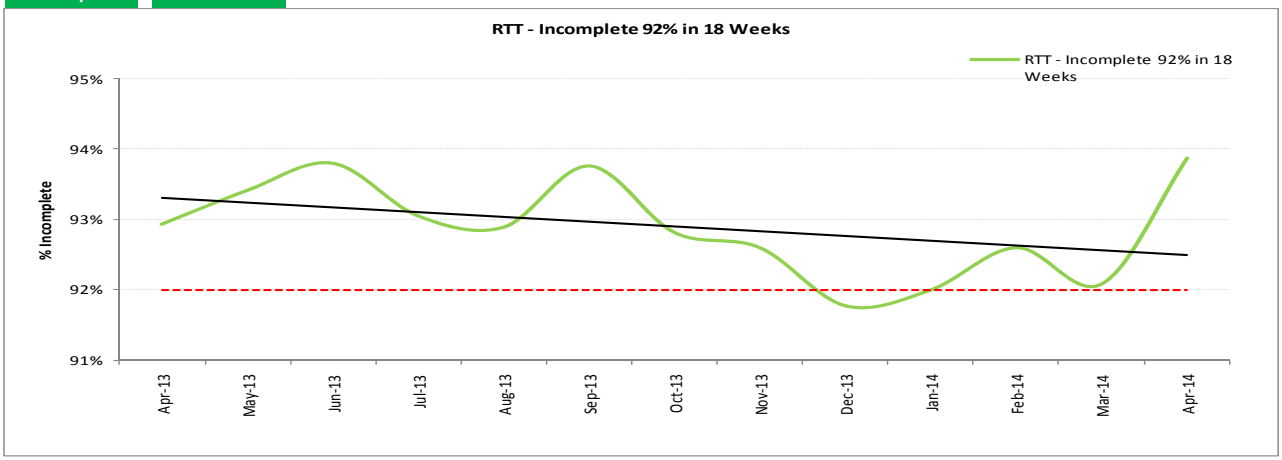
2013/14 Mth



Non-admitted performance (UHL and Alliance) during April was 94.3%, with the specialty level failures in ENT, Orthopaedics and Ophthalmology.

b) RTT Incomplete Pathways

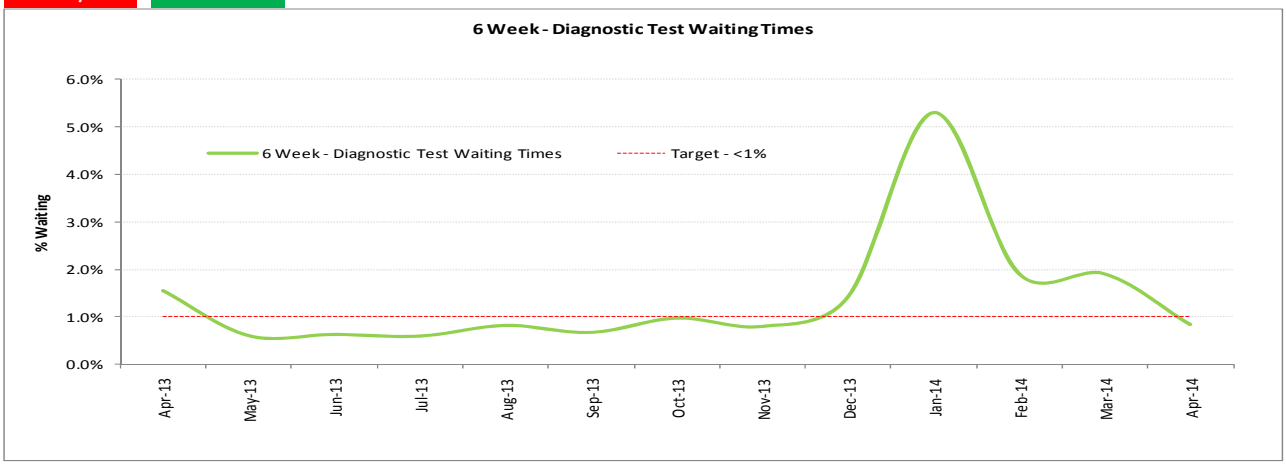
2013/14 Mth



RTT incomplete (i.e. 18+ week backlog) for UHL and Alliance is compliant at 93.9%. In numerical terms the total number of patients waiting 18+ weeks for treatment (admitted and non-admitted) at the end of April was 2,861.

6.5 Diagnostic Waiting Times

2013/14 Mth



At the end of April 0.8% of UHL and Alliance patients were waiting for diagnostic tests longer than 6 weeks.

6.6 Cancer Targets

a) Two Week Wait

2013/14 Mth

March performance for the 2 week to be seen for an urgent GP referral for suspected cancer was achieved at 95.3% (national performance 95.3%). Full year performance was 94.8%.

2013/14 Mth

March performance for the 2 week symptomatic breast patients (cancer not initially suspected) was achieved at 94.3% (national performance 93.2%). Full year performance was 94%.

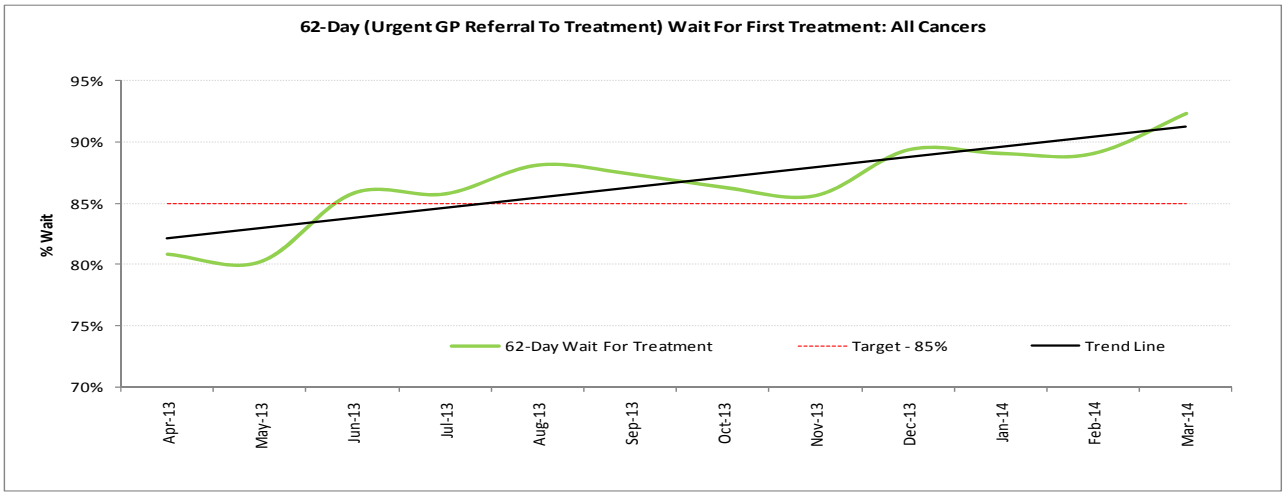
b) 31 Day Target

2013/14 Mth

All four of 31 day cancer targets have been achieved in March, with the full year performance exceeding each of the targets.

c) 62 Day Target

2013/14 Mth

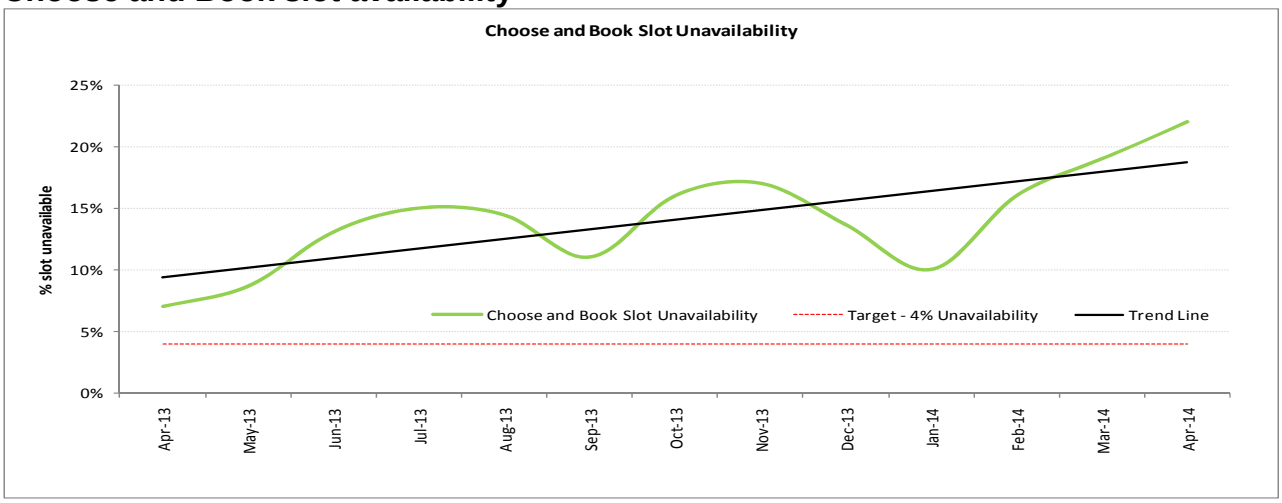


The 62 day urgent referral to treatment cancer performance in March was 92.4% (national performance March was 85.6%) against a target of 85%. The full year position has also being delivered at 86.7%.

Current waiters over 62 days = 61 patients (not all confirmed cancers at this stage)

Waits over 100 days = 5 patients - Haematology x1 / Gynaecology x1/ Breast surgery x2 / Head and Neck x1.

6.7 Choose and Book slot availability

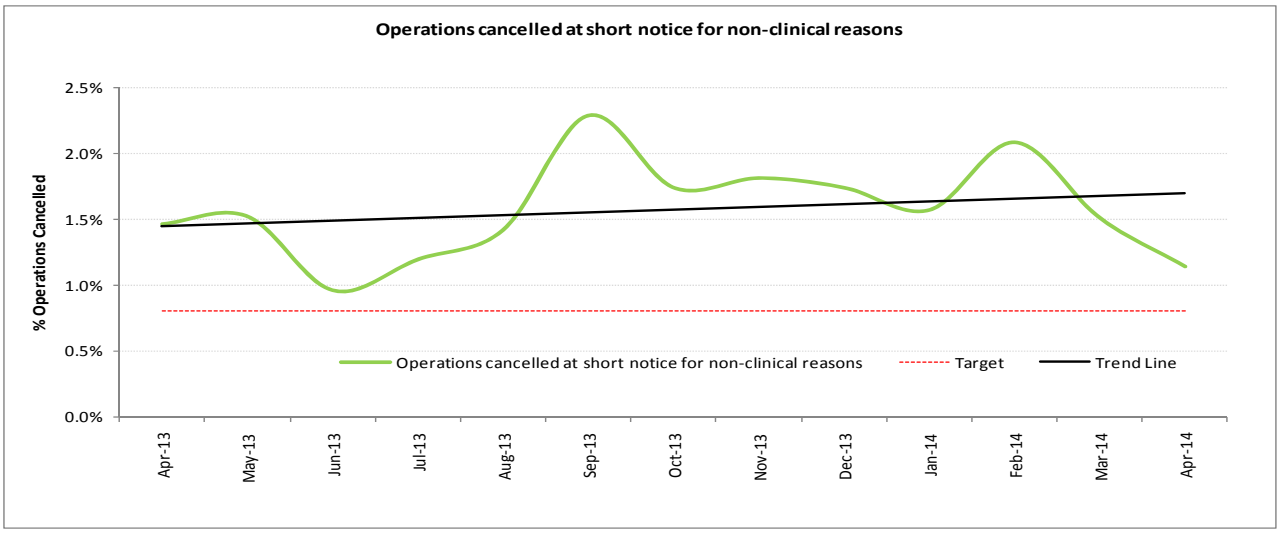


Choose and book slot availability performance for April was 22% a deteriorated position from March with the national average at 13%. Resolution of slot unavailability requires a reduction in waiting times for 1st outpatient appointments in key specialties. For ENT, General surgery and Orthopaedics, this forms part of the 18 week remedial action plan, the effect of these plans will be seen quarter 2 and quarter 3 of 2014/15.

In addition Neurology is a significant issue, a locum is starting in mid June, and the Trust is recruiting to 2 additional consultants, this is likely to take 3-6 months for these post to be filled. In the meantime additional sessions are being run by existing staff

6.8 Short Notice Cancelled Operations

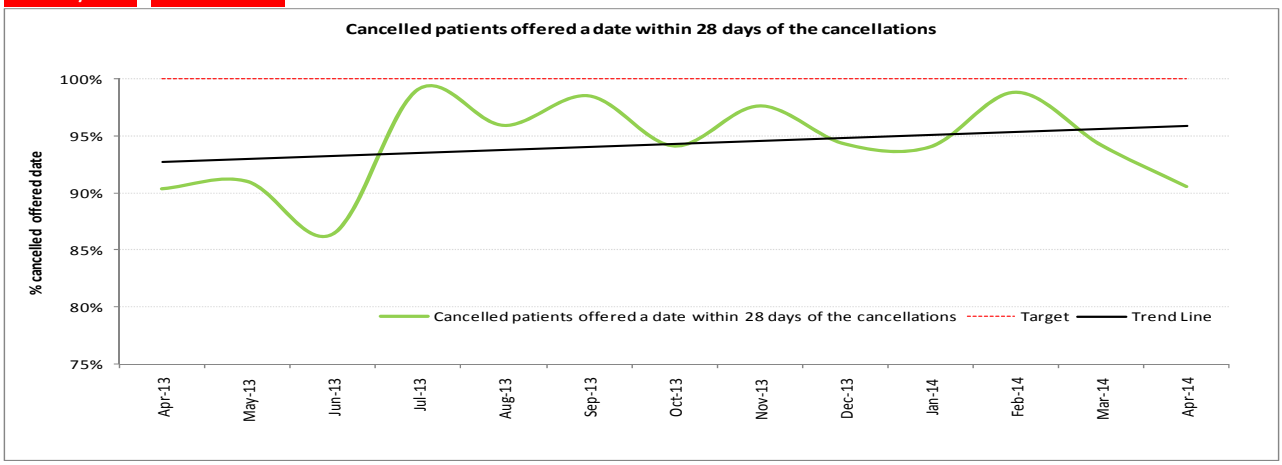
2013/14 Mth



The percentage of operations cancelled on/after the day activity for non-clinical reasons during April (UHL and Alliance) was 1.1%. An exception report is provided in Appendix 4.

Cancelled patients offered a date within 28 days

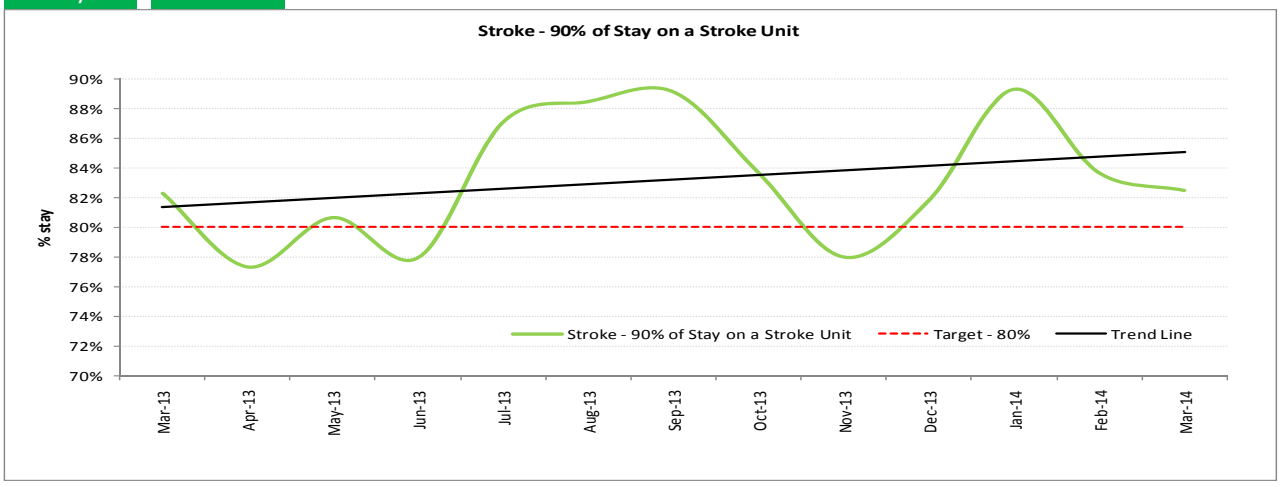
2013/14 Mth



The number of patients breaching this standard in April (UHL and Alliance) was 10 with 90.6% offered a date within 28 days of the cancellation.

6.9 Stroke % stay on stroke ward

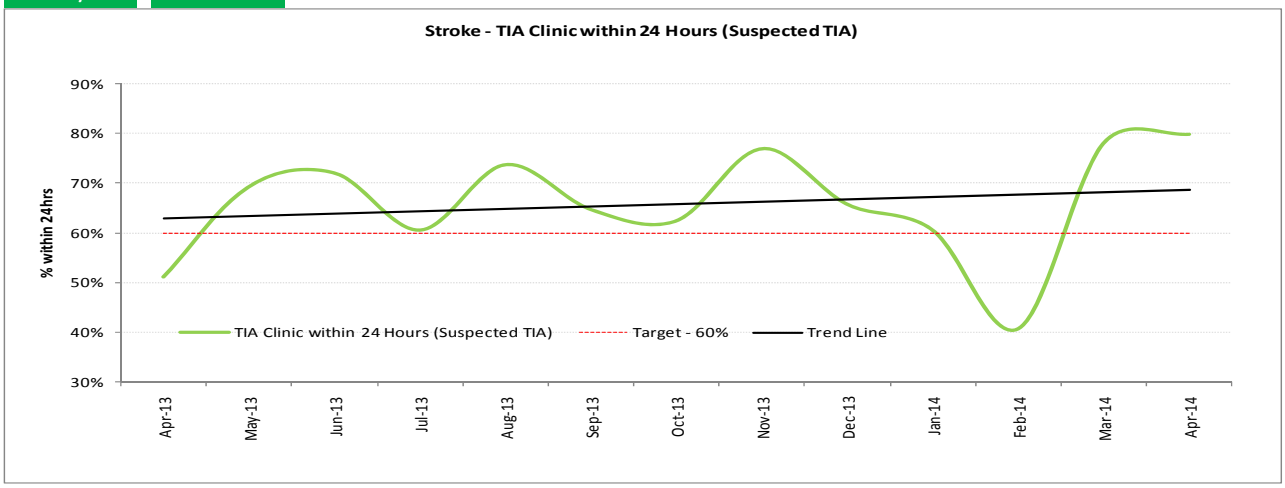
2013/14 Mth



The percentage of stoke patients spending 90% of their stay on a stroke ward in March (reported one month in arrears) is 82.5% against a target of 80%. The full year position is 83.2%.

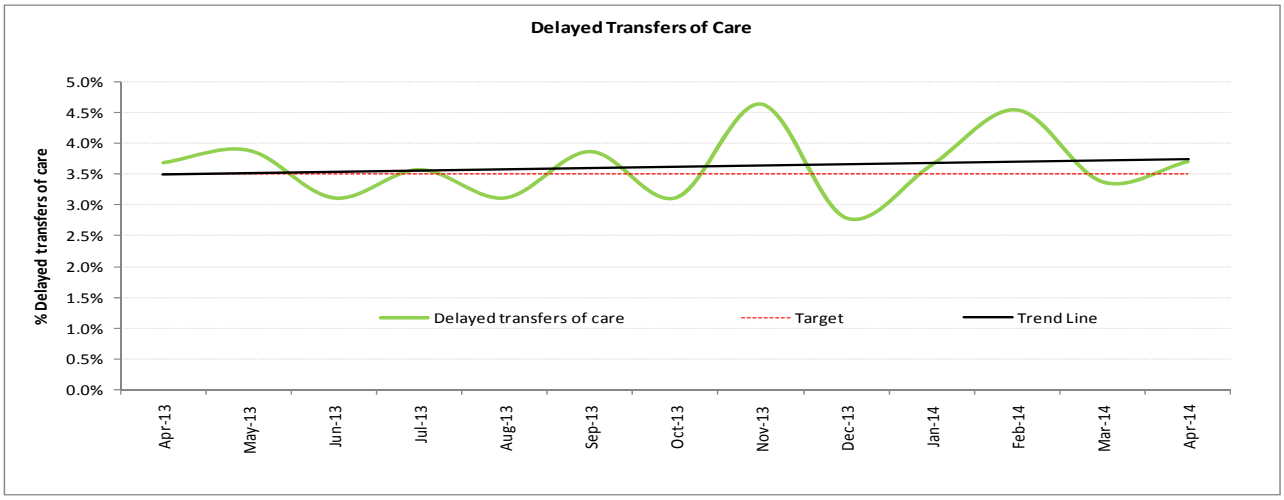
6.10 Stroke TIA

2013/14 Mth



The percentage of high risk suspected TIAs receiving relevant investigations and treatment within 24 hours of referral is 79.7% against a national target of 60.0%.

6.11 Delayed Transfers of Care

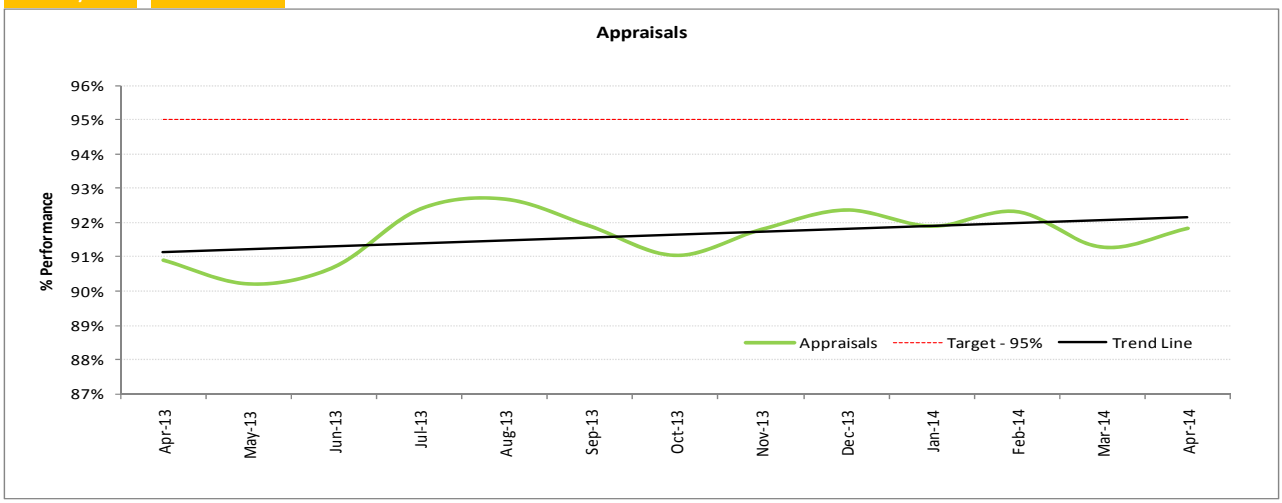


The delayed transfer of care performance for April was 3.7% against a target of 3.5%.

7 HUMAN RESOURCES – KATE BRADLEY

7.1 Appraisal

2013/14 Mth



There continues to be considerable appraisal activity over the last month, there has been a slight improvement in performance for April. There are increasing numbers of clinical and corporate areas achieving between 94% and 100%.

Appraisal performance and quality remains high on the CMG business agenda HR and CMG Leads continue to collectively focus on non–compliant teams and action plan improvements.

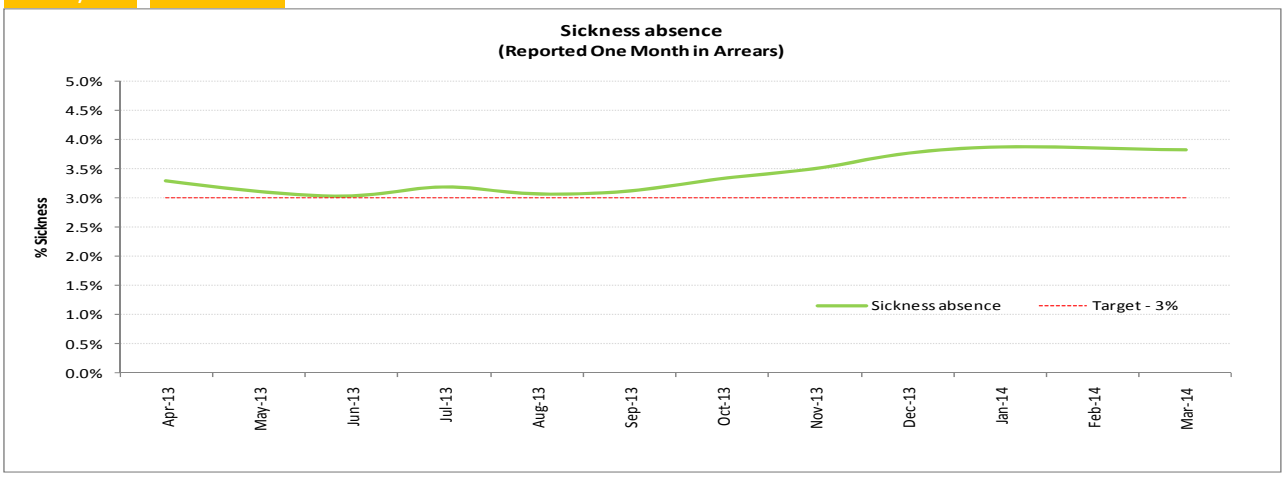
The annual Appraisal Quality Audit has been completed, the audit results will be collated and analysed for each CMG and Directorate area, and where required, actions will be identified to improve the appraisal experience and support will be given to enable this.

A task and finish group are undertaking a review and benchmarking of the current appraisal process and documentation to identify further improvements.

Work continues with IBM, IM&T & OCB Media in developing the new e-appraisal system to improve reporting functionality.

7.2 Sickness

2013/14 Mth



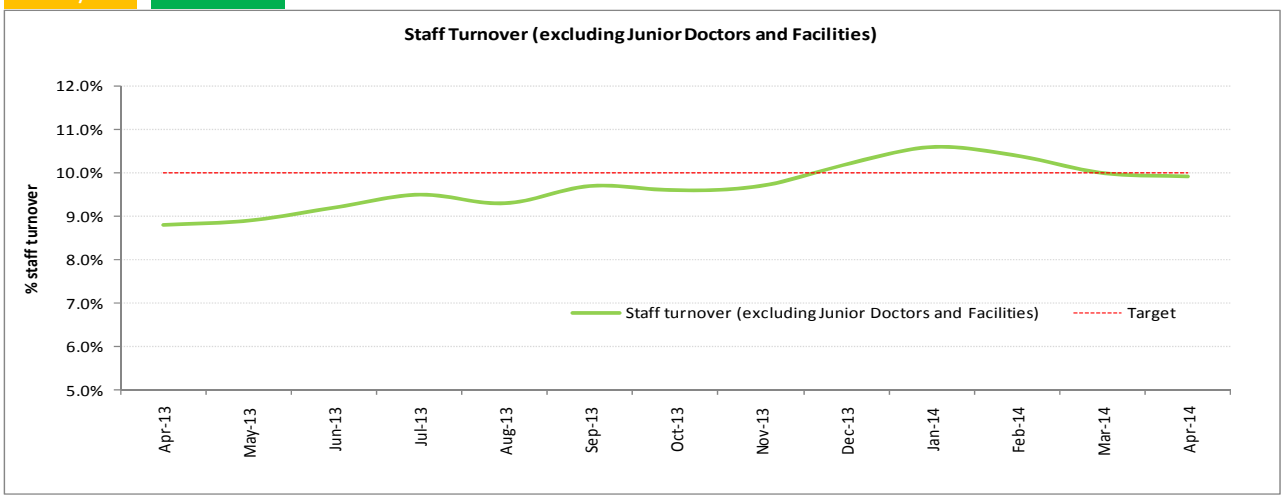
The sickness rate for March 2014 is 3.8% and the February figure has now adjusted to 3.9% to reflect closure of absences. The overall cumulative sickness figure is 3.4%. This is close to the target of 3.4% but slightly above the Trust stretch target of 3%. The figures for April 2014 will be reported in May 2014.

Further analysis of sickness absence trends has indicated a high proportion of pregnancy related absence. We are currently working with senior midwives to develop workshops to support staff during pregnancy as such specific interventions have been successful in the past. Having identified that we have an ageing workforce, we are also developing specific interventions to support this.

In order to improve the uptake of flu vaccinations, plans are in place to incentivise staff to have the vaccine and there will be a programme in place to enable clinical colleagues to peer vaccinate where appropriate.

7.3 Staff Turnover

2013/14 Mth



The cumulative Trust turnover figure (excluding junior doctors) has decreased slightly from 10.0% to 9.9%. The latest figure includes the TUPE transfer of 27 IM &T staff to IBM on 30 November 2013 and the transfer of 65 sexual health services staff to Staffordshire and Stoke on Trent Partnership NHS Trust and therefore skews the overall turnover figures.

7.4 Statutory and Mandatory Training

2013/14 | Mth

UHL Statutory & Mandatory Training Summary - 280414

CMG / Corporate Directorates	Fire Training	Moving & Handling	Infection Preventio n	Equality & Diversity	Informat'n Gover'ce	Safeguard Children	Conflict Resolution	Safeguard Adults	Resus - BLS Equivalent	Average Compliance
CHUGS	69%	69%	74%	74%	78%	81%	74%	78%	71%	74%
Corporate Directorates	75%	78%	78%	81%	78%	83%	75%	77%	66%	77%
CSI	80%	85%	84%	87%	87%	90%	83%	85%	72%	84%
Emergency & Speciality Medicine	72%	77%	75%	73%	70%	79%	66%	68%	62%	71%
ITAPS	73%	87%	87%	85%	84%	90%	80%	85%	73%	83%
Musculoskeletal & Specialist Surgery	71%	76%	80%	80%	81%	85%	80%	81%	72%	78%
Renal, Respiratory & Cardiac	74%	77%	82%	81%	80%	84%	78%	80%	70%	78%
Womens and Childrens	75%	78%	78%	80%	80%	91%	75%	71%	79%	79%
Total compliance by subject	74%	78%	79%	80%	79%	85%	76%	78%	70%	
UHL staff are this compliant with their mandatory & statutory training from the key 9 subjects										78%
Performance Against Trajectory (Set at 78% at 30th April 14)										On Target

At the end of April, we were reporting against nine core subjects, identified by the Skills for Health, Core Skills Training Framework, in relation to Statutory and Mandatory Training. These were Fire Safety Training, Moving & Handling, Infection Prevention, Hand Hygiene, Equality & Diversity, Information Governance, Safeguarding Children, Conflict Resolution, Safeguarding Adults and Resuscitation (BLS Equivalent). The Resuscitation Figure includes all Medical Staff & Nursing Staff (both registered and non-registered).

The Health & Safety eLearning package is now live on eUHL and will be added to the list of core subjects reported on 1st July, 2014. At the end of April after 4 weeks of being live more than 4,000 members of staff had already completed this programme.

The period between March and April staff compliance against Statutory and Mandatory Training has increased from 76% to 78% across the nine core areas.

New trajectories to help the Trust achieve its target for 31st March, 2015 of 95% for Statutory & Mandatory Training are being launched in early May.

These trajectories are as follows:

30th June, 2014	Above 80% compliance
30th September, 2014	Above 85% compliance
31st December, 2014	Above 90% compliance
31st March, 2015	Above 95% compliance

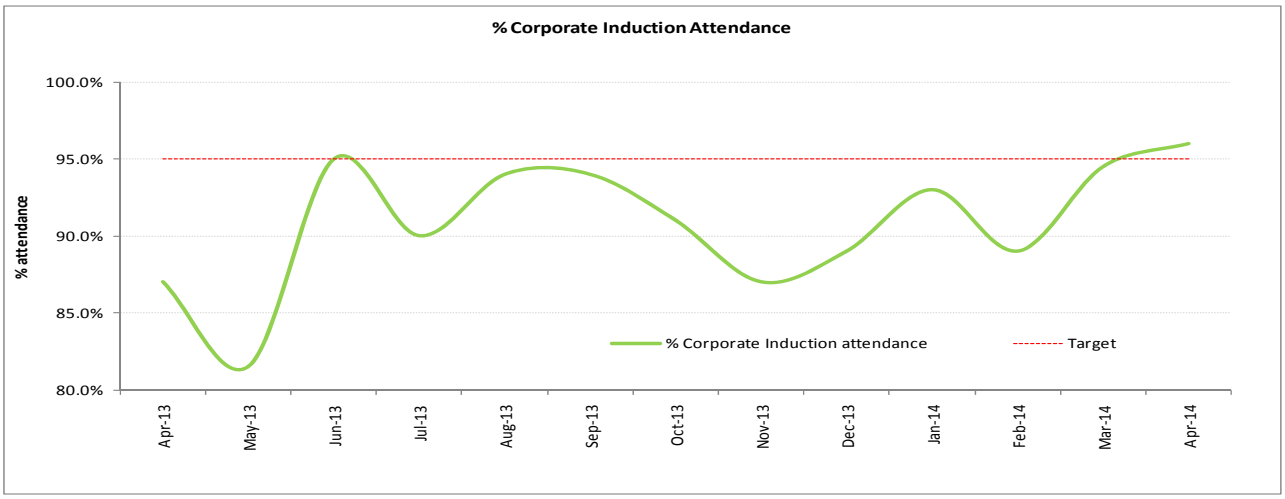
We continue to communicate progress, essential training requirements and follow up on non-compliance at an individual and team level.

Work continues with IBM, IM&T & OCB Media in developing the new Learning Management System to improve reporting functionality, programme access and data accuracy. A detailed

specification document has been requested from OCB Media to ensure the new system will meet all essential criteria

7.5 Corporate Induction

2013/14 Mth



Performance has improved significantly at the end of April to 96% with the introduction of the new weekly Corporate Induction Programme. The programme is having a positive impact on induction attendance.

It is anticipated that the new weekly Corporate Induction Programme will continue to be refined to reflect feedback from new staff and the organisation.

8 UHL - FACILITIES MANAGEMENT– RACHEL OVERFIELD

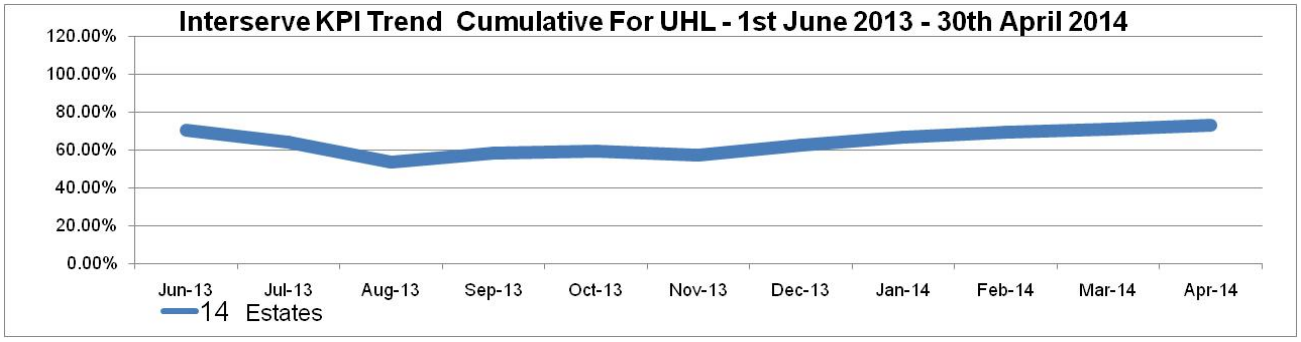
8.1 Introduction

This report covers a review of overall performance on the Facilities Management (FM) service delivery provided by Interserve FM (IFM) and contract managed by NHS Horizons for the month of April 2014 and sees the IFM contract enter into the month 2 of the second year. The FM contract provides 14 different services to the Trust and is underpinned by 83 Key Performance Indicators (KPI's) and the summary information and trend analysis below details a snapshot of 5 key Indicators over the last Twelve months.

8.2 Key Performance Indicators

KPI 14 – Estates

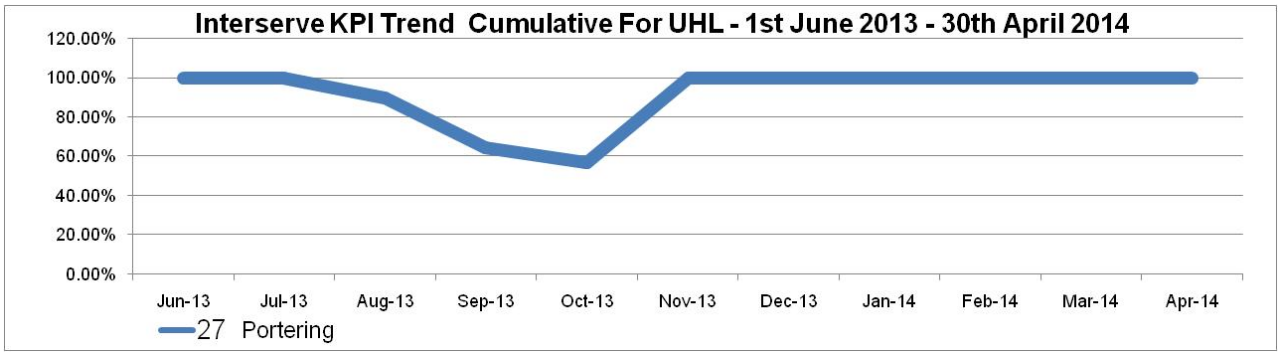
Percentage of routine requests achieving response time



KPI 14 This KPI measures the response by estates for routine requests. The trend of improving results for this KPI has been maintained for April. As previously reported the move to 24/7 covers for Estates personnel over all 3 acute sites and recruitment to vacant posts appear to be having a positive impact. There are still on-going issues to be resolved with electronic dispatching however it is anticipated that this improvement can be sustained and improved upon going forward during the second year of the contract.

KPI 27 – Portering

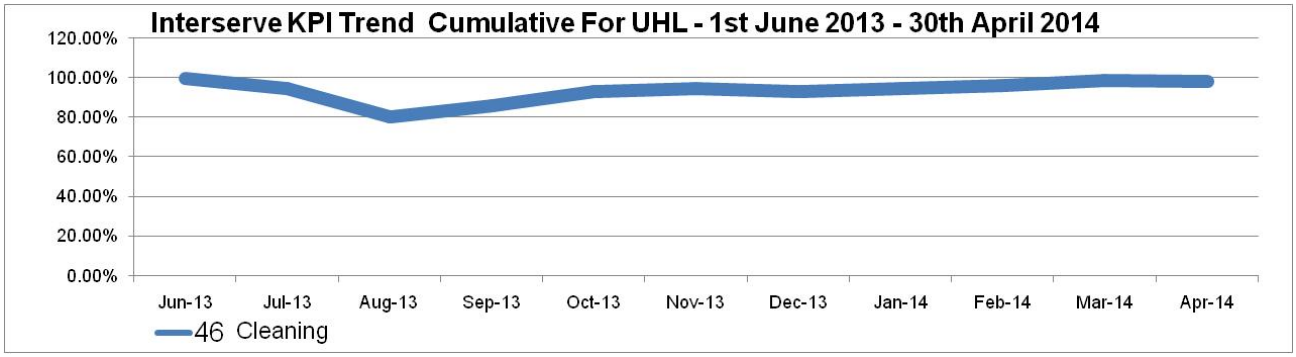
Percentage of emergency portering tasks achieving response time



KPI 27 IFM continues to achieve 100% emergency response times for this service in April.

KPI 46 – Cleaning

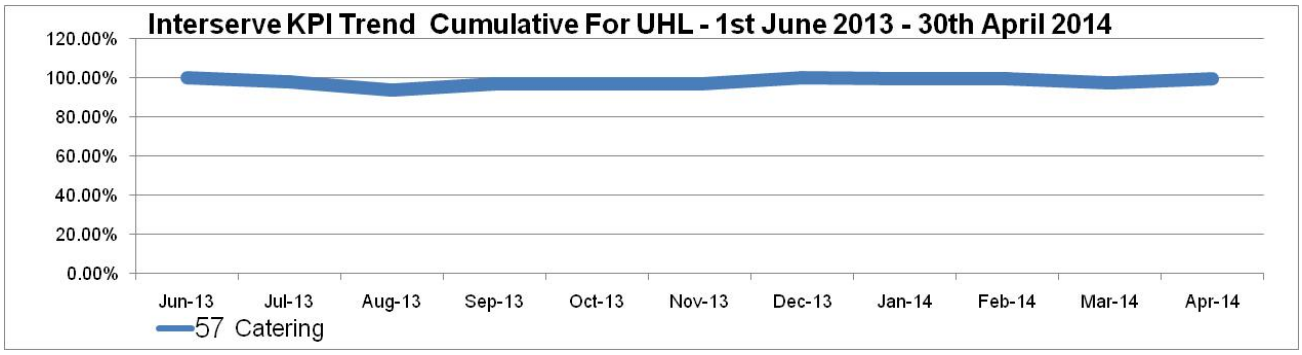
Percentage of audits in clinical areas achieving National Specification for cleaning audit scores above 90%



KPI 46 The trend for cleaning continues with April at 98.00% dipping slightly from March's 98.87%. Servicetrac which is an electronic auditing tool for recording cleaning performance is now in full use across the UHL. Further training and familiarisation is on-going with both IFM and Horizons staff. The Performance & Quality team (P&Q) team are actively involved in monitoring the way this KPI is evidenced against the software results and its use by IFM Auditors.

KPI 57 – Catering

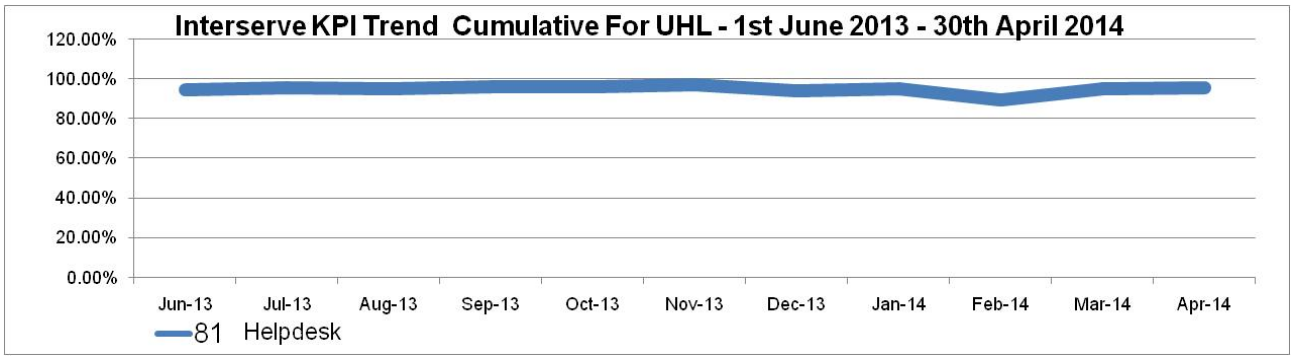
Percentage of meals delivered to wards in time for the designated meal service as per agreed schedules



KPI 57 The result for this KPI in April shows 99.45%. The Catering service continues to improve with the IFM patient satisfaction survey showing an improvement in patient's comments about the service and the food they receive.

KPI 81 – Helpdesk

Percentage of telephone calls to the helpdesk answered within 5 rings using a non-automated solution



KPI 81 The Customer Service Centre (CSC) continues to show improvement with the introduction of additional staff appointments and the completion of helpdesk staff induction and technical training. Following onsite service audits carried out by the P&Q team it has been recorded that the service continues to improve despite the underlying difficulties of a high turnover of staff in this area.

8.3 General Summary

A small variation from previous reports is regard the reporting of KPI 18 measuring quotations for New Works which is currently under review as IFM restructures its method of service delivery and the inclusion of both Lot 1 & 2 requests for larger capital backlog schemes.

The general summary for recorded performance for April, when measured against the 14 services and 83 KPI's demonstrates an overall improvement in services delivered by IFM. The NHS Horizons, Performance & Quality team continue to monitor services through onsite and electronic evidence audits to validate the required KPI's and interact proactively with IFM Performance managers and Service managers to monitor and support improved service delivery.

9 IM&T Service Delivery Review

9.1 Highlights

Go live of UHL telephone book. Managed Business Partner/UHL joint work.

9.2 IT Service Review

There were 7679 (7175 previous month) incidents logged during March, out of which 5571 (6360 previous month) were resolved. Incidents logged via X8000, email and self-service.

There were 6150 telephone calls to X8000 with 1181 (962 previous month) incidents closed on first contact.

Performance against service level agreements is as expected and follows the flight path for service level agreements.

Number of official complaints relating to service has increased to 12 in month (4 in previous month).
There were 1057 (799 previous month) incidents logged out of hours via the 24/7 service desk function.

9.3 Issues

Managed Print – Some applications (iCM/Hiss) cannot be configured locally and require external work by the third part vendor – CSC.

9.4 Future Action

Desktop

- Power changes will need to be prioritised to allow the installation to be completed.

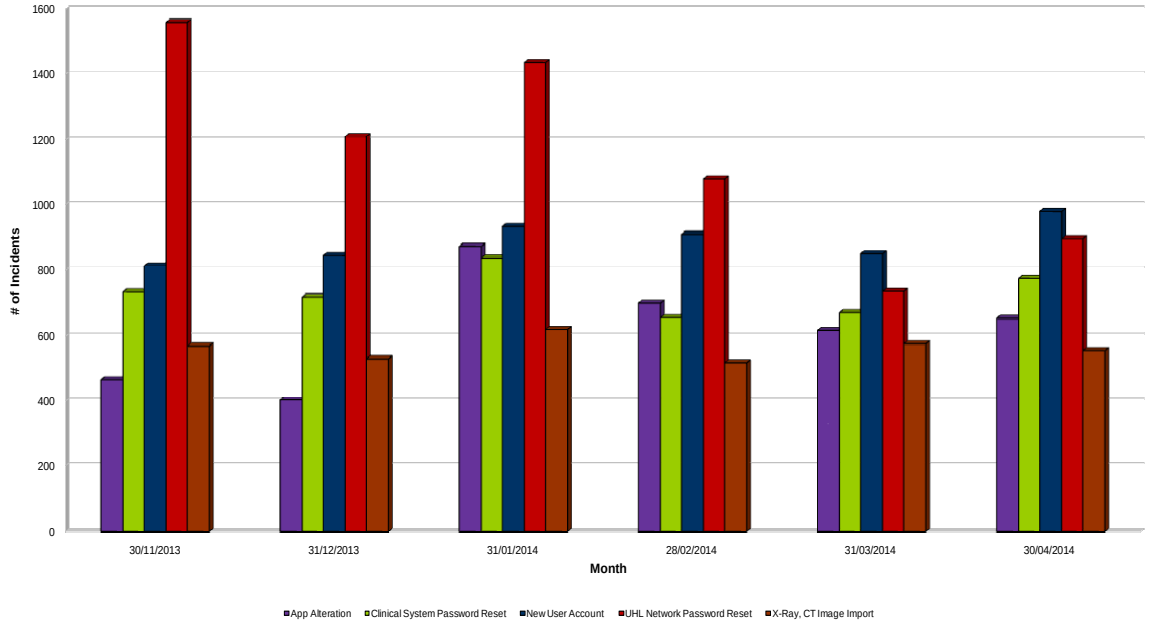
EDRM

- Complete production WinDip technical configuration for both streams - deploy active-X and scanners.
- Mop-up user training sessions for both workstreams.
- Provide support to Go Live
- Execute plan to scan remaining Clin Gen notes corpus on rolling basis during trial.
- Finalise benefits catalogue and capture approach.
- Gather initial user feedback and commence benefits tracking.
- Commence communications to broader UHL audience and develop evolution road map.

Managed Print

- Complete all possible deployments not affected by CSC Config within ICM, power or network issue.
- Schedule outstanding installations and drive pre-requisite work

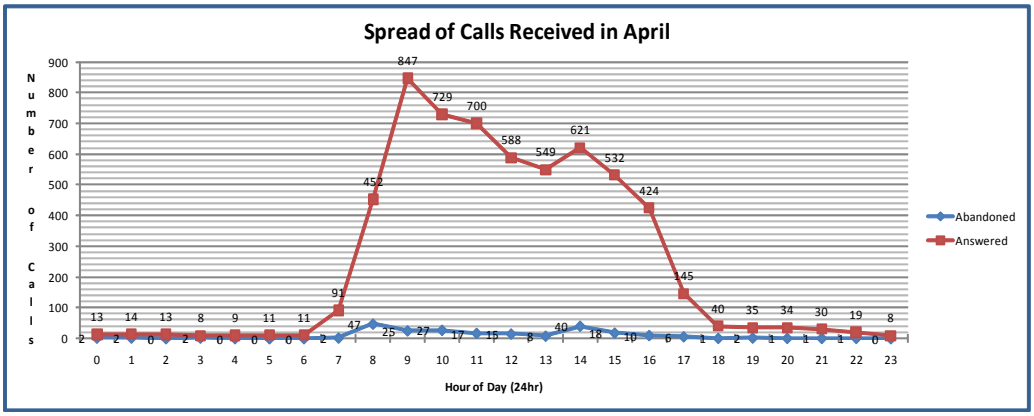
9.5 IM&T Service Desk top 5 issues



9.6 IM&T Service Desk Heatmap

Telephone	Metric	
	Total Calls Answered	5923
	Total Calls Abandoned	227
	Total Calls Received	6150
	Answered in 30secs (SLA 90%)	93.69%

NOTE	Incident Logging Route
	SD Request email - email to sdrequest@uhl-tr.nhs.uk
	SelfService Portal - LANDesk web portal for end user
	Service Desk - call to x8000
	SS/WebDesk - Resolving Analysts logged own incident



Incident Logging Route	SD Request email		Self Service Portal		Service Desk		SS/WebDesk		Total Logged
	Logged	%	Logged	%	Logged	%	Logged	%	
April 2013	1217	21.49%	506	8.94%	3300	58.28%	639	11.29%	5662
May 2013	1078	21.10%	479	9.38%	3095	60.59%	456	8.93%	5108
June 2013	1113	23.13%	733	15.24%	2580	53.63%	385	8.00%	4811
July 2013	1391	23.65%	643	10.93%	3097	52.66%	750	12.75%	5881
August 2013	1737	23.44%	385	5.19%	3788	51.11%	1501	20.25%	7411
September 2013	1609	21.86%	458	6.22%	3830	52.04%	1463	19.88%	7360
October 2013	1735	22.19%	702	8.98%	4195	53.66%	1186	15.17%	7818
November 2013	1961	25.36%	654	8.46%	4059	52.50%	1058	13.68%	7732
December 2013	2178	27.17%	685	8.55%	4350	54.27%	802	10.01%	8015
January 2014	2697	29.75%	776	8.56%	4676	51.58%	912	10.06%	9066
February 2014	2685	34.01%	598	7.58%	3944	49.96%	667	8.45%	7894
March 2014	2294	31.97%	525	7.32%	4225	58.89%	131	1.83%	7175
April 2014	2704	35.21%	615	8.01%	4292	55.89%	68	0.89%	7679

Incidents Resolved when Logged	AD Password Reset	Contact/ Technical Query	RA Services	Total	% of Total Logged
April 2013	1656	1410	0	3066	60%
May 2013	1353	855	0	2208	46%
June 2013	951	777	0	1728	29%
July 2013	1788	2082	0	3870	52%
August 2013	2397	4116	0	6513	88%
September 2013	2352	3618	0	5970	76%
October 2013	2253	3090	0	5343	69%
November 2013	1956	2718	0	4674	58%
December 2013	1629	1995	0	3624	40%
January 2014	660	654	279	1593	20%
February 2014	580	501	263	1344	19%
March 2014	518	215	229	962	13%
April 2014	572	322	287	1181	15%

10 FINANCE – PETER HOLLINSHEAD

10.1 Introduction

This paper provides an update on performance against the Trust's key financial duties namely:

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

The paper also provides further commentary on the key risks.

10.2 Financial Duties

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

Financial Duty	YTD Plan £'Ms	YTD Actual £'Ms	Forecast Plan £'Ms	Forecast Actual £'Ms	RAG
Delivering the Planned Surplus	(4.3)	(4.3)	(40.7)	(40.7)	G
Achieving the EFL	(1.5)	(0.5)	(8.9)	(8.9)	G
Achieving the Capital Resource Limit	0.4	1.0	34.5	34.5	G

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

Better Payment Practice Code	Apr-14	
	Number	Value £000s
Total bills paid in the year	13,293	50,129
Total bills paid within target	6,285	35,631
Percentage of bills paid within target	**47.3**	**71.1**

Key issues

- The Trust does not have an agreed contract and as such there is a significant risk to the reported income position as this does not account for CCG proposed local fines and penalties.
- Shortfall of £6.6m on the forecast CIP delivery against the £45m target.
- The Capital Plan is currently over-committed and is predicated on Emergency Floor external funding, the commitments may be in advance of the receipt of funding.

10.3 Finance RAG Assessment

As well as the statutory duties the Trust will be monitored by the TDA against a number of measures to show in year financial delivery. These measures and the RAG rating criteria are shown in the following tables;

Ratings	Overall RAG Rating Criteria
REDs	Override - assessed as red indicator 1a OR has 3 or more other indicators as red
AMBERs	Maximum of 2 indicators assessed as red from the remaining indicators OR 3 or more assessed as amber from the remaining indicators
GREENs	Maximum of 2 Amber, all other indicators are assessed as Green

Individual Indicators Risk Assessment Criteria

Indicator Number	Indicator Description	Individual risk assessment criteria			UHL April 2014
		Red	Amber	Green	
1a	Bottom line I&E position - Forecast compared to Plan	FOT deficit or more than a 20% reduction in FOT surplus	Adverse variance that is a change in surplus between 5% and 20%	Positive variance of reduction giving a less than 5% change in surplus	Red
1b	Bottom line I&E position - Year to date actual compared to Plan	More than a 20% reduction in surplus	Adverse variance that is a change in surplus between 10% and 20%	Positive variance of reduction giving a less than 10% change in surplus	Green
2a	Actual efficiency recurring/non-recurring compared to plan - Year to date actual compared to Plan	Under delivery of efficiencies either in total or the recurring element of more than 20%	Under delivery of efficiencies either in total or the recurring element of up to 20%	Over delivery of efficiencies or breakeven	Red
2b	Actual efficiency recurring/non-recurring compared to plan - Forecast compared to Plan	Under delivery of efficiencies either in total or the recurring element of more than 10%	Under delivery of efficiencies either in total or the recurring element of up to 10%	Over delivery of efficiencies or breakeven	Green
3	Forecast underlying surplus/deficit compared to plan	Variance moves Trust to deficit or is more than a 20% reduction in planned surplus	Variance is 10% to 20% reduction in surplus	Positive variance or adverse variance is less than a 10% reduction in surplus	Red
4	Forecast year end charge to capital resource limit	Forecast overspending capital programme or under spending by more than 20%	Forecast overspending capital programme or under spending by more than 10%-20%	Forecast breakeven or under spend of less than 10%	Green
5	Is this Trust forecasting permanent PDC for liquidity purposes?	Yes		No	Red
		Overall RAG rating			Red

This RAG rating criteria highlights the following;

- An overall RAG rating of Red.
- The rating is driven by;
    - o The yearend forecast deficit position of £40.7m (indicator 1a)
    - o Under delivery against the YTD CIP plan (indicator 2a)
    - o An underlying deficit (indicator 3)
    - o A forecast for PDC to support liquidity (indicator 5)

Friends & Families Test

What is the Friends & Family test?

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

Patients can choose from one of the following answers:

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

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

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

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

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

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

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

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FRIENDS AND FAMILY TEST : Previous 6 months up to April '14

								APRIL SCORE BREAKDOWN				
		Nov-13	Dec-13	Jan-14	Feb-14	Mar-14	Apr-14	Total Responses	Promoters	Passives	Detractors	Score
GLENFIELD HOSPITAL	GH WD 15	73	70	85	95	85	82	28	22	5	0	82
	GH WD 16 Respiratory Unit	87	100	83	81	90	80	40	32	8	0	80
	GH WD 17	58	72	74	69	90	79	29	23	6	0	79
	GH WD 20	56	79	62	56	75	85	34	30	3	1	85
	GH WD 23A	82	0	89	80	89	86	42	36	6	0	86
	GH WD 24	100	88	86	80	97	85	40	34	6	0	85
	GH WD 26	80	94	91	90	100	94	65	61	4	0	94
	GH WD 27	74	25	96	86	96	90	30	27	3	0	90
	GH WD 28	80	87	68	69	74	74	31	24	6	1	74
	GH WD 29 EXT 3656	90	88	82	85	96	93	14	13	1	0	93
	GH WD 31	95	87	100	100	89	81	16	13	3	0	81
	GH WD 32	79	84	96	84	88	83	36	30	6	0	83
	GH WD 33	79	76	83	77	95	85	90	76	13	0	85
	GH WD 33A	87	95	95	95	90	68	38	27	10	1	68
	GH WD Clinical Decisions Unit	65	28	66	58	39	58	108	68	31	7	58
	GH WD Coronary Care Unit	89	79	94	78	88	94	18	17	1	0	94
	GH WD 24	100	88	86	80	97	85	40	34	6	0	85

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FRIENDS AND FAMILY TEST : Previous 6 months up to April '14

								APRIL SCORE BREAKDOWN				
		Nov-13	Dec-13	Jan-14	Feb-14	Mar-14	Apr-14	Total Responses	Promoters	Passives	Detractors	Score
LEICESTER GENERAL HOSPITAL	LGH WD 1	84	0	0	90	80	0	0	0	0	0	0
	LGH WD 10	70	100	70	73	80	80	20	16	4	0	80
	LGH WD 14	46	74	88	71	81	80	61	50	10	1	80
	LGH WD 15A HDU Neph	75	0	71	100	-	63	8	6	1	1	63
	LGH WD 15N Nephrology	86	0	100	60	78	67	9	7	1	1	67
	LGH WD 16	70	74	83	76	79	73	44	34	8	2	73
	LGH WD 17 Transplant	79	82	78	90	89	71	28	20	8	0	71
	LGH WD 18	85	81	69	83	95	84	57	48	9	0	84
	LGH WD 19	88	0	0	80	71	0	0	0	0	0	0
	LGH WD 2	46	63	0	-	50	25	8	4	2	2	25
	LGH WD 20	0	0	0	-	-	0	0	0	0	0	0
	LGH WD 22	42	52	45	55	75	35	20	10	7	3	35
	LGH WD 23	44	50	90	64	68	71	66	47	19	0	71
	LGH WD 26 SAU	60	67	71	57	52	56	25	15	9	1	56
	LGH WD 27	60	33	50	74	53	73	26	19	7	0	73
	LGH WD 28 Urology	60	68	65	50	53	46	76	39	30	5	46
	LGH WD 29 EMU Urology	33	34	43	54	47	62	84	56	24	4	62
	LGH WD 3	80	40	50	-	50	67	3	2	1	0	67
	LGH WD 31	79	76	80	75	83	71	51	37	13	1	71
	LGH WD Brain Injury Unit	50	0	33	100	50	100	1	1	0	0	100
	LGH WD 1	84	0	0	90	80	0	0	0	0	0	0
	LGH WD 10	70	100	70	73	80	80	20	16	4	0	80
	LGH WD 19	88	0	0	80	71	0	0	0	0	0	0

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FRIENDS AND FAMILY TEST : Previous 6 months up to April '14

								APRIL SCORE BREAKDOWN				
		Nov-13	Dec-13	Jan-14	Feb-14	Mar-14	Apr-14	Total Responses	Promoters	Passives	Detractors	Score
LEICESTER ROYAL INFIRMARY	LRI WD 17 Bal L5	0	50	30	50	40	32	22	10	9	3	32
	LRI WD 18 Bal L5	0	65	0	57	70	59	17	12	3	2	59
	LRI WD 23 Win L3	90	90	47	100	100	86	28	25	2	1	86
	LRI WD 24 Win L3	18	28	62	36	37	58	25	15	8	1	58
	LRI WD 25 Win L3	85	80	90	95	95	74	23	18	4	1	74
	LRI WD 26 Win L3	86	71	95	100	67	94	17	16	1	0	94
	LRI WD 29 Win L4	67	75	71	79	70	55	23	15	4	3	55
	LRI WD 30 Win L4	100	0	0	56	95	89	9	8	1	0	89
	LRI WD 31 Win L5	40	65	90	75	65	64	25	18	5	2	64
	LRI WD 33 Win L5	77	81	79	66	67	57	55	37	9	7	57
	LRI WD 34 Windsor Level 5	70	68	81	71	100	53	34	18	13	1	53
	LRI WD 36 Win L6	63	95	84	60	88	81	31	25	6	0	81
	LRI WD 37 Win L6	100	0	72	100	49	58	24	15	8	1	58
	LRI WD 38 Win L6	92	86	96	93	78	60	20	12	8	0	60
	LRI WD 39 Osb L1	76	44	70	86	65	80	55	44	11	0	80
	LRI WD 40 Osb L1	61	72	63	68	77	77	48	39	7	2	77
	LRI WD 41 Osb L2	86	83	56	73	68	76	25	19	6	0	76
	LRI WD 7 Bal L3	61	59	48	53	87	80	80	65	14	1	80
	LRI WD 8 SAU Bal L3	40	44	39	56	23	40	82	46	21	14	40
	LRI WD Bone Marrow	86	100	0	77	100	86	14	12	2	0	86
	LRI WD Fielding John Vic L1	82	83	85	69	82	77	39	30	9	0	77
	LRI WD GAU Ken L1	71	0	70	48	78	70	96	71	21	4	70
	LRI WD IDU Infectious Diseases	25	73	71	53	50	79	29	24	4	1	79
	LRI WD Kinmonth Unit Bal L3	76	73	81	74	60	73	41	30	9	1	73
	LRI WD Osborne Assess Unit	76	85	56	69	80	76	33	25	8	0	76
	LRI WD 15 AMU Bal L5	67	73	58	-	67	54	152	89	56	7	54
	LRI WD 19 Bal L6	63	53	41	88	46	35	23	11	9	3	35

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FRIENDS AND FAMILY TEST : Previous 6 months up to April '14

								APRIL SCORE BREAKDOWN				
		Nov-13	Dec-13	Jan-14	Feb-14	Mar-14	Apr-14	Total Responses	Promoters	Passives	Detractors	Score
EMERGENCY DEPARTMENT	ED - Majors	59	64	58	52	56	65	156	107	43	6	65
	ED - Minors	62	69	64	57	60	68	398	279	110	8	68
	ED - (not stated)	69	69	69	61	66	55	53	33	16	4	55
	Eye Casualty	51	69	83	64	85	91	176	160	14	1	91
	Emergency Decisions Unit	61	65	58	65	58	54	121	71	40	7	54

APPENDIX 2 - MONTHLY CLINICAL MEASURES DASHBOARD: April '14

Division	Type	Ward	Budgeted Qualified %	Total vacancies %	Total vacancies (WTE)	Current appraisal Rate % (rolling 12 months)	Sickness Absence % (month in arrears)	Friends & Family score	No. of complaints	Safety Thermometer - No new harms %	Hand Hygiene %	Pressure Ulcers - Grade 2 (avoidable)	Pressure Ulcers - Grade 3 (avoidable)	Pressure Ulcers - Grade 4 (avoidable)	No. MRSA Bacteraemias (post 48 hrs)	MRSA Screening - Non elective %	MRSA Screening - Elective %	No. of C Diff cases (post 48 hrs)	No. of falls	No. of patient safety SUI's (severe)	No. Patient safety incidents (moderate)	No. Patient safety incidents (low)	No. of medication errors
		GREEN THRESHOLD	> = 60%	0 - 4.9%	< = 5	> = 95%	< = 3%	> = 75.0	< = 1	> = 95%	> = 90%	0	0	0	0	> = 100%	> = 100%	0	0	0	0	0	0
		AMBER THRESHOLD	-	5 - 10 %	-	-	3.1% - 3.9%	56 - 74	2	-	-	-	-	-	-	-	-	-	1 - 3	-	1	1 - 4	-
		RED THRESHOLD	< 60%	> 10%	> 5	< 95%	> = 4%	< = 55.0	> 2	< 95%	< 90%	> = 1	> = 1	> = 1	> = 1	< 100%	< 100%	> = 1	> = 4	> = 1	> 1	> = 5	> = 1
CHUGS	DC	F25E	-	-	-	-	-	↓ 75.6	↓ 0	-	0%	↔ 0	↔ 0	↔ 0	↔ 0	-	↑ >= 100%	↔ 0	↓ 0	↔ 0	↔ 0	↔ 0	↔ 0
	DC	FGI	-	-	-	-	-	-	↔ 0	-	0%	↔ 0	↔ 0	↔ 0	↔ 0	-	-	↔ 0	↔ 0	↔ 0	↔ 0	↔ 0	↔ 0
	DC	GDC1	-	-	-	-	-	-	↔ 0	-	↔ 100%	↔ 0	↔ 0	↔ 0	↔ 0	-	↔ >= 100%	↔ 0	↓ 0	↔ 0	↔ 0	↑ 3	↑ 1
	DC	GDC2	-	-	-	-	-	-	↔ 0	-	↓ 0%	↔ 0	↔ 0	↔ 0	↔ 0	-	↔ >= 100%	↔ 0	↔ 0	↔ 0	↔ 0	↔ 0	↔ 0
	DC	GEND	-	-	-	-	-	↓ 80.9	↔ 0	-	↓ 0%	↔ 0	↔ 0	↔ 0	↔ 0	-	↔ >= 100%	↔ 0	↔ 0	↔ 0	↔ 0	↔ 0	↔ 0
	DC	RCHM	-	-	-	-	-	↑ 82.8	↔ 0	-	0%	↔ 0	↔ 0	↔ 0	↔ 0	-	↓ 56%	↔ 0	↔ 0	↔ 0	↔ 0	↔ 0	↔ 0
	DC	RHAD	-	-	-	-	-	↓ 77.9	↔ 0	-	0%	↔ 0	↔ 0	↔ 0	↔ 0	-	↑ 77%	↔ 0	↔ 0	↔ 0	↔ 0	↔ 0	↔ 0
	DC	RHAM	-	-	-	-	-	↓ 0.0	↔ 0	-	0%	↔ 0	↔ 0	↔ 0	↔ 0	-	↔ >= 100%	↔ 0	↔ 0	↔ 0	↔ 0	↔ 0	↔ 0
	DC	RHTU	-	-	-	-	-	-	↔ 0	-	0%	↔ 0	↔ 0	↔ 0	↔ 0	-	↓ 41%	↔ 0	↔ 0	↔ 0	↔ 0	↔ 0	↔ 0
	IP	G19	↓ 72%	↓ -8.8%	↓ -0.95	↓ 79%	↑ 6.9%	↓ 0.0	↑ 1	↔ 100%	↑ 100%	↔ 0	↔ 0	↔ 0	↔ 0	-	↔ >= 100%	↔ 0	↓ 2	↔ 0	↓ 0	↓ 0	↔ 0
	IP	G20	62.1%	0.04	0.61	↑ 90%	↔ 0.0%	0.00	↑ 1	-	0%	↔ 0	↔ 0	↔ 0	↔ 0	-	↔ >= 100%	↔ 0	↑ 1	↔ 0	↔ 0	↑ 2	↔ 2
	IP	G22	↓ 61%	↓ 8.0%	↓ 2.03	↓ 79%	↓ 4.4%	↓ 35.0	↔ 0	↔ 100%	0%	↔ 0	↔ 0	↔ 0	↔ 0	-	-	↔ 0	↔ 2	↔ 0	↔ 0	↔ 2	↔ 0
	IP	G26	↔ 66%	↓ 4.5%	↓ 1.26	↓ 76%	↑ 7.5%	↑ 56.0	↔ 0	↔ 96%	0%	↔ 0	↔ 0	↔ 0	↔ 0	-	-	↓ 0	↑ 1	↔ 0	↔ 0	↓ 0	↔ 0
	IP	G27	↑ 61%	↑ 16.5%	↑ 4.20	↑ 93%	↓ 5.4%	↑ 73.1	↔ 0	↓ 95%	↓ 86%	↔ 0	↔ 0	↔ 0	↔ 0	-	-	↓ 1	↑ 5	↔ 0	↔ 0	↑ 6	↔ 0
	IP	G28	↔ 62%	↔ 12.0%	↔ 4.23	↓ 75%	↑ 10.7%	↓ 45.9	↑ 1	↔ 100%	0%	↔ 0	↔ 0	↔ 0	↔ 0	>= 100%	-	↔ 0	↔ 0	↔ 0	↔ 0	↓ 0	↔ 0
	IP	GSAC	↔ 68%	↔ 6.4%	↔ 1.06	↔ 100%	↓ 5.3%	↓ 0.0	↓ 0	-	↑ 90%	↔ 0	↓ 0	↔ 0	↔ 0	-	-	↔ 0	↔ 0	↔ 0	↓ 0	↔ 1	↑ 3
	IP	GUEA	↔ 58%	↑ 18.7%	↑ 7.15	↓ 86%	↓ 1.0%	↑ 61.9	↔ 0	-	↓ 0%	↔ 0	↔ 0	↔ 0	↔ 0	>= 100%	↔ >= 100%	↔ 0	↑ 2	↔ 0	↔ 0	↔ 1	↑ 1
	IP	R22	↔ 63%	↓ 7.1%	↓ 2.56	↑ 76%	↑ 6.4%	↑ 61.0	↑ 1	↓ 97%	↓ 0%	↓ 0	↓ 0	↔ 0	↔ 0	-	↔ >= 100%	↔ 0	↓ 0	↔ 0	↔ 0	↑ 6	↔ 2
	IP	R39	↓ 65%	↓ 5.9%	↓ 1.40	↓ 92%	↓ 0.5%	↑ 80.0	↑ 1	↓ 92%	90%	↓ 0	↔ 0	↔ 0	↔ 0	-	-	↔ 0	↑ 8	↔ 0	↔ 0	↑ 4	↔ 1
	IP	R40	↓ 69%	↑ 6.6%	↑ 1.60	↓ 86%	↓ 0.9%	↓ 77.1	↔ 0	↔ 100%	0%	↔ 0	↔ 0	↔ 0	↔ 0	-	-	↔ 0	↔ 0	↔ 0	↔ 0	↔ 0	↔ 0
	IP	RBMT	↔ 97%	↔ -0.7%	↔ -0.10	↓ 94%	↓ 2.7%	↓ 85.7	↑ 2	↔ 100%	100%	↔ 0	↔ 0	↔ 0	↔ 0	-	-	↔ 0	↓ 1	↔ 0	↓ 0	↑ 6	↑ 3
	IP	RODA	↔ 72%	↓ 14.4%	↓ 4.80	↓ 89%	↓ 3.4%	-	↔ 0	-	0%	↔ 0	↔ 0	↔ 0	↔ 0	-	-	↔ 0	↔ 0	↔ 0	↔ 0	↔ 0	↔ 0
	IP	ROND	↑ 76%	↓ 3.6%	↓ 0.48	↔ 100%	↓ 0.0%	↓ 75.8	↔ 0	-	90%	↔ 0	↔ 0	↔ 0	↔ 0	>= 100%	-	↔ 0	↔ 0	↔ 0	↔ 0	↔ 0	↔ 0
	IP	RSAU	↓ 56%	↓ 12.7%	↓ 5.72	↓ 63%	↑ 5.2%	↑ 39.5	↔ 0	↑ 100%	↓ 0%	↔ 0	↔ 0	↔ 0	↔ 0	>= 100%	-	↔ 0	↔ 0	↔ 0	↔ 0	↓ 0	↔ 0
Emergency & Specialist Medicine	DC	G1	-	-	-	-	-	↓ 0.0	↑ 1	-	100%	↔ 0	↔ 0	↔ 0	↔ 0	-	↓ 56%	↔ 0	↑ 2	↔ 0	↔ 0	↓ 1	↑ 1
	DC	REND	-	-	-	-	-	↓ 77.8	↔ 0	-	0%	↔ 0	↔ 0	↔ 0	↔ 0	-	↑ >= 100%	↔ 0	↔ 0	↔ 0	↔ 0	↔ 0	↔ 0
	DC	ROPS	-	-	-	-	-	↓ 0.0	↓ 0	-	↓ 0%	↔ 0	↔ 0	↔ 0	↔ 0	-	↔ >= 100%	↔ 0	↔ 1	↔ 0	↓ 0	↓ 3	↔ 0
	IP	R15	↑ 60%	↑ 2.4%	↑ 2.82	↓ 93%	↑ 4.9%	↓ 53.9	↔ 0	↔ 100%	90%	↔ 0	↔ 0	↔ 0	↔ 0	>= 100%	-	↔ 0	↔ 0	↔ 0	↔ 0	↔ 0	↔ 0
	IP	R16	↑ 60%	↑ 2.4%	↑ 2.82	↓ 93%	↑ 4.9%	-	↓ 1	↑ 100%	90%	↔ 0	↔ 0	↔ 0	↔ 0	>= 100%	-	↓ 0	↔ 0	↔ 0	↔ 0	↑ 5	↑ 2
	IP	R24	↔ 60%	↓ 24.0%	↓ 9.25	↑ 75%	↑ 3.8%	↑ 58.3	↔ 0	↑ 89%	0%	↑ 1	↔ 0	↔ 0	↔ 0	-	-	↔ 0	↑ 1	↑ 1	↔ 0	↑ 2	↓ 1
	IP	R25	↑ 70%	↑ 5.6%	↑ 3.25	↑ 100%	↓ 8.8%	↓ 73.9	↔ 3	↓ 94%	↓ 63%	↔ 0	↔ 0	↔ 0	↔ 0	>= 100%	-	↔ 0	↓ 3	↔ 0	↓ 1	↑ 10	↑ 2
	IP	R29	↔ 60%	↓ 17.9%	↓ 6.60	↓ 97%	↓ 5.0%	↓ 54.5	↔ 0	↓ 93%	0%	↔ 0	↑ 1	↔ 0	↔ 0	-	-	↔ 0	↑ 8	↔ 0	↔ 0	↓ 5	↔ 0
	IP	R30	↔ 60%	↔ 16.0%	↔ 6.32	↑ 97%	↑ 7.3%	↓ 88.9	↑ 3	↔ 100%	85%	↔ 1	↔ 0	↔ 0	↔ 0	-	-	↔ 0	↑ 6	↔ 0	↓ 0	↔ 1	↔ 2
	IP	R30H	↔ 60%	↔ 16.0%	↔ 6.32	↑ 97%	↑ 7.3%	-	↔ 0	-	0%	↔ 0	↔ 0	↔ 0	↔ 0	-	-	↔ 0	↑ 5	↔ 0	↑ 1	↑ 6	↔ 0
	IP	R33	↑ 57%	↑ 31.0%	↑ 14.91	↓ 88%	↓ 8.3%	↓ 56.6	↑ 2	↔ 100%	↑ 91%	↔ 0	↓ 0	↔ 0	↔ 0	>= 100%	-	↔ 0	↔ 1	↔ 0	↔ 0	↓ 3	↑ 2
	IP	R37	↓ 60%	↑ 17.1%	↑ 6.54	↓ 97%	↑ 9.0%	↑ 58.3	↑ 2	↔ 96%	0%	↓ 0	↔ 0	↔ 0	↔ 0	-	-	↔ 0	↔ 0	↓ 0	↓ 0	↔ 2	↓ 2
	IP	R38	↔ 60%	↑ 15.3%	↑ 5.57	↔ 94%	↑ 9.2%	↓ 60.0	↑ 1	↓ 96%	↑ 85%	↓ 0	↓ 0	↔ 0	↔ 0	-	-	↔ 0	↓ 3	↔ 0	↔ 0	↑ 9	↑ 1
	IP	RACB	↑ 57%	↑ 31.0%	↑ 14.91	↓ 88%	↓ 8.3%	-	↑ 2	-	0%	↔ 0	↔ 0	↔ 0	↔ 0	>= 100%	-	↔ 0	↑ 10	↔ 0	↓ 1	↑ 5	↔ 0
	IP	RAMB	↔ 100%	↔ 0.0%	↔ 0.00	↔ 100%	↔ 66.7%	-	↔ 0	-	0%	↔ 0	↔ 0	↔ 0	↔ 0	>= 100%	-	↔ 0	↓ 3	↔ 0	↔ 1	↓ 3	↑ 3
	IP	REDU	↔ 67%	↑ 29.1%	↑ 8.19	↓ 96%	↓ 2.2%	-	↓ 1	↑ 100%	↔ 100%	↔ 0	↔ 0	↔ 0	↔ 0	>= 100%	-	↔ 0	↑ 4	↔ 0	↔ 0	↑ 9	↔ 0
	IP	REFU	-	-	-	-	-	-	↑ 2	-	0%	↔ 0	↔ 0	↔ 0	↔ 0	-	-	↔ 0	↔ 6	↔ 0	↑ 1	↓ 2	↔ 0
	IP	RIDU	↓ 60%	↑ 5.0%	↑ 1.18	↑ 100%	↓ 2.0%	↑ 79.3	↔ 0	↑ 100%	↔ 100%	↔ 0	↔ 0	↔ 0	↔ 0	-	-	↔ 0	↔ 0	↔ 0	↔ 0	↔ 0	↔ 0
	IP	G2	↔ 60%	↑ 36.1%	↑ 11.44	↑ 67%	↑ 7.3%	↓ 25.0	↔ 0	↔ 100%	0%	↔ 0	↔ 0	↔ 0	↔ 0	-	-	↔ 0	↔ 2	↔ 0	↓ 0	↔ 1	↔ 0
	IP	GBIU	↑ 70%	↑ 22.8%	↑ 6.25	↓ 87%	↓ 12.0%	↑ 100.0	↓ 1	↔ 86%	0%	↔ 0	↔ 0	↔ 0	↔ 0	-	-	↔ 0	↔ 1	↔ 0	↔ 0	↓ 1	↔ 1
	IP	GYDU	↑ 60%	↑ 45.7%	↑ 15.23	↓ 80%	↑ 6.6%	-	↔ 0	↑ 100%	0%	↔ 0	↔ 0	↔ 0	↔ 0	-	-	↔ 0	↔ 0	↔ 0	↔ 0	↔ 0	↔ 0
	IP	R19	↔ 60%	↑ 16.4%	↑ 6.94	↓ 69%	↑ 3.9%	↓ 34.8	↑ 1	↑ 100%	↓ 0%	↔ 0	↓ 0	↔ 0	↔ 0	-	-	↔ 0	↔ 0	↔ 0	↔ 0	↔ 0	↔ 2
	IP	R23	↔ 60%	↑ 25.6%	↑ 10.11	↑ 97%	↓ 1.0%	↓ 85.7	↔ 0	↓ 93%	↓ 0%	↔ 0	↔ 0	↔ 0	↔ 0	-	-	↔ 0	↔ 0	↔ 0	↔ 0	↔ 0	↔ 0
	IP	R26	↑ 70%	↑ 5.6%	↑ 3.25	↑ 100%	↓ 8.8%	↑ 94.1	↓ 0	↓ 88%	70%	↔ 0	↔ 0	↔ 0	↔ 0	-	-	↑ 2	↓ 0	↔ 0	↔ 0	↑ 7	↓ 1
	IP	R31	↔ 60%	↔ 10.3%	↔ 4.34	↑ 100%	↑ 2.8%	↓ 64.0	↓ 0	↑ 97%	↔ 100%	↔ 0	↔ 0	↔ 0	↔ 0	-	-	↔ 0	↓ 4	↔ 0	↓ 0	↑ 5	↔ 0
	IP	R34	↓ 60%	↓ -41.3%	↓ -13.59	↑ 92%	↓ 3.3%	↓ 53.1	↔ 0	↓ 95%	↓ 72%	↑ 2	↓ 0	↔ 0	↔ 0	-	-	↔ 0	↔ 0	↔ 0	↔ 0	↑ 2	↔ 0
	IP	R36	↔ 60%	↑ 16.2%	↑ 6.40	↑ 97%	↑ 7.0%	↓ 80.6	↔ 0	↓ 96%	↓ 92%	↑ 1	↔ 0	↔ 0	↔ 0	-	-	↔ 0	↔ 0	↔ 0	↔ 0	↔ 0	↔ 0
	IP	RFJW	↔ 60%	↑ 28.1%	↑ 10.80	↔ 100%	↑ 2.1%	↓ 76.9	↑ 1	↑ 95%	↔ 100%	↔ 0	↔ 0	↔ 0	↔ 0	-	-	↔ 0	↔ 3	↔ 0	↔ 0	↑ 3	↔ 0
	IP	G3	↑ 60%	↑ 14.6%	↑ 4.04	↓ 92%	↓ 11.1%	↑ 66.7	↑ 1	↓ 93%	↓ 0%	↔ 0	↔ 0	↔ 0	↔ 0	-	-	↔ 0	↓ 2	↔ 0	↔ 0	↓ 0	↔ 2
Musculoskeletal & Specialist Surgery	DC	F23A	↑ 65%	↑ 33.8%	↑ 12.51	↓ 85%	↓ 3.3%	↓ 85.7	↓ 0	-	100%	↔ 0	↔ 0	↔ 0	↔ 0	-	↔ >= 100%	↔ 0	↔ 0	↔ 0	↔ 0	↑ 2	↔ 0
	DC	F24	↑ 67%	↓ -11.9%	↓ -1.72	↑ 100%	↑ 5.7%	↓ 85.0	↔ 0	↓ 96%	↔ 100%	↔ 0	↑ 1	↔ 0	↔ 0	-	-	↔ 0	↔ 3	↔ 0	↑ 1	↓ 2	↔ 0
	DC	RDAY	-	-	-	-	-	↑ 74.6	↔ 0	-	92%	↔ 0	↔ 0	↔ 0	↔ 0	-	↔ >= 100%	↔ 0	↔ 0	↔ 0	↔ 0	↔ 0	↔ 0
	DC	RTAA	-	-	-	-	-	-	↔ 0	-	↑ 76%	↔ 0	↔ 0	↔ 0	↔ 0	-	↔ >= 100%	↔ 0	↔ 0	↔ 0	↔ 0	↔ 0	↔ 0
	DC	GSM	↔ 100%	↔ 0.0%	↔ 0.00	↔ 100%	↔ 0.0%	-	↔ 0	-	0%	↔ 0	↔ 0	↔ 0	↔ 0	-	-	↔ 0	↔ 0	↔ 0	↔ 0	↑ 4	↑ 1
	DC	ROMO	↓ 54%	↓ -8.7%	↓ -2.48	↓ 94%	↓ 0.8%	-	↑ 2	-	↔ 100%	↔ 0	↔ 0	↔ 0	↔ 0	-	-	↔ 0	↔ 0	↔ 0	↔ 0	↑ 2	↔ 1
	IP	R07	↑ 58%	↑ 10.8%	↑ 3.66	↑ 100%	↓ 5.8%	↓ 80.0	↔ 0	-	0%	↔ 0	↔ 0	↔ 0	↔ 0	>= 100%	↔ >= 100%	↔ 0	↔ 0	↔ 0	↔ 0	↔ 0	↔ 0
	IP	R17	↓ 56%	↓ 0.3%	↓ 0.13	↑ 98%	↓ 1.1%	↓ 31.8	↔ 0	↓ 89%	↓ 70%	↔ 0	↑ 1	↔ 0	↔ 0	>= 100%	-	↔ 0	↑ 1	↔ 0	↔ 0	↑ 5	↑ 7
	IP	R18	↓ 54%	↓ 3.6%	↓ 1.46	↔ 100%	↑ 1.5%	↓ 58.8	↔ 1	↔ 100%	↓ 80%	↔ 0	↓ 0	↔ 0	↔ 0	>= 100%	>= 100%	↔ 0	↑ 2	↔ 0	↑ 1	↑ 3	↑ 1
	IP	R21	↔ 61%	↓ 6.0%	↓ 2.02	↔ 100%	↓ 2.4%	↓ 72.4	↔ 0	↓ 96%	↑ 71%	↔ 0	↔ 0	↔ 0	↔ 0	-	↔ >= 100%	↔ 0	↔ 0	↔ 0	↑ 1	↓ 1	↔ 1
	IP	RKIN	↓ 62%	↓ -7.1%	↓ -1.71	↑ 100%	↓ 1.4%	↑ 72.5	↔ 0	↑ 100%	↓ 0%	↔ 0	↔ 0	↔ 0	↔ 0	↑ >= 100%	↑ >= 100%	↔ 0	↔ 0	↔ 0	↔ 0	↔ 0	↔ 0
	IP	G14	↑ 70%	↓ -8.4%	↓ -1.86	↓ 92%	↓ 0.4%	↓ 80.3	↔ 0	↔ 100%	↓ 0%	↓ 0	↔ 0	↔ 0	↔ 0	-	↔ >= 100%	↔ 0	↔ 0	↔ 0	↔ 0	↔ 0	↔ 0
	IP	G16	↓ 64%	↓ -7.3%	↓ -1.50	↔ 100%	↓ 9.1%	↓ 72.7	↔ 0	↔ 100%	↓ 90%	↔ 0	↔ 0	↔ 0	↔ 0	-	↔ >= 100%	↔ 0	↔ 0	↔ 0	↔ 0	↔ 0	↔ 0
	IP	R32	↑ 57%	↑ 4.1%	↑ 1.65	↓ 98%	↓ 1.5%	↓ 25.0	↔ 0	↔ 100%	↓ 70%	↔ 0	↔ 0	↔ 0	↔ 0	>= 100%	>= 100%	↔ 0	↔ 5	↔ 0	↑ 1	↑ 6	↔ 3
	IP	G18	↑ 61%	↓ -2.6%	↓ -0.61	↔ 100%	↑ 4.8%	↓ 84.2	↔ 0	↔ 100%	↔ 100%	↔ 0	↔ 0	↔ 0	↔ 0	-	↔ >= 100%	↔ 0	↓ 0	↔ 0	↑ 1	↑ 2	↓ 0
	IP	F29	↑ 62%	↑ 8.7%	↑ 2.65	↑ 77%	↓ 2.3%	↓ 92.9	↔ 0	↑ 96%	88%	↓ 0	↔ 0	↔ 0	↔ 0	-	-	↔ 0	↑ 3	↔ 0	↔ 0	↓ 2	↔ 0

NURSING METRICS

RED: < 80 AMBER: 80 - 90 GREEN: >90

Division	Type	Ward	1 Fluid Balance chart	2 Nutrition & Hydration-Protected Meal Time	2 Nutrition & Hydration-Patient assessment	2 Nutrition & Hydration-Staff Knowledge	3 Urinary Catheter	4 Falls-Patient assessment	4 Falls-Stage Two assessment	5 Hygiene-Patient assessment	5 Hygiene-Ward observations	6 Patient observations & EWS	7 Pressure Ulcer care-Patient assessment	7 Pressure Ulcer care-Staff knowledge	8 Privacy & Dignity-Observation of Practice	8 Privacy & Dignity-Staff Knowledge	9 Discharge	10 Infection Prevention-Patient review	10 Infection Prevention-Ward review	11 Resuscitation Equipment	12 Medicines Management-Patient assessment	12 Medicines Management-Ward assessment	13 Safeguarding Children & Young people	14Communication/Partnership
CHUGS	DC	F25E	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
	DC	FGI	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
	DC	GDC1	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
	DC	GDC2	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
	DC	GEND	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
	DC	RCHM	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
	DC	RHAD	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
	DC	RHAM	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
	DC	RHTU	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
	IP	G19	N/A	N/A	N/A	100%	N/A	100%	N/A	100%	100%	100%	93%	100%	100%	100%	100%	100%	100%	67%	100%	100%	-	-
	IP	G20	100%	100%	100%	100%	N/A	100%	100%	76%	100%	100%	100%	100%	100%	100%	50%	70%	100%	100%	100%	100%	-	-
	IP	G22	87%	100%	67%	100%	87%	100%	100%	100%	100%	94%	95%	100%	100%	100%	55%	100%	100%	100%	97%	67%	-	-
	IP	G26	100%	100%	83%	100%	100%	100%	N/A	100%	100%	97%	97%	100%	100%	100%	50%	100%	100%	100%	97%	67%	-	-
	IP	G27	89%	50%	71%	100%	65%	98%	N/A	84%	50%	77%	79%	100%	100%	100%	75%	100%	80%	100%	100%	100%	-	-
	IP	G28	100%	50%	86%	100%	100%	90%	80%	80%	100%	63%	87%	73%	100%	100%	67%	100%	40%	100%	100%	100%	-	-
	IP	GSAC	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
	IP	GUEA	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
	IP	R22	100%	100%	57%	100%	70%	75%	N/A	62%	100%	79%	78%	100%	100%	90%	50%	70%	100%	67%	100%	33%	-	-
	IP	R39	70%	100%	67%	93%	67%	98%	83%	100%	100%	91%	85%	93%	100%	86%	65%	100%	100%	67%	100%	100%	-	-
	IP	R40	83%	100%	68%	87%	40%	100%	N/A	100%	100%	78%	84%	80%	100%	81%	55%	100%	80%	67%	100%	100%	-	-
	IP	RBMT	100%	N/A	75%	93%	N/A	100%	N/A	87%	100%	97%	100%	73%	100%	86%	100%	100%	100%	67%	100%	100%	-	-
	IP	RODA	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
	IP	ROND	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
	IP	RSAU	81%	100%	95%	100%	80%	96%	N/A	88%	100%	84%	97%	100%	100%	86%	50%	100%	80%	67%	100%	100%	-	-
Emergency & Specialist Medicine	DC	G1	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
	DC	REND	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
	DC	ROPS	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
	IP	R15	93%	100%	83%	100%	90%	98%	75%	N/A	100%	83%	100%	87%	100%	95%	100%	100%	100%	67%	100%	100%	-	-
	IP	R16	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
	IP	R24	87%	50%	78%	80%	83%	96%	73%	100%	100%	73%	81%	87%	100%	100%	50%	100%	80%	33%	40%	100%	-	-
	IP	R25	88%	DNC	74%	100%	87%	100%	87%	100%	100%	91%	90%	100%	88%	100%	90%	100%	100%	100%	94%	67%	-	-
	IP	R29	70%	50%	60%	100%	50%	96%	75%	55%	75%	93%	99%	100%	88%	100%	50%	70%	60%	67%	100%	100%	-	-
	IP	R30	70%	50%	66%	100%	97%	100%	78%	88%	100%	77%	89%	100%	100%	95%	40%	50%	80%	33%	100%	100%	-	-
	IP	R30H	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
	IP	R33	83%	100%	100%	100%	100%	100%	100%	100%	100%	83%	100%	87%	100%	100%	100%	100%	80%	100%	100%	67%	-	-
	IP	R37	85%	0%	40%	67%	60%	78%	90%	52%	75%	53%	70%	93%	88%	67%	55%	100%	20%	33%	78%	67%	-	-
	IP	R38	40%	50%	10%	53%	47%	78%	72%	68%	75%	60%	66%	73%	50%	62%	60%	90%	20%	33%	94%	67%	-	-
	IP	RACB	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
	IP	RAMB	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
	IP	REDU	N/A	100%	97%	100%	N/A	98%	83%	100%	100%	94%	100%	80%	100%	100%	100%	100%	100%	100%	100%	100%	-	-
	IP	REFU	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
	IP	RIDU	93%	100%	80%	100%	100%	100%	83%	100%	100%	83%	90%	100%	100%	100%	90%	100%	100%	67%	94%	100%	-	-
	IP	G2	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
	IP	GBIU	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
	IP	GYDU	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
	IP	R19	90%	100%	73%	100%	100%	100%	50%	68%	100%	80%	77%	80%	100%	90%	50%	55%	100%	33%	100%	67%	-	-
	IP	R23	67%	50%	68%	73%	77%	85%	63%	N/A	100%	100%	80%	80%	100%	48%	25%	100%	100%	100%	80%	67%	-	-
	IP	R26	97%	DNC	90%	100%	98%	100%	96%	96%	100%	97%	99%	100%	88%	100%	70%	100%	100%	100%	97%	67%	-	-
	IP	R31	67%	100%	43%	67%	77%	100%	77%	N/A	75%	93%	96%	100%	88%	100%	25%	DNC	100%	33%	90%	33%	-	-
	IP	R34	83%	100%	91%	100%	100%	87%	92%	80%	100%	77%	100%	87%	75%	86%	100%	100%	100%	100%	100%	100%	-	-
	IP	R36	80%	50%	55%	87%	70%	80%	58%	100%	100%	63%	81%	100%	88%	95%	67%	80%	100%	0%	DNC	100%	-	-
	IP	RFJW	84%	100%	80%	100%	90%	98%	84%	100%	100%	61%	90%	100%	75%	81%	50%	100%	100%	100%	100%	100%	-	-
	IP	G3	96%	100%	93%	100%	97%	100%	92%	92%	100%	97%	90%	100%	100%	100%	40%	90%	80%	100%	100%	67%	-	-
Musculoskeletal & Specialist Surgery	DC	F23A	N/A	100%	100%	100%	N/A	92%	N/A	100%	100%	94%	93%	100%	100%	100%	100%	100%	100%	100%	100%	100%	-	-
	DC	F24	87%	100%	92%	80%	73%	100%	42%	100%	100%	77%	100%	73%	88%	38%	65%	70%	80%	100%	97%	67%	-	-
	DC	RDAY	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
	DC	RTAA	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
	DC	GSM	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
	DC	ROMO	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
	IP	R07	10%	DNC	100%	100%	N/A	86%	17%	92%	100%	84%	80%	100%	75%	100%	70%	DNC	DNC	DNC	DNC	DNC	-	-
	IP	R17	76%	100%	100%	100%	93%	96%	100%	96%	100%	100%	96%	100%	75%	81%	80%	100%	100%	100%	100%	100%	-	-
	IP	R18	60%	100%	70%	100%	60%	89%	75%	100%	100%	66%	89%	100%	75%	86%	25%	100%	100%	100%	93%	100%	-	-
	IP	R21	N/A	100%	90%	100%	90%	91%	58%	100%	100%	86%	90%	100%	88%	100%	100%	100%	100%	100%	100%	100%	-	-
	IP	RKIN	83%	50%	42%	100%	45%	87%	N/A	46%	100%	91%	66%	100%	100%	86%	55%	60%	60%	33%	80%	100%	-	-
	IP	G14	N/A	N/A	100%	100%	N/A	98%	N/A	100%	100%	100%	98%	100%	100%	100%	100%	100%	100%	67%	100%	100%	-	-
	IP	G16	78%	100%	90%	87%	N/A	95%	N/A	100%	100%	100%	96%	100%	100%	100%	100%	100%	100%	100%	100%	100%	-	-
	IP	R32	88%	100%	100%	100%	87%	98%	83%	100%	100%	97%	100%	100%	100%	71%	55%	100%	100%	100%	100%	100%	-	-
	IP	G18	100%	100%	100%	100%	70%	100%	N/A	100%	100%	100%	94%	100%	100%	100%	100%	100%	100%	67%	100%	100%	-	-
	IP	F29	83%	100%	71%	100%	100%	91%	83%	96%	100%	93%	99%	100%	63%	100%	95%	100%	100%	67%	100%	100%	-	-

APPENDIX 2 - MONTHLY CLINICAL MEASURES DASHBOARD: April '14

Division	Type	Ward	Budgeted Qualified %	Total vacancies %	Total vacancies (WTE)	Current appraisal Rate % (rolling 12 months)	Sickness Absence % (month in arrears)	Friends & Family score	No. of complaints	Safety Thermometer - No new harms %	Hand Hygiene %	Pressure Ulcers - Grade 2 (avoidable)	Pressure Ulcers - Grade 3 (avoidable)	Pressure Ulcers - Grade 4 (avoidable)	No. MRSA Bacteraemias (post 48 hrs)	MRSA Screening - Non elective %	MRSA Screening - Elective %	No. of C Diff cases (post 48 hrs)	No. of falls	No. of patient safety SUI's (severe)	No. Patient safety incidents (moderate)	No. Patient safety incidents (low)	No. of medication errors
		GREEN THRESHOLD	> = 60%	0 - 4.9%	< = 5	> = 95%	< = 3%	> = 75.0	< = 1	> = 95%	> = 90%	0	0	0	0	> = 100%	> = 100%	0	0	0	0	0	0
		AMBER THRESHOLD	-	5 - 10 %	-	-	3.1% - 3.9%	56 - 74	2	-	-	-	-	-	-	-	-	-	1 - 3	-	1	1 - 4	-
		RED THRESHOLD	< 60%	> 10%	> 5	< 95%	> = 4%	< = 55.0	> 2	< 95%	< 90%	> = 1	> = 1	> = 1	> = 1	< 100%	< 100%	> = 1	> = 4	> = 1	> 1	> = 5	> = 1
Renal, Respiratory and Cardiac	DC	G10D	-	-	-	-	-	-	↔ 0	-	0%	↔ 0	↔ 0	↔ 0	↔ 0	-	↔ >= 100%	↔ 0	↑ 1	↔ 0	↑ 1	↓ 1	↔ 0
	DC	F32	↓ 63%	↓ 12.5%	↓ 2.35	↑ 95%	↑ 11.1%	↓ 83.3	↔ 0	↑ 100%	↔ 100%	↔ 0	↔ 0	↔ 0	↔ 0	-	↔ >= 100%	↔ 0	↔ 0	↔ 0	↔ 0	↔ 0	↔ 0
	DC	F20	-	-	-	-	-	↑ 85.3	↔ 0	↑ 100%	0%	↔ 0	↔ 0	↔ 0	↔ 0	-	-	↔ 0	↑ 2	↔ 0	↔ 0	↑ 1	↔ 0
	DC	FCID	-	-	-	↓ 89%	↑ 5.1%	-	↔ 0	-	0%	↔ 0	↔ 0	↔ 0	↔ 0	-	-	↔ 0	↔ 0	↓ 0	↔ 0	↑ 6	↑ 1
	IP	F27	↔ 62%	↓ 0.6%	↓ 0.20	↑ 93%	↓ 2.4%	↓ 90.0	↔ 0	↓ 96%	↓ 80%	↔ 0	↔ 0	↔ 0	↔ 0	-	-	↔ 0	↔ 0	↔ 0	↔ 0	↔ 0	↔ 0
	IP	F31	↑ 77%	↑ 5.2%	↑ 2.34	↓ 88%	↑ 2.9%	↓ 81.3	↔ 0	↔ 100%	↑ 100%	↔ 0	↔ 0	↔ 0	↔ 0	↑ >= 100%	↓ 98%	↔ 0	↔ 0	↔ 0	↔ 0	↑ 5	↑ 7
	IP	FCCU	↓ 76%	↓ 10.8%	↓ 5.75	↓ 95%	↓ 2.8%	↑ 94.4	↔ 0	↔ 100%	↑ 100%	↔ 0	↔ 0	↔ 0	↔ 0	>= 100%	-	↔ 0	↔ 0	↔ 0	↔ 0	↔ 0	↔ 0
	IP	FCDU	↔ 63%	↑ 10.7%	↑ 10.22	↑ 91%	↑ 5.3%	↑ 57.5	↔ 0	↓ 92%	↑ 100%	↔ 0	↔ 0	↔ 0	↔ 0	>= 100%	-	↔ 0	↓ 1	↔ 0	↔ 0	↓ 1	↔ 1
	IP	G15A	↓ 84%	↓ 5.0%	↓ 1.44	↑ 93%	↑ 1.9%	62.50	↔ 0	↑ 100%	↔ 72%	↔ 0	↔ 0	↔ 0	↔ 0	>= 100%	-	↔ 0	↓ 0	↔ 0	↔ 0	↓ 0	↓ 0
	IP	G17	↑ 71%	↑ 4.8%	↑ 0.96	↑ 100%	↑ 3.2%	↓ 71.4	↔ 0	↔ 100%	↔ 100%	↔ 0	↔ 0	↔ 0	↔ 0	>= 100%	↔ >= 100%	↔ 0	↔ 4	↔ 0	↔ 0	↓ 0	↓ 0
	IP	GDCM	↓ 94%	↑ -0.2%	↑ -0.14	↑ 98%	↑ 5.0%	↑ 100.0	↔ 0	-	89%	↔ 0	↔ 0	↔ 0	↔ 0	-	-	↔ 0	↓ 0	↔ 0	↔ 0	↔ 3	↑ 1
	IP	RITU	↑ 91%	↑ 4.8%	↑ 5.45	↓ 92%	↓ 3.2%	↓ 70.0	↔ 0	↓ 92%	↓ 85%	↔ 0	↔ 0	↔ 0	↔ 0	>= 100%	-	↔ 0	↔ 0	↔ 0	↔ 0	↓ 0	↔ 0
	IP	RPAC	↔ 83%	↓ 19.3%	↓ 7.94	↔ 100%	↑ 5.4%	-	↔ 0	-	0%	↔ 0	↔ 0	↔ 0	↔ 0	-	-	↔ 0	↔ 0	↔ 0	↔ 0	↑ 1	↑ 1
	IP	FCIC	-	-	-	-	-	-	↔ 0	-	0%	↔ 0	↔ 0	↔ 0	↔ 0	>= 100%	-	↔ 0	↔ 0	↔ 0	↔ 0	↔ 0	↔ 0
	IP	FITU	↑ 93%	↑ 9.9%	↑ 13.02	↑ 97%	↓ 6.8%	↓ 81.0	↔ 0	-	↑ 90%	↔ 0	↔ 0	↔ 0	↔ 0	>= 100%	-	↔ 0	↔ 0	↔ 0	↔ 0	↔ 0	↔ 0
	IP	G10	↓ 61%	↑ 11.7%	↑ 4.61	↑ 97%	↑ 3.5%	↔ 80.0	↔ 0	↔ 100%	↔ 100%	↔ 0	↔ 0	↔ 0	↔ 0	>= 100%	-	↔ 0	↔ 0	↔ 0	↔ 1	↔ 3	↔ 0
	IP	G15N	↑ 65%	↑ 22.1%	↑ 7.47	↓ 87%	↑ 3.2%	↓ 66.7	↔ 0	↔ 100%	↑ 70%	↔ 0	↑ 1	↔ 0	↔ 0	>= 100%	-	↔ 0	↔ 3	↔ 0	↔ 0	↑ 3	↔ 0
	IP	F16	↔ 63%	↑ 23.9%	↑ 8.70	↑ 60%	↑ 9.9%	↓ 80.0	↔ 1	↑ 93%	↔ 90%	↓ 0	↔ 0	↔ 0	↔ 0	-	-	↔ 0	↔ 0	↔ 0	↔ 0	↑ 4	↓ 0
	IP	F33	↔ 70%	↓ 3.8%	↓ 1.28	↓ 93%	↑ 5.1%	↓ 85.4	↔ 0	↔ 100%	↑ 90%	↔ 0	↔ 0	↔ 0	↔ 0	-	-	↑ 1	↓ 0	↔ 0	↔ 0	↓ 0	↔ 0
	IP	F15	↑ 61%	↑ 11.0%	↑ 4.38	↓ 92%	↓ 4.2%	↓ 81.5	↓ 0	↑ 96%	↑ 100%	↔ 0	↔ 0	↔ 0	↔ 0	-	-	↔ 0	↓ 3	↔ 0	↔ 0	↓ 1	↑ 2
	IP	F17	↓ 74%	↑ 4.8%	↑ 1.97	↑ 83%	↑ 3.1%	↓ 79.3	↔ 0	↑ 97%	↔ 90%	↔ 0	↔ 0	↔ 0	↔ 0	-	-	↔ 0	↓ 1	↔ 0	↔ 0	↑ 4	↑ 2
	IP	F17H	↓ 74%	↑ 4.8%	↑ 1.97	↑ 83%	↑ 3.1%	-	↔ 0	-	0%	↔ 0	↔ 0	↔ 0	↔ 0	-	-	↔ 0	↔ 0	↔ 0	↔ 0	↔ 0	↔ 0
	IP	F26	↑ 77%	↑ 9.5%	↑ 2.92	↓ 91%	↑ 6.3%	↓ 93.8	↔ 0	↔ 100%	↓ 86%	↑ 1	↔ 0	↔ 0	↔ 0	>= 100%	↓ 93%	↔ 0	↔ 0	↔ 0	↔ 0	↔ 0	↔ 0
	IP	F28	↔ 60%	↑ 5.9%	↑ 2.02	↓ 94%	↑ 3.9%	↑ 74.2	↑ 1	↔ 100%	↔ 100%	↔ 0	↔ 0	↔ 0	↔ 0	>= 100%	-	↔ 0	↑ 6	↔ 0	↔ 0	↓ 2	↔ 0
	IP	F31H	↑ 77%	↑ 5.2%	↑ 2.34	↓ 88%	↑ 2.9%	-	↓ 0	-	0%	↔ 0	↔ 0	↔ 0	↔ 0	-	-	↔ 0	↑ 5	↔ 0	↑ 1	↓ 0	↔ 0
	IP	F33A	↔ 64%	↓ 0.2%	↓ 0.05	↑ 100%	↓ 0.8%	↓ 68.4	↑ 1	↑ 100%	↔ 100%	↔ 0	↔ 0	↔ 0	↔ 0	-	-	↔ 0	↓ 0	↓ 0	↔ 0	↓ 1	↓ 0
	IP	FCHD	↔ 70%	↓ 3.8%	↓ 1.28	↓ 93%	↑ 5.1%	-	↑ 1	-	0%	↔ 0	↔ 0	↔ 0	↔ 0	-	-	↔ 0	↔ 1	↔ 0	↓ 0	↔ 6	↔ 1
	IP	F26H	↑ 77%	↑ 9.5%	↑ 2.92	↓ 91%	↑ 6.3%	-	↑ 2	-	0%	↔ 0	↔ 0	↔ 0	↔ 0	-	-	↔ 0	↑ 1	↔ 0	↑ 1	↔ 1	↑ 1
	IP	F30	↓ 78%	↑ 11.5%	↑ 2.41	↑ 91%	↑ 2.7%	↔ 100.0	↔ 0	↔ 100%	↓ 0%	↔ 0	↔ 0	↔ 0	↔ 0	-	↔ >= 100%	↔ 0	↔ 3	↔ 0	↔ 0	↑ 2	↓ 0
	IP	FPIC	↔ 95%	↓ 14.7%	↓ 6.69	↓ 88%	↑ 10.0%	↑ 100.0	↔ 0	-	↓ 0%	↔ 0	↔ 0	↔ 0	↔ 0	-	-	↔ 0	↔ 0	↔ 0	↔ 0	↔ 0	↔ 0
	IP	FREC	↑ 92%	↑ 17.1%	↑ 4.40	↑ 92%	↑ 8.1%	-	↔ 0	-	100%	↔ 0	↔ 0	↔ 0	↔ 0	-	-	↔ 0	↔ 0	↔ 0	↓ 0	↓ 0	↓ 0
Women's and Children's	DC	GGSU	-	-	-	-	-	-	↔ 0	-	↓ 0%	↔ 0	↔ 0	↔ 0	↔ 0	-	-	↔ 0	↓ 0	↔ 0	↔ 0	↓ 1	↑ 1
	DC	RGAU	↔ 69%	↑ 8.5%	↑ 2.37	↑ 100%	↑ 5.3%	↓ 69.8	↔ 0	↔ 100%	0%	↔ 0	↔ 0	↔ 0	↔ 0	>= 100%	↔ >= 100%	↔ 0	↓ 1	↔ 0	↔ 0	↔ 1	↔ 0
	DC	RPOD	-	-	-	-	-	-	↔ 0	-	90%	↔ 0	↔ 0	↔ 0	↔ 0	-	-	↔ 0	↔ 0	↔ 0	↔ 0	↓ 4	↑ 6
	DC	RCDW	-	-	-	-	-	-	↑ 2	-	100%	↔ 0	↔ 0	↔ 0	↔ 0	-	-	↔ 0	↔ 0	↔ 0	↔ 0	↔ 0	↔ 0
	IP	R28	↔ 74%	↑ 24.2%	↑ 6.32	↑ 96%	↑ 8.0%	↓ 0.0	↑ 1	↔ 100%	↓ 0%	↔ 0	↔ 0	↔ 0	↔ 0	-	-	↔ 0	↑ 4	↔ 0	↓ 0	↑ 7	↑ 1
	IP	RPSS	-	-	-	-	-	-	↔ 0	-	0%	↔ 0	↔ 0	↔ 0	↔ 0	-	-	↔ 0	↔ 0	↔ 0	↓ 0	↑ 2	↔ 1
	IP	G30	↓ 74%	↑ -1.8%	↑ -2.16	↑ 97%	↑ 4.8%	-	↓ 1	↔ 100%	0%	↔ 0	↔ 0	↔ 0	↔ 0	-	↔ >= 100%	↔ 0	↔ 5	↔ 0	↔ 0	↓ 0	↑ 2
	IP	G31	↔ 61%	↔ 0.3%	↔ 0.09	↓ 97%	↑ 6.9%	↓ 70.6	↔ 1	↔ 100%	↔ 100%	↔ 0	↔ 0	↔ 0	↔ 0	-	>= 100%	↔ 0	↔ 2	↔ 0	↔ 0	↑ 1	↔ 0
	IP	R27	↔ 80%	↑ 19.0%	↑ 5.42	↑ 86%	↓ 2.7%	↓ 0.0	↓ 2	↔ 100%	0%	↔ 0	↔ 0	↔ 0	↔ 0	-	-	↔ 0	↓ 3	↔ 0	↓ 0	↑ 4	↑ 2
	IP	R27A	↔ 80%	↑ 19.0%	↑ 5.42	↑ 86%	↓ 2.7%	-	↓ 0	-	0%	↔ 0	↔ 0	↔ 0	↔ 0	-	-	↔ 0	↑ 2	↔ 0	↓ 2	↑ 3	↑ 1
	IP	RCAU	↔ 69%	↑ 9.2%	↑ 2.38	↔ 100%	↓ 0.7%	↓ 68.6	↑ 2	-	0%	↔ 0	↔ 0	↔ 0	↔ 0	-	-	↔ 0	↑ 3	↔ 0	↔ 1	↑ 7	↔ 1
	IP	RSCB	↔ 90%	↑ 15.6%	↑ 14.11	↑ 96%	↑ 2.2%	-	↔ 0	-	0%	↔ 0	↔ 0	↔ 0	↔ 0	-	-	↔ 0	↓ 0	↔ 0	↔ 0	↓ 1	↔ 0
	IP	R10	↔ 69%	↑ 13.7%	↑ 3.78	↓ 92%	↓ 1.9%	↓ 0.0	↔ 0	↔ 100%	↔ 100%	↔ 0	↔ 0	↔ 0	↔ 0	-	-	↔ 0	↔ 0	↔ 0	↓ 0	↑ 2	↔ 0
	IP	R14	↔ 70%	↓ 3.9%	↓ 1.06	↑ 97%	↑ 2.5%	↓ 0.0	↔ 0	↔ 100%	↔ 100%	↔ 0	↔ 0	↔ 0	↔ 0	-	-	↔ 0	↔ 0	↔ 0	↔ 0	↓ 0	↔ 0
	IP	R11	↔ 70%	↓ 1.4%	↓ 0.51	↓ 90%	↓ 1.9%	↓ 0.0	↔ 0	↔ 100%	↔ 100%	↔ 0	↔ 0	↔ 0	↔ 0	-	-	↔ 0	↔ 0	↔ 0	↔ 0	↔ 0	↔ 0
	IP	R12	↑ 83%	↑ 7.1%	↑ 2.07	↓ 94%	↑ 2.0%	↓ 0.0	↔ 0	↔ 100%	↔ 100%	↔ 0	↔ 0	↔ 0	↔ 0	-	-	↔ 0	↔ 0	↔ 0	↔ 0	↔ 0	↔ 0
	IP	R05	↑ 60%	↓ 3.1%	↓ 1.22	↑ 82%	↓ 4.3%	-	↔ 1	-	100%	↔ 0	↔ 0	↔ 0	↔ 0	-	-	↔ 0	↔ 0	↔ 0	↓ 0	↓ 0	↔ 0
	IP	R06	↔ 63%	↑ 4.8%	↑ 2.06	↓ 86%	↓ 5.8%	-	↔ 0	-	↓ 70%	↔ 0	↔ 0	↔ 0	↔ 0	-	-	↔ 0	↔ 0	↔ 0	↔ 0	↓ 0	↔ 0
	IP	R12A	↑ 83%	↑ 7.1%	↑ 2.07	↓ 94%	↑ 2.0%	-	↔ 0	-	100%	↔ 0	↔ 0	↔ 0	↔ 0	-	-	↔ 0	↔ 0	↔ 0	↔ 0	↑ 6	↔ 0
	IP	RCIC	↔ 95%	↓ 14.7%	↓ 6.69	↓ 88%	↑ 10.0%	↔ 100.0	↓ 0	100%	100%	↔ 0	↔ 0	↔ 0	↔ 0	-	-	↔ 0	↓ 4	↔ 0	↔ 0	↑ 7	↓ 0

NURSING METRICS

RED: < 80 AMBER: 80 - 90 GREEN: >90

Type	Ward	1 Fluid Balance chart	2 Nutrition & Hydration-Protected Meal Time	2 Nutrition & Hydration-Patient assessment	2 Nutrition & Hydration-Staff Knowledge	3 Urinary Catheter	4 Falls-Patient assessment	4 Falls-Stage Two assessment	5 Hygiene-Patient assessment	5 Hygiene-Ward observations	6 Patient observations & EWS	7 Pressure Ulcer care-Patient assessment	7 Pressure Ulcer care-Staff knowledge	8 Privacy & Dignity-Observation of Practice	8 Privacy & Dignity-Staff Knowledge	9 Discharge	10 Infection Prevention-Patient review	10 Infection Prevention-Ward review	11 Resuscitation Equipment	12 Medicines Management-Patient assessment	12 Medicines Management-Ward assessment	13 Safeguarding Children & Young people	14Communication/Partnership
DC	G10D	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
DC	F32	N/A	100%	100%	60%	N/A	96%	N/A	N/A	100%	87%	83%	53%	88%	14%	100%	100%	80%	100%	97%	100%	-	-
DC	F20	78%	DNC	87%	87%	87%	94%	100%	75%	75%	81%	79%	87%	88%	90%	60%	100%	60%	33%	100%	67%	-	-
DC	FCID	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
IP	F27	95%	100%	83%	100%	100%	100%	76%	100%	100%	90%	97%	100%	100%	100%	70%	80%	100%	33%	100%	100%	-	-
IP	F31	100%	100%	73%	87%	57%	98%	93%	92%	100%	94%	100%	67%	88%	38%	90%	45%	80%	100%	89%	100%	-	-
IP	FCCU	100%	100%	87%	100%	100%	100%	92%	84%	100%	94%	100%	100%	88%	86%	100%	100%	100%	100%	100%	100%	-	-
IP	FCDU	72%	50%	57%	67%	50%	90%	N/A	100%	100%	89%	88%	93%	100%	76%	100%	40%	60%	67%	97%	33%	-	-
IP	G15A	100%	100%	88%	100%	80%	89%	44%	100%	100%	100%	96%	100%	100%	100%	33%	90%	100%	100%	100%	67%	-	-
IP	G17	83%	50%	47%	100%	0%	95%	50%	76%	100%	100%	82%	100%	100%	100%	85%	60%	80%	100%	91%	67%	-	-
IP	GDCM	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
IP	RITU	100%	100%	95%	100%	100%	87%	N/A	100%	100%	100%	100%	100%	88%	81%	100%	100%	100%	33%	100%	100%	-	-
IP	RPAC	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
IP	FCIC	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
IP	FITU	100%	50%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	88%	100%	100%	100%	100%	100%	100%	100%	-	-
IP	G10	100%	100%	90%	100%	100%	100%	83%	100%	100%	100%	100%	100%	100%	100%	100%	100%	80%	100%	100%	67%	-	-
IP	G15N	84%	100%	68%	100%	100%	92%	80%	60%	100%	87%	87%	100%	100%	100%	73%	100%	80%	0%	97%	67%	-	-
IP	F16	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
IP	F33	83%	100%	40%	100%	85%	85%	83%	88%	100%	69%	92%	100%	75%	81%	93%	80%	100%	100%	96%	67%	-	-
IP	F15	42%	100%	67%	100%	50%	82%	N/A	68%	100%	70%	69%	100%	100%	62%	53%	60%	40%	67%	88%	67%	-	-
IP	F17	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
IP	F17H	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
IP	F26	93%	DNC	95%	80%	95%	100%	93%	60%	100%	100%	100%	87%	88%	95%	80%	100%	100%	100%	100%	67%	-	-
IP	F28	93%	100%	90%	100%	80%	96%	60%	92%	75%	97%	96%	100%	100%	100%	73%	0%	60%	33%	95%	100%	-	-
IP	F31H	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
IP	F33A	94%	50%	77%	87%	85%	78%	42%	84%	100%	97%	93%	100%	75%	71%	80%	100%	60%	100%	100%	33%	-	-
IP	FCHD	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
IP	F26H	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
IP	F30	100%	100%	-	-	N/A	100%	-	100%	100%	100%	100%	60%	88%	100%	100%	100%	100%	67%	100%	67%	100%	100%
IP	FPIC	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
IP	FREC	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
DC	GGSU	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
DC	RGAU	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
DC	RPOD	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
DC	RCDW	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
IP	R28	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
IP	RPSS	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
IP	G30	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
IP	G31	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
IP	R27	96%	95%	-	-	N/A	100%	-	100%	100%	94%	100%	100%	100%	100%	100%	100%	80%	67%	100%	67%	0%	100%
IP	R27A	90%	74%	-	-	N/A	93%	-	92%	100%	77%	88%	40%	100%	86%	73%	100%	100%	33%	98%	67%	97%	80%
IP	RCAU	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
IP	RSCB	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
IP	R10	92%	75%	-	-	N/A	100%	-	100%	100%	93%	88%	100%	100%	86%	92%	100%	100%	67%	100%	100%	100%	100%
IP	R14	80%	79%	-	-	N/A	98%	-	100%	100%	97%	83%	100%	100%	90%	100%	100%	60%	67%	90%	67%	100%	92%
IP	R11	100%	98%	-	-	N/A	100%	-	100%	100%	100%	88%	100%	100%	100%	100%	100%	80%	67%	100%	67%	100%	100%
IP	R12	96%	81%	-	-	N/A	100%	-	100%	100%	100%	88%	93%	100%	86%	100%	100%	100%	33%	93%	100%	89%	100%
IP	R05	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
IP	R06	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
IP	R12A	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
IP	RCIC	100%	96%	-	-	80%	100%	-	100%	100%	100%	75%	40%	100%	86%	100%	100%	80%	100%	90%	67%	95%	100%

Trust Board paper U - appendix 3

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

Title:	RTT Improvement Report

Author: Richard Mitchell, Chief Operating Officer

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

The Report is provided to the Board for:

Decision		Discussion	
Assurance	√	Endorsement	

Summary / Key Points:

- Reasons for RTT deterioration are well known
- There are four challenged specialities; ophthalmology, ENT, orthopaedics and general surgery.
- Some specialities have begun to improve waiting times / reductions in waiting list size
- Admitted compliant performance is expected in November 2014
- Non-admitted compliant performance is expected in August 2014
- Patients are being checked to ensure there has been no deterioration in their conditions linked to waits longer than 18 weeks.
- The plan remains very high risk which may result in significant fines.

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

Previously considered at another UHL corporate Committee N/A

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

Resource Implications (eg Financial, HR)
Yes

Assurance Implications
90% admitted and 95% non-admitted RTT performance.

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

Equality Impact
N/A

Information exempt from Disclosure
N/A

Requirement for further review
Monthly

REPORT TO: **Trust Board**
REPORT FROM: **Richard Mitchell, Chief Operating Officer**
REPORT SUBJECT: **RTT Improvement Report**
REPORT DATE: **May 2014**

Introduction

The reasons for UHL's deterioration in RTT performance are well documented. This report is the third monthly update. The high level trajectories are detailed below and attached. Trust level compliant non admitted performance is expected in August 2014 and trust level compliant admitted performance is expected in November 2014. The high level risks to the plan are detailed below.

Performance overview

UHL's RTT performance is mainly challenged in four specialities; ENT, ophthalmology, orthopaedics and general surgery. The specialities have put in place detailed plans to reduce their non-recurrent backlog and make permanent changes to increase their recurrent capacity. The table below details the expected rate of improvement. The two Appendices goes into greater detail showing performance at speciality level and waiting list sizes for both outpatient and electives (key indicators of RTT backlog reduction).

	Admitted Trust level RTT														
	Jan-14	Feb-14	Mar-14	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15
Trajectory	80.8%	80.5%	81.2%	81.2%	82.3%	84.3%	86.9%	87.7%	88.8%	89.5%	90.5%	90.5%	90.5%	90.4%	92.0%
Actual	81.8%	79.3%	76.7%	75.7											
Including Alliance				78.9%											
	Non admitted Trust level RTT														
	Jan-14	Feb-14	Mar-14	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15
Trajectory	92.3%	92.7%	92.8%	93.1%	93.6%	94.1%	94.8%	95.1%	95.3%	95.3%	95.5%	96.1%	96.1%	96.1%	96.1%
Actual	93.4%	93.5%	93.9%	93.4%											
Including Alliance				94.3%											

This table details at a Trust level the size of the admitted and non-admitted backlogs over a 2 month period indicating overall reductions.

Trust level backlog over 18 weeks Week Ending	23/03/2014	30/03/2014	06/04/2014	13/04/2014	20/04/2014	27/04/2014	04/05/2014	11/05/2014	18/05/2014
RTT Non Admitted Backlog Actual No	1705	1704	1497	1415	1436	1527	1288	1260	1268
RTT Admitted Backlog Actual No	1475	1527	1494	1525	1551	1551	1372	1318	1335

The Trust will unfortunately be reporting 3 breaches of the 52 week RTT standard in April. These are maxillofacial patients, a full investigation into the reasons for these is being carried out.

In April a joint RTT performance board was set up with commissioners, this meets every two weeks to monitor recovery plans and performance

Risks

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

- Ability to deliver agreed capacity improvements including theatre, bed and outpatient space and staffing resources within agreed timelines
- Changes to emergency demand

An additional third risk is that the CCGs have served notice that they plan to impose significant fines for non-compliance with the trajectory or elements of the trajectory. This will have a significant impact on the UHL finances as fines could be as much as £2.5m to £3.6m.

Recommendations
The board are asked to:

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

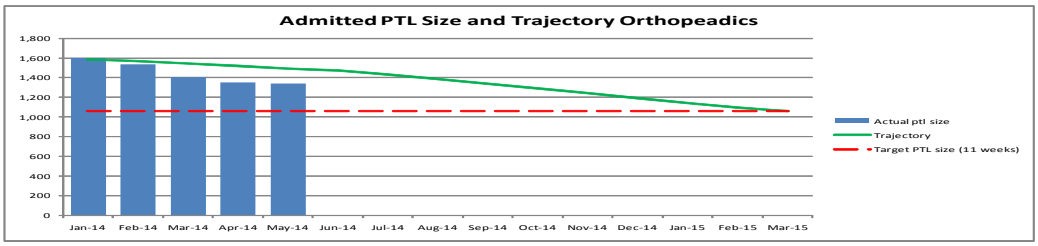
Specialty Level Trajectory

	Admitted Trust level RTT														
	Jan-14	Feb-14	Mar-14	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15
Trajectory	80.8%	80.5%	81.2%	81.2%	82.3%	84.3%	86.9%	87.7%	88.8%	89.5%	90.5%	90.5%	90.5%	90.4%	92.0%
Actual	81.8%	79.3%	76.7%	75.7											
Including Alliance				78.9%											
	Non admitted Trust level RTT														
	Jan-14	Feb-14	Mar-14	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15
Trajectory	92.3%	92.7%	92.8%	93.1%	93.6%	94.1%	94.8%	95.1%	95.3%	95.3%	95.5%	96.1%	96.1%	96.1%	96.1%
Actual	93.4%	93.5%	93.9%	93.4%											
Including Alliance				94.3%											
	Adult Ophthalmology Admitted RTT														
	Jan-14	Feb-14	Mar-14	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15
Trajectory	58.8%	61.0%	62.3%	63.1%	69.5%	80.4%	90.1%	90.2%	90.3%	90.6%	90.6%	90.5%	90.8%	90.7%	90.8%
Actual	57.8%	60.0%	53.6%	50.3%											
	Adult Ophthalmology Non admitted RTT														
	Jan-14	Feb-14	Mar-14	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15
Trajectory	83.7%	83.1%	82.3%	85.3%	88.8%	98.1%	93.5%	95.4%	95.1%	95.0%	95.2%	95.2%	95.1%	95.1%	95.1%
Actual	86.6	90.2	91.46	89.80%											
	Paediatric Ophthalmology Admitted RTT (other category)														
	Jan-14	Feb-14	Mar-14	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15
Trajectory	80.8%	80.5%	81.2%	81.2%	82.1%	84.4%	84.4%	86.6%	90.6%	90.2%	90.5%	90.5%	90.5%	90.4%	92.0%
Actual			80.1%	73.10%											
	Paediatric Ophthalmology Non admitted RTT(other category)														
	Jan-14	Feb-14	Mar-14	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15
Trajectory	92.3%	92.7%	92.8%	93.3%	92.7%	95.1%	95.4%	95.6%	95.6%	95.6%	95.7%	95.3%	95.3%	95.3%	95.3%
Actual			93%	93.20%											
	Adult ENT Admitted RTT														
	Jan-14	Feb-14	Mar-14	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15
Trajectory	62.6%	64.5%	61.3%	61.1%	66.1%	72.8%	75.0%	83.1%	90.5%	90.5%	90.4%	90.3%	90.3%	90.2%	90.4%
Actual	69.8%	56.3%	61.8%	61.90%											
	Adult ENT Non admitted RTT														
	Jan-14	Feb-14	Mar-14	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15
Trajectory	89.0%	90.7%	90.4%	93.3%	92.4%	92.4%	93.4%	95.1%	95.4%	95.3%	95.5%	95.5%	95.5%	95.5%	95.5%
Actual	86%	82.7%	86.3%	86.70%											
	Paediatric ENT Admitted RTT (other category)														
	Jan-14	Feb-14	Mar-14	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15
Trajectory	80.8%	80.5%	81.2%	81.2%	82.1%	84.4%	84.4%	86.6%	90.6%	90.2%	90.5%	90.5%	90.5%	90.4%	92.0%
Actual			80.1%	73.10%											
	Paediatric ENT Non admitted RTT(other category)														
	Jan-14	Feb-14	Mar-14	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15
Trajectory	92.3%	92.7%	92.8%	93.3%	92.7%	95.1%	95.4%	95.6%	95.6%	95.6%	95.7%	95.3%	95.3%	95.3%	95.3%
Actual			93%	93.20%											
	Orthopaedics Admitted RTT														
	Jan-14	Feb-14	Mar-14	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15
Trajectory	70.0%	69.7%	75.3%	75.5%	74.4%	76.2%	78.6%	75.9%	77.6%	79.7%	81.0%	82.3%	82.2%	82.3%	90.1%
Actual	70.1%	70.5%	66.5%	70.50%											
	Orthopaedics Non admitted RTT														
	Jan-14	Feb-14	Mar-14	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15
Trajectory	78.8%	79.3%	80.4%	78.4%	80.7%	81.2%	82.0%	83.4%	84.1%	85.0%	86.0%	95.2%	95.1%	95.1%	95.1%
Actual	78.30%	78.40%	80.5%	76%											
	General surgery Admitted RTT														
	Jan-14	Feb-14	Mar-14	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15
Trajectory	75.2%	72.8%	73.7%	74.4%	74.6%	73.3%	77.4%	82.5%	84.2%	88.2%	90.2%	90.2%	90.2%	90.2%	90.2%
Actual	65.9%	56.9%	66.2%	74.20%											
	General surgery Non admitted RTT														
	Jan-14	Feb-14	Mar-14	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15
Trajectory	95.1%	95.1%	95.9%	95.1%	95.3%	95.9%	95.1%	95.3%	95.2%	95.3%	95.6%	95.1%	95.1%	95.1%	95.1%
Actual	84%	75.1%	96.7%	95.90%		Appendix A									

Inpatient waiting list size

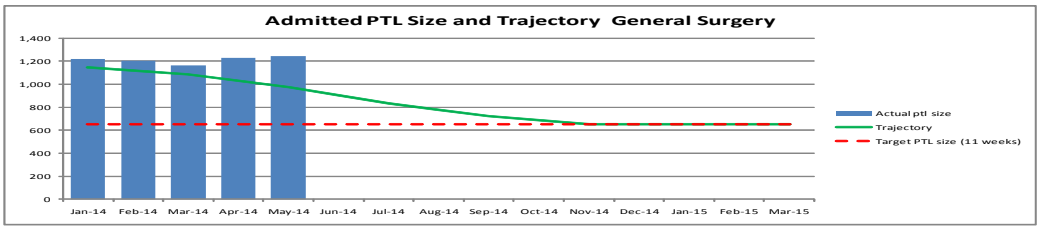
Othopaedics

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



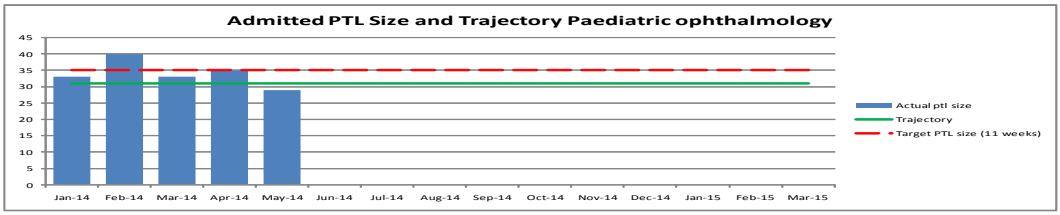
General surgery

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



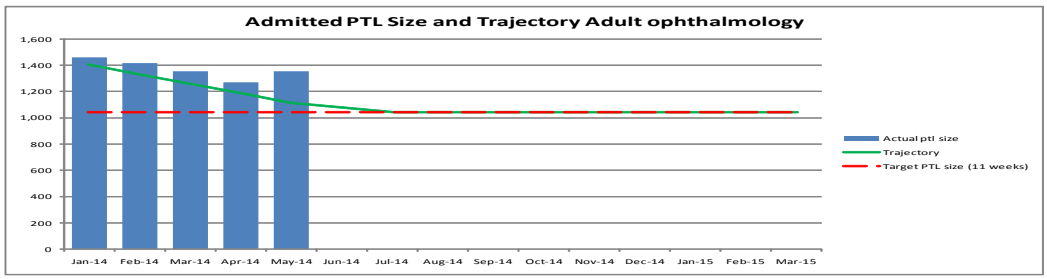
Paediatric ophthalmology

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



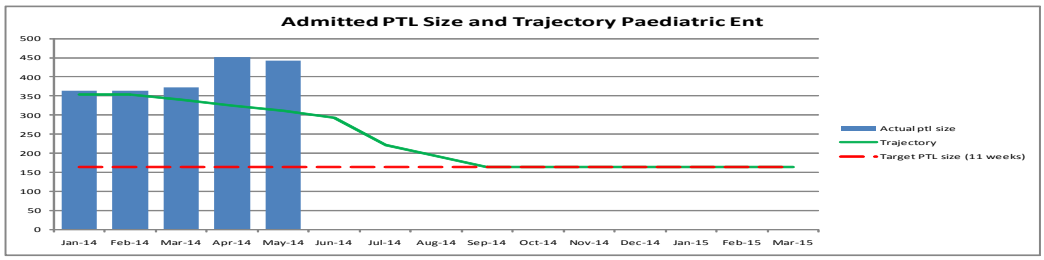
Adult ophthalmology

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



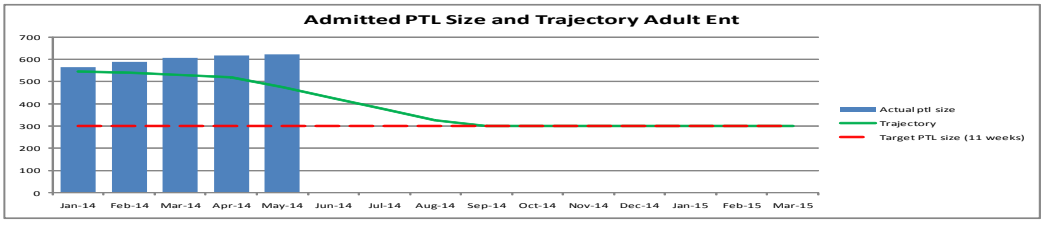
Paediatric ENT

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



Adult Ent

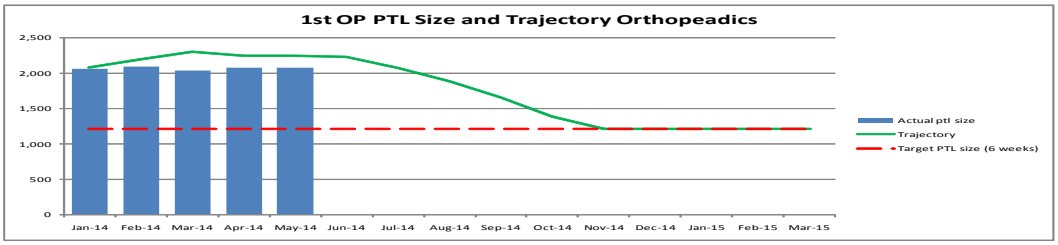
	Jan-14	Feb-14	Mar-14	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15
Actual ptl size	565	589	606	618	621	-	-	-	-						
Trajectory	545	540	529	518	475	425	375	326	300	300	300	300	300	300	300
Target PTL size (11 weeks)	300	300	300	300	300	300	300	300	300	300	300	300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



Outpatient waiting list size

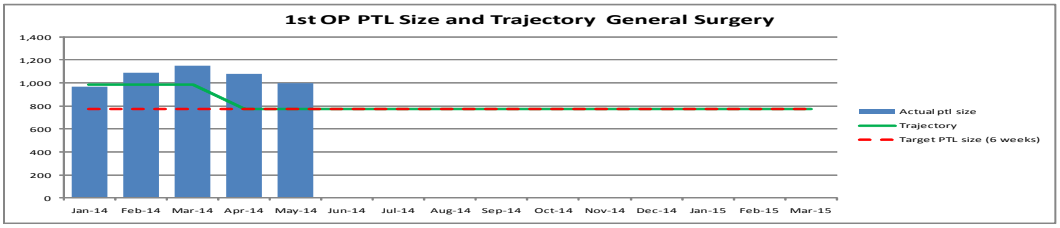
Othopaedics

	Jan-14	Feb-14	Mar-14	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15
Actual ptl size	2,055	2,089	2,036	2,076	2,074	-	-	-	-						
Trajectory	2,080	2,197	2,299	2,241	2,241	2,230	2,073	1,879	1,653	1,383	1,208	1,208	1,208	1,208	1,208
Target PTL size (6 weeks)	1,208	1,208	1,208	1,208	1,208	1,208	1,208	1,208	1,208	1,208	1,208	1,208	1,208	1,208	1,208



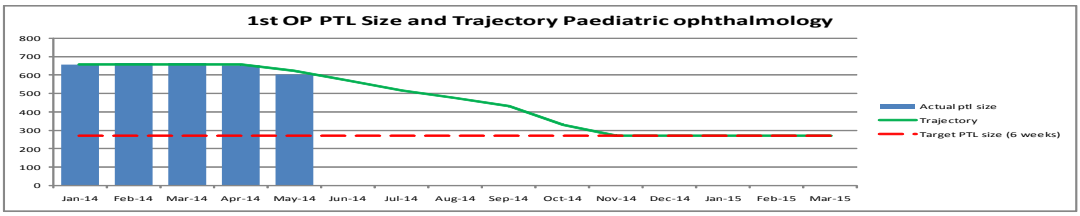
General surgery

	Jan-14	Feb-14	Mar-14	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15
Actual ptl size	967	1,089	1,149	1,080	997	-	-	-	-						
Trajectory	983	983	983	773	773	773	773	773	773	773	773	773	773	773	773
Target PTL size (6 weeks)	773	773	773	773	773	773	773	773	773	773	773	773	773	773	773



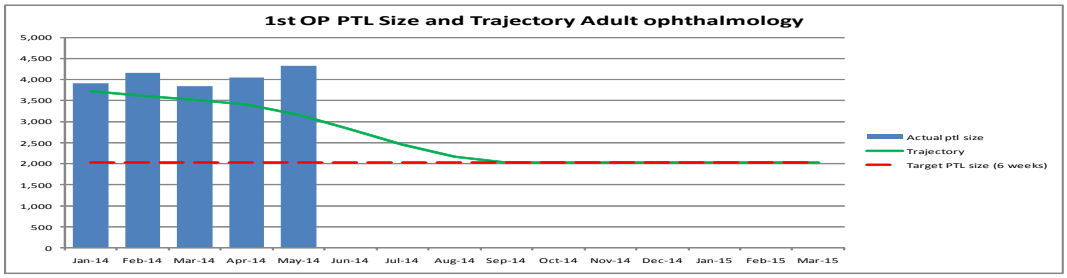
Paediatric ophthalmology

	Jan-14	Feb-14	Mar-14	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15
Actual ptl size	656	667	665	652	604	-	-	-	-						
Trajectory	657	657	657	657	625	571	517	474	431	330	269	269	269	269	269
Target PTL size (6 weeks)	269	269	269	269	269	269	269	269	269	269	269	269	269	269	269



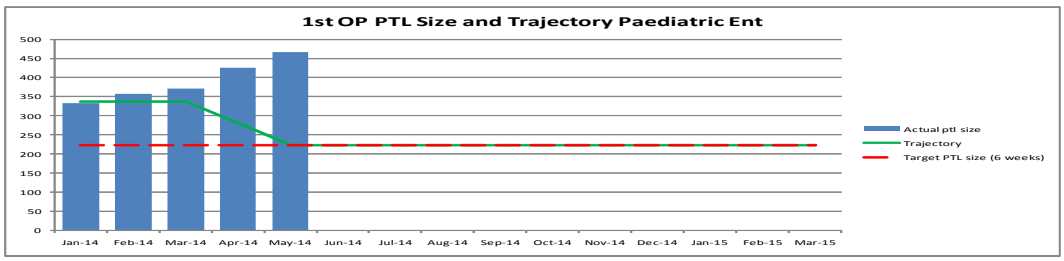
Adult ophthalmology

	Jan-14	Feb-14	Mar-14	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15
Actual ptl size	3,911	4,155	3,846	4,047	4,319	-	-	-	-						
Trajectory	3,726	3,619	3,513	3,406	3,167	2,812	2,457	2,173	2,031	2,031	2,031	2,031	2,031	2,031	2,031
Target PTL size (6 weeks)	2,031	2,031	2,031	2,031	2,031	2,031	2,031	2,031	2,031	2,031	2,031	2,031	2,031	2,031	2,031



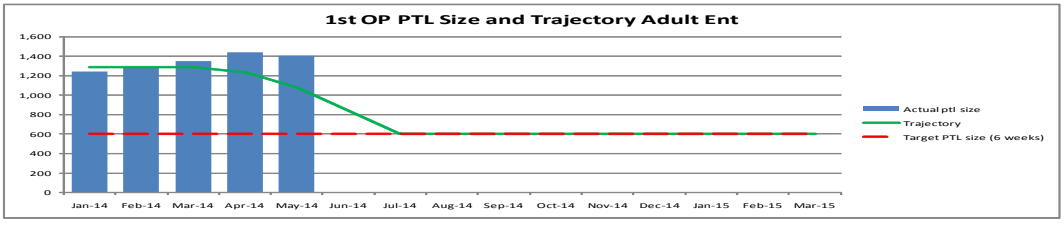
Paediatric ENT

	Jan-14	Feb-14	Mar-14	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15
Actual ptl size	333	357	371	426	466	-	-	-	-						
Trajectory	337	337	337	280	223	223	223	223	223	223	223	223	223	223	223
Target PTL size (6 weeks)	223	223	223	223	223	223	223	223	223	223	223	223	223	223	223



Adult Ent

	Jan-14	Feb-14	Mar-14	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15
Actual ptl size	1,243	1,276	1,350	1,442	1,407	-	-	-	-						
Trajectory	1,286	1,286	1,286	1,236	1,081	843	605	605	605	605	605	605	605	605	605
Target PTL size (6 weeks)	605	605	605	605	605	605	605	605	605	605	605	605	605	605	605



UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST

OPERATIONAL PERFORMANCE EXCEPTION REPORT

REPORT TO: **TRUST BOARD**

DATE: **29 May 2014**

REPORT BY: **Richard Mitchell, Chief Operating Officer**

AUTHOR: **Phil Walmsley, Interim General Manager, ITAPS**

CMG GENERAL MANAGER: **Phil Walmsley**

SUBJECT: **Short notice cancelled operations**

Introduction

The cancelled operations target comprises of three components:

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

Trust performance in March:-

1. *The percentage of operations cancelled on/after the day* for non-clinical reasons during April was 1.1% against a target of 0.8%.
2. *The % of patients cancelled who are offered another date within 28 days of the cancellation.* The number of patients breaching this standard in April was 10 with 90.1% offered a date within 28 days of the cancellation. This is a worse position against March.
3. *The number of urgent operations cancelled for a second time* ; Zero

A remedial action plan against the two standards that the Trust is failing has been formally signed off by commissioners and a revised recovery trajectory has been accepted.
Against standard 1) The focus is on reducing the number of non bed related cancellations (over which the Trust has greater control). The table below is the agreed trajectory reduction , with a residual number of 10 which are unavoidable , such as complications in surgery resulting in cancelling patients.

Proposed reduction in non bed related cancellations	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14
Monthly trajectory	40	34	26	18	10	10
Actual number	37					

It is anticipated that standard 2) will be recovered by July 2014. The key action to enable this is the daily reporting of patients cancelled requiring redating within 28 days and escallating to CMG Directors and General Managers for resolution.

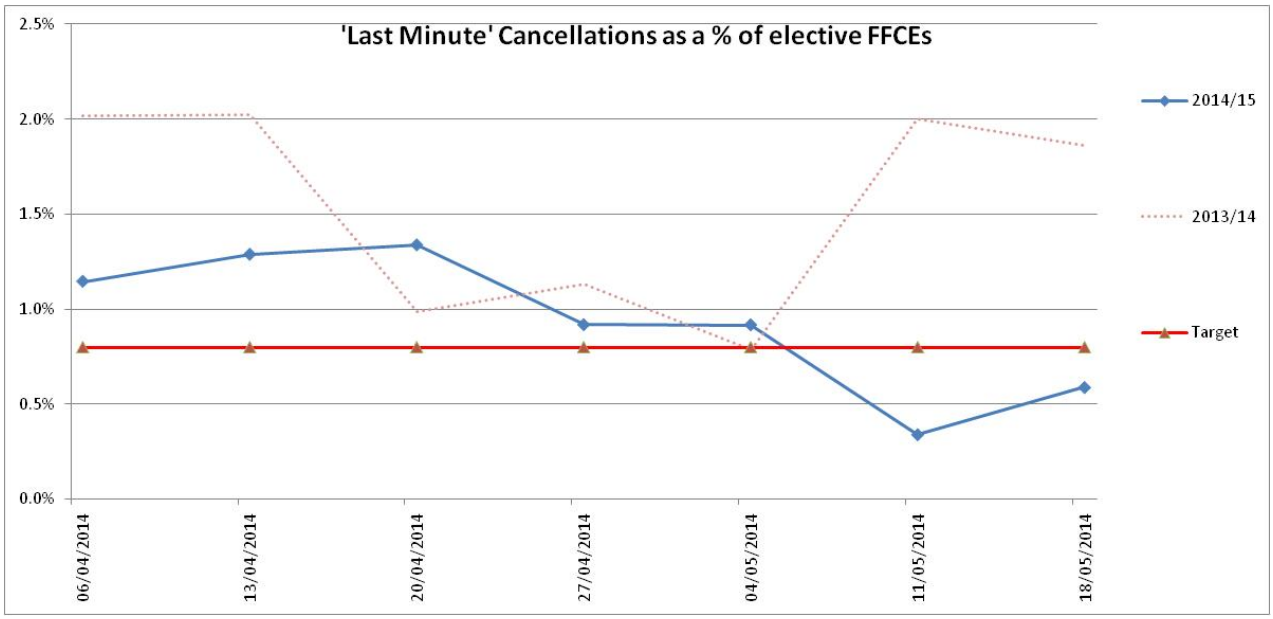
The revised UHL process for reporting cancelled operations has been circulated and is now in use. This appears to be having a positive impact in the April figures.

In April, Nottingham University Hospitals 'Cancelled Ops' project manager was invited to present their sucessful improvement against these key standards to UHL theatre and operational staff. Learning from Nottingham is being implemented at UHL , including the recruitment of a similar post.

Risks to delivery of recovery plan

There are risks to delivery of the plan to reduce cancellations on the day. These are mainly associated with bed availability. Circa 75% of cancellations on the day are due to no bed availability (review carried our over 3 months, showed no beds to be either direct or indirect cause of cancellations on the day.

Performance against standard 1 for the start of May is showing positive signs.

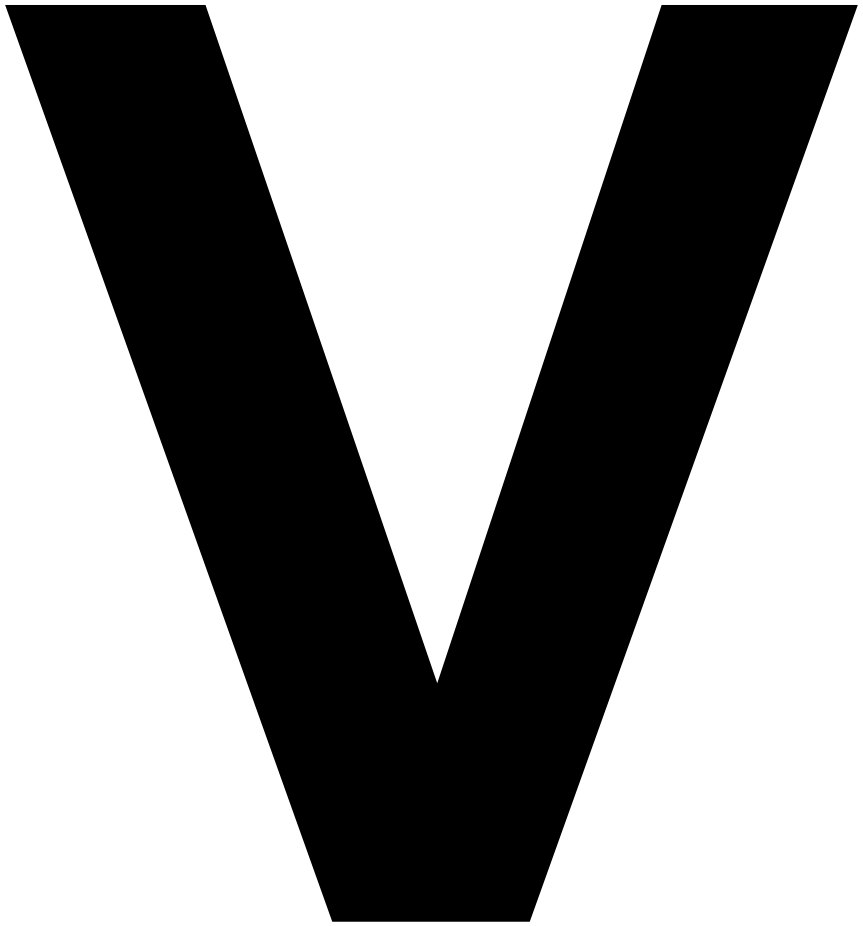


Week ending	2014/15	2013/14	Target
06/04/2014	1.1%	2.0%	0.8%
13/04/2014	1.3%	2.0%	0.8%
20/04/2014	1.3%	1.0%	0.8%
27/04/2014	0.9%	1.1%	0.8%
04/05/2014	0.9%	0.8%	0.8%
11/05/2014	0.3%	2.0%	0.8%
18/05/2014	0.6%	1.9%	0.8%

Details of senior responsible officer

CMG SRO: P Walmsley

Corporate Ops: P Walmsley



UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST

REPORT TO: **Trust Board**

DATE: **29 May 2014**

REPORT BY: **Rachel Overfield – Chief Nurse**

SUBJECT: **HARD TRUTHS COMMITMENTS**

- **How to ensure the right people with the right skills are in place at the right time – NHS England guidance (Nursing) November 2013**
- **The publishing of staffing data (Nursing) – NHS England March 2014**
- **NICE Safe Staffing Guidelines Consultation Document – May 2014**

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1. Introduction

The following report is intended to brief the relevant Trust committees and assure the Trust Board that UHL is either compliant or working towards compliance in the recommendations and expectations set out in the above recent documents; all of which relate to health care staffing arrangements.

2. How to ensure the right people, with the right skills are in the right place at the right time - NHS England Guidance November 2013 (Nursing)

2.1 This document issued by Jane Cummings, Chief Nursing Officer England and the National Quality Board was intended to assist organisations to make the right decisions about staffing arrangements to ensure safety, caring, compassionate nursing care could always be provided.

The document acknowledged that it was not possible to give a single formula for calculating nurse staffing ratios and urged organisations to use acuity tools, real time measurements, output quality indicators and staff and patient feedback to make decisions regarding staffing levels.

The guidance set out ten expectations (table 1) and details how organisations could deliver against these expectations.

2.2 The UHL Chief Nurse and senior colleagues assessed where UHL were against the expectations set out in the guidance and have been working towards compliance over the last few months (table 1)

Table 1

	Expectation	RAG	Outstanding Actions Required
1.	Trust Boards take full Responsibility for quality of care provided to patients and as a key determinant of quality, take full and collective responsibility for nursing staffing capacity and capability.		Process/systems are all in place but require final agreement with Trust Board re reporting arrangements / format etc.
	• 6/12 establishment review and report to Trust Board with sign off.	**G**	
	• Regular updates to Trust Board.	**G**	
	• Assurance that escalation policies /contingency plans are in place.	**G**	
	• Use of Dashboards / heatmaps by ward.	**G**	
2.	Processes are in place to enable staffing establishments to be met on a shift by shift basis.		
	• Daily shift on shift reviews of staffing should happen at 'group' level.	**G**	Real time staffing in place, bur is not yet fully 'owned' at CMG level.
	• e roster should be in place and used to deploy staff to most needed areas.	**A**	e roster will be in place in all patient areas by end of June 2014.
	• Escalation / contingency plans should be in place and staff feel enabled to use them.	**A**	Evidence of escalation is difficult to measure as it is not currently recorded.
3.	Evidence based tools are used to inform on staffing capacity and capability e.g:-		
	• Safer nursing care tool.	**A**	Will be in place and able to update daily from June.

	• Nurse sensitive indicators	**G**	Fully in place and reported on ward dashboard.
	• Birth-rate plus (midwives)		
4.	Clinical and managerial leaders foster a culture of professionalism and responsiveness where staff feel able to raise concerns	**A**	£800k Nursing Technology fund – nerve centre roll out plus bedside monitoring. LIA Nursing into Action Chief Nurse clinics. Nursing staff council to be established.
5.	A multi-professional approach is taken when setting nursing and midwifery staffing establishments. • Establishment reviews done and signed off with Chief Operating Officer, Finance Director, Medical Director and Director of Human Resources taking into account all interdependencies, (see appendix 1).	**G**	New performance review processes with CMGs will support this
6.	Nurses and midwives have sufficient time to fulfil responsibilities that are additional to direct care duties. • CPD Supervision • Suspension / management • Leadership	**A** **R**	Whilst some additional funding is included in establishments for supervisory leadership and establishments have a % for non-clinical time included – given the current vacancy factor CPD and supervision is not being met in many cases.
7.	Trust Boards receive monthly updates on workforce information and staffing capacity and capability and discuss in public at least every six months. • Monthly ward dataset. • Staffing on a shift by shift basis. • Staffing related to quality metrics.	**G**	Included in Quality & Performance report, although requires some modification, Trust Board needs to decide on the potential requirement to have a six monthly nurse workforce paper as well as a Q&P report.
8.	NHS providers clearly display	**A**	There is a system to enable this

	information about care staff present on each ward, clinical setting and department each shift.		but it is cumbersome. E roster is being rolled out for all wards. We have not commenced work for paediatrics, maternity and all departments yet.
9.	Providers of NHS services take an active role in securing staff in line with their workforce requirements.	**G**	Recruitment strategy. Good retention rates. International recruitment.
10.	Commissioners actively seek assurance that staffing capacity and capability is safe with providers with whom they commission.	**G**	Q&P report shared with commissioners. Nurse workforce information shared with commissioners routinely.

3.0 Hard Truths Commitments regarding the Publishing of Staffing Data

Jane Cummings and Professor Sir Mike Richards wrote to CEO's at the end of March 2014 giving clear guidance regarding the delivery of the Hard Truth Commitments associated with publishing staff data. Staffing data is to be published by June 2014 at the latest. This is to be done in the following ways:-

- **6 monthly establishment reviews to the Trust Board using evidence based tools**

  Trust Response
  The Trust Board signed off and agreed investment in new ward establishment in August 2013. Due to recruitment difficulties these establishments are not yet fully in place.

  Recommend Trust Board receives a review of where we are ward by ward against new establishments in June with a plan to carry out a full acuity based assessment of establishments for October. This is to include maternity, paediatrics and departments.

- **Information about nurses, midwives and care staff deployed for each shift compared to what has been planned, displayed at ward level.**

  Trust Response
  This will be in place across all adult wards by June and in Women's and Children's and departments by September.

- **Monthly Board report detailing shift by shift variance of planned vs actual staffing by ward**

Trust Response
We already have the ability to collect this but are struggling to embed the system within wards and groups. Some reporting is possible but will not yet be entirely accurate.

- **Reports must be provided on the Trust website and on NHS Choices.**

Trust Response
Working towards being able to do this and expect to be in place by June – this will be a mixture of data taken from 'manual' systems and e roster initially.

3.1 Stock takes on compliance with these duties are taking place which the Trust has responded positively to.

3.2 The TDA and CQC will include compliance with these actions as part of their assurance regimes.

4.0 NICE Safe Staffing Guidance

NICE have just issued a consultation document on safe staffing levels in adult patient wards in acute hospitals. The consultation period runs from 12 May to 6 June 2014.

The document recognises that there is no single nurse to patient ratio that can be applied across all areas. The guidance recommends factors that need to be systematically applied at ward level to assess staffing needs. These factors are very similar to those described in the previous two documents described in this report, i.e:-

- Ensure the right culture is in place to support staff;
- Use evidence based tools to calculate staffing needs;
- Regularly review staffing arrangements;
- Link staffing level to quality outcomes;
- Recognise environmental factors. Assess all patient needs over and above those clinically admitted with e.g:- LD, dementia.

5.0 Conclusion

There is now clear guidance and expectation placed on providers to plan, monitor and respond to nursing, midwifery and care staffing requirements. Gaps in planned staffing will be published publicly both at ward level and on NHS Choices.

UHL has systems and processes in place to meet most of these expectations but further work is required to fully roll out and embed these processes by June deadline.

The Board has previously had information regarding nursing workforce, vacancies, quality impact and impact of staffing groups. The Board now need to decide in what format and frequency it wishes to receive this information in the future.

NON-EXECUTIVE DIRECTORS OF THE BOARD

- Ensure there are robust systems and processes in place across the organisation to make informed and accurate decisions concerning workforce planning and provision.
- Review data on workforce, quality of care and patient safety on a regular basis and hold Executive Directors to account for ensuring that the right staff are in place to provide high quality care to patients
- Ensure that decisions being taken at a board level, such as implementing cost improvement plans, have sufficiently considered and taken account of impacts on staffing capacity and capability and key quality and outcomes measures
- Understand the principles which should be followed in workforce planning, and seek assurance that these are being followed in the organisation

CHIEF EXECUTIVE

- Ensure that the organisation has the right number of staff with the required knowledge and skills to provide safe and effective patient care
- Ensure that there is an agreed nursing and midwifery establishment for all clinical areas
- Ensure there are robust systems and processes in place across the organisation to make informed and accurate decisions concerning workforce planning and provision.
- Ensure that appropriate escalation policies are in place and action is taken when staffing falls below that expected
- Ensure workforce plans are clinically and financially viable, and that they inform education commissioning process in place through the Local Education and Training Board (LETB) and Health Education England (HEE)
- Ensure that the Executive Team have SMART objectives (specific, measurable, achievable, realistic, timely) aligned to staffing and that these are reviewed and performance tracked regularly.

EXECUTIVE BOARD MEMBERS

- Report to the Board on nursing, midwifery and care staffing capacity and capability, highlighting concerns and making recommendations where necessary. Workforce data should be triangulated with data on quality of care
- Where staffing capacity and capability is insufficient to provide safe care to patients and cannot be restored, undertake a full risk assessment and consider the suspension of services and closure of wards in conjunction with the Directors of Operations, Chief Executive and Commissioners
- Foster a culture of openness and honesty amongst staff, supported by nursing and midwifery leaders, where staff feel able to raise concerns, and concerns are acted upon

DIRECTOR OF NURSING

Develop the nursing and midwifery leadership team to ensure that they understand the principles of workforce planning and can use evidence based tools informed by their professional judgement to develop workforce plans and make staffing decisions on a day to day basis

Assure the Board that there are nursing and midwifery workforce plans in place for all patient care areas/pathways

On a monthly basis, report workforce information to the Board on expected vs actual staff in post on a shift-to-shift together with information on key quality and outcome measures

Ensure there is an uplift in planned establishments to allow for planned and unplanned leave and ensure absence is managed effectively

DIRECTOR OF WORKFORCE (HR)

Ensure that human resources support and policies are available to secure sufficient staffing capacity and capability to provide high quality care to patients

Ensure that there are systems and processes in place to capture accurate data on establishment, staffing levels and skill mix, staff movements, training and turnover to inform decisions on workforce planning

Develop and implement policies that support all staff working within areas of competence

Develop and implement a strategic recruitment plan to provide the required resources and fill current and future vacancies

CHIEF OPERATING OFFICER/DIRECTOR OF OPERATIONS

Ensure that the management of the organisation supports delivery of the workforce plan and there is sufficient staffing capacity and capability to provide high quality care to patients

Ensuring that there are systems and processes in place to capture accurate data on quality of care, patient pathways and volume to inform decisions on workforce planning

DIRECTOR OF FINANCE

Ensure that finance decisions which could have an impact on staff capacity and capability and patient outcomes are taken with consideration of staffing and workforce planning implications, and that these are reflected in any advice provided for decision to the Board, linking proposals to patient outcomes and quality

Ensure there are staff recruitment and retention strategies in place, and regularly review the effectiveness of these

Ensure that there are systems and processes in place to capture accurate data on establishment, staffing levels and skill mix, to inform decisions on workforce planning

Appendix 1

NURSING LEADERS: HEAD OF NURSING / MATRON / SENIOR MIDWIFE

- Review and approve rosters submitted from wards
- Reallocate staff and authorise the use of temporary staffing solutions if necessary and where required
- Continuously review and monitor nursing, midwifery and care staffing capacity and capability across areas of responsibility
- Produce data / information to inform the Board and management of the organisation, and to inform workforce planning
- Hold Service Managers to account for having appropriate staffing capacity and capability on a shift to shift basis, and following escalation procedures where necessary

SISTER / CHARGE NURSE/TEAM LEADER

- Produce and manage safe and efficient staff rosters
- Measure quality of care and outcomes achieved for patients and the capacity and capability of staff on a ward-to-ward basis
- Respond in a timely manner to unplanned changes in staffing, changing patient acuity / dependency or numbers, including the request for and use of temporary staffing where nursing/midwifery shortages are identified
- Escalate concerns to line manager where staffing capacity and capability are inadequate to meet patient needs
- Understand the evidence based methodology used to determine the nursing and/or midwifery staffing in your area of responsibility

OTHER HEALTH AND CARE STAFF

- Complete data returns where requested about the staffing in your workplace to inform workforce planning decisions
- Participate in discussions and decisions regarding staffing in your clinical area
- Understand the agreed staffing capacity and capability are for your clinical area on a shift by shift basis
- Raise concerns regarding staffing and/or the quality of clinical care within your organisation when they arise

These roles and responsibilities only seek to cover responsibilities related to nursing, midwifery and care staffing capacity and capability, and are not exhaustive. They are not mandatory and should be read in the context of each organisation and its governance and management structures. It is important to empower ward Sisters/Charge Nurses to take responsibility for their clinical areas with delegated authority to act, supported by their organisations.

Roles will, over time, evolve and change as new innovations come into practice and these guidelines will need to be updated to take this into account.

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UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST

REPORT TO: **Trust Board**

DATE: **29th May 2014**

REPORT FROM: **Peter Hollinshead, Interim Director of Financial Strategy**

SUBJECT: **2014/15 Financial Position to Month 1**

1. Introduction and Context

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

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

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

2. Key Financial Duties

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

Financial Duty	YTD Plan £'Ms	YTD Actual £'Ms	Forecast Plan £'Ms	Forecast Actual £'Ms	RAG
Delivering the Planned Surplus	(4.3)	(4.3)	(40.7)	(40.7)	G
Achieving the EFL	(1.5)	(0.5)	(8.9)	(8.9)	G
Achieving the Capital Resource Limit	0.4	1.0	34.5	34.5	G

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

Better Payment Practice Code	Apr-14	
	Number	Value £000s
Total bills paid in the year	13,293	50,129
Total bills paid within target	6,285	35,631
Percentage of bills paid within target	**47.3**	**71.1**

Key issues

- The Trust does not have an agreed contract and as such there is a significant risk to the reported income position as this does not account for CCG proposed local fines and penalties.
- Shortfall of £6.6m on the forecast CIP delivery against the £45m target.
- The Capital Plan is currently over-committed and is predicated on Emergency Floor external funding, the commitments may be in advance of the receipt of funding.

3. Year to Date Financial Position (Month 1)

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

	April 2014		
	Plan £m	Actual £m	Var (Adv) / Fav £m
Income			
Patient income	56.8	56.4	(0.4)
Teaching, R&D	6.9	6.8	(0.1)
Other operating Income	3.2	3.1	(0.0)
Total Income	**66.9**	**66.3**	**(0.5)**
Operating expenditure			
Pay	41.2	40.7	0.5
Non-pay	26.3	26.1	0.2
Total Operating Expenditure	**67.5**	**66.8**	**0.7**
EBITDA	**(0.7)**	**(0.5)**	**0.2**
Net interest	-	-	-
Depreciation	(2.8)	(2.9)	(0.1)
PDC dividend payable	(0.9)	(0.9)	0.0
Net deficit	**(4.3)**	**(4.3)**	**0.0**
EBITDA %		**-0.8%**	

3.2. The Trust is reporting;

- A deficit at the end of April 2014 of £4.3m, which is £27k favourable to the planned surplus.
- The Trust is still forecasting delivery of the year-end financial plan of a deficit of £40.7m, subject to the risks described in this paper.

3.3 At the time of writing, the Trust does not have an agreed contract with its main commissioners. The key issues of dispute are the impact of QIPP, the baseline level of activity and the Trust's CIP income assumptions. A revised proposal has been submitted to the CCG and further escalation may be required with NHSE and NTDA input.

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

Patient Care Income

- Patient care income is under performing against the Trust's Plan (0.8%). The details by point of delivery and the price/volume impact are shown in Appendix 2 for NHS patient care income.

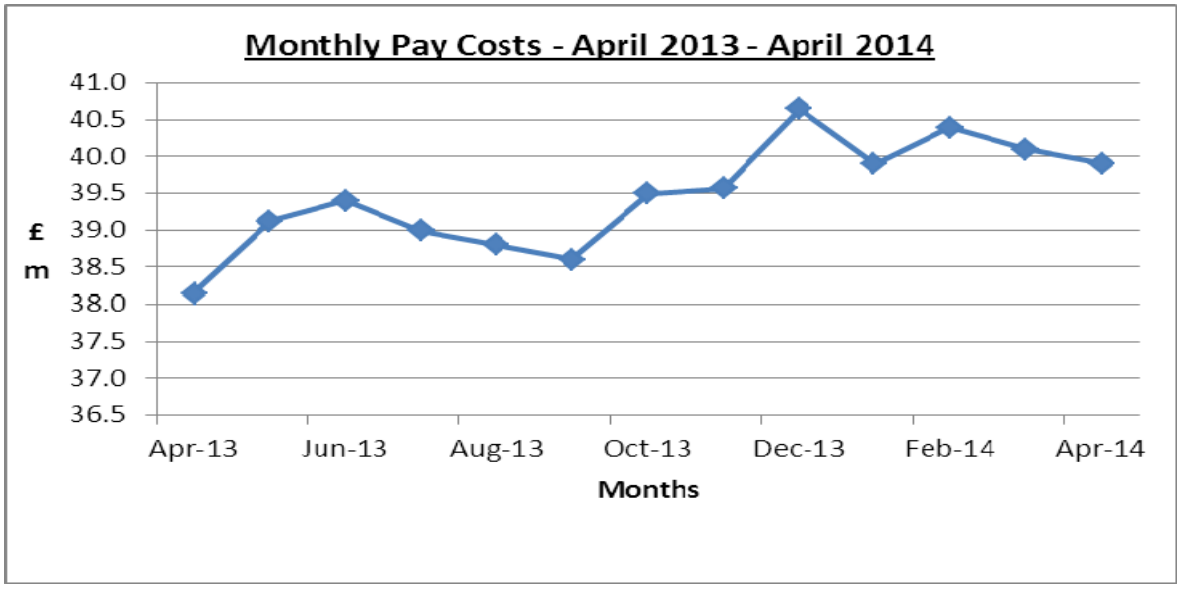
- The key factors to highlight from the appendix are;

  - £0.2m adverse position for Transplant Services due to the temporary closure of the service in April.
  - Significant over performance, £0.5m, in emergency activity, 141 spells (2%).
  - Adverse position against the Emergency Threshold (MRET), of £0.6m.

- 9% overperformance in elective inpatients, £0.4m
- Adverse performance against Plan for both Excluded drugs and devices, £0.2m (though the offset is seen as a reduction in non pay), and critical care, £0.4m, 3% down on bed days.

Pay

- Pay expenditure in month is £40.7m compared to the budget of £41.2m. The significant factors to note are:
  - As well as being under budget, pay costs in April are also at a lower than the March spend. The graph below shows the pay cost trend, after excluding the impact of the Alliance contract in April.
  - Continued progress in recruiting substantive nurses



Non Pay

- Non pay costs are £26.1m against a budget of £26.3m, resulting in a £0.2m favourable position. The key reason for the non-pay underspend is £0.2m underspend on excluded drugs and devices. The Trust continues to enact non pay controls across the CMGs and Corporate Directorates

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

Cost Improvement Programme

Appendix 3 shows CIP performance in April by CMG and Corporate Directorate against the original CIP plan. This currently shows an adverse position of £0.5m.

The following actions are planned over the next month towards ensuring deliver of the year end £45m CIP target:

- Focused work with Clinical Management Teams

- Work to identify and drive additional savings through a number of trust-wide schemes
- Short-term measures to reduce run-rate expenditure
- Service reviews in loss-making specialties

4. Risks

4.1. Within the financial position and year end plan there continue to be following potential risks:

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

  Mitigation: The Trust is planning to open an additional 45 beds for which both the revenue and capital costs are within the financial plan.

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

  At the time of writing, the Trust does not have an agreed contract with its main commissioners. The key issues are the impact of QIPP, the baseline level of activity and the Trust's CIP income assumptions.

  A revised proposal has been submitted to the CCG and further escalation may be required with NHSE and NTDA input.

- **Referral To Treat (RTT)**

  There is a risk to the delivery of the RTT target resulting in additional premium costs.

  Mitigation: RTT plan performance managed through fortnightly meeting with CCG/TDA and IST to review robustness of the plan.

- **CIP Delivery**

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

  Mitigation: External consultancy support from Ernst & Young, along with revised CIP governance arrangements, a weekly CIP Board and CMG Performance meetings.

- **Liquidity**

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

  Mitigation: Application and successful receipt of Temporary Borrowing. £15.5m received in April

- **Unforeseen events**

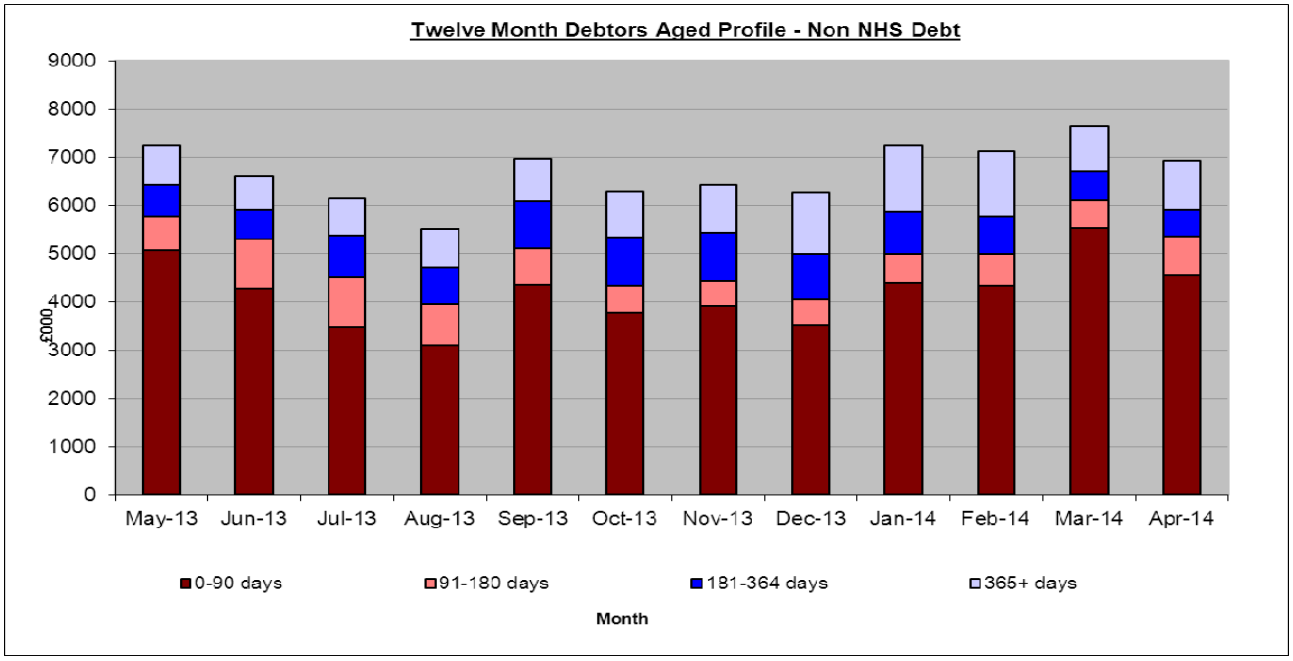
  The Trust has very little flexibility and a minimal contingency (£3.8m, 0.5% of turnover) for unforeseen financial pressures and as such any risks above the contingency will impact on the bottom line position

5. Balance Sheet

5.1. The effect of the Trust's financial position on its balance sheet is provided in Appendix 4.

5.2. The retained earnings reserve has reduced by the Trust's £4.3m deficit for Month 1.

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



5.4. The overall level of non-NHS debt at Month 1 was reduced from the year end the April 2013 position although the proportion of debt over 365 days has increased from £908k (12%) at the end of March 2014 to £1,028k (15%) in Month 1.

5.5. The Trust will be undertaking regular debt write-off exercises during the year by the year end which will reduce the level of outstanding aged debt. All debts to be written will already have been provided for 100% in the Trust's bad debt provision and there will be no impact on the financial position as a result of these write-offs.

5.6. The Better Payments Practice Code (BPPC) performance for April is disappointing but this is primarily due to the fact that a large number of payments made in April related to the £12m of overdue and unpaid invoices that were outstanding from the prior financial year. We are anticipating that the BPPC performance will improve from month 2 onwards.

6. Cash Flow Forecast

6.1. The Trust's cashflow forecast is provided in Appendix 5 and is consistent with the forecast income and expenditure position. Cash has increased by £13.3m from the year end and this is primarily due to the receipt of a £15.5m Temporary Borrowing Loan (TBL) from the Department of Health, which is currently repayable at the end of June.

6.2. We are required to submit a detailed cashflow forecast each time we apply for TBL funding and we cannot apply for this funding in advance of need and must prove that we would be overdrawn if we were not to receive the cash.

6.3. We have held discussions with the NTDA over the funding of our £40.7m deficit plan for the year and the £12m cash needed for the payment of the backlog invoices carried forward from

the prior year. Both of these issues contribute to a total revenue cash requirement of £52m for the year.

6.4. The NTDA are currently discussing our overall cash requirement with the Department of Health, based on the two year plan that we have submitted, and they hope to reach agreement on this soon.

6.5. We have agreed with the NTDA that we will continue to apply for temporary TBL cash when necessary during the year until we are in a position to apply for permanent PDC funding once we have more certainty over our capital PDC requirements. We have been advised that it would be beneficial for us to submit a combined PDC application for capital and revenue funding due to the level of work involved and the timescales involved.

6.6. The Trust's 2014-15 plan is to achieve a year end cash balance of £277k (2013/14 Actual - £515k) based on the Income & Expenditure (I&E) deficit of £40.7m.

6.7. This level of planned cash equates to a negative External Financing Limit (EFL) of (£8.9m), which is a statutory financial duty that the Trust must achieve. Failure to achieve the planned level of cash means that we will not achieve our EFL.

6.8. The Trust's cash flow forecast to the end of 2014-15 is provided in the appendices and demonstrates when the Trust will be applying for temporary borrowing in the first half of 2014/15 until permanent financing is secured.

6.9. Additionally we are working with the LLR CCGs to agree for them to pay us a proportion of the total monthly SLA monies on the 1st of each month instead of the 15th. This will enable us to better manager in month fluctuations in our cashflow.

7. Capital

7.1. Capital expenditure at the end of April was £1.0m

7.2. The Capital Plan has been reviewed and the proposed changes are detailed in Appendix 6.

7.3. The changes support the capital for bed capacity proposals and to allow for early works to commence on the ED Floor.

7.4. There is a risk that the Emergency Floor external funding will be delayed which would entail commitments being made in advance of funding.

7.5. The summary position is as follows:

Funding	**£m**
Opening CRL	**33.0**
Safer Hospitals Technology Fund	1.2
Improving Maternity Care Settings	0.1
Donations	0.3
CRL	**34.5**
Assumed External Funding	7.8
Applications	**42.3**
As per Appendix 6	**47.0**
Over-Commitment	**4.7**

8. Conclusion

8.1. The Trust, at the end of month 1, has a small favourable surplus of £27k against the Planned deficit of 4.3m

9. Next Steps & Recommendations

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

- **Note** the contents of this report
- **Discuss and agree** the actions required to address the key issues:
    - Lack of an agreed contract
    - Shortfall on the CIP programme
    - Managing the capital programme/aspirations and to confirm the changes to the capital programme

Appendix 1

Income and Expenditure Account for the Period Ended 30 April 2014

	April 2014		
	Plan £ 000	Actual £ 000	Variance (Adv) / Fav £ 000
Elective	5,598	5,968	370
Day Case	4,542	4,546	4
Emergency (incl MRET)	14,386	14,304	(82)
Outpatient	8,117	8,125	8
Non NHS Patient Care	458	461	3
Other	23,700	22,970	(730)
Patient Care Income	**56,802**	**56,374**	**(428)**
Teaching, R&D income	6,908	6,831	(77)
Other operating Income	3,166	3,127	(39)
Total Income	**66,876**	**66,332**	**(544)**
Pay Expenditure	**41,197**	40,697	**500**
Non Pay Expenditure	**26,346**	26,137	**209**
Total Operating Expenditure	**67,543**	**66,834**	**709**
EBITDA	**(667)**	**(502)**	**165**
Interest Receivable	8	8	0
Interest Payable	0	(3)	(3)
Depreciation & Amortisation	(2,793)	(2,928)	(135)
Surplus / (Deficit) Before Dividend and Disposal of Fixed Assets	**(3,452)**	**(3,425)**	**27**
Dividend Payable on PDC	(869)	(869)	0
Net Surplus / (Deficit)	**(4,321)**	**(4,294)**	**27**
EBITDA MARGIN		**-0.76%**	

Appendix 2

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

Case mix	Plan to Date (Activity)	Total YTD (Activity)	Variance YTD (Activity)	Variance YTD (Activity %)	Plan to Date (£000)	Total YTD (£000)	Variance YTD (£000)	Variance YTD (Activity %)
Day Case	6,844	6,782	(62)	(0.91)	4,542	4,546	4	0.08
Elective Inpatient	1,763	1,921	159	9.00	5,598	5,968	370	6.60
Emergency / Non-elective Inpatient	8,364	8,505	141	1.69	14,907	15,394	487	3.27
Marginal Rate Emergency Threshold (MRET)	0	0	0	0.00	(521)	(1,090)	(569)	109.31
Outpatient	60,744	60,278	(466)	(0.77)	8,117	8,125	8	0.09
Emergency Department	11,700	12,418	718	6.13	1,269	1,346	77	6.06
Winter Monies	0	0	0	0.00	0	0	0	0.00
Other	701,616	701,916	300	0.04	22,431	21,624	(807)	(3.60)
Grand Total	**791,030**	**791,819**	**789**	**0.10**	**56,344**	**55,913**	**(431)**	**(0.76)**

Average tariff	Price Variance YTD %	Volume Variance YTD %	Price / Mix Variance (£000)	Volume Variance (£000)	Variance YTD (£000)
Day Case	1.0	(0.9)	45	(41)	4
Elective Inpatient	(2.2)	9.0	(134)	504	370
Emergency / Non-elective Inpatient	1.6	1.7	236	251	487
Marginal Rate Emergency Threshold (MRET)			(569)	0	(569)
Outpatient	0.9	(0.8)	70	(62)	8
Emergency Department	(0.1)	6.1	(1)	78	77
Winter Monies			0	0	0
Other			0	(807)	(807)
Grand Total	**(0.9)**	**0.1**	**(354)**	**(77)**	**(431)**

Appendix 3

Financial Performance by CMG & Corporate Directorate

I&E and CIP - to April 2014

CMG / Directorate	Net YTD Budget £000s	Net YTD Actual £000s	Net Variance £000s	CIP YTD Plan £000s	CIP YTD Actual £000s	CIP YTD Variance £000s
CMGs:						
C.H.U.G.S	3,082	3,061	-21	399	242	-158
Clinical Support & Imaging	-3,102	-3,093	9	474	439	-35
Emergency & Specialist Med	626	949	323	396	512	116
I.T.A.P.S	-3,759	-4,065	-306	209	49	-160
Musculo & Specialist Surgery	2,634	2,503	-131	301	236	-65
Renal, Respiratory & Cardiac	2,226	2,098	-129	372	345	-27
Womens & Childrens	2,960	2,998	38	518	248	-270
	4,667	**4,450**	**-217**	**2,670**	**2,071**	**-599**
Corporate:						
Communications & Ext Relations	-61	-60	1	6	6	0
Corporate & Legal	-284	-287	-3	7	7	0
Corporate Medical	-245	-234	11	8	8	0
Facilities	-3,348	-3,163	185	367	367	0
Finance & Procurement	-572	-569	3	27	27	0
Human Resources	-358	-347	11	17	17	0
Im&T	-819	-840	-21	5	5	0
Nursing	-1,762	-1,716	46	30	30	0
Operations	-313	-349	-36	0	0	0
Strategic Devt	-249	-198	52	17	17	0
	-8,011	**-7,762**	**248**	**484**	**484**	**0**
Other:						
Alliance Elective Care	0	-25	-25			
R&D	97	97	0			
Central	-1,075	-1,054	21			
	-978	**-981**	**-3**			
Total	**-4,322**	**-4,294**	**27**	**3,154**	**2,555**	**-599**

Appendix 4

Balance Sheet

Trust Board paper W

	Mar-14 £000's Actual	Apr-14 £000's Actual	Mar-15 £000's Forecast
Non Current Assets			
Property, plant and equipment	362,465	360,188	442,516
Intangible assets	8,019	7,788	5,327
Trade and other receivables	3,123	3,311	2,253
TOTAL NON CURRENT ASSETS	**373,607**	**371,287**	**450,096**
Current Assets			
Inventories	13,937	13,711	14,200
Trade and other receivables	53,483	44,492	41,908
Other Assets	0	0	0
Cash and cash equivalents	515	13,850	500
TOTAL CURRENT ASSETS	**67,935**	**72,053**	**56,608**
Current Liabilities			
Trade and other payables	(112,726)	(102,381)	(115,364)
Dividend payable	0	(1,025)	0
Borrowings	(6,590)	(6,590)	(2,800)
Loan	0	(15,500)	
Provisions for liabilities and charges	(1,585)	(1,585)	(426)
TOTAL CURRENT LIABILITIES	**(120,901)**	**(127,081)**	**(118,590)**
NET CURRENT ASSETS (LIABILITIES)	**(52,966)**	**(55,028)**	**(61,982)**
TOTAL ASSETS LESS CURRENT LIABILITIES	**320,641**	**316,259**	**388,114**
Non Current Liabilities			
Borrowings	(5,890)	(5,794)	(8,971)
Other Liabilities	0	0	0
Provisions for liabilities and charges	(2,070)	(2,048)	(1,806)
TOTAL NON CURRENT LIABILITIES	**(7,960)**	**(7,842)**	**(10,777)**
TOTAL ASSETS EMPLOYED	**312,681**	**308,417**	**377,337**
Public dividend capital	282,625	282,625	417,819
Revaluation reserve	64,598	64,598	64,628
Retained earnings	(34,542)	(38,806)	(105,110)
TOTAL TAXPAYERS EQUITY	**312,681**	**308,417**	**377,337**

Appendix 5

Trust Board paper W

Cash Flow Statement for the period ended 30 April 2014	2014-15 Apr Plan £ 000	2014-15 Apr Actual £ 000	2014-15 Apr Variance £ 000
CASH FLOWS FROM OPERATING ACTIVITIES			
Operating surplus before Depreciation and Amortisation	(600)	(502)	98
Donated assets received credited to revenue and non cash		(13)	(13)
Interest paid	(38)	(68)	(30)
Movements in Working Capital:			
- Inventories (Inc)/Dec	-	226	226
- Trade and Other Receivables (Inc)/Dec	(1,215)	8,991	10,206
- Trade and Other Payables Inc/(Dec)	(9,237)	(9,320)	(83)
- Provisions Inc/(Dec)	585	22	(563)
PDC Dividends paid	-	-	-
Other non-cash movements	-	132	132
Net Cash Inflow / (Outflow) from Operating Activities	**(10,505)**	**(532)**	**9,973**
CASH FLOWS FROM INVESTING ACTIVITIES			
Interest Received	8	7	(1)
Payments for Property, Plant and Equipment	(3,533)	(1,037)	2,496
Capital element of finance leases	(761)	(603)	158
Net Cash Inflow / (Outflow) from Investing Activities	**(4,286)**	**(1,633)**	**2,653**
CASH FLOWS FROM FINANCING ACTIVITIES			
New PDC / LOAN	15,500	15,500	-
Other Capital Receipts	-	-	-
Net Cash Inflow / (Outflow) from Financing	**15,500**	**15,500**	**-**
Opening cash	515	515	-
Increase / (Decrease) in Cash	709	13,335	**12,626**
Closing cash	**1,224**	**13,850**	**12,626**

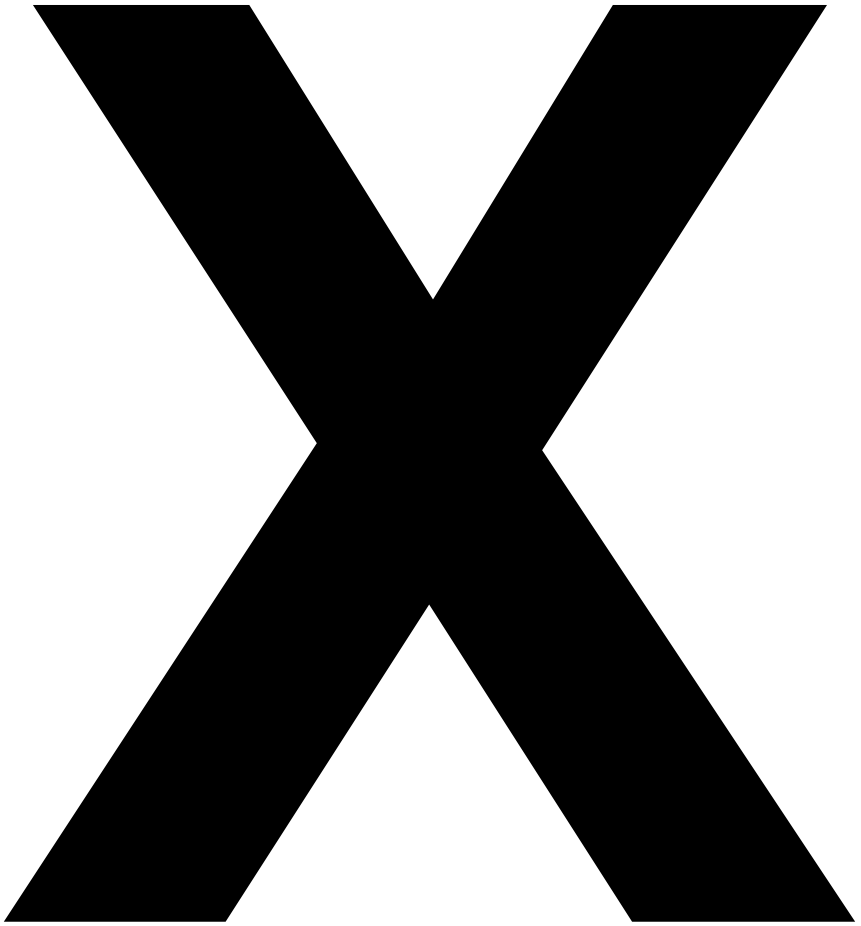
Cashflow 12 month forecast April 2014 to March 2015	Apr £000s	May £000s	Jun £000s	Jul £000s	Aug £000s	Sep £000s	Oct £000s	Nov £000s	Dec £000s	Jan £000s	Feb £000s	Mar £000s
Cash Flows from Operating Activities												
Operating Surplus/(Deficit)	(3,393)	(2,652)	(2,465)	553	(2,138)	281	(43)	(4,256)	(3,718)	(2,578)	(6,369)	(1,991)
Depreciation and Amortisation	2,793	2,793	2,794	2,784	2,784	2,784	2,729	2,729	2,729	2,691	2,691	2,695
Impairments and Reversals	0	0	0	0	0	(1,445)	0	0	0	0	0	0
Interest Paid	(38)	(38)	(38)	(38)	(38)	(38)	(38)	(38)	(38)	(38)	(38)	(38)
Dividend (Paid)/Refunded	0	0	0	0	0	(6,118)	0	0	0	0	0	(6,118)
(Increase)/Decrease in Trade and Other Receivables	(2,415)	(1,070)	83	(3,322)	2,898	(979)	(2,054)	3,929	(1,095)	(1,062)	4,070	(4,810)
(Increase)/Decrease in Other Current Assets	1,200	1,200	1,200	1,200	1,200	1,200	1,200	1,200	1,200	1,200	1,200	1,200
Increase/(Decrease) in Trade and Other Payables	(9,237)	(4,762)	(1,131)	889	1,070	(7,885)	2,306	(535)	(212)	2,041	1,864	(3,845)
Provisions Utilised	(22)	(22)	(22)	(22)	(22)	(1,022)	(22)	(22)	(22)	(22)	(22)	(25)
Increase/(Decrease) in Movement in non Cash Provisions	607	958	907	1,060	888	880	1,156	814	871	713	889	889
Net Cash Inflow/(Outflow) from Operating Activities	**(10,505)**	**(3,593)**	**1,328**	**3,104**	**6,642**	**(12,342)**	**5,234**	**3,821**	**(285)**	**2,945**	**4,285**	**(12,043)**
CASH FLOWS FROM INVESTING ACTIVITIES												
Interest Received	8	8	8	8	8	8	8	8	8	8	8	8
(Payments) for Property, Plant and Equipment	(3,533)	(3,634)	(3,630)	(4,532)	(4,761)	(4,198)	(5,003)	(3,693)	(4,564)	(5,757)	(6,751)	(7,734)
Net Cash Inflow/(Outflow) from Investing Activities	**(3,525)**	**(3,626)**	**(3,622)**	**(4,524)**	**(4,753)**	**(4,190)**	**(4,995)**	**(3,685)**	**(4,556)**	**(5,749)**	**(6,743)**	**(7,726)**
NET CASH INFLOW/(OUTFLOW) BEFORE FINANCING	**(14,030)**	**(7,219)**	**(2,294)**	**(1,420)**	**1,889**	**(16,532)**	**239**	**136**	**(4,841)**	**(2,804)**	**(2,458)**	**(19,769)**
CASH FLOWS FROM FINANCING ACTIVITIES												
New Public Dividend Capital received in year: PDC Capital						8,000						9,534
New Public Dividend Capital received in year: PDC Revenue	15,500	8,000	3,000	2,000		9,000			6,000	3,000	4,000	2,943
Loans received from DH - Revenue Support Loans	0	0	0	0	0	0	0	0	0	0	0	0
Loans repaid to DH - Revenue Support Loans Repayment of Principal						0	0	0	0	0	0	0
Capital element of payments relating to PFI, LIFT Schemes and finance leases	(761)	(761)	(761)	(761)	(761)	(761)	(761)	(761)	(761)	(761)	(761)	(761)
Net Cash Inflow/(Outflow) from Financing Activities	**14,739**	**7,239**	**2,239**	**1,239**	**(761)**	**16,239**	**(761)**	**(761)**	**5,239**	**2,239**	**3,239**	**18,739**
NET INCREASE/(DECREASE) IN CASH AND CASH EQUIVALENTS	**709**	**20**	**(55)**	**(181)**	**1,128**	**(293)**	**(522)**	**(625)**	**398**	**(565)**	**781**	**(1,030)**
Cash and Cash Equivalents (and Bank Overdraft) at Beginning of the Period	**512**	**1,221**	**1,241**	**1,186**	**1,005**	**2,133**	**1,840**	**1,318**	**693**	**1,091**	**526**	**1,307**
Cash and Cash Equivalents (and Bank Overdraft) at the end of the period	**1,221**	**1,241**	**1,186**	**1,005**	**2,133**	**1,840**	**1,318**	**693**	**1,091**	**526**	**1,307**	**277**

Trust Board paper W

Capital Plan 2014/15

Appendix 6

Version 11 - May2014	Scheme Committed (Y/N)	Version 08 £ ' 000	Changes £ ' 000	Version 11 £ ' 000	Project Lead	Project Director
CHUGGS CMG						
Endoscopy GH	N	309		309	Capital Planning & Delivery Team	Kate Shields
Lithotripter Machine	N	430	0	430	Michael Nattrass	John Jameson
Sub-total: CHUGGS CMG		**739**	**0**	**739**		
CSI CMG						
Aseptic Suite	Y	400		400	Pharmacy	Suzanne Khalid
MES Installation Costs	N	1,250	-248	1,002	Helen Seth / Nigel Bond	Suzanne Khalid
Sub-total: CSI CMG		**1,650**	**-248**	**1,402**		
Women's and Children's CMG						
Maternity Interim Development	Y	1,000	0	1,000	David Yeomanson	Ian Scudamore
Bereavement Facilities	N	62		62	David Yeomanson	Ian Scudamore
Sub-total: Women's & Children's CMG		**1,062**	**0**	**1,062**		
Renal, Respiratory & Cardiac CMG						
Renal Home Dialysis Expansion	N	708		708	Samantha Leak	Nick Moore
Sub-total: Renal, Respiratory & Cardiac CMG		**708**	**0**	**708**		
Emergency & Specialist Medicine CMG						
DVT Clinic Air Conditioning	N	0	30	30	Jane Edyvean	Catherine Free
Sub-total: Renal, Respiratory & Cardiac CMG		**0**	**30**	**30**		
Corporate / Other Schemes						
Stock Management Project	N	2,949	-737	2,212	Andrea Smith	Peter Hollinshead
Medical Equipment Executive Budget	N	3,737	-500	3,237	Paul Spiers / Mark Norton	Kevin Harris
LiA Schemes	N	500	-250	250	Michelle Cloney	John Adler
Odames Library	N	1,500	-500	1,000	Capital Planning & Delivery	Kate Shields
Donations	N	300		300		Peter Hollinshead
Sub-total: Corporate / Other Schemes		**8,986**	**-1,987**	**6,999**		
IM&T Schemes						
IM&T Sub Group Budget	N	3,000	-1,000	2,000	IT - John Clarke	John Adler
Safer Hospitals Technology Fund	N	1,150		1,150	IT - John Clarke	John Adler
EDRM System	N	3,300		3,300	IT - John Clarke	John Adler
EPR Programme	N	3,100		3,100	IT - John Clarke	John Adler
Unified Comms	N	1,850		1,850	IT - John Clarke	John Adler
Sub-total: IM&T Schemes		**12,400**	**-1,000**	**11,400**		
Facilities / NHS Horizons Schemes						
Facilities Backlog Maintenance	N	6,000	-500	5,500	Horizons - Andrew Chatten	Rachel Overfield
Accommodation Refurbishment	N	2,400	-1,200	1,200	Clare Blakemore / Andrew Chatten	Kate Bradley
CHP Units LRI & GH	Y	800		800	Horizons - Nigel Bond	Rachel Overfield
Sub-total: Facilities / NHS Horizons Schemes		**9,200**	**-1,700**	**7,500**		
ED Enabling Schemes						
ED Enabler: Clinic 1 & 2 Works	N	814		814	Capital Planning & Delivery/Louise Nay	Kate Shields
ED Enabler: Old Cancer Centre Conversion	N	1,050		1,050	Capital Planning & Delivery/Louise Nay	Kate Shields
ED Enabler: Oliver Ward Conversion	N	1,260		1,260	Capital Planning & Delivery/Louise Nay	Kate Shields
ED Enabler: Clinical Genetics	N	158		158	Capital Planning & Delivery/Louise Nay	Kate Shields
ED Enabler: Chapel Relocation	N	315		315	Capital Planning & Delivery/Louise Nay	Kate Shields
ED Enabler: Victoria Main Reception	N	525		525	Capital Planning & Delivery/Louise Nay	Kate Shields
ED Enabler: Modular Wards LRI	Y	3,700		3,700	Capital Planning & Delivery/Louise Nay	Kate Shields
Sub-total: ED Enabling schemes		**7,822**	**0**	**7,822**		
ED Early Works	N		3,500	3,500	Capital Planning & Delivery	Kate Shields
Reconfiguration Schemes						
Theatre Recovery LRI	N	2,785	-270	2,515	Capital Planning & Delivery/Ian Currie	Kate Shields
Interim ITU LRI	Y	500		500	Capital Planning & Delivery	Kate Shields
Vascular Enabling	N	520	-520	0	Capital Planning & Delivery/Debra Gre	Kate Shields
KSOPD Refurbishment	N	250	-250	0	Capital Planning & Delivery	Kate Shields
Ward 4 LGH	N	1,000		1,000	Capital Planning & Delivery/Nicky Topl	Kate Shields
Additional Beds (GH & LRI)	N	0	1,750	1,750	Capital Planning & Delivery	Kate Shields
Feasibility Studies	N	100		100	Capital Planning & Delivery	Kate Shields
Sub-total: Reconfiguration Schemes		**5,155**	**710**	**5,865**		
Total Schemes funded via internal sources		**47,722**	**-695**	**47,027**		
CRL Funding		***34,507***	***0***	***34,507***		
ED Enabling Schemes (assumed external funding)		***7,822***	***0***	***7,822***		
CRL Funding Gap		***5,393***	***-695***	***4,698***		
Schemes to be funded via external loans						
Emergency Floor	N	11,523	-5,523	6,000	Capital Planning & Delivery/Nicky Topl	Kate Shields
GGH Vascular Surgery 9inc.Ward, Ang, Hybrid	N	4,000	-1,500	2,500	Capital Planning & Delivery/Rachel Gri	Kate Shields
Sub-total: External Loans		**15,523**	**-7,023**	**8,500**		
Total Capital Plan		**63,245**	**-7,718**	**55,527**		



Trust Board paper X

To:	**Trust Board**
From:	**Richard Mitchell, Chief Operating Officer**
Date:	**29 May 2014**
CQC regulation:	**As applicable**

Title:	Emergency Department Performance Report

Author: Richard Mitchell, Chief Operating Officer

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

The Report is provided to the Board for:

Decision		Discussion	
Assurance	√	Endorsement	

Summary / Key Points:

- Performance in April was 86.92%
- Performance month to date (22 May 2014) was 83.31%
- Performance remains poor because of:
- Recent high attendances (700 patients on 19 May 2014)
- High admissions and a fixed bed base
- Deterioration in internal processes primarily because of the sustained pressure caused by the above
- Little progress on the delayed transfer of care (DTOC) rate
- Dr Ian Sturgess began working with UHL and LLR on 19 May 2014
- UHL has agreed an improvement plan with the TDA
- Current level of performance is unacceptable

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

Previously considered at another UHL corporate Committee N/A

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

Resource Implications (eg Financial, HR)
Yes

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

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

Equality Impact
N/A

Information exempt from Disclosure
N/A

Requirement for further review
Monthly

REPORT TO:	**Trust Board**
REPORT FROM:	**Richard Mitchell, Chief Operating Officer**
REPORT SUBJECT:	**Emergency Care Performance Report**
REPORT DATE:	**29 May 2014**

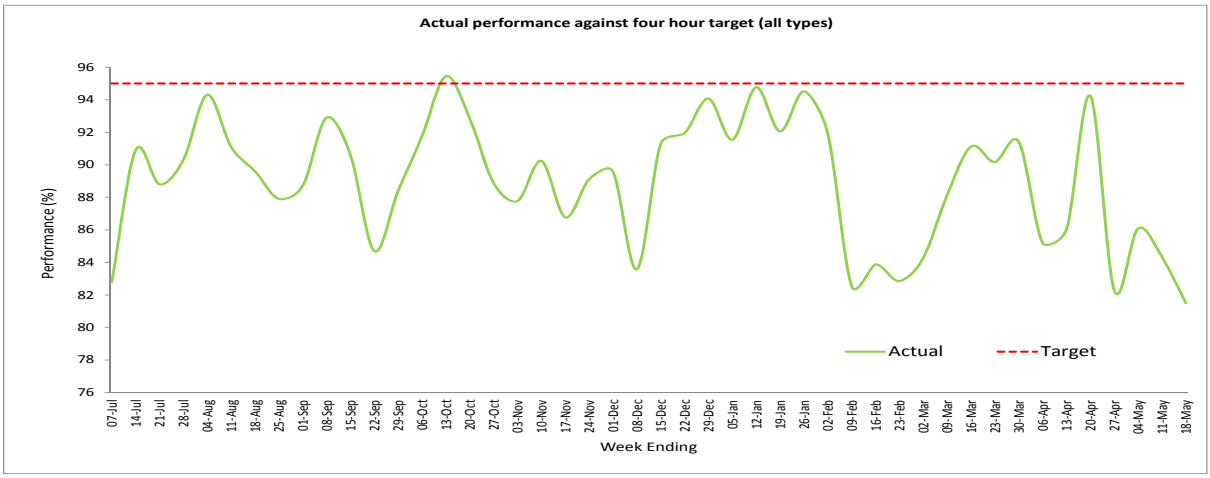
Introduction

Performance in April 2014 was 86.92%. Emergency admissions fell for the second month in a row but were 9.4% higher than April 2013. UHL continues to struggle with high numbers of emergency admissions and the LLR health economy is unable to increase the UHL discharge rate as quickly. In May we have seen spikes of attendances with 700 patients (campus level) attending in one day this week.

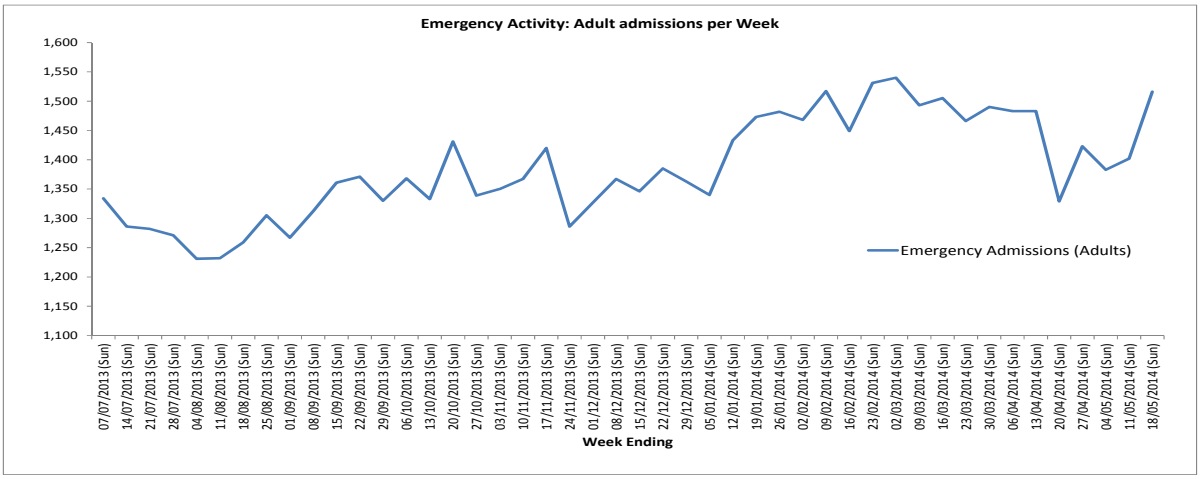
We continue to work on our internal actions and a new internal action plan has been agreed with the TDA.

Performance overview

Performance in April was poor despite one week of performance being 94.2% (graph one). There were four days of performance above 95% and relatively high levels of admissions throughout the month, apart from the week of strong performance when admission significantly dropped (graph two).



(graph one)



(graph two)

Reasons for deterioration in performance

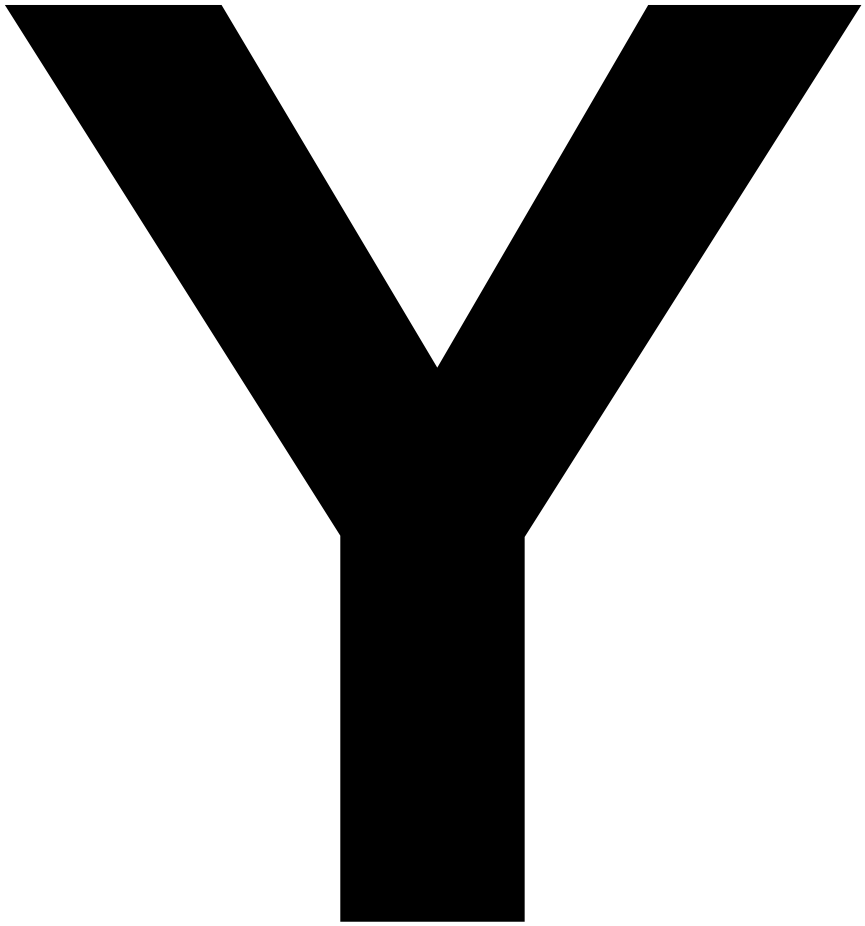
High admissions – Admissions remain very high.
Internal process - Internal processes in April remain poor. This is the central feature to the updated plan (attached) and is the key work that Ian Sturgess will support UHL with.
Delayed transfers of care – DTOCs remain high.

The key actions remain:

- Reduction in the number of GP patients being admitted – we have shared with the CCGs information at a practice level about where the increase in admissions is coming from
- Reduction in the number of admissions – we have implemented a change in A&E where patients can only be admitted with senior sign off (mainly consultant)
- Move towards seven day services and use of 'super weekends'. Discharge rate is now consistently higher than before the super weekends
- Continue to work on maximising internal process

Recommendations
The Board is asked to:

- Note the contents of the report and action plan
- Acknowledge the reasons for why performance continues to be poor
- Support the actions being taken to improve performance.



To:	Trust Board
From:	Stephen Ward, Director of Corporate & Legal Affairs
Date:	29th May 2014
CQC regulation:	N/A

Title:	NHS trust oversight self certification

Author/Responsible Director: Helen Harrison, FT Programme Manager / Stephen Ward, Director of Corporate & Legal Affairs

Purpose of the Report:

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

In accordance with the Accountability Framework, the Trust is required to complete two self certifications in relation to the Foundation Trust application process. Copies of the April 2014 self certifications are attached as Appendix A and B.

The Report is provided to the Board for:

Decision	X	Discussion	X
Assurance		Endorsement	

Summary / Key Points:

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

Recommendations:

The Trust Board is asked to provide the Director of Corporate and Legal Affairs with the delegated authority to agree a form of words with the Chief Executive in respect of the May 2014 self certifications to be updated following the Trust Board meeting and submitted to the NHS Trust Development Authority accordingly

Previously considered at another corporate UHL Committee? No

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

Resource Implications (eg Financial, HR): No

Assurance Implications: Yes

Patient and Public Involvement (PPI) Implications: No

Stakeholder Engagement Implications: No

Equality Impact: None

Information exempt from Disclosure: None

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

NHS TRUST DEVELOPMENT AUTHORITY

OVERSIGHT: Monthly self-certification requirements - Compliance Monitor

Monthly Data.

CONTACT INFORMATION:

Enter Your Name: John Adler

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

Full Telephone Number: 01162588940 Tel Extension: 8940

SELF-CERTIFICATION DETAILS:

Select Your Trust: University Hospitals Of Leicester NHS Trust

Submission Date: 30/04/2014 Reporting Year: 2013/14

Select the Month

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

COMPLIANCE WITH MONITOR LICENCE REQUIREMENTS FOR NHS TRUSTS:

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

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

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

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

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

COMPLIANCE WITH MONITOR LICENCE REQUIREMENTS FOR NHS TRUSTS:

		Comment where non-compliant or at risk of non-compliance
1. Condition G4 Fit and proper persons as Governors and Directors.	Yes	
		Timescale for compliance:
2. Condition G5 Having regard to monitor Guidance.	Yes	
		Timescale for compliance:
3. Condition G7 Registration with the Care Quality Commission.	Yes	
		Timescale for compliance:

		Comment where non-compliant or at risk of non-compliance
4. Condition G8 Patient eligibility and selection criteria.	Yes	
		Timescale for compliance:

		Comment where non-compliant or at risk of non-compliance
5. Condition P1 Recording of information.	Yes	
		Timescale for compliance:
6. Condition P2 Provision of information.	Yes	
		Timescale for compliance:
7. Condition P3 Assurance report on submissions to Monitor.	Yes	
		Timescale for compliance:
8. Condition P4 Compliance with the National Tariff.	Yes	
		Timescale for compliance:

		Comment where non-compliant or at risk of non-compliance
9. Condition P5 Constructive engagement concerning local tariff modifications.	Yes	
		Timescale for compliance:

		Comment where non-compliant or at risk of non-compliance
10. Condition C1 The right of patients to make choices.	Yes	
		Timescale for compliance:
11. Condition C2 Competition oversight.	Yes	
		Timescale for compliance:
12. Condition IC1 Provision of integrated care.	Yes	
		Timescale for compliance:

NHS TRUST DEVELOPMENT AUTHORITY

OVERSIGHT: Monthly self-certification requirements - Board Statements

Monthly Data.

CONTACT INFORMATION:

Enter Your Name: John Adler

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

Full Telephone Number: 01162588940 Tel Extension: 8940

SELF-CERTIFICATION DETAILS:

Select Your Trust: University Hospitals Of Leicester NHS Trust

Submission Date: 30/04/2014 Reporting Year: 2013/14

Select the Month

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

BOARD STATEMENTS:

CLINICAL QUALITY
FINANCE
GOVERNANCE

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

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

BOARD STATEMENTS:

For CLINICAL QUALITY, that

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

1. CLINICAL QUALITY Indicate compliance.	Yes
Timescale for compliance:	
RESPONSE: Comment where non-compliant or at risk of non-compliance	

BOARD STATEMENTS:

For CLINICAL QUALITY, that

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

2. CLINICAL QUALITY
Indicate compliance.

Yes

Timescale for compliance:

RESPONSE:

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

BOARD STATEMENTS:

For CLINICAL QUALITY, that

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

3. CLINICAL QUALITY
Indicate compliance.

Yes

Timescale for compliance:

RESPONSE:

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

BOARD STATEMENTS:

For FINANCE, that

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

4. FINANCE
Indicate compliance.

Yes

Timescale for compliance:

RESPONSE:

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

BOARD STATEMENTS:

For GOVERNANCE, that

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

5. GOVERNANCE
Indicate compliance.

Yes

Timescale for compliance:

RESPONSE:

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

BOARD STATEMENTS:

For GOVERNANCE, that

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

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

BOARD STATEMENTS:

For GOVERNANCE, that

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

7. GOVERNANCE Indicate compliance.	Yes
Timescale for compliance:	
RESPONSE: Comment where non-compliant or at risk of non-compliance	

BOARD STATEMENTS:

For GOVERNANCE, that

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

8. GOVERNANCE
Indicate compliance.

Yes

Timescale for compliance:

RESPONSE:

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

BOARD STATEMENTS:

For GOVERNANCE, that

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

9. GOVERNANCE
Indicate compliance.

Yes

Timescale for compliance:

RESPONSE:

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

BOARD STATEMENTS:

For GOVERNANCE, that

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

10. GOVERNANCE
Indicate compliance.

No

Timescale for compliance:

31/03/2015

RESPONSE:

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

UHL is currently non compliant with the ED 4 hour wait target and the Referral to Treatment (RTT) - admitted and non-admitted targets.

The Trust is working towards sustainable compliance with the ED target. An Emergency Care Improvement Hub has been established, which brings together partners from across health and social care.

An RTT recovery plan has been agreed with commissioners.

BOARD STATEMENTS:

For GOVERNANCE, that

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

11. GOVERNANCE
Indicate compliance.

Yes

Timescale for compliance:

RESPONSE:

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

BOARD STATEMENTS:

For GOVERNANCE, that

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

12. GOVERNANCE
Indicate compliance.

Yes

Timescale for compliance:

RESPONSE:

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

BOARD STATEMENTS:

For GOVERNANCE, that

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

13. GOVERNANCE
Indicate compliance.

Yes

Timescale for compliance:

RESPONSE:

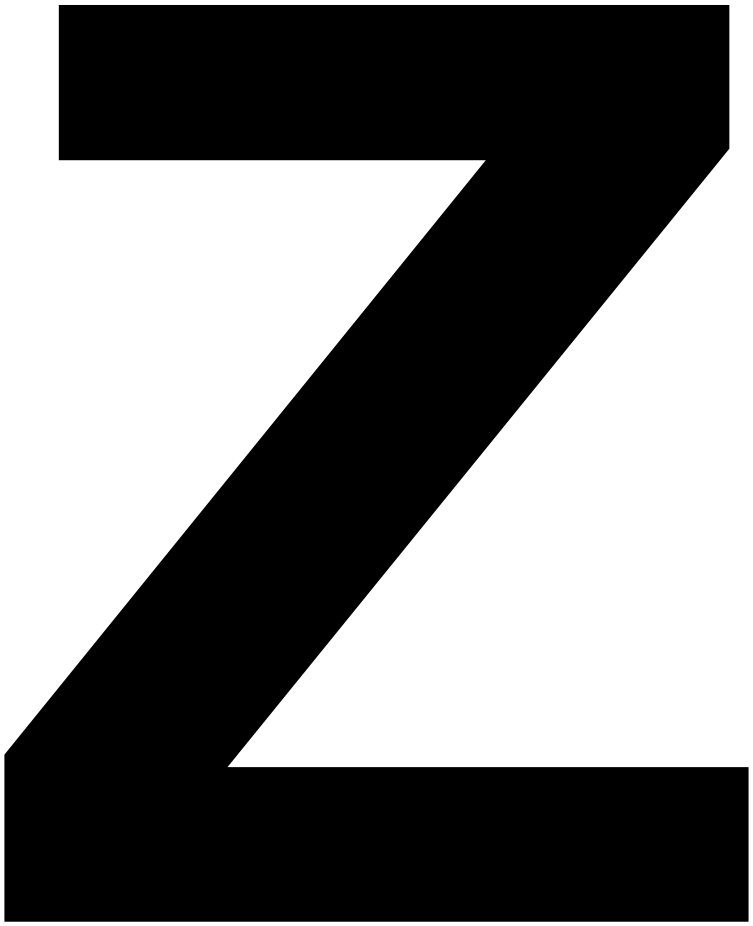
Comment where non-compliant or at risk of non-compliance

BOARD STATEMENTS:

For GOVERNANCE, that

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

14. GOVERNANCE Indicate compliance.	Yes
Timescale for compliance:	
RESPONSE:	
Comment where non-compliant or at risk of non-compliance	



Trust Board Paper Z

University Hospitals of Leicester NHS
NHS Trust

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST

REPORT BY TRUST BOARD COMMITTEE TO TRUST BOARD

DATE OF TRUST BOARD MEETING: 29 May 2014

COMMITTEE: **Audit Committee**

CHAIRMAN: **Ms K Jenkins, Non-Executive Director**

DATE OF COMMITTEE MEETING: 15 April 2014

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

- **None**

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

- **None**

DATE OF NEXT COMMITTEE MEETING: 27 May 2014

Ms K Jenkins
7 May 2014

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST

MINUTES OF A MEETING OF THE AUDIT COMMITTEE HELD ON TUESDAY 15 APRIL 2014 FROM 10.30AM IN THE ASH ROOM, KNIGHTON STREET OFFICES LEICESTER ROYAL INFIRMARY

Present:
Ms K Jenkins – Non-Executive Director (Chair)
Mr I Crowe – Non-Executive Director
Mr P Panchal – Non-Executive Director (until part 28/14/3)

In Attendance:
Mr J Clarke – Chief Information Officer (for Minute 27/14)
Mr P Cleaver – Risk and Assurance Manager (for Minute 26/14 only)
Mr P Hollinshead – Interim Director of Financial Strategy
Mrs S Hotson – Director of Clinical Quality (for Minute 25/14 only)
Mrs H Majeed – Trust Administrator
Mr R Manton – Risk and Safety Manager (for Minute 26/14 only)
Mr N Sone – Financial Controller (from Minute 28/14)
Dr P Rabey – Deputy Medical Director (for Minute 24/14 only)

Ms J Clarke – Local Counter Fraud Specialist (360 Assurance) – until Minute 27/14
Mr I Morris – Local Counter Fraud Team (360 Assurance) – until Minute 27/14
Mr D Hayward – Manager, KPMG (the Trust's External Auditor)
Mr D Sharif – Senior Manager, KPMG (the Trust's External Auditor)
Ms C Wood – Internal Audit Manager, PwC (the Trust's Internal Auditor)

RESOLVED ITEMS **ACTION**

19/14 PRIVATE DISCUSSIONS WITH BOTH SETS OF AUDITORS

In line with the guidance detailed within paper A, private discussions took place between the Chair and members of the Audit Committee and External and Internal Audit representatives ahead of the start of the formal meeting.

Resolved – that the position be noted.

20/14 WELCOME AND APOLOGIES

Apologies for absence were received from Mr A Bostock, KPMG; Ms A Breadon, PwC; Ms R Overfield, Chief Nurse and Ms J Watson, PwC.

21/14 MINUTES

Resolved – that the Minutes of the meeting held on 7 March 2014 (papers B and B1 refer) be confirmed as a correct record.

22/14 MATTERS ARISING FROM THE MINUTES

The Committee Chair selected the following key actions from paper C and members reported on progress:-

22/14/1 Minute 4/14/(ii) of 7 March 2014 – responding to a query from the Committee Chair in respect of the measures that had been implemented to prevent staff from working

elsewhere whilst on sick leave, the Local Counter Fraud Specialist advised that each CMG used a variety of 'return to work from sickness' documentation. In discussion on this matter, the Interim Director of Financial Strategy undertook to liaise with the Director of Human Resources to check whether the return to work documentation used by the Trust explicitly asked staff to confirm whether they have not been working elsewhere whilst absent. The Committee Chair requested that if the documentation did not have this question then it needed to be amended to ensure that this question was included. She also noted the need for a timetable to be in place for this documentation to be rolled out across CMGs. An update on this matter be scheduled on the agenda for the Audit Committee in July 2014.

IDFS

DHR

DHR/TA

22/14/2 Minute 06/14/1 of 7 March 2014 – the Local Counter Fraud Specialist advised that a meeting had been held with NHS Horizons and Interserve colleagues and Interserve had agreed to cooperate in terms of training all staff on fraud awareness and sharing information on fraud and theft incidents with the Counter Fraud Specialists. The training would be provided through e-learning and dissemination of workbooks. The Committee Chair requested that a further update on progress be provided via the matters arising log for the May 2014 Audit Committee meeting.

LCFS

22/14/3 Minute 10/14 of 7 March 2014 – an update on clinical coding had been provisionally scheduled to be presented to the Audit Committee in May 2014. The Committee Chair suggested that this item be deferred to the July 2014 (if required) highlighting that the agenda for the May 2014 might be busy due to the discussion of the Trust's annual accounts.

TA

22/14/4 Minute 11/14/2 of 7 March 2014 – the Interim Director of Financial Strategy advised that the outstanding internal audit recommendations was discussed at the Executive Performance Board (EPB) in March 2014 and the EPB had suggested that the future versions of this report included a column indicating the 'Responsible Director' for each action. The Committee Chair queried whether the EPB discussed the overall risk in terms of the high level of outstanding overdue actions – it was noted that this matter was not covered in the March 2014 EPB discussion, however the Interim Director of Financial Strategy undertook to raise this matter at the EPB on 22 April 2014.

IDFS

22/14/5 Minute 13/4/2 (i) of 7 March 2014 – the Committee Chair agreed to liaise with the Chair of the Finance and Performance (F&P) Committee to ensure that relevant elements of the private patients and overseas visitors report were considered and addressed by the F&P Committee.

Chair

22/14/6 Minute 53/13/2 (ii) of 10 September 2013 – the Local Counter Fraud Specialist advised that national fraud trends information had not been released by NHS Protect , therefore she would try to seek regional information and provide an update to a future meeting of the Audit Committee.

LCFS

<u>Resolved</u> – that the matters arising report (paper C) and the actions now required, as detailed above, be noted.

IDFS/ DHR/ LCFS/ Chair/TA

23/14 ITEMS FROM THE LOCAL COUNTER FRAUD SPECIALIST

23/14/1 <u>Local Counter Fraud Specialist Annual Report 2013-14</u>

Paper D detailed a summary of the annual report of counter fraud work for 2013-14. Responding to a query, Ms J Clarke, Local Counter Fraud Specialist (LCFS) undertook to check whether the counter fraud e-learning package was now available on the e-UHL system (noting that there had been some technical difficulties in synchronising the software with the UHL system) and inform the Trust Administrator who would then

LCFS

email Audit Committee members to provide confirmation. She advised that the counter fraud training was a part of mandatory training (provided at induction with a requirement to undertake a refresher training every 3 years). **TA**

In particular discussion about an overseas visitor debt, the Local Counter Fraud Specialist provided background information and made members aware of the processes in place to inform a number of agencies (i.e. DoH, UKBA etc.) in respect of such cases.

In respect of the preventing and deterring fraud activities by the LCFS, Mr P Panchal, Non-Executive Director cited an example re. members of the public who were not allowed free NHS treatment might not report an outbreak which might be dangerous for the Community. In discussion on this matter, the Committee Chair suggested that discussion be held with appropriate colleagues (i.e. Health Protection Agency) to understand the policies in place in terms of outbreaks in the local population. **CN**

<u>Resolved</u> – that (A) the annual report of counter fraud work for 2013-14 (paper D) be noted;

(B) the Local Counter Fraud Specialist be requested to email the Trust Administrator to confirm whether the counter fraud training package was now available on e-UHL. Further to this, the Trust Administrator to email members of the Audit Committee, and **LCFS/ TA**

(C) the Chief Nurse to liaise with appropriate colleagues to ascertain the policies in place in terms of outbreaks in the local population. **CN**

23/14/2 <u>Report noting the actions that had been implemented as a result of two previous cases</u>

Ms J Clarke, Local Counter Fraud Specialist tabled a report (paper E) which the Committee Chair requested be included on the agenda for discussion at the July 2014 Audit Committee meeting. **LCFS/ TA**

<u>Resolved</u> – that the tabled report be scheduled on the agenda for the Audit Committee in July 2014. **LCFS/ TA**

23/14/3 <u>Staff Survey Report</u>

Paper F provided the results of an independent survey undertaken by LCFS on behalf of the Trust which had been designed to evaluate staff perception of where risks of fraud, bribery and/or corruption were highest and gain an insight into staff understanding of Trust Fraud, Bribery and Corruption policy.

In response to a query from Mr I Crowe, Non-Executive Director re. staff perception about counter fraud, it was noted that the 2013-14 survey had generated some negative comments and some staff groups were not aware of the counter fraud work undertaken in the Trust. The Committee Chair suggested that in future surveys consideration be given to collecting the staff groups or at least the CMGs in which the staff were working. Mr I Morris, Local Counter Fraud Specialist advised that his team would be working with the Trust's Communications team to ensure that the newsletters and other briefings were circulated to a wider group (noting that some staff had raised concerns that they were no longer receiving the 'Fraudulent Times' newsletter). The Committee Chair suggested that the Chief Executive's briefing be used as a means to raise the profile of counter fraud work, an update on the survey and case outcomes. **LCFS**

The Committee Chair requested the action plan in section 4 of the report included **LCFS**

timescales and was cross-referenced with the work plan.

Mr I Crowe, Non-Executive Director noted the need for IBM staff also to be made aware of the counter fraud work within the Trust. **LCFS**

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

(B) the Local Counter Fraud Specialist to:-

- **give consideration to collecting the staff groups or at least the CMGs in which the staff were working in future counter fraud surveys;** **LCFS**
- **work with the Trust's Communications team to ensure that the newsletters and other briefings were circulated to a wider staff group, as appropriate;**
- **consider if an update on the counter fraud work, survey and case outcomes was included in the Chief Executive's briefings, and**
- **update the action plan in section 4 of the report to include timescales and cross-reference it with the work plan.**

23/14/4 Report from the Local Counter Fraud Specialist

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

24/14 CONSULTANT JOB PLANNING FRAMEWORK

Paper H provided an update on the steps being taken to improve medical job planning, including monitoring of fulfilment of job plans. Dr P Rabey, Deputy Medical Director attended for this item. Responding to a query, it was noted that an update on this matter had already been presented to the Finance and Performance (F&P) Committee. The Audit Committee Chair undertook to check with the F&P Committee Chairman re. whether future updates on this matter would be discussed at F&P Committee accordingly. **Chair**

Members noted that there was inconsistency between specialties and CMGs in respect of job planning. In response, the Deputy Medical Director advised that the Medical Job Planning Consistency Committee was being established to resolve this issue. The Job Planning framework had been re-submitted to the Local Negotiating Committee, however agreement to the framework had not yet been obtained. Therefore, a subgroup had been set up to resolve the issues and it was expected that the framework would be signed-off by May 2014. The first 10% of the job plans was expected to be in place by end of June 2014 and the rest by December 2014. Medical Productivity had been badged as one of the cross cutting workstreams and support from EY colleagues had been sought to take this forward. A Medical Productivity Board had also been established. It was suggested that metrics be put in place in order that this could be monitored appropriately. **DMD**

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

(B) the Deputy Medical Director be requested to develop metrics to ensure that the job planning framework was appropriately monitored, and **DMD**

(C) the Committee Chair to liaise with the F&P Committee Chair to ensure that updates on job planning were discussed at F&P Committee accordingly. **Chair**

25/14 QUALITY ACCOUNTS TIMETABLE

The Audit Committee noted paper I - the letter from NHS England to NHS Trusts' Chief Executives on reporting requirements of the 2013-14 Quality Accounts and the project plan for UHL's 2013-14 Quality Account (appendix A refers).

Members noted that Annex 2 listed the indicators that NHS Trusts and non-NHS bodies were required to report in their Quality Accounts. In respect of the Trust's patient reported outcome measures scores for (i) groin hernia surgery, (ii) varicose vein surgery, (iii) hip replacement surgery, and (iv) knee replacement surgery – members advised that this did not routinely feature in the Trust's Quality and Performance report. The Committee Chair undertook to liaise with the Quality Assurance Committee (QAC) Chair re. whether this matter needed to be discussed at the QAC meeting. **Chair**

In discussion, it was noted that the final draft of the quality accounts would be available in May 2014 (i.e. after the submission of the Trust's annual report and annual accounts) and therefore the Committee Chair noted the need for the Annual Governance Statement to make reference to the sources of assurance that management have relied upon in respect of outcomes relating to quality aspects. The Interim Director of Financial Strategy undertook to feedback this to the Director of Corporate and Legal Affairs. **IDFS/ DCLA**

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

(B) the Committee Chair to take forward the action listed above, and **Chair**

(C) the Interim Director of Financial Strategy to feedback comments to the Director of Corporate and Legal Affairs in respect of the quality assurance sources that needed to be referenced in the Annual Governance Statement. **IDFS/ DCLA**

26/14 UHL RISK REPORT INCORPORATING THE BOARD ASSURANCE FRAMEWORK (BAF) FOR THE PERIOD 1 FEBRUARY – 31 MARCH 2014

The Risk Assurance Manager and Risk and Safety Manager attended to present paper J, which provided an overview of significant risks impacting upon the Trust and also detailed information in relation to the effectiveness of risk management processes within the Trust.

In respect of the new high risk on UHL's risk register relating to 'The Forensic Toxicology service will fail resulting in a substantial loss of income and prestige for the Department/Empath', Mr I Crowe, Non-Executive Director queried whether this was a significant financial loss for the Trust – in response, the Interim Director of Financial Strategy undertook to find out the details. **IDFS**

Mr I Crowe, Non-Executive Director queried whether appropriate escalation processes were in place to flag risks from the UHL risk register. In response, members were advised that all risks with a score of 15 or more were escalated to the Executive Team each month and new risks scoring 15 or above were reported to the Trust Board every month. The Risk and Assurance Manager advised that a rolling programme was being established for CMGs to attend future meetings of the Audit Committee to report on operational risks. Appendix 6 provided a list of suggested areas of scrutiny in respect of CMG risk register – it was suggested that the CMG's objectives be included to this list.

In order to address any weaknesses in the risk escalation process, the Audit Committee noted the need to identify lessons to be learned from the two week pause of the Renal Transplant service. The Interim Director of Financial Strategy noted that the Quality Assurance Committee was reviewing lessons learned from the above

referenced matter and (any other recent examples) and suggested that an update on that learning be presented to Audit Committee, as appropriate. **QAC Chair**

In respect of the refreshed UHL strategic objectives and the BAF 2014-15, it was noted that a discussion was scheduled to be held with the Executive Team in the afternoon on 15 April 2014 regarding the principal risk themes and the process for developing of the 2014-15 BAF ahead of the Trust Board development session in June 2014 which had been set aside for that purpose. PwC would be facilitating the session to update the BAF and the Committee Chair suggested that lessons be learned from last year's session. The Internal Audit Manager agreed to feedback this to her colleagues. **IA**

Attendance at UHL risk awareness training continued to be low and a training needs analysis had been undertaken and an action plan had been developed to ensure that the correct level of risk management training was focussed on the appropriate staff groups. An update on attendance of risk training would be provided in the next risk report to the Audit Committee.

<u>Resolved</u> – that (A) the contents of this paper be received and noted, and the recommendations contained therein endorsed;

(B) the Interim Director of Financial Strategy to find out the details of the financial loss in respect of the forensic toxicology service; **IDFS**

(B) the Quality Assurance Committee be requested to consider and report to the Audit Committee its review of the two week pause of the Renal Transplant Service including any weaknesses identified relating to risk management and escalation processes, and **QAC Chair**

(C) the Internal Audit Manager to feedback comments from the Audit Committee to her colleagues in respect of the session to update the BAF. **IA**

27/14 IT INFORMATION SECURITY MANAGEMENT

Paper K provided an update on IM&T - business continuity/disaster recovery and information security arrangements. Responding to a query from Mr P Panchal, Non-Executive Director in respect of hacking systems, the Chief Information Officer advised that appropriate testing processes were in place. Discussion on this matter was held regularly at the Operational Security Group and exception reports were presented to the Joint (UHL/IBM) Governance Board. In response to a suggestion, the Chief Information Officer undertook to provide six monthly reports to the Joint Governance Board, as appropriate.

<u>Resolved</u> – that the contents of paper K and verbal update be noted.

28/14 ITEMS FROM INTERNAL AUDIT

28/14/1 <u>Internal Audit Reviews</u>

(a) <u>IBM Contract Review</u>

The Internal Audit Manager advised that this report was currently in 'draft' highlighting that it was a low risk report with some minor areas for improvement. The final report would be available for the Audit Committee in May 2014. **IA**

<u>Resolved</u> – that the IBM contract review report be presented to the Audit Committee in May 2014. **IA**

(b) Data Security

It was noted that this review report was also in 'draft' currently and had some medium risk issues but no high risk recommendations. In respect of data privacy, it was noted that no privacy breach software was used in the Trust. The final report would be available for the Audit Committee in May 2014. **IA**

Resolved – that the data security report be presented to the Audit Committee in May 2014. **IA**

28/14/2 2013-14 Draft Annual Report and Head of Internal Audit Opinion

Paper L , the Internal Audit annual report set out the internal audit work that had been undertaken in 2013-14 and included the Head of Internal Audit's annual opinion on the adequacy and effectiveness of the Trust's framework of governance, risk management and control.

It was noted that during 2013-14, Internal Audit had not undertaken specific work in the following areas of principal risk that were recorded on the Trust's Board Assurance Framework:

- Risk 4 – failure to transform the emergency care system;
- Risk 5 – patient experience/ satisfaction, and
- Risk 7 – ineffective organisational transformation.

The Trust would therefore need to consider where other forms of assurance had been derived in these areas, as part of the development of its Annual Governance Statement. **DCLA**

The delayed transfer of care and quality assurance framework reviews were still in progress and the final reports would be available for the May 2014 Audit Committee meeting.

In respect of the internal audit outstanding recommendations, the Internal Audit Manager advised that there had been an improvement in the Trust's processes to monitor the actions.

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

(B) the Director of Corporate and Legal Affairs be requested to take forward the actions listed above. **DCLA**

28/14/3 2014-15 Internal Audit Plan

Paper M which set out the work that had been carried out in relation to assessing risk and the proposed internal audit work for 2014-15.

In respect of the testing on charitable funds transactions, Mr P Panchal, Non-Executive Director/ Chair of the Charitable Funds Committee suggested that Internal Auditors contacted him outside the meeting in respect of additional controls that could be put in place in respect of approval of charitable funds. It was also suggested that the timing of the charitable funds transaction audit be reviewed to check when it would be most appropriate to take it forward. **IA**

In discussion on appendix 3 of paper M, members noted that the risks from the BAF had been considered when preparing the internal audit plan and the areas where no internal audit work was planned in 2014-5 had been highlighted in 'red'. The **IDFS**

Committee Chair requested that the Executive Team considered the level of assurance obtained from other sources for areas not covered by the internal audit plan. In respect of appendix 4, the Committee Chair noted that no reviews had yet been undertaken for a number of 'Human Resources' areas apart from the Organisational Development plan review in 2013-14, the Interim Director of Financial Strategy undertook to discuss this with the Executive Team. The Internal Audit Manager requested that a report from the Executive Team re. where they had sought assurance for areas that had not been reviewed by Internal Audit would prove useful. **IDFS**

The 2014-15 Internal Audit plan was approved subject to confirmation from the Executive Team in respect of the points raised above and a further discussion at the Trust Board Development session in May 2014.

In response to a query from Mr I Crowe, Non-Executive Director, it was noted that the audit regarding the CMG structure would ascertain whether the CMGS were following the Trust's governance policies and processes. The Committee Chair advised that she was due to attend one of the CMG Board meetings and suggested that it would be useful for other Non-Executive Directors to attend some CMG meetings to observe.

Resolved – that (A) the 2014-15 Internal Audit plan be approved subject to Executive Team consideration of the level of assurance obtained from other sources for areas not covered by the internal audit plan and in particular that no reviews had yet been undertaken for a number of 'Human Resources' areas apart from the Organisational Development plan review in 2013-14, and **IDFS**

(B) Internal Audit to liaise with Mr P Panchal, Non-Executive Director/ Chair of the Charitable Funds Committee for a further discussion re. testing on charitable funds transactions. **IA**

29/14 ITEMS FROM EXTERNAL AUDIT

29/14/1 External Audit Progress Report

Paper N provided an update on work undertaken since the last meeting in March 2014, forthcoming work ahead of the May 2014 Audit Committee and included technical updates for noting.

In discussion on the CQC inspection report, the Committee Chair noted the need for the Annual Governance Statement to include all the basis of assurance (i.e. CNST etc.).

External Auditors would be holding further meetings with the Trust to discuss emerging issues, as well as the Value for Money and Going Concern conclusions.

Resolved – that the contents of paper N, which detailed the progress report for External Audit at April 2014, be received and noted.

30/14 FINANCE – STRATEGIC AND OPERATIONAL ISSUES

30/14/1 Discretionary Procurement Actions

Paper O detailed the discretionary procurement actions for the period March 2014 in line with the Trust's Standing Orders.

In discussion re.the single tender action for additional car parking places with a value of £550,000.00 needed to be approved by the Trust Board, the Interim Director of

Financial Strategy advised that this was a one-off/time critical requirement and an enabler for the Emergency Floor project.

Resolved – that the contents of paper O, which reported on the discretionary procurement actions for March 2014 in line with the Trust's Standing Orders, be received and noted.

30/14/2 Losses and Special Payments

Paper P provided an update on losses and special payments for the year ending March 2014.

Responding to a query from Mr I Crowe, Non-Executive Director, the Financial Controller advised that the some of the overseas debts had been written off (previously provided for) further to instruction from debt collection agencies that the debts were uneconomical to pursue. The Interim Director of Financial Strategy suggested that the age of the debt and contextual information be included in future such reports. **FC**

Discussion also took place regarding the reasons for outstanding debt in relation to private patients and overseas visitors, and members noted the need for a root cause analysis to be undertaken with a lessons learned report and an action plan to be developed. It was noted that progress in this regard was dependent upon the resource and capacity of the team, in respect of which work was in progress. It was agreed that the Financial Controller would reflect on this matter and report back to the Audit Committee in May 2014. **FC/TA**

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

(B) the Financial Controller to include the age of the debt and contextual information in future losses and special payments reports, and **Chair**

(B) the Financial Controller be requested to report to the May 2014 Audit Committee in respect of a root cause analysis of overseas visitors and private patients' debts, lessons learned and an action plan to address the issues. **FC/TA**

30/14/3 Report from the Interim Director of Financial Strategy

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

31/14 DRAFT ANNUAL GOVERNANCE STATEMENT (AGS) 2013-14

Paper R provided an update on the preparation of the draft annual governance statement 2013-14, the final version of the AGS would be presented to the Audit Committee in May 2014. **DCLA**

Resolved – that the Annual Governance Statement 2013-14 be submitted to the Audit Committee in May 2014. **DCLA/ TA**

32/14 ASSURANCE GAINED FROM THE FINANCE AND PERFORMANCE COMMITTEE AND THE QUALITY AND ASSURANCE COMMITTEE ON KEY RISKS / ISSUES OF THE TRUST

Resolved – that the Committee confirmed the assurance gained from the Finance and Performance Committee and the Quality and Assurance Committee on key risks / issues for the Trust.

33/14 ITEM FOR INFORMATION

33/14/1 Activation of Business Continuity Arrangements

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

34/14 MINUTES FOR INFORMATION AND DISCUSSION

34/14/1 Quality Assurance Committee

Resolved – that the Minutes of the Quality Assurance Committee meeting held on 26 February 2014 (paper T refers) be received and noted.

34/14/2 Finance and Performance Committee

Resolved – that the Minutes of the Finance and Performance Committee meeting held on 26 February 2014 (paper U refers) be received and noted.

35/14 ANY OTHER BUSINESS

Resolved – that there were no further items of business.

36/14 IDENTIFICATION OF KEY ISSUES THAT THE COMMITTEE WISHES TO DRAW TO THE ATTENTION OF THE TRUST BOARD

Resolved – that there were no specific issues, which the Committee wished to draw to the attention of the Trust Board.

37/14 DATE OF NEXT MEETING

Resolved – that (A) the next meeting of the Audit Committee be held on Tuesday 27 May 2014 at 10.30am in the Teaching Room 2, Clinical Education Centre, Leicester Royal Infirmary, and

(B) it be noted that this meeting would be preceded by a private meeting between the Audit Committee Chair and the Non-Executive Director members at 10:00am, with representatives from Internal and External Audit to attend from 10:15am in the Teaching Room 2, Clinical Education Centre, Leicester Royal Infirmary.

The meeting closed at 1:09pm.

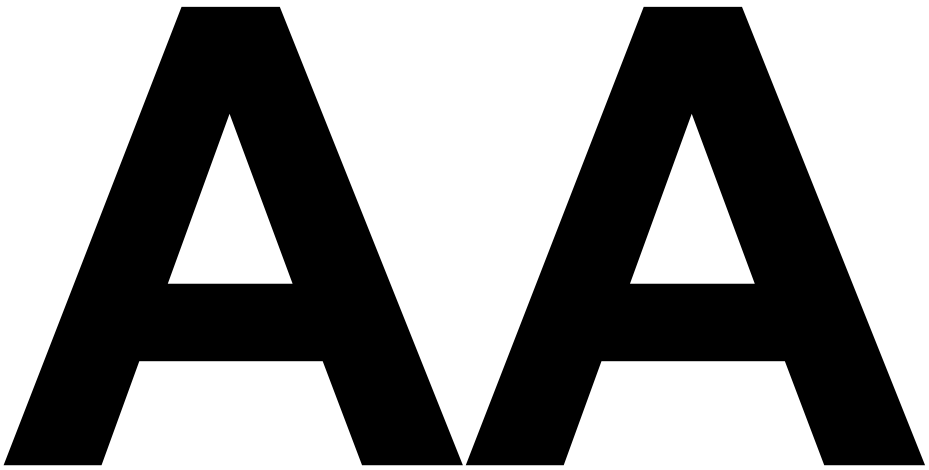
Hina Majeed,
Trust Administrator

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

Name	Possible	Actual	% attendance
K Jenkins (Chair)	1	1	100%
I Crowe	1	1	100%
P Panchal	1	1	100%

Attendees

Name	Possible	Actual	% attendance
P Hollinshead	1	1	100%
S Ward	1	0	0%
R Overfield	1	0	0%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Trust Board Paper AA

University Hospitals of Leicester NHS
NHS Trust

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST

REPORT BY TRUST BOARD COMMITTEE TO TRUST BOARD

DATE OF TRUST BOARD MEETING: 29 May 2014

COMMITTEE: Finance and Performance Committee

CHAIRMAN: Mr R Kilner, Non-Executive Director

DATE OF COMMITTEE MEETING: 23 April 2014

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

- Minute 38/14 – updated 2 Year Operational Plan;
- Minute 39/14 – 2014-15 Financial Plan and Budget Book
- Minute 40/14 – confidential report by the Interim Director of Financial Services, and
- Minute 41/14 – UHL Capacity Plan 2014-15.

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

- Minute 46/14/1 – cancelled operations performance and the impact of continued high levels of emergency demand;
- Minute 46/14/2 – consideration of the RTT improvement plan;
- Minute 46/14/3 – clinical letters backlog reduction plans, and
- Minute 47/14/2 – Cost Improvement Programme 2014-15.

DATE OF NEXT COMMITTEE MEETING: 28 May 2014

Mr R Kilner
23 May 2014

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST

MINUTES OF A MEETING OF THE FINANCE AND PERFORMANCE COMMITTEE, HELD ON WEDNESDAY 23 APRIL 2014 AT 8.30AM IN THE LARGE COMMITTEE ROOM, MAIN BUILDING, LEICESTER GENERAL HOSPITAL

Present:
Mr R Kilner – Acting Chairman (Committee Chair)
Mr J Adler – Chief Executive
Colonel (Retired) I Crowe – Non-Executive Director
Mr P Hollinshead – Interim Director of Financial Strategy
Mr R Mitchell – Chief Operating Officer
Mr G Smith – Patient Adviser (non-voting member)
Ms J Wilson – Non-Executive Director

In Attendance:
Ms L Bentley – Head of Financial Management and Planning (on behalf of the Deputy Director of Finance)
Ms S Leak – General Manager, Renal, Respiratory and Cardiac CMG (for Minute 45/14/1)
Mr N Moore – Clinical Director, Renal Respiratory and Cardiac CMG (for Minute 45/14/1)
Mrs K Rayns – Trust Administrator

ACTION

RECOMMENDED ITEMS

38/14 **UPDATED 2 YEAR OPERATIONAL PLAN 2014-16**

Further to Minute 26/14 of 26 March 2014 and in the absence of the Director of Strategy, the Interim Director of Financial Strategy introduced paper D, providing the updated overview of key aspects of the 2 year operational plan and highlighting a specific focus on finance, capacity planning and workforce. He noted the inclusion of additional narrative relating to the CQC action plan and the Quality Commitment and opportunities identified to improve the scale and pace of changes in service delivery (such as creation of a centralised outpatients function, improving ambulatory care services and increasing rates of day case surgery).

Appendix A provided the Trust's 2014-15 financial plan and budget book as developed with all CMGs and Corporate Directorates over the last 2 months and signed off formally by the Executive Team as the basis for the 2014-15 integrated performance management meetings. A deficit plan of £40.75m had been submitted to the TDA and plans to deliver financial balance within the next 3 years were due to be submitted on 20 June 2014. Members noted that the contractual discussions regarding re-investment of penalties and fines had fallen outside the arbitration process and that these separate negotiations were not yet concluded. The Interim Director of Financial Strategy drew members' attention to the key risks surrounding CIP delivery, any penalties over and above the £3.5m already provided for within the plan, and operational risks including ED and RTT performance. From an operational risk perspective, bed capacity, winter funding and financial support for the continuation of super weekend activities would all be key. The Committee Chairman clarified that the cost of the additional capacity (due to be considered later under Minute 41/14 below) was still being scoped and was not therefore included within the financial plan.

Appendix C provided an update on the development of the 2 year detailed workforce plan and the 5 year workforce plan required as part of the Integrated Business Plan (IBP) and Long Term Financial Model (LTFM) for 2014-19 which was due to be submitted to the TDA on 20 June 2014. Section 2.4 provided an update on the nursing vacancy position and the recruitment of an additional 50 international nurses due to commence with the Trust in May 2014. Section 2.5 summarised the expected reductions in non-contracted workforce expenditure as a result of successful workforce recruitment strategies.

Particular discussion took place regarding the apparent increase of 998 worked whole time equivalent posts and the breakdown of these staff groups was provided in section 4.2 – this figure was noted to include 461 contracted nursing posts (offset by reductions in agency staffing) and 218 staff transferring across to UHL with the Alliance Elective Care contract. The Interim Director of Financial Strategy provided assurance that by the time of the 20 June 2014 submission to the TDA the workforce bridge and the financial bridge would be more aligned.

Members of the Finance and Performance Committee noted the need for further validation of the CMG level workforce plans and that workforce confirm and challenge sessions had been arranged in May 2014 for this purpose. Further opportunities to reduce workforce costs were being explored through the CIP Programme Board, alongside schemes to improve productivity. In further discussion, the Chief Executive noted the need for transparency within the process for translating reductions in non-contracted and premium rate staffing costs into whole time equivalent posts. It was also noted that the workforce impact of CIP schemes rated as red or amber had not yet been factored into the plans. The Committee Chairman highlighted some potential anomalies within the budget book relating to pay trends and whole time equivalent forecasts, suggesting that the average pay costs per head were not realistic.

Members recommended that the updated 2 year operational plan be supported for Trust Board approval, subject to appropriate clarity being provided to the Committee on 28 May 2014 in respect of the workforce impact associated with CIP schemes.

<u>Recommended</u> – that (A) the updated 2 Year Operational Plan for 2014-16 be supported for Trust Board approval on 24 April 2014 (as presented in paper D), and

(B) clarity be provided to the Finance and Performance Committee on 28 May 2014 regarding the workforce impact associated with CIP schemes.

39/14 2014-15 FINANCIAL PLAN

Paper E provided the 2014-15 Financial Plan and detailed budget book which had been discussed earlier under the 2 Year Operational Plan (Minute 38/14 above refers). The Finance and Performance Committee received and noted the contents of this report and recommended the 2014-15 Financial Plan and Budget Book for Trust Board approval on 24 April 2014.

<u>Recommended</u> – that the 2014-15 Financial Plan and Budget Book (paper E refers) be supported for Trust Board approval on 24 April 2014.

40/14 REPORT BY THE INTERIM DIRECTOR OF FINANCIAL STRATEGY

<u>Recommended</u> – that this Minute be classed as confidential and taken in private accordingly, on the grounds of commercial interests and that public consideration at this stage could be prejudicial to the effective conduct of public affairs.

41/14 UHL CAPACITY PLAN 2014-15

The Chief Operating Officer introduced paper L, providing an update on the proposals for modelling the "right-sizing" of UHL capacity for 2014-15. Members noted that the proposed additional bed capacity had reduced from 88 (in February 2014) to 55 following development of work streams relating to day case rates, decreasing delayed transfers of care and surgical triage had been taken into account. The breakdown of beds included provision of a modular ward on the LRI site for use as ward decant accommodation.

Capital and revenue costs for the additional beds were set out in paper L, although the revenue consequences of the capital costs had not yet been completed. The Chief

Executive confirmed the strong support of the Executive Team and advised that the proposals were due to be presented to an extended meeting of the Clinical Senate on 25 April 2014. In order to accommodate the capital expenditure, the Trust would be reviewing the capital programme to identify any schemes which could be removed or deferred to the subsequent year. Revenue funding was being explored through the winter plan.

The Committee Chairman particularly noted that no additional income for patient activity had been assumed and members considered ways in which the financial benefits of reducing elective cancellations, improving progress with the RTT improvement plan and reducing reliance upon independent sector providers could be included. In respect of nurse staffing, the additional beds had been costed on the basis of agency nursing rates for the first 6 months and a quality impact assessment was being undertaken to assess any risks relating to nurse staffing and recruitment.

Recommended – that the proposals for additional bed capacity (as set out in paper L) be supported for Trust Board approval, subject to additional financial modelling being undertaken to account for increases in elective activity.

RESOLVED ITEMS

42/14 APOLOGIES

Apologies for absence were received from Mr S Sheppard, Deputy Director of Finance and Ms K Shields, Director of Strategy.

43/14 MINUTES

Resolved – that the Minutes of the 26 March 2014 Finance and Performance Committee meeting (papers A and A1) be confirmed as correct records.

44/14 MATTERS ARISING PROGRESS REPORT

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

(a) Minute 30/14/2 of 26 March 2014 – the Committee Chairman and the Chief Executive noted that they now received monthly reports on e-rostering. A progress report on the resolution of e-rostering functionality issues was due to be scheduled on the June 2014 Finance and Performance Committee agenda; **CN**

(b) Minute 17/14/1(a) of 26 February 2014 – the Executive Team was due to consider the issue of management capacity to support the interface between UHL and Interserve in respect of the MES II contract with Asteral early in May 2014 and the Interim Director of Financial Strategy advised that a report was being considered at a meeting of the Capital Group later that afternoon. It was agreed to remove this item from the matters arising report; **TA**

(c) Minute 17/14/3 of 26 February 2014 – the Committee Chairman requested that the timetable for seeking PPI engagement in UHL's key strategic priorities be included in future reports to the Trust Board. **CE** The Chief Executive requested the Trust Administrator to provide him with the relevant extracts from meeting notes when PPI engagement had been discussed; **TA**

(d) Minute 5/14/1 of 29 January 2014 – members noted that a joint East Midlands procurement framework was now in place for agency nurses and it was agreed to remove this item from the matters arising report and the list of forward agenda items; **TA**

(e) Minute 5/14/3 of 29 January 2014 – in the absence of the Deputy Director of Finance at this meeting, the expected progress report on the Trust's programme of financial and business awareness training was deferred to May 2014, and **DDF**

(f) Minute 28/13/3 of 27 March 2013 – updates on the actions and timescales for apportionment of funding for clinical academic posts between UHL and the University of Leicester and the landlord elements of University occupied UHL premises were provisionally scheduled on the 28 May 2014 Finance and Performance Committee agenda. **IDFS**

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

45/14 STRATEGIC MATTERS

45/14/1 Renal, Respiratory and Cardiac CMG Presentation

Prior to the presentation team being invited into the meeting room, members considered the key issues they would like to see covered during the presentation and subsequent questions. These were identified as (1) emergency flow of patients through the Glenfield Hospital Clinical Decisions Unit (CDU), (2) any issues identified by the Care Quality Commission (CQC) for further action, (3) risks surrounding the kidney transplant service and why these hadn't been escalated earlier, and (4) the quality of the renal dialysis patient environments at Harborough Lodge and the Leicester General Hospital sites and any actions planned to mitigate their impact upon patient experience.

The Clinical Director and General Manager attended the meeting from the Renal, Respiratory and Cardiac (RRC) Clinical Management Group (CMG) to present paper C providing a summary of the CMG's financial and operational performance. Introductions took place. During the presentation, Finance and Performance Committee members particularly noted:-

(a) elements of good practice highlighted by the CQC visit and the arrangements being made to roll out such practices within the whole of the CMG;
(b) good progress with the identification of £5.9m in CIP savings for 2014-15 and the focus on delivering these schemes as planned;
(c) a proposed renal services framework agreement which would enable the Trust to call-off future renal services contracts in a more agile manner, subject to Trust Board approval and appropriate mini-competition processes to ensure value for money. Assurance was provided that any concerns regarding the quality of the renal dialysis patient environment would be addressed by the implementation of this procurement framework;
(d) the process in place to resolve issues affecting UHL's renal transplant service and the actions going forward with a view to lifting the "pause" and re-starting this service at the earliest opportunity. A detailed report on this issue was due to be considered by the Quality Assurance Committee meeting later that afternoon;
(e) that CDU emergency care performance data was provided for "time to assessment", "time to be seen by a doctor" and "time from request to senior clinical review", but the data for "time to bed" was not yet available;
(f) opportunities to grow aspects of Cardiac services through additional activity from Burton and Norwich (which might require additional UHL theatre and bed capacity), and
(g) the scope for increasing the CMG's level of earned autonomy and reducing areas of duplication within the Trust's mechanism for monitoring CMG performance.

Following the presentation, Committee members raised the following comments and questions:-

(1) the Committee Chairman queried whether the Chief Operating Officer was sighted to the areas of potential activity growth from Burton and Norwich and the associated impact upon theatre and bed capacity. In response, it was noted that this was a very recent development and plans had not yet reached that stage. However, the Chief Operating Officer advised that the methodology was now in place to capture the impact of such activity changes and model the adjustments to capacity required moving forwards;

(2) the Chief Operating Officer commented upon the impact of CDU emergency care performance upon UHL's overall performance, noting the workstreams underway to review clinical staffing levels and patient pathways with a view to delivering the 4 hour target for "time to bed". A summary of the additional resources and diagnostic standards required for the CDU was due to be presented to the Emergency Care Action Team (ECAT) meeting within the next 2 weeks. In addition, a separate reporting line was being created within the site report to increase visibility of the CDU's contribution to 4 hour ED performance;

(3) the Chief Operating Officer sought and received additional information regarding the CMG's clinical letters backlog, noting that 20% of letters were currently waiting for longer than 10 days for typing, but the average wait had reduced to 3 weeks (from a previous average of 6 weeks). In respect of reducing any clinical risks associated with the letters backlog, the CMG advised that any clinically important letters were flagged as such and prioritised accordingly;

(4) the Chief Operating Officer compared the performance for the "time from request to senior review" in Respiratory services (82 minutes) and Cardiology services (166 minutes) and sought assurance regarding clinical engagement within the Cardiology team. The General Manager, RRC advised that clinical engagement was progressing well and that all clinical teams were keen to balance their performance and address any weaknesses in their PLICS data. In addition, the Chief Executive advised that a Listening into Action (LiA) pioneering team from Cardiology services had recently been supported by the LiA Sponsor Group to develop an LiA scheme around heart failure and the role of the specialist nurse;

(5) Ms J Wilson, Non-Executive Director drew members' attention to the workforce slide within the presentation pack (paper C) and queried the current vacancy levels and the potential impact of CIP schemes upon the workforce headcount. In response, the General Manager reported on the active recruitment processes which were hoped to fill the current 50 qualified nurse vacancies by the end of May 2014. In terms of medical staffing, plans were in place to fill the gaps in junior doctor rotations and Nephrology. It was noted that the majority of the CMG's CIP schemes were income related (eg undertaking additional patient care activity with the same number of staff) and that there were expected to be very few headcount reductions delivered through the CIP process;

(6) in the final slide, the CMG had requested support from the Trust Board in reducing the amount of duplication and repeated assurance processes conducted through the various performance management meetings, eg monthly performance management meetings, quarterly quality and safety performance management meetings and other meetings which focused on workforce and strategy related themes. The Interim Director of Financial Strategy suggested that the cycle of financial and operational performance meetings might be reduced as confidence in the CMG's performance was developed – a form of earned autonomy. The Committee Chairman requested that an overview of the agendas for each of the regular CMG review meetings be undertaken to remove any unnecessary duplication; **CE/ COO/ IDFS**

(7) the Committee Chairman sought and received additional information regarding the

circumstances leading up to the suspension of renal transplantation for a period of 2 weeks as a precautionary measure. In response, the Clinical Director briefed the Committee on the impact of changes in the service since the appointment of 2 additional transplant surgeons, noting that the 2 incumbent surgeons had previously delivered a safe service but there had been some scope to improve effectiveness and efficiency. The review had highlighted weaknesses in communications and joint working practices within the team and these were now being addressed. It was estimated that between 7 and 9 transplant operations would be carried out at other centres during the pause in UHL's services. In the longer term, the number of transplant operations carried out at UHL was expected to rise from 75 to 140 (and above) transplants per annum. Discussion took place regarding any potential risks to patients and members noted the views expressed by the Clinical Director that the issues mainly related to the way that the multi-professional team functioned and the destabilisation of the existing arrangements within a small team;

(8) the Committee Chairman drew a comparison between the small renal transplantation team and the historical issue relating to single handed practice in Paediatric Neurology. He invited the Committee to consider whether there were any other service areas operated by small clinical teams which might benefit from a detailed review. Colonel (Retired) I Crowe, Non-Executive Director commented upon the scope to benchmark the performance of small teams with other similarly sized units in other Trusts and it was agreed to request the Medical Director and the Director of Human Resources to reflect upon this point and seek assurance through the CMG review meetings; **MD/ DHR**

(9) the Chief Executive sought and received additional information regarding the viability of the recent approach from Norwich to increase UHL's cardiac surgery activity, noting that discussions were at a very early phase but an expansion of the service by 100 cases per year would seem realistic at the current time. Discussions relating to additional activity from the Burton area were noted to be more developed and the Director of Strategy had started attending these meetings to support the contractual elements of these discussions.

<u>Resolved</u> – that (A) the presentation on the Renal, Respiratory and Cardiac CMG's operational and financial performance be received and noted, and

(B) the Chief Executive, Chief Operating Officer and Interim Director of Financial Strategy be requested to review the agendas for all CMG review meetings to identify any scope to avoid duplication, and **CE/ COO/ IDFS**

(C) the Medical Director and the Director of Human Resources be requested to consider the scope for benchmarking practice amongst small clinical teams and seeking assurance through the CMG review meetings to ensure that the performance of small teams was monitored appropriately. **MD/ DHR**

45/14/2 <u>Progress report on UHL's Financial and Business Awareness Training Programme</u>

In the absence of the Deputy Director of Finance, members noted that the expected progress report on the above subject (paper F) had not been circulated and this item was deferred to the May 2014 meeting.

<u>Resolved</u> – that the progress report on UHL's Financial and Business Awareness Training Programme be deferred to the 28 May 2014 Finance and Performance Committee meeting **DDF**

45/14/3 <u>Draft Finance and Performance Committee Work Programme</u>

The Interim Director of Financial Strategy introduced paper G, providing the proposed

draft 2014-15 work programme for the Committee, noting the scope to include additional elements at a later date, pending the outcome of the Board Effectiveness Review. Members commented on the schedule and proposed amendments as follows:-

(a) flexibility would be required regarding the optimum timing for the review of particular projects/business cases according to progress of each scheme and the timescales for any key milestones;
(b) workforce plans would be reviewed as part of the 2 year operational plans and the 5 year strategic plans;
(c) Emergency Department (ED) performance would continue to be scrutinised through the Trust Board meetings until sustainable compliance with the 4 hour ED target had been achieved. This would help to reduce duplication at other sub-Board Committees and maintain the current Board-level focus;
(d) there was currently no date set for the Committee's consideration of the Emergency Floor business case. Whilst it was suggested that this might be aligned with the 20 June 2014 submission of the Trust's 5 year strategic plans and any expectations relating to the TDA approval process, members noted that the Committee could also set review dates independently of such external influences where necessary. It was agreed that the work programme would be populated with dates to fit with UHL's internal processes; **DDF**
(e) monthly reports on the Cost Improvement Programme (CIP) would also include progress with the cross-cutting schemes and there would be no need for the Committee to receive the meeting notes from the CIP Programme Board, and
(f) reports on RTT performance would be presented on a monthly basis (instead of alternate months as indicated on the programme currently).

<u>Resolved</u> – that the Deputy Director of Finance be requested to update the proposed Finance and Performance Committee Work Programme for further consideration at the next meeting. **DDF**

46/14 PERFORMANCE

46/14/1 <u>Month 12 Quality, Finance and Performance Report</u>

Paper I provided an overview of UHL's quality, patient experience, operational targets, HR and financial performance against national, regional and local indicators for the month ending 28 February 2014 and a high level overview of the Divisional Heatmap report. The Committee Chairman noted his intention to request each Executive Director to select 2 or 3 key areas for specific focus during the meeting.

Noting that a separate report on ED performance would be presented to the 24 April 2014 Trust Board meeting, the Chief Operating Officer reported on the following aspects of UHL's operational performance:-

Cancer Performance – all 8 of UHL's cancer performance indicators were compliant against target and this had been the case for the last 3 months. In this respect UHL's cancer services appeared to be a positive outlier when compared with national performance trends. The Committee Chairman commended this excellent performance and suggested that future reports on cancer performance would only be required on the basis of exceptions to compliant performance;

RTT 18 Week Performance – a separate report was due to be considered later on the agenda for this meeting (Minute 46/14/2 below refers);

Cancelled Operations – compliant performance against the threshold of 1.0% had not been achieved in the last 36 months. Members noted the integral link with bed capacity – although approximately 40% of cancellations were noted not to be related to bed availability and discussions continued with the ITAPS CMG to resolve other contributory

factors. Members noted the scope for Commissioners to apply significant penalties in this area.

The Committee Chairman requested that future iterations of the exception report for cancelled operations also included a breakdown of the causes for cancellations. He noted the impact of high levels of ED admissions upon elective cancellations and made reference to a recently commissioned whole system redesign review which was due to commence on 19 May 2014. Non-Executive Directors had been briefed on this issue and he intended to raise this matter during the next day's Trust Board meeting. The Chief Executive briefed members on the need for a shared formal understanding between UHL and the CCGs in respect of improving the alignment between primary care demand management and acute care capacity. The Chief Operating Officer was requested to arrange for a breakdown of the causation factors for hospital cancellations to be provided to the next meeting, alongside a proposed trajectory for reducing cancelled operations. **COO**

Financial Performance – the Interim Director of Financial Strategy reported on the Trust's financial performance under Minute 47/14/2 below.

Resolved – that (A) the month 12 Quality, Finance and Performance report (paper I) and the subsequent discussion be received and noted, and

(B) the Chief Operating Officer be requested to provide a breakdown of the causes for cancelled operations and provide a recovery trajectory for cancelled operations at the 28 May 2014 meeting. **COO**

46/14/2 Progress Report on Referral to Treatment (RTT) Improvement Plan

Further to Minute 26/14/3 of 26 March 2014, the Chief Operating Officer introduced paper J providing an update on the RTT improvement plan. Significant improvements had been demonstrated by Ophthalmology which had the highest volume of patients. The remaining 3 challenged specialties were noted to be ENT, Orthopaedics and General Surgery and it was agreed to request the Musculoskeletal and Specialist Surgery CMG to focus on their RTT improvement plans during their scheduled financial and operational performance presentation on 28 May 2014. The following comments and queries were raised in discussion on paper J:- COO/TA

(a) the Committee Chairman sought a view from the Chief Operating Officer whether the Trust should be undertaking any additional actions not already included in the improvement plans. In response, the Chief Operating Officer noted the scope to ring fence a proportion of the 12 beds allocated to the ENT service, noting that at any given time there could be up to 7 medicine patients outlying in these beds. He undertook to raise this issue for discussion at the next RTT Board meeting; **COO**

(b) the Committee Chairman queried whether the significant fines which CCGs had served notice of their intention to impose (for elements of non-compliance with the RTT trajectory) were new fines and the Chief Executive clarified that there were 2 types of fines associated with the recovery plan and a caveat surrounding overall activity levels would be incorporated into the final agreement, and

(c) Ms J Wilson, Non-Executive Director queried what actions the RTT Board were pursuing to mitigate the risks of non-compliance with the RTT trajectory. In response the Chief Operating Officer reported that it was not currently possible to reliably model the impact of additional activity upon the RTT improvement plan, although it was evident that as emergency demand increased, elective cancellations also increased. Specialty-level risk logs were being retained and the Chief Operating Officer was requested to include the key drivers for mitigating these risks in his May 2014 RTT report. **COO**

Resolved – that (A) the MSS CMG be requested to focus on the RTT improvement plans for ENT and Orthopaedics within their scheduled presentation on financial **COO/ TA**

and operational performance on 28 May 2014, and

(B) the Chief Operating Officer be requested to:-

- **raise the possibility of ring-fencing a number of ENT beds at the next RTT Board meeting, and** **COO**
- **include the key drivers for mitigating service level RTT penalties in the next update report on RTT improvements.** **COO**

46/14/3 Progress Report on Clinical Letters Backlog

Further to Minute 30/14/4 of 26 March 2014, the Chief Operating Officer introduced paper K, updating the Committee on progress with reducing the backlog of clinical letters. Following consideration at the Executive Performance Board on 22 April 2014, a centralised focus group was being established by the Clinical Director, Clinical Support and Imaging. The Chief Operating Officer and the Medical Director had been nominated as Executive Director sponsors. In addition, the Chief Medical Information Officers (CMIOs) would be supporting this work stream relating to the electronic transfer of patient letters to GPs (for completion by the end of September 2014).

The Committee considered the scope to centralise the clinical letters functions within the Trust (alongside similar proposals for a centralised outpatient booking service) and opportunities to increase the level of outsourced transcription service provision. Members noted that the Ophthalmology clinical letters backlog had reduced significantly with the application of additional resources and some outsourced activity. However, one patient incident had been escalated as a Serious Untoward Incident (SUI) where one of the contributory factors had been a delay in typing the clinic letter. A report on this incident would be provided to the Trust Board on 24 April 2014.

Resolved – that (A) the progress report on reducing the backlog of clinical letters be received and noted, and

(B) a further report on the clinical letters backlog be presented to the Finance and Performance Committee on 28 May 2014. **COO**

47/14 FINANCE

47/14/1 2014-15 Cost Improvement Programme

Further to Minute 26/14/2 of 26 March 2014, the Chief Operating Officer introduced paper M, noting that the risk-adjusted total of CMG plans for 2014-15 had risen from £20.15m (in March 2014) to £24.69m and that £14.63m of these schemes had been RAG-rated as green (approved schemes). The combined risk-adjusted value of all schemes across the Trust now stood at £30.03m, with £19.45m being RAG-rated as green.

Members particularly noted that the weekly CIP Programme Board was chaired by the Interim Director of Financial Strategy and that the Executive Team would be conducting a monthly review of the Trust-wide CIP schemes. Ernst Young had highlighted some weaknesses in the PMO function and mitigating actions were underway to address these within the next month. Appendix 6 described a series of measures aimed at reducing the Trust's expenditure run-rate for quarter 1 whilst the full CIP implementation phase was taking place. The Chief Executive noted his concerns regarding the phasing of savings and requested that a summary of the CIP financial benefits be provided to the Finance and Performance Committee and the Executive Performance Board in May 2014, setting out the values of savings broken down by pay, non-pay and additional income for each area. The Interim Director of Financial Strategy highlighted the need to avoid-any double counting in respect of CMG and cross-cutting CIP schemes.

The Committee Chairman queried at what point the Trust would make a decision to

centralise its outpatients booking function and he noted in response the Chief Operating Officer's view that such a proposal had been supported by the Executive Team on 15 April 2014.

In her capacity as Chair of the Quality Assurance Committee, Ms J Wilson, Non-Executive Director queried when that Committee would have oversight of the CIP quality and safety impact assessments. The Chief Operating Officer briefed the Committee on the process for the Chief Nurse and the Medical Director to sign-off the assessments relating to all the approved schemes and confirmed his understanding that a report on this matter would be presented to the 28 May 2014 Quality Assurance Committee meeting. Other CIP schemes (those currently RAG-rated as red and amber) would have quality and safety impact assessments completed as and when they were approved and these would be submitted for sign-off in the same way.

Resolved – that the 2014-15 CIP update be received and noted and a further progress report be presented to the Finance and Performance Committee on 28 May 2014. **COO**

47/14/2 2013-14 Financial Performance

Papers N and N1 provided an update on UHL's performance against the key financial duties surrounding delivery of a planned surplus, achievement of the External Financing Limit (EFL) and achievement of the Capital Resource Limit (CRL), as submitted to the 24 April 2014 Trust Board and the 22 April Executive Performance Board (respectively).

The Interim Director of Financial Strategy confirmed that the deficit control total of £39.8m had been delivered as forecast and both the EFL and CRL limits had been met. In addition, he highlighted performance against the subsidiary duty to pay all suppliers invoices within 30 days under the Better Payment Practice Code (BPPC). Between April 2013 and March 2014, the Trust had paid 46.4% of invoices and 72.4% of the value within the target 30 days. Members noted that the Trust was expected to receive an adverse value for money audit opinion on the 2013-14 annual accounts, in view of the year end income and expenditure deficit.

Section 4.5 of paper N made reference to a write-off of approximately £660,000 outstanding overseas visitors' debts which had already been provided for within the bad debt provision. Discussion took place regarding the review of private patient and overseas visitor processes, as considered by the Audit Committee on 15 April 2014. The Chief Executive also briefed members on the development of a new Listening into Action (LiA) pioneering team which would be looking at the appropriate identification of such debts and improving the process for collection. The Interim Director of Financial Strategy was requested to include an update on potential investment in resources to improve private and overseas visitor debt collection processes in his next financial performance report to the 28 May 2014 meeting. Section 5.2 of the report detailed the temporary borrowing in place and members noted that a longer term financial loan would be subject to submission of 3 year financial recovery plans at the end of June 2014. **IDFS**

In discussion on the Trust's financial performance, members of the Finance and Performance Committee raised the following comments and queries:-

(a) the Chief Executive drew members' attention to the 3 main areas of variance from their year end control totals (ie ITAPS, MSS and IM&T) and advised that the Interim Director of Financial Strategy was reviewing these areas closely with a view to identifying the lessons learned and applying any actions required moving forwards;
(b) Ms J Wilson, Non-Executive Director sought and received assurance that smaller local companies were being prioritised in accordance with the Better Payment Practice Code (BPPC). Members considered the process issues that were likely to prevent compliance with the target to pay 95% of invoices within 30 days and the

Interim Director of Financial Strategy confirmed that this was a realistic target which had been achieved by other Trusts. He confirmed that BPPC performance would continue to be reported on a monthly basis as it remained a good indicator for identifying other performance issues, and

(c) the Committee Chairman sought additional information regarding the risks associated with longer term borrowing in the event that robust 3 year recovery plans were not available by the end of June 2014. In response, the Interim Director of Financial Strategy reported on the scope for further short term borrowing but members noted the challenges associated with finalising the 2014-15 financial year end position on the basis of short term borrowing.

Resolved – that the report on the Trust's Month 2013-14 financial performance be received and noted as papers N and N1.

48/14 SCRUTINY AND INFORMATION

48/14/1 Clinical Management Group (CMG) Performance Management Meetings

Resolved – that the action notes arising from the March 2014 CMG Performance management meetings (papers O and O1) be received and noted.

48/14/2 Executive Performance Board

Resolved – that the notes of the 25 March 2014 Executive Performance Board meeting (paper P) be received and noted.

48/14/3 Quality Assurance Committee (QAC)

Resolved – that the 26 March 2014 QAC meeting was cancelled due to the CQC Quality Summit being held on the same date.

48/14/4 CIP Programme Board

Resolved – that (A) the notes of the CIP Programme Board meetings held on 3, 8 and 15 April 2014 be received and noted, and

(B) the Committee agreed that these meeting notes would not be required for submission to future meetings.

49/14 ITEMS FOR DISCUSSION AT THE NEXT FINANCE AND PERFORMANCE COMMITTEE

Paper R provided a draft agenda for the 28 May 2014 meeting and the following additional agenda items were agreed:-

TA

- the item deferred from today's meeting relating to UHL's programme of financial and business awareness training;
- a separate report on the 2014-15 Capital Programme, and
- clarity to be provided that the May 2014 report on CIP performance would include a progress report on each of the cross-cutting CIP schemes.

The Trust Administrator was requested to update the agenda with the additional items agreed at this meeting and circulate a revised version outside the meeting.

Resolved – that (A) the items for consideration at the Finance and Performance Committee meeting on 28 May 2014 (paper R) be noted, and

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

it outside the meeting.

50/14 ANY OTHER BUSINESS

Resolved – that there were no items of any other business raised.

51/14 ITEMS TO BE HIGHLIGHTED TO THE TRUST BOARD

Recommended – that the following issues be highlighted for approval at the Trust Board meeting on 24 April 2014:-

- Minute 38/14 – updated 2 Year Operational Plan;
- Minute 39/14 – 2014-15 Financial Plan and Budget Book
- Minute 40/14 – confidential report by the Interim Director of Financial Services, and
- Minute 41/14 – UHL Capacity Plan 2014-15.

Resolved – that the following issues be highlighted verbally to the Trust Board meeting on 24 April 2014:-

- Minute 46/14/1 – cancelled operations performance and the impact of continued high levels of emergency demand;
- Minute 46/14/2 – consideration of the RTT improvement plan;
- Minute 46/14/3 – clinical letters backlog reduction plans, and
- Minute 47/14/2 – Cost Improvement Programme 2014-15.

52/14 DATE OF NEXT MEETING

Resolved – that the next Finance and Performance Committee be held on Wednesday 28 May 2014 from 8.30am – 11.30am in the Large Committee Room, Main Building, Leicester General Hospital.

The meeting closed at 11.03am

Kate Rayns, Trust Administrator

Attendance Record 2014-15

Name	Possible	Actual	% attendance	Name	Possible	Actual	% attendance
R Kilner (Chair)	1	1	100%	P Hollinshead	1	1	100%
J Adler	1	1	100%	G Smith *	1	1	100%
I Crowe	1	1	100%	J Wilson	1	1	100%
R Mitchell	1	1	100%				

* non-voting members

BB

University Hospitals of Leicester NHS
NHS Trust

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST

REPORT BY TRUST BOARD COMMITTEE TO TRUST BOARD

DATE OF TRUST BOARD MEETING: 29 May 2014

COMMITTEE: Quality Assurance Committee

CHAIRMAN: Ms J Wilson, Non-Executive Director

DATE OF COMMITTEE MEETING: 23 April 2014

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

- **None.**

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

- **Statutory and Mandatory Training Update Report (Minute 22/14/1);**
- **Achievement of the C Diff Reduction Target (Minute 22/14/2);**
- **The positive work detailed in the update regarding Neonatal Prescribing (Minute 23/14/10), and**
- **Triangulation of Patient Experience (Minute 24/14/1).**

DATE OF NEXT COMMITTEE MEETING: 28 May 2014

Ms J Wilson
23 May 2014

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST

MINUTES OF A MEETING OF THE QUALITY ASSURANCE COMMITTEE HELD ON WEDNESDAY 23 APRIL 2014 AT 12 NOON IN THE LARGE COMMITTEE ROOM, LEICESTER GENERAL HOSPITAL

Present:
Ms J Wilson – Non-Executive Director (Chair)
Mr J Adler – Chief Executive (up to and including Minute 23/14/7)
Mr M Caple – Patient Adviser (non-voting member)
Dr K Harris – Medical Director
Ms R Overfield – Chief Nurse
Mr P Panchal – Non-Executive Director

In Attendance:
Mrs G Belton – Trust Administrator
Mrs K Bradley – Director of Human Resources (for Minute 22/14/1 only)
Miss M Durbridge – Director of Safety and Risk
Mrs S Hotson – Director of Clinical Quality
Mrs C Ribbins – Director of Nursing
Ms K Tomlinson – PWC (Observer)

RESOLVED ITEMS **ACTION**

19/14 APOLOGIES

Apologies for absence were received from Dr S Dauncey, Non-Executive Director, Ms C O'Brien, Chief Nurse and Quality Officer, East Leicestershire CCG, Dr B Collett, Associate Medical Director (Clinical Effectiveness), Ms K Jenkins, Non-Executive Director and Professor D Wynford-Thomas, Non-Executive Director and Dean of the University of Leicester Medical School.

20/14 MINUTES

Members confirmed that the Minutes of the meeting held on 26 February 2014 (papers A and A1 refer) were a correct record, subject to the inclusion of Ms C Ribbins, Director of Nursing, on the list of those in attendance. **TA**

Resolved – that the Minutes of the meeting held on 26 February 2014 (papers A & A1 refer) be confirmed as a correct record, subject to the inclusion of Ms C Ribbins, Director of Nursing, on the list of those in attendance. **TA**

21/14 MATTERS ARISING REPORT

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

(a) Minute 13/14/2 (re reasons for any delays in implementing pressure ulcer prevention measures) – the Director of Nursing advised members that upon investigation, sufficient equipment was available, and the specific issue related to the need for timely ordering. She confirmed that there were on-going education and validation meetings. The QAC Chair noted that she had received positive feedback on this issue at recent Safety Walkabouts;

(b) Minute 13/14/3 (re extended QAC meeting in June 2014) – the QAC Chair requested that members noted in their diaries the extension to the 25 June 2014 QAC meeting (now to be held from 12 noon until 4pm) for the purpose of receiving Annual Reports from the EQB sub-committees; **QAC Members**

(c) Minute 13/14/3 (re QAC workplan) – the QAC Chair noted that a meeting between herself, the Chief Nurse and the Trust Administrator was to be re-scheduled for the purposes of reviewing the QAC work plan; **QAC Chair/ CN/TA**

(d) Minute 13/14/3 (regarding the frequency of the submission of safeguarding data to QAC) – the Director of Nursing informed members that, in future, this information would be submitted to the EQB, and QAC meeting immediately thereafter, on a quarterly basis; **DN/TA**

(e) Minute 14/14/2 (re Information Boards at Ward entrances) – the Director of Nursing reported verbally to confirm that the purchase of the Information Boards had been supported by charitable funds, and would be ordered this week. A template had been developed for use by wards for the interim period between the ordering and fitting of the Boards. Members noted the importance of ensuring that the Boards were kept up-to-date;

(f) Minute 4/14/2 (re the in-patient survey document) – the surveying of patients regarding the elements they considered relevant to be retained within the in-patient survey had now been concluded and the results would be analysed by the Patient Experience Group; **PEG**

(g) Minute 5/14/6 (re the updated action plan with progress updates following the NTDA visit to review IP procedures) – the Chief Nurse confirmed that the Lead Infection Prevention Doctor and Lead Infection Prevention Nurse would be producing one action plan to monitor all relevant aspects, and this item could be removed from future iterations of the Matters Arising report, and **LIPD/ LIPN**

(h) Minute 18/13 (b) (re EPMA reporting) – the Medical Director noted that a report regarding the longer-term strategy for EPMA was due to be submitted to the Executive Team, further to which it could be submitted to the QAC meeting in either June or July 2014 (jf required). It was also noted that Dr B Collett, Associate Medical Director, was no longer the responsible officer for this workstream. **MD**

<u>Resolved</u> – that the matters arising report (paper B) and the actions above, be noted and undertaken by those staff members identified.

22/14 QUALITY

22/14/1 <u>Statutory and Mandatory Training Update Report</u>

Further to Minute 120/13/3 of 17 December 2013, the Director of Human Resources attended to present paper 'C', which informed the Committee of statutory and mandatory training compliance at the end of March 2014 and provided an update on key development priorities to sustain and improve performance over 2014/15. Particular note was made of the significant improvement in overall compliance rates over 2013/14, with the Chief Executive noting the view expressed at the Executive Team meeting the previous day that the Trust should now move to a target of 95% compliance by the end of 2014/15, subject to resolution of specific capacity issues. Members were assured by the clarity provided in terms of the priority actions going forward.

Specific discussion took place regarding the following points:

(i) access to suitable training venues - it was noted that the Director of Human Resources, along with relevant colleagues, would be progressing estates issues in respect of training venues outwith the meeting; **DHR**

(ii) the provision of resuscitation training in terms of who held the budget for this (it was held centrally) and how it was managed in terms of new junior doctor intake (with specific note made of the work on-going around the development of an East Midlands Training Passport in this respect). Note was also made

that it was the Trust's duty (as employer) to be responsible for the mandatory training of FY1 doctors, and

(iii) the need to consider the conflict resolution training provided for staff in light of changing security arrangements by the Trust's Facilities Management provider. It was noted that consideration was currently being given to this matter by the Health and Safety Services Manager (in terms of identifying which staff members required what level of training) in order that capacity could be planned accordingly and attendance at relevant training could be facilitated.

In conclusion, the Chair thanked Mrs Bradley for attending today's meeting and noted the Committee's recognition of the work undertaken by Ms Kotecha, Assistant Director of Learning and Organisational Development and Mr E Thurlow, Learning Management System Trainer.

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

(B) the Director of Human Resources, in conjunction with relevant colleagues, be requested to continue to progress the work outlined under point (i) above. **DHR**

22/14/2 Month 11 – Quality and Performance Update

Members received and noted the contents of paper 'D', detailing the quality and performance updates for the period ending February 2014 (Month 11), noting that the format of this report was currently under-going revision.

Particular discussion took place regarding the recently changed criteria announced by NHS England in terms of a specific type of Never Event (i.e. retained items) which had now been downgraded from a Never Event if specific circumstances existed (i.e. the retained items were deliberately left in situ and intended for removal at a later date) as in a recent case at the Trust relating to a retained vaginal swab. The Chair noted that a report on this specific SUI was due to be presented at the next (May 2014) meeting of the Quality Assurance Committee. Discussion also took place on mortality rates, the VTE target and RTT target, which would be the subject of a report at a future meeting of the EQB. Specific note was made of the Trust's achievement in meeting its C Diff reduction target, having been one of the few Trusts nationally to achieve this. **DSR** **MD**

Specific discussion took place regarding capacity issues which were affecting elective patients booked to undergo procedures requiring an anaesthetic, and of the on-going work taking place in the Trust in this respect.

Discussion also took place regarding specific wards which consistently scored less well on the Friends and Family test, which triangulated with other collected data, which was being addressed through the Nursing Executive Team and the Patient Experience Group. The QAC Chair noted that little information was provided within the report regarding specific ward performance (in terms of which wards were focussed on and why in terms of the Ward Performance Dashboard reviewed at NET), and it was agreed that the Chief Nurse would send this specific information onto QAC members after the meeting. **CN**

In terms of facilities management at the Trust, note was made of improvements against KPIs. However, further improvement was required specifically regarding maintenance issues on specific wards and also around (non-patient safety critical) portering response times. Note was also made of the changes in security arrangements (as also referenced under Minute 22/14/1 above).

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

(B) the details of the completed investigation into a specific SUI be presented at

the next (May 2014) QAC meeting, **DSR**

(C) the RTT target be the subject of a report to a future meeting of EQB, and **MD**

(D) the Chief Nurse be requested to send onto QAC members information regarding which wards were focussed on and why in respect of the Ward Performance Dashboard reviewed at NET. **CN**

22/14/3 CQC Report and Action Plan

The Director of Clinical Quality presented paper 'E', which detailed the action plan that had been developed in response to the findings of the Care Quality Commission; their three site-based reports having been published on 28 March 2014. This action plan had been shared with the Head of Hospital Inspections, who had confirmed that it was fit for purpose. Note was made that the action plan detailed both specific and generic actions.

Particular discussion took place in respect of the following:

(i) the arrangement for monitoring progress against the action plan – it was noted that progress would reported on a monthly basis at the EQB, and thereafter at QAC, and this item should therefore form a standing agenda item for future EQB and QAC meetings; **DCQ/TA**

(ii) the fact that the identification of items within the action plan that were relevant to individual CMGs would be addressed through the Quality and Safety reviews, and (in response to a query from the QAC Chair), the Chief Nurse advised that CMGs would be asked to provide evidence that they had followed up on actions before these were 'signed-off';

(iii) the fact that some of the actions made reference to the time required for initial review of a particular issue, when implementing the solution would require a longer timeframe, and it was agreed that such issues should be captured in a covering statement to the action plan, and would necessitate a two-stage plan (in time comprising a second version of the action plan); stage one comprising the initial scoping and stage two, the time for completion of all actions required as part of the identified solution. Re-inspection by the CQC would be required upon completion of the second phases of the action plan; **DCQ**

(iv) the need to amend the section of the action plan concerning nurse recruitment (page 15) to note that this was on-going, and should therefore be RAG-rated as a '4' rather than a '5' or 'completed action'; **DCQ**

(v) noted that a number of identified actions would sit within other action plans, so cross-checking would be required;

(vi) noted the need, in future iterations of the action plan, to RAG-rate against all actions or none of the actions, however noted the need to highlight to the CQC actions that had already been completed; **DCQ**

(vii) medical staffing levels – it was noted that Dr Rabey, Deputy Medical Director was undertaking a medical staffing review, the results of which would be submitted to the EQB. Issues specifically regarding medical staffing levels had not been identified as part of the CQC Report, other than on one specific ward. It was noted that this was an issue for consideration by the Trust Board, and it was agreed that the medical staffing review should comprise part of the Workforce item scheduled for discussion at a future Trust Board development session. **DMD/STA**

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

(B) this item form a standing agenda item at future EQB meetings and QAC meetings held immediately thereafter; **DCQ/TA**

(C) the Director of Clinical Quality be requested to undertake the actions identified

under points (iii), (iv) and (vi), and **DCQ**

(D) the Medical Staffing review comprise part of the Workforce item scheduled for discussion at a future Trust Board Development session. **DMD/STA**

22/14/4 CQC Registration of Alliance Contract Locations

The Director of Clinical Quality reported verbally to confirm that the Trust (as host organisation) and its partners forming the Alliance Contract were now formally registered with the CQC to provide services in the community (e.g. in Loughborough, Market Harborough, Hinckley etc). In response to a request, the Director of Clinical Quality confirmed that the Trust was co-registered along with LPT. A paper regarding governance issues in respect of the Alliance Contract was due to be submitted to the next (May 2014) meeting of the EQB.

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

(B) a report regarding the governance arrangements in respect of the Alliance contract be submitted to the next (May 2014) meeting of the EQB. **Alliance Director/ TA**

22/14/5 Draft Quality Account

The Director of Clinical Quality presented paper 'F', which detailed the Draft Quality Account, and requested that members provided feedback on the draft Quality Account (noting that certain content was mandatory in nature and could, therefore, not be re-worded) and noted that further information, including end of year performance data was still to be submitted for inclusion, and once available and validated, the Quality Account would be updated accordingly.

Note was made that the Chief Nurse and Director of Clinical Quality had met with the Patient Advisers on 1st April 2014, who had submitted comments in respect of the Quality Account, and would be receiving a detailed response to these (some of which were included within the Quality Account). Mr Caple, Patient Adviser, thanked the Chief Nurse and Director of Clinical Quality in this respect, noting that it had been key to the Patient Advisers to have had this opportunity at this stage of the process. It was noted that the Draft Quality Account would be issued to stakeholders on 28 April 2014 for comments to be received back within one month. QAC members were therefore requested to feedback any additional comments they had on the Draft Quality Account to the Director of Clinical Quality by the end of Friday 25 April 2014. **QAC Members**

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

(B) QAC members be requested to feedback any additional comments on the Draft Quality Account to the Director of Clinical Quality by the end of Friday 25 April 2014. **QAC Members**

22/14/6 Quality Commitment

The Director of Clinical Quality presented paper 'G', which detailed an update on the refreshed Quality Commitment priorities for 2014/15, this document having been updated following discussion at the Trust Board Development session on 10th April 2014.

Following further discussion, members suggested two further changes to the Quality Commitment, as follows:

(1) to include the wider issue of 'Carers' under the 'Care and Compassion' heading, and
(2) to change the 'Effectiveness' heading to now read' ' Be Effective – Improve **DCQ**

Patient Outcomes'.

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

(B) the Director of Clinical Quality be requested to update the Quality Commitment as per the amendments requested by QAC members. **DCQ**

22/14/7 Claims and Inquest Report

The Chief Nurse presented paper 'H', which detailed information in respect of Claims and Inquests and had been produced by the Head of Legal Services at the request of the Chief Nurse for submission to the EQB.

During discussion at the EQB, it had been agreed that such a report should be submitted to the EQB on a quarterly basis, to also include details of Regulation 28 reports, and the QAC Chair requested that this same quarterly report was submitted thereafter to the following QAC meeting, where discussion could be undertaken on any items relevant to Regulation 28. **TA**

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

(B) the Claims and Inquest report submitted to EQB on a quarterly basis be submitted thereafter to the following QAC meeting. **TA**

22/14/8 CIP Schemes Quality Impact Assessment

The Chief Nurse reported verbally, noting that she was continuing to assess the quality impact of CIP schemes. A summary of the schemes would be submitted to the next (May 2014) meeting of the Quality Assurance Committee for assurance purposes. **CN/TA**

The Chief Executive noted that CIP schemes could not be quality assessed when only in the early stages of development, and the first tranche of schemes would have been completed by the month end. This work was slightly behind schedule currently.

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

(B) the Chief Nurse be requested to submit a summary of the schemes to the next (May 2014) meeting of the Quality Assurance Committee. **CN/TA**

23/14 SAFETY

23/14/1 Report by the Acting Chief Pharmacist

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

23/14/2 Report by the Chief Executive

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

23/14/3 Patient Safety Report

The Director of Safety and Risk presented paper 'K', which detailed the monthly patient safety report. Members' attention was drawn to the key points highlighted on pages 1 and 2 of the report, particularly bullet point 2 regarding the new national patient safety movement announced by NHS England. It was noted that the Director of Safety and Risk and the Medical Director would give consideration to the aspects concerning mortality outwith the meeting, and report to a future meeting of the EQB accordingly. **MD/DSR**

Particular discussion took place regarding the following points:

(i) the fact that feedback on actions taken to address issues identified as part of the Safety Walkabouts would be included in future Patient Safety reports; **DSR**

(ii) the agreement to invite representatives of the Women's and Children's CMG to the next (7 May 2014) EQB meeting to discuss particular issues identified regarding observations in children; **TA**

(iii) the planned follow-up regarding potentially ring-fencing elective capacity (in respect of the use of the day ward), and **CEO**

(iv) the fact that the critical safety actions update was included in the monthly Quality and Performance report and the quarterly Patient Safety report, without triangulation of the data, and members requested that this matter was reviewed in only one of these two reports in future – the Chief Nurse noted that, in future, information would feature in the Quality Commitment and monthly Quality and Performance report and not in the Patient Safety report, with a dashboard approach to be utilised.

(v)

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

(B) feedback on actions taken to address issues identified as part of the Safety Walkabouts be included in future Patient Safety reports; **DSR**

(C) the Trust Administrator be requested to invite representatives of the Women's and Children's CMG to the next (7 May 2014) EQB meeting to discuss particular issues identified regarding observations in children, and **TA**

(D) the Chief Executive be requested to follow-up the potential ring-fencing of elective capacity (in respect of the use of the day ward). **CEO**

23/14/4 Update on Complaints Process and Engagement Event

The Director of Safety and Risk presented paper 'L', which sought to update colleagues on progress against actions in a previous post-Clwyd complaints report and actions identified at the complaints handling Trust Board Development session in February 2014. The action plan detailed within the report described progress against the Trust Board actions on complaint management and handling and detailed timescales and action leads. The report also confirmed the intention to hold a complaints engagement event on 11 June 2014.

Discussion took place in respect of the following points:

(i) the high numbers of complaints currently being received, particularly in relation to waiting times and cancellations;

(ii) training provision in respect of complaints handling, and the intention to develop an e-learning package;

(iii) confirmation that the triage process employed upon receipt of complaints had been revised, along with confirmation as to which staff members were required to sign off complaints;

(iv) the intention to link complaints data to the triangulation of patient views, and address the root cause of complaints at an early stage (leading to issues being addressed earlier and not becoming formal complaints, which was the end stage of the process), and

(v) the aspiration to have a clinician as Deputy Chair of the Patient Experience Group, and the need, generally, to have wider representation from various staff groups on Committees. The Medical Director noted the need to identify a clinician with sufficient time within their job plan to undertake this work.

In conclusion, it was noted that the Committee would review continuing progress on this

matter in July 2014 (after the end of quarter 1). **DSR/TA**

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

(B) a further update report on progress be submitted to the July 2014 QAC meeting. **DSR/TA**

23/14/5 Report from the Medical Director

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

23/14/6 Report from the Medical Director

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

23/14/7 Report from the Medical Director

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

23/14/8 Report from the Medical Director and Director of Safety and Risk

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

23/14/9 Report from the Director of Nursing

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

23/14/10 Update regarding Neonatal Prescribing

Dr Cusack, Head of the Neonatal Service, attended to present paper 'P', which provided an update against action plans and a summary of repeat audits in respect of prescribing errors. He particularly noted the training that had been implemented and a number of actions undertaken in response to practical issues in terms of the lighting of drug preparation stations, drug fridges etc.

Specific discussion took place regarding on-going support issues regarding Pharmacy (due to sickness absence) and under-dosing of medication (now improved to 0.25%). Members congratulated Dr Cusack on the progress made to-date, from which they took significant assurance. They also considered that it would be useful to utilise the details provided by Dr Cusack along with details regarding 'Epiphany' to comprise the patient story element of a future Trust Board meeting. **MD/TA**

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

(B) the details provided by Dr Cusack regarding neonatal prescribing along with details regarding 'Epiphany' be utilised to comprise the patient story element of a future Trust Board meeting. **MD/TA**

23/14/11 Quarterly Infection Prevention Report

The Chief Nurse presented paper 'Q', which detailed a summary of key performance indicators for infection control, and represented a very positive report.

The fact that the Trust had achieved its C Diff reduction target was specifically noted.

Figures relating to e-coli would be presented in an attributed format in future versions of this report (whether UHL or community attributed). Particular focus would be given to surgical site infections and multi-resistant bugs in 2014/15.

In response to a query raised by the Chair as to whether the Chief Nurse had confidence that infection prevention had the required amount of focus in each of the CMGs, she advised that she did. The Trust's Infection Prevention Assurance Committee monitored this situation and further impetus was provided by the large number of Infection Prevention Champions throughout the Trust.

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

24/14 PATIENT EXPERIENCE

24/14/1 Triangulation of Patient Feedback

The Director of Nursing presented paper 'R', which detailed work recently undertaken for the purpose of routinely triangulating patient feedback. Appendix 1 to the report detailed triangulation of patient feedback, complaints and web-based feedback.

The main negative themes arising from the triangulation of feedback related to waiting times, cancellations, catering, parking and cleanliness, with the main 'positive' theme relating to caring and compassionate staff.

Work was currently being undertaken regarding standardising the criteria for such 'theming' with subsequent embedding and feeding back to CMGs, with CMGs having their own actions plans to address the issues raised. Members were very supportive of this approach, noting the importance of engagement with patients (recognising the associated financial cost of such engagement) debating where this responsibility for taking forward this agenda lay (whether in Communications or in Corporate Nursing).

The Director of Safety and Risk noted that future iterations of this report required the inclusion of specific complaints data (rate, trend and numbers of complaints by CMG). It was noted that a monthly data report would be produced with a detailed report provided on a quarterly basis. **DN**

Particular discussion took place regarding the potential for trust-wide initiatives on waiting times, and note was made of the self-assessment tools to collate from CMGs information as to what issues were within their gift to resolve. There was a need to coach the CMGs as to the specific data they should be reviewing. In response to a query as to whether the theme 'waiting times' could be broken down any further, the Director of Safety and Risk confirmed that this could be sub-divided into waiting times in out-patients and for procedures and operations etc. It was agreed that it would be helpful to circulate to Trust Board members the table on the last page of paper R in advance of the Trust Board meeting due to be held the following day. **TA**

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

(B) specific complaints data (to include rate, trends and numbers by CMG) be included in future iterations of this report, **DN**

(C) the data report be produced on a monthly basis, with a detailed quarterly analysis provided, and **DN**

(D) the Trust Administrator be requested to issue to Trust Board members immediately following the meeting the table featured on the last page of paper R (in advance of the following day's Trust Board meeting). **TA**

24/14/2 CQC National In-Patient Survey

The Director of Nursing presented paper 'S', which detailed reports recently submitted to the Clinical Quality Review Group in respect of the CQC National In-Patient Survey.

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

24/14/3 Dementia Implementation Plan

The Chief Nurse presented paper 'T', which detailed the Trust's Dementia Implementation Plan as endorsed by the Executive Quality Board at its last meeting held on 2 April 2014. The plan would be monitored at the EQB and would form part of the quarterly patient experience report.

Particular discussion took place regarding the plan as it related to the different patient communities the Trust served, and members considered that it would be beneficial and reassuring to patients to publicise the strategy.

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

(B) the Dementia Implementation Plan be monitored through the EQB and form part of the quarterly Patient Experience report. **CN**

25/14 MINUTES FOR INFORMATION

25/14/1 Finance and Performance Committee

Resolved – that the public Minutes of meetings of the Finance and Performance Committee held on 26 February 2014 and 26 March 2014 (papers U and U1) be received and noted.

25/14/2 Executive Quality Board

The Minutes of the Executive Quality Board meeting held on 5 March 2014 (paper V refers) were received and noted. It was agreed imperative that QAC received the Minutes of the most recent EQB meeting at each of its meetings, with the Chief Nurse / Chair of EQB to specifically highlight to QAC members any particular issues discussed at the preceding EQB meeting requiring escalation to / notifying to QAC. **TA/CN**

Resolved – that (A) the Minutes of the Executive Quality Board meeting held on 5 March 2014 (paper V refers) be received and noted, and

(B) it be agreed that QAC receive the Minutes of the EQB meeting immediately preceding (i.e. in the same month) as QAC, with the Chief Nurse (EQB Chair) requested to specifically highlight to QAC members any particular issues discussed requiring escalation to or notification to QAC. **TA/CN**

25/14/3 Executive Performance Board

Resolved – that the Minutes of the Executive Performance Board meeting held on 25 March 2914 (paper W refers) be received and noted.

26/14 ANY OTHER BUSINESS

Resolved – that there were no further items of business.

27/14 IDENTIFICATION OF ANY KEY ISSUES FOR THE ATTENTION OF THE TRUST BOARD

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

- **Statutory and Mandatory Training Update report (Minute 22/14/1);**
- **Achievement of the C Diff reduction target (Minute 22/14/2);**
- **Report by the Acting Chief Pharmacist (Minute 23/14/1);**
- **The positive work detailed in the update regarding Neonatal Prescribing (Minute 23/14/10), and**
- **the Triangulation of Patient Experience (as an addition to the Q & P report) – Minute 24/14/1.**

28/14 DATE OF NEXT MEETING

Resolved – that the next meeting of the Quality Assurance Committee be held on Wednesday 28 May 2014 from 12.30pm until 3.30pm in the Large Committee Room, Leicester General Hospital.

The meeting closed at 3.53pm.

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

Name	*Possible*	*Actual*	*% attendance*	*Name*	*Possible*	*Actual*	*% attendance*
J Adler	1	1	100	*R Overfield*	1	1	100
*M Caple**	1	1	100	*P Panchal*	1	1	100
S Dauncey	1	0	0	*C Ribbins*	1	1	100
K Harris	1	1	100	*J Wilson (Chair)*	1	1	100
K Jenkins	1	0	0	*D Wynford-Thomas*	1	0	0
*C O'Brien – East Leicestershire/Rutland CCG**	1	0	0				

- ** non-voting members*

Gill Belton
Trust Administrator

CC

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST

Trust Board Bulletin – 29 May 2014

The following reports are attached to this Bulletin as items for noting, and are circulated to UHL Trust Board members and recipients of public Trust Board papers accordingly:-

- **Quarter 4 update on progress against the 2013-14 Annual Operational Plan**– Lead contact point Ms K Shields, Director of Strategy (0116 258 8566) – **paper 1**.

It is intended that these papers will not be discussed at the formal Trust Board meeting on 29 May 2014, unless members wish to raise specific points on the reports.

This approach was agreed by the Trust Board on 10 June 2004 (point 7 of paper Q). Any queries should be directed to the specified lead contact point in the first instance. In the event of any further outstanding issues, these may be raised at the Trust Board meeting with the prior agreement of the Chairman.

University Hospitals of Leicester NHS
NHS Trust

Trust Board Paper CC

To:	**Trust Board**
From:	**Kate Shields, Director of Strategy**
Date:	**29 May 2014**
CQC regulation:	**All**

Title:	**QUARTER 4 REVIEW 2013/14 ANNUAL OPERATING PLAN (AOP)**

Author/Responsible Director: Jo Bee/Kate Shields

Purpose of the Report:
To present to Trust Board a high level overview of performance against our 2013/14 AOP objectives between Jan – Mar 2013/14 (quarter four – Q4) and in the context of individual quarterly reviews already received by the Board, provide assurance on the activity already being undertaken to address any area of adverse variance.

The Report is provided to the Board for:

Decision		Discussion	X
Assurance	X	Endorsement	X

Summary / Key Points:
The 2013/14 Annual Operating Plan outlines the Trust's objectives to deliver changes towards financial and clinical sustainability. Our Q4 report captures a high level overview of what is working well and what needs to be improved.

What is working well:

The Trust has made the following progress with key performance targets:

- Cancer targets: The Trust has continued to make excellent progress with the cancer target, improving waiting times, patient experience and clinical outcomes
- CQUIN: The Trust achieved full compliance with all its targets.
- Infection rates: Results for 2013/14 show outstanding result on infection rate.
- Falls and Pressure Ulcers: We have continued to see a reduction in pressure ulcers and falls as a consequence of the concerted efforts of our nursing team.
- Stroke compliance: The Trusts compliance has improved as a result of ring-fencing the stroke beds
- Safety: Never Events have been halved.

What Needs to be improved:

- Emergency process**:** The 2013/2014 year end performance for the ED 4 hour target was 88.4%. The Trust continues to struggle with high numbers of emergency admissions and a fixed bed base. In order to meet the demand for emergency beds the Trust is finalising plans to increase beds by 55 and ring fence elective capacity.

  The improvement plan to streamline the emergency process is continuing with additional action now focussed on 3 key areas:

  - reducing admissions

- improving flow
- expediting discharges

- Cancelled Operations: The target percentage for operations cancelled on/after the day (for non-clinical reasons) is 0.8% against the year-end performance of 1.6%.

- Financial performance: The Trust has not delivered its planned surplus and has not met its breakeven duty. It has delivered the revised year end forecast deficit of £39.8m.

- Referral to Treatment Time: A plan has been agreed with commissioners but not signed off at present due to a dispute regarding penalties. Trust level compliance for non-admitted performance is expected by August 2014 and compliance for admitted performance is expected by November 2014.

Our priorities for 2014/15 will need to focus heavily on:

- 4-hour performance
- RTT (18 weeks)
- Cancelled operations
- Finance

Recommendations: The Trust Board are asked to:

RECEIVE this report

NOTE the progress against Q4 delivery of our Annual Operational Plan and the overall, high level RAG rating of key aspects

NOTE the key areas of variance and the outline action proposed to rectify the position

Previously considered at another corporate UHL Committee?
No

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

Resource Implications (eg Financial, HR): Set out in the AOP 2013**/**14**.**

Assurance Implications: N/A

Patient and Public Involvement (PPI) Implications: See below "Stakeholder engagement implications".

Stakeholder Engagement Implications:

Prospective Board of Governors and our Patient Advisors have received an overview presentation of our AOP for 2013/14

Equality Impact: The AOP is subject to the Trust's equality impact processes.

Information exempt from Disclosure: None

Requirement for further review? No

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST

REPORT TO: Trust Board

REPORT FROM: Kate Shields, Director of Strategy

RE: Quarter 4 review of the 2013/14 Annual Operational Plan

DATE: 29th May 2014

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1. Quarterly brief review of delivery against the Trust's 2013/2014 Annual Operational Plan

This paper is intended to compliment a number of other more detailed quarterly and monthly updates received by the Trust Board (for example the monthly Quality and Performance Report, the quarterly R&D update and the quarterly Organisational Development Plan Priorities Update Report).

2. NHS Trust Development Authority Accountability Framework

2013/14 is the first year that the development and delivery of provider (i.e. trust) plans has been overseen by the NHS Trust Development Authority (NTDA).

In early April 2013 the NTDA published the *Delivering High Quality Care for Patients: The Accountability Framework for NHS Trust Boards.* The Accountability Framework sets out five different categories by which Trusts are defined, depending on key quality, delivery and finance standards.

The five categories are:

1) No identified concerns
2) Emerging concerns
3) Concerns requiring investigation
4) Material issue
5) Formal action required

As a consequence of our poor financial and emergency performance during 2013/14, UHL falls within the material issue escalation category along with 10 other trusts in the Midlands and East regions.

A copy of the full NTDA report 'Winter report: NHS Trust Performance Report August 2013 – January 2014' can be found on the NTDA website here:
http://www.ntda.nhs.uk/wp-content/uploads/2014/03/winter_report_web-FINAL.pdf

3. High Level Overview

The 2013/13 Annual Operating Plan was based on four common themes that we know must be addressed through the planning process if UHL is going to be safe and sustainable.

These themes are:

- the emergency process
- clinical and financial sustainability
- delivering quality
- securing clinical reconfiguration.

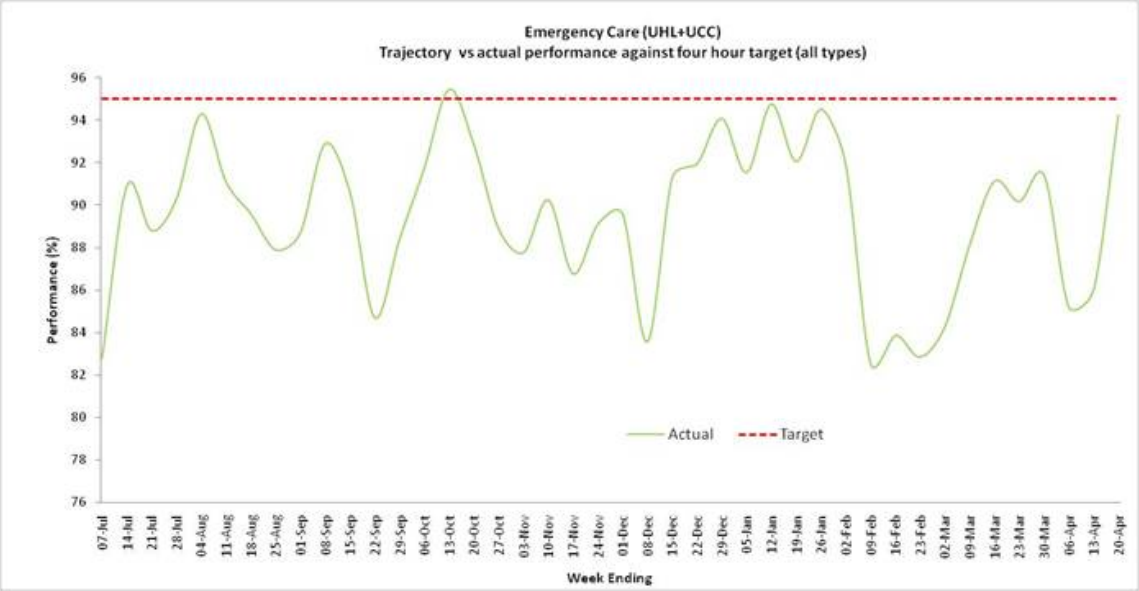
3.1 Emergency process

The 2013/2014 year end performance for the ED 4 hour target was 88.4%.

The Trust continues to struggle with high numbers of emergency admissions and a fixed bed base. Adult emergency admissions have increased by 12.4% from Q4 2012/13 to Q4 2013/14. In order to meet the demand for emergency beds the Trust is finalising plans to increase beds by 55 and ring fence elective capacity.

The improvement plan to streamline the emergency process is continuing with additional action now focussed on 3 key areas:

- reducing admissions
- improving flow
- expediting discharges

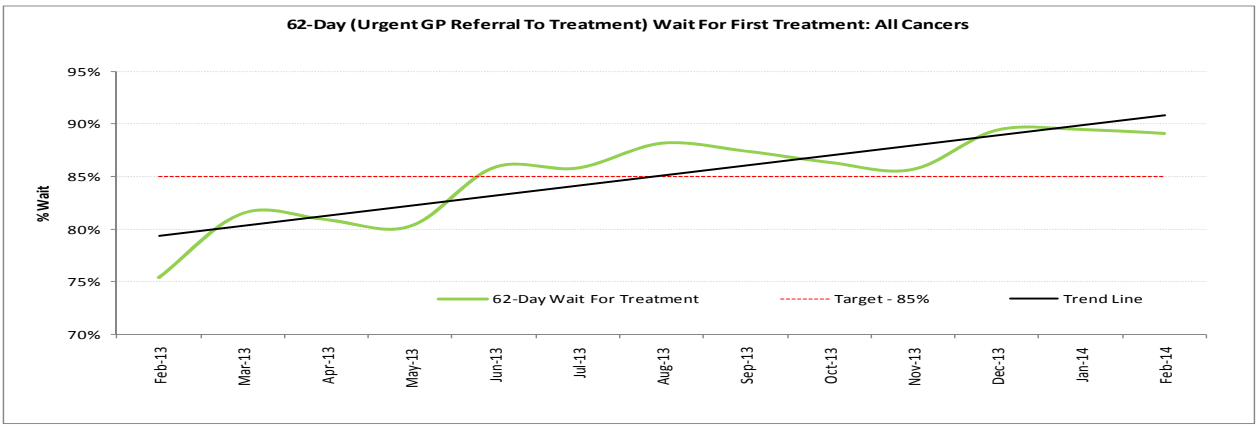


3.2 Clinical and Financial Sustainability

3.2.1 Performance

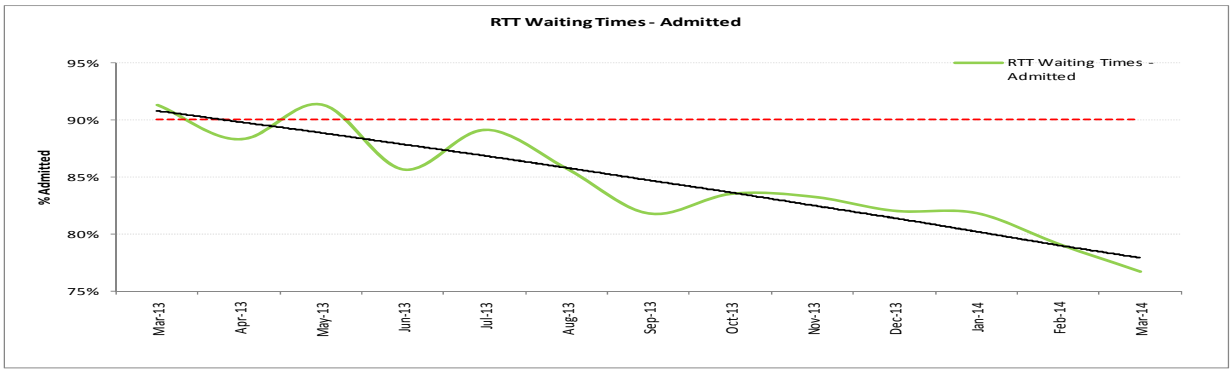
The Trust has made the following progress with key performance targets:

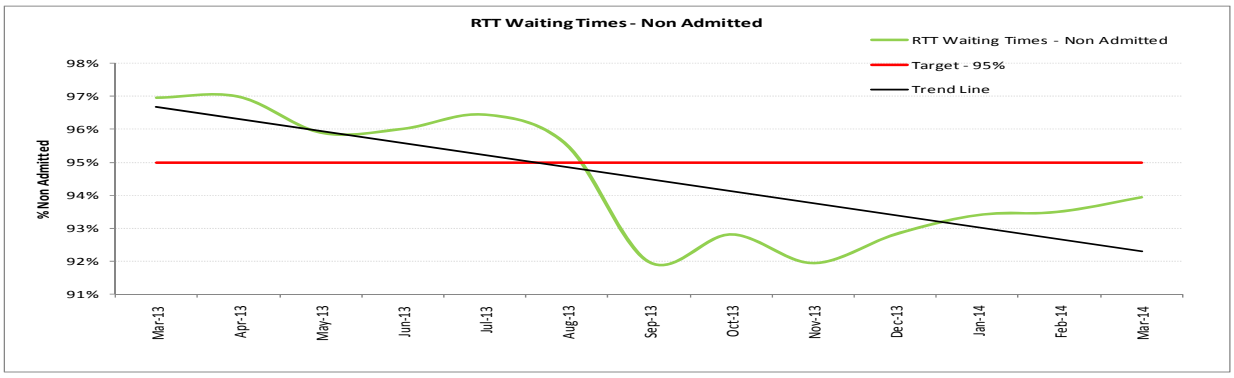
Cancer targets: The Trust has continued to make excellent progress with the cancer target, improving waiting times, patient experience and clinical outcomes. It received full achievement of all the main targets including the 62 day cancer with performance for year-end performance at 86.2%.



Stroke compliance: The Trusts compliance has improved as a result of ring-fencing the stroke beds with the percentage of stoke patients spending 90% of their stay on a stroke ward year target is 80%, with year-end performance at 83.1%.

Referral to Treatment Time: A plan has been agreed with commissioners but not signed off at present due to a dispute regarding penalties. Trust level compliance for non-admitted performance is expected by August 2014 and compliance for admitted performance is expected by November 2014.





Cancelled Operations: The target percentage for operations cancelled on/after the day (for non-clinical reasons) is 0.8% against the year-end performance of 1.6%.

3.2.3 Financial performance

The Trust has not delivered its planned surplus and has not met its breakeven duty. It has delivered the revised year end forecast deficit of £39.8m.

	March 2014			April - March 2014		
	Plan £m	Actual £m	Var (Adv) / Fav £m	Plan £m	Actual £m	Var (Adv) / Fav £m
Income						
Patient income	53.9	58.5	4.6	634.2	659.1	24.9
Teaching, R&D	6.0	5.0	(1.0)	73.6	70.2	(3.4)
Other operating Income	3.1	5.6	2.5	38.2	40.7	2.5
Total Income	**63.1**	**69.1**	**6.0**	**746.0**	**770.0**	**24.0**
Operating expenditure						
Pay	37.1	41.1	(4.0)	447.6	474.2	(26.6)
Non-pay	23.0	26.6	(3.6)	274.7	294.0	(19.3)
Reserves	(2.1)	-	(2.1)	(24.1)	-	(24.1)
Total Operating Expenditure	**58.1**	**67.7**	**(9.7)**	**698.2**	**768.2**	**(69.9)**
EBITDA	**5.0**	**1.4**	**(3.6)**	**47.7**	**1.8**	**(45.9)**
Net interest	-	-	-	0.0	0.0	0.0
Depreciation	(2.7)	(2.4)	0.3	(32.5)	(31.0)	1.5
PDC dividend payable	(1.0)	(0.4)	0.6	(11.6)	(10.7)	0.9
Net deficit	**1.3**	**(1.4)**	**(2.7)**	**3.7**	**(39.8)**	**(43.5)**
EBITDA %		**2.0%**			**0.2%**	

3.3 Delivering Quality

3.3.1 Delivering our Quality Commitment

The Trust Board has approved a refreshed Quality Commitment which reflects the CQC report, NTDA guidance and local and national priorities. The High level aims are:

- Provide Effective Care – Improve Patient Outcomes
- Improve Safety – Reduce Harm
- Care and Compassion – Improve Patient Experience (LiA Nursing into Action)

The final CQC Inspection Report (from their visit in January 2014) is encouraging, especially around caring staff, leadership and direction of travel.

3.3.2 2013/14 Achievement against key targets

- CQUIN: The Trust achieved full compliance with all its targets.
- Infection rates: Results for 2013/14 show outstanding result on infection rates and is one of a small number of trusts to hit the CDiff target. Only 1 MRSA recorded.
- Falls and Pressure Ulcers: We have continued to see a reduction in pressure ulcers and falls as a consequence of the concerted efforts of our nursing team.
- Safety: Never Events halved to 3.

3.3.2 Quality Outcomes

The quality outcomes data for the year has ended in a positive position.

Successes	Target	2012 /13	Apr 13	May 13	June 13	Jul 13	Aug 13	Sept 13	Oct 13	Nov 13	Dec 13	Jan 14	Feb 14	Mar 14	YTD
C-section rates	25%	23.9%	23.8%	26.1%	26.1%	25.0%	25.2%	24.6%	25.6%	27.5%	25.2%	23.9%	25.5%	24.3%	25.2%
VTE risk assessment	95%	94.5%	94.1%	94.5%	93.1%	95.9%	95.2%	95.4%	95.5%	96.7%	96.1%	95.6%	95.0%	95.6%	95.3%
Avoidable pressure ulcers (grade 3 & 4)	<8 per month	98	10	4	8	7	8	5	5	4	5	7	3	6	72
Friends & Family Test		64.5	66.4	73.9	64.9	66.0	69.6	67.6	66.2	70.3	68.7	71.8	69.0	69.9	

3.4 Securing Clinical Reconfiguration

A £1.6m reception area for patients having surgery at Royal Infirmary was officially opened on 26 March. The project, which started in May 2013, has been completed in three phases over the last ten months. The Theatre Arrivals Area, staff changing rooms and sterile services hub were all relocated and refurbished to create a more up to date, functional space for patients and theatre staff.

A newly reconfigured and refurbished Surgical Triage Unit has been completed on Ward 8 at the Royal. It is intended that this new facility will enhance the patient experience and provide senior decision making at the beginning of the patient process by providing:

- a new waiting area with reception facilities
- two new consultation rooms with storage areas
- a new disabled access WC
- refurbished staff rest room in order to provide a doctors' office on Ward 8.

Our commissioners have supported the increase in capacity of our critical care beds and a capital scheme has been approved. The work involves the reconfiguration and enhancement of the existing entrance corridor and ancillary areas to the ITU department together with the creation of three additional ITU bed spaces. Interserve Construction started the first phase of the work on 17th March 2014 and completion is expected by 4th August 2014.

4. Objectives for 2014/15 - What we need to improve?

Our priorities for 2014/15 will need to focus heavily on:

- 4-hour performance
- RTT (18 weeks)
- Cancelled operations
- Finance

5. Recommendations

The Trust Board is asked to:

RECEIVE this report

NOTE the progress against Q4 delivery of our Annual Operational Plan.